

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administered pain medication as ordered by physician for 1 (R1) of 3 residents reviewed for pain in a sample of 11. This failure resulted in R1 experiencing unrelieved pain and having been sent to the local hospital for pain management. Findings Include: R1's admission Record documented an admission date of 6/9/2026 with the following diagnoses including anxiety disorder, unspecified, chronic kidney disease, unspecified, depression, unspecified, complete traumatic amputation of two or more left lesser toes, subsequent encounter and diabetes mellitus with other skin complications. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Mental Interview Score (BIMS) of 15 indicating that R1 is cognitively intact. Under section M1040 Wounds and Skin problems documented R1 had a surgical wound. Under section J0100: Received scheduled pain medication regimen documented Yes and section J0530 Pain Interference with day-to-day activities documented occasionally. R1's Care Plan documented a focus area of pain with no date initiated that included interventions of anticipating the resident's need for pain relief and respond immediately to any complaint of pain. R1's Physician Order Summary documented Oxycodone 5 Milligram (MG) tablet. Give 2 tablets every 4 hours as needed for pain with a start date of 6/9/2026. R1's Hospital Discharge summary dated [DATE] documented diagnoses including acute 1. osteomyelitis of right ankle or foot, 2. Chronic foot ulcer with fat layer exposed, left. 5. osteomyelitis of great toe of right foot. This same document had an Operative Note by V15 (Doctor of Podiatric Medicine) documented under procedure: right foot incision and drainage, right foot ulceration debridement to bone, and right foot bone biopsy with date of service of 5/29/2026. with findings of necrotic tissue. R1's Progress Note dated 6/9/2026 at 12:22 PM by V3 (Licensed Practical Nurse /LPN) documented R1 arrived at the facility via hospital transport. is non weight bearing related to right foot wound. On 7/7/2026 at 9:47 AM R1 stated, she had been at a previous facility before being placed at this facility. R1 stated, she had been in the out-of-town hospital related to an amputation of her right foot and infection. R1 stated, she was discharged from the out-of-town hospital to this facility on 6/9/2026. R1 stated, she had not been given her pain medication for about 3 to 4 days as ordered and/or when requested. R1 stated, she had been discharged from the hospital with pain medication of Oxycodone 5 milligrams (MG) 2 tablets every 4 hours as needed related to her pain from a surgical amputation to her right foot. R1 stated, when she would ask the nursing staff why she was not able to get her Oxycodone they would tell her that it was the pharmacy's fault for not having her medication available. R1 stated, on 6/12/2026 the pain from her surgery on the right foot was so bad she requested to be sent to the local emergency room so she could receive some pain medication. R1 stated, she was very upset that she could not get her pain medication and was vomiting and hurting. R1 stated, my foot was amputated, that causes pain. On 7/7/2026 at 10:51 AM V3 (Licensed Practical Nurse/LPN) stated, R1 did admit to the facility on 6/9/2026 from an out-of-town hospital post (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146131
		If continuation sheet Page 1 of 10

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F 0697 Level of Harm - Actual harm Residents Affected - Few	amputation of the right foot. V3 stated, R1 did arrive sometime in the afternoon with hard scripts from the hospital that were faxed over to pharmacy and included Oxycodone 5 MG, 2 tablets by mouth every 4 hours as needed for pain. V3 stated, there had been some issues with the prescriptions because the hospital had placed the wrong facility name on the scripts and V2 (Director of Nursing/DON) worked on getting this corrected. V3 stated, she did give R1 Oxycodone 5 MG 2 tablets by mouth on 6/9/2026 at 4:37 PM from the emergency kit for pain. On 7/8/2026 at 9:23 AM V5 (Registered Nurse/RN) stated, R1 did admit to the facility from the hospital related to an amputation of right foot on 6/9/2026. V5 stated, there had been issues with R1's Oxycodone 5 MG 2 tablets every 4 hours as needed for pain arriving from the pharmacy to the facility in a timely manner. V5 stated, R1 did get sent out via ambulance to the local hospital on 6/12/2026 for pain management because she had not been able to receive her pain medication as ordered since admitting to the facility. On 7/8/2026 at 9:57 AM V6 (LPN) stated, R1 had been admitted to the facility from the hospital related to an amputation of the right foot on 6/9/2026. V6 stated, her first interaction with R1 had been on 6/11/2026 in the morning when she started her shift. V6 stated, R1 had requested her pain medication of Oxycodone 5 MG 2 tablets every 4 hours as needed related to her pain. V6 stated, when she went to pull the medication, it was not available in the facility. V6 stated, she explained to R1 that she would call the pharmacy to figure out why her medication still was not in the facility. V6 stated, she called the pharmacy, and unknown pharmacist told her that R1's script was not valid. V6 stated, V9 (RN) took over from their and resent the script to the pharmacy. V6 stated, about 15 minutes later, the pharmacy told V9 that the medicine was on its way but then again returned a call sometime later and said the script was not valid. V6 stated, she could not pull the medication from the emergency kit because R1 had to have a valid script on file with pharmacy or the pharmacist must confirm with a physician over the phone. V6 stated, she does not know what happened after that because she left for the day. On 7/8/2026 at 10:17 AM V2 (Director of Nursing/DON) stated, R1 had been admitted to the facility from the hospital related to an amputation of the right foot on 6/9/2026. V2 stated, the facility had issues obtaining R1's pain medication of Oxycodone 5 MG 2 tablets every 4 hours as needed related to her pain. V2 stated, R1 did arrive at the facility in the afternoon with hard scripts from the hospital for medications. V2 stated, all scripts were faxed to the pharmacy. V2 stated, R1's pain medication was able to be pulled from the emergency kit on 6/9/2026 at 4:37 PM by V3 (LPN). V2 stated, R1 did not get her Oxycodone as ordered from 6/9/2026 after 4:37 PM until 6/11/2026 at 5:57 PM when the facility had access to the medicine in the emergency kit for a one-time dose, again. V2 stated, on the morning of 6/12/2026, R1 had been sent to the local emergency room via ambulance for pain management. V2 stated, R1 did not receive her prescribed pain medication as ordered. On 7/8/2026 at 10:53 AM V8 (Nurse Practitioner/NP) stated, R1 did admit to the facility on 6/9/2026 from a hospital related to an amputation of the right foot. V8 stated, she is aware that R1 was unable to get her prescribed pain medication of Oxycodone 5 MG 2 tablets by mouth every 4 hours as needed for pain. V8 stated, it was her understanding that there were issues with the pharmacy delivering R1's pain medication to the facility which caused missed doses of her pain medication. V8 stated, she did give an order for R1 to be sent to the local hospital for pain management on 6/12/2026. On 7/8/2026 at 12:21 PM V7 (Director of Clinical Services) stated, the pharmacy does not document any notes on interactions with the facility. V7 stated, the pharmacist might have documented on the script, but she would have to look at the script to see if anything was documented. V7 stated, the facility did receive a refill for the emergency kit on 6/11/2026 but it was probably enough for 1 dose because that was the minimum amount set for Oxycodone. On 7/8/2026 at 12:49 PM V1 (Administrator) stated, R1 did admit to the facility on 6/9/2026. V1 stated, she was not aware of what had happened prior to (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer antianxiety medication, administer sliding scale insulin and monitor blood sugars as directed per physician orders for 2 (R1, R2) of 3 residents reviewed for medication administration in the sample of 11. This failure resulted in R1 being sent to the emergency room for chest pain. Findings include:1.R1's admission Record documented an admission date of 6/9/2026 with the following diagnoses including anxiety disorder, unspecified, chronic kidney disease, unspecified, depression, unspecified, complete traumatic amputation of two or more left lesser toes, subsequent encounter and diabetes mellitus with other skin complications. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Mental Interview Score (BIMS) of 15 indicating that R1 is cognitively intact. This same document under Active Diagnoses: (I5700)Psychiatric/Mood Disorder: is marked with R1 having an anxiety disorder. R1's Care plan documented a focus area of a mood problem with no date initiated with an intervention to administer medication as ordered. R1's Physician Order Summary documented Lorazepam 1 MG. Give 1 tablet by mouth every 8 hours as needed for anxiety with a start date of 6/9/2026. On 7/7/2026 at 9:47 AM R1 stated, sometime last week around 6/29/2026 for about 3-4 days she did not receive her Lorazepam 1 MG every 8 hours as ordered. R1 stated, she was given the last dose on 6/28/2026 before the nursing staff had placed a refill. R1 stated, she went 3-4 days without her Lorazepam and went to the hospital for her anxiousness on 7/1/2026. R1 stated, the nursing staff notified her that the pharmacy had not delivered her Lorazepam prescription. R1 stated, without her Lorazepam she had become aggressive, upset, anxious and started having chest pain. R1 stated, she did receive Lorazepam at the local hospital then returned to the facility. R1 stated, anytime she asked staff why she was unable to get her medications the answer was always it was the pharmacy's fault. On 7/8/2026 at 9:23 AM V5 (Registered Nurse/RN) stated, he did work on 7/1/2026 when R1 had been sent out to the local hospital for complaints of chest pain. V5 stated, it could have been related to her not having her lorazepam for a few days, because they had been without her medications before. On 7/8/2026 at 10:17 AM V2 (Director of Nursing/DON) stated, R1 did go without her Lorazepam 1 MG tablet by mouth every 8 hours as needed for anxiety starting 6/29/2026 through 7/1/2026 because the pharmacy had not delivered her medication to the facility and did not have any available in the emergency kit. V2 stated, R1 did go to the local emergency room via ambulance on 7/1/2026 related to anxiety symptoms and chest pain. V2 stated, R1's Lorazepam had been delivered to the facility on 7/1/2026. V2 stated, there is no documentation in R1's EHR that she had been out of her Lorazepam or that she had been sent to the local emergency room, however, there is a note that she took meds in emergency room. On 7/8/2026 at 10:53 AM V8 (Nurse Practitioner/NP) stated, she is aware that R1 had been without her Lorazepam 1 MG tablet every 8 hours by mouth for anxiety from 6/29/2026 until 7/1/2026. V8 stated, she did give an order for R1 to be sent to the local hospital via ambulance related to chest pain. V8 stated, it was her understanding that R1's Lorazepam was not available in the facility and there had not been any in the emergency kit to pull from. On 7/8/2026 at 1:47 PM V9 (RN) stated, R1 had run out of her Lorazepam 1 MG by mouth every 8 hours as needed on 6/29/2026 through 7/1/2026. V9 stated, she arrived at work on 7/1/2026 with R1 requesting her Lorazepam and notifying her that she had not had it in a few days. V9 stated, R1 was aggressive, yelling at staff, then started to complain of chest pain. V9 stated, R1 was sent to the local emergency room via ambulance for further evaluation. V9 stated, when she contacted the pharmacy about R1's Lorazepam 1 MG refill, she said the pharmacist told her that it was sent the night before on 6/30/2026. V9 stated, she is not (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	sure what happened but later found out that the Lorazepam supply was missed being delivered on 6/30/2026 by driver. V9 stated, there was no Lorazepam to pull from the emergency kit either. R1's local hospital Nurse's Notes dated 7/1/2026 at 9:10 AM documented under Presentation: R1 complaint of nursing home out of her lorazepam so she is having chest pain. Has not had a dose in 3 days. Documented under Triage Assessment: General: R1 appears uncomfortable. Cardiovascular: reports R1 stated having chest pain but believes its due to the fact that the nursing home ran out of Lorazepam and she is supposed to be taking it 3 times a day. R1 stated her chest pain is the same she gets when she has anxiety attacks. R1's local hospital Physician Documentation dated 7/1/2026 at 12:30 PM documented under History of Present Illness (HPI): R1 is transported to the emergency department via ambulance for local skilled nursing facility (SNF). R1 states that she has not had her anxiety mediations (Lorazepam) for several days because the SNF has run out. R1's Administration Note dated 7/1/2026 at 1:16 PM by V5 (RN) documented Gabapentin Oral 100 MG. Give 2 tablets by mouth three times a day for pain. Medication given at local emergency room. R1's Medication Administration Record dated June 2026 documented no record of Lorazepam 1 MG by mouth every 8 hours as needed for anxiety on 6/29/2026 and 6/30/2026. 2. R2's admission Record documented an admission date of 9/17/2025 with the following diagnoses including type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease, unspecified, other recurrent depressive disorders, anxiety disorder and insomnia, unspecified. R2's Minimum Data Set (MDS) dated [DATE] documented a Brief Mental Interview Score (BIMS) of 15 indicating that R1 is cognitively intact. This same document under Active Diagnoses: I2900 Diabetes Mellitus marked with R2 having. R2's Care Plan documented a focus area of diabetes: actual/at risk and/or potential for complications with diabetes. Concern of insulin dependent-daily and/or sliding scale with a date initiated of 10/14/2025 with an intervention of finger-stick blood sugar as ordered/accepted. R2's Physician Orders documented Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 201 - 250 = 4u; 251 - 300 = 6u; 301 - 350 = 8u; 351 - 400 = 10u; 401+ Notify MD, subcutaneously before meals and at bedtime for diabetes with a start date of 12/24/2025. On 7/8/2026 at 10:17 AM V2 (DON) stated, she had been notified by V4 (RN) on 6/29/2026 around 7:00 PM that the facility had run out of glucometer strips and they did not have any in the building to use. V2 stated, she did go to the local store to purchase glucometer strips and brought them to the facility around 8:30 PM. V2 stated, when she arrived at the facility with the strips the strips would not work in the glucometer. V2 stated, she ended up buying a new glucometer with strips the next morning and bringing them to the facility. V2 stated, the facility did not have glucometer strips on 6/29/2026 at 7:00 PM until 6/30/2026 in the am. V2 stated, R2 was not able to get her blood sugar monitored the night of 6/29/2026 and did not receive her sliding scale dose of insulin related to this. V2 stated, V8 (Nurse Practitioner/NP) had been notified but there was no documentation in R2's electronic health record (EHR) of the notification. On 7/8/2026 at 10:53 AM V8 (NP) stated, she had been notified by the facility that they had run out of glucometer strips on 6/29/2026 and R2 would not be receiving her sliding scale insulin order. V8 stated, it is her expectation that the facility has resident's medications and supplies on hand. On 7/8/2026 at 1:47 PM V9 (RN) stated, she was aware that the facility did not have any glucometer strips on 6/29/2026. V9 stated, V2 reached out to her around 7:00 PM to see if she could go to the local store and purchase some glucometer strips and take them to the facility. V9 stated, she had been out of town and unable to do this so V2 was going to take care of it. V9 stated, the facility did have 3 bottles of glucometer strips on 6/24/2026 when cleaning the supply room. V9 stated, V2 does complete all supply orders for the facility, so she must have missed getting them ordered. R2's Medication Administration Record (MAR) dated June 2026 (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	documented Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 201 - 250 = 4u; 251 - 300 = 6u; 301 - 350 = 8u; 351 - 400 = 10u; 401+ Notify MD, subcutaneously before meals and at bedtime for diabetes with a start date of 12/24/2025 with V13 (RN) documented under Blood Sugar (BS) a reading of 266 at 5:00 PM on 6/29/2026, V4 (RN) documented under BS with a 1 meaning R2 had refused blood glucose monitoring and a 6 meaning see progress note for reason at 8:00 PM on 6/29/2026. R2's blood sugar reading documented by V5 (RN) on 6/30/2026 at 6:00 AM with a reading of 400. No progress note provided by facility of V4 (RN) documenting the reason R2 did not receive her sliding scale dose on 6/29/2026 as referenced on R2's MAR June 2026. V4 (RN) did not return any calls during this survey from 7/7/2026 to 7/9/2026. On 7/8/2026 at 12:49 PM V1 (Administrator) stated, she did not know until today that R1 had been out of her Lorazepam from 6/29/2026 through 7/1/2026 but did know she had gone to the local emergency room on 7/1/2026. V1 stated, she was not aware the facility had been without glucometer strips on 6/29/2026 causing R2 not to be able to receive her insulin dose as prescribed. V1 stated, it is her expectation that the facility has resident's medication and supplies on hand and available in a timely manner. On 7/9/2026 at 1:02 PM V11 (Medical Director) stated, he had not been notified of R1 being without her Lorazepam 1 MG tablet from 6/29/2026 to 7/1/2026 and being sent to the local emergency room or that the facility did not have blood glucose strips to complete glucose monitoring for R2 and not receiving her insulin. V11 stated, he does agree that the facility should be able to have access to residents' medication and supplies in a timely manner. The facility's Pharmacy Name Policy and Procedure (dated 5/2024) documented under Section 5.1 Drug Administration - General Guidelines. Procedure: 2. Medications are administered in accordance with written orders of the attending physician. If an unusual dose is ordered, considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition; the physician is contacted for clarification prior to the administration of the medication. The pharmacist is also available for consultation for drug therapy concerns or questions. This interaction with the physician is documented in the nursing notes and elsewhere in the medical records as appropriate.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were available as ordered by the physician for 1 (R1) of 3 residents reviewed for pharmacy services in the sample of 11. Findings include: R1's admission Record documented an admission date of 6/9/2026 with the following diagnosis including anxiety disorder, unspecified, chronic kidney disease, unspecified, depression, unspecified, complete traumatic amputation of two or more left lesser toes, subsequent encounter and diabetes mellitus with other skin complications. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Mental Interview Score (BIMS) of 15 indicating that R1 is cognitively intact. R1's Physician Order Summary documented Oxycodone 5 Milligram (MG) tablet. Give 2 tablets every 4 hours as needed for pain and Lorazepam 1 MG. Give 1 tablet by mouth every 8 hours as needed for anxiety with a start date of 6/9/2026. On 7/7/2026 at 9:47 AM R1 stated, she had been discharged from an out-of-town hospital to this facility on 6/9/2026. R1 stated, she had not been given her pain medication for about 3 to 4 days as ordered and/or when requested. R1 stated, she had been discharged from the hospital with pain medication of Oxycodone 5 milligrams (MG) 2 tablets every 4 hours as needed related to her pain from a surgical amputation to her right foot. R1 stated, when she would ask the nursing staff why she was not able to get her Oxycodone they would tell her that it was the pharmacy's fault for not having her medication available. R1 stated, sometime last week around 6/29/2026 for about 3-4 days she did not receive her Lorazepam 1 MG every 8 hours. R1 stated, she was given the last dose on 6/28/2026 before the nursing staff had placed a refill. R1 stated, the nursing staff notified her that the pharmacy had not delivered her Lorazepam prescription. R1 stated, anytime she asked staff why she was unable to get her medications the answer was always it was the pharmacy's fault. On 7/8/2026 at 9:23 AM V5 (Registered Nurse/RN) stated, R1 did admit to the facility from the hospital related to an amputation of right foot on 6/9/2026. V5 stated, there had been issues with R1's Oxycodone 5 MG 2 tablets every 4 hours as needed for pain arriving from the pharmacy to the facility in a timely manner. V5 stated, the pharmacy did receive R1's script on 6/9/2026 and again on 6/11/2026, however they did not receive the medication until 6/12/2026. V5 stated, the pharmacy had made a delivery with the emergency kit medications of Oxycodone to be replaced on 6/11/2026 but they did not bring R1's stock supply. V5 stated, he had signed for medications that day and explained to the pharmacy that the facility did not receive R1's Oxycodone stock supply and it does come in a separate bag. V5 stated, he does believe later the pharmacy had found the medication in the driver's car and it had been missed being brought into the facility on 6/11/2026. V5 stated, he did work on 7/1/2026 when R1 had been sent out to the local hospital for complaints of chest pain. V5 stated, it could have been related to her not having her lorazepam for a few days, because they had been without her medications before. On 7/8/2026 at 9:57 AM V6 stated, R1 had requested her pain medication of Oxycodone 5 MG 2 tablets every 4 hours as needed related to her pain. V6 stated, when she went to pull the medication, it was not available in the facility. V6 stated, she explained to R1 that she would call the pharmacy to figure out why her medication still was not in the facility. V6 stated, she called the pharmacy, and unknown pharmacist told her that R1's script was not valid. V6 stated, V9 (RN) took over from their and resent the script to the pharmacy. V6 stated, about 15 minutes later, the pharmacy told V9 that the medicine was on its way but then again returned a call and said the script was not valid. V6 stated, she could not pull the medication from the emergency kit because R1 had to have a valid script on file with pharmacy or the pharmacist must (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirm with a physician over the phone. V6 stated, she does not know what happened after that because she left for the day. V6 stated, there have been issues with getting medications to the facility by the pharmacy. V6 stated, this is a new pharmacy for the facility as of 6/1/2026 and it is located out of state. On 7/8/2026 at 10:17 AM V2 (Director of Nursing/DON) stated, V2 stated, the facility had issues obtaining R1's pain medication of Oxycodone 5 MG 2 tablets every 4 hours as needed related to her pain. V2 stated, R1 did go without her Lorazepam 1 MG tablet by mouth every 8 hours as needed for anxiety starting 6/29/2026 through 7/1/2026 because the pharmacy had not delivered her medication to the facility and did not have any available in the emergency kit. V2 stated, R1 did go to the local emergency room via ambulance on 7/1/2026 related to anxiety symptoms and chest pain but no documentation was made in R1's electronic health record. V2 stated, V11 ([NAME] Director) physician group does not have electronic signatures set up and the local retail pharmacies will not accept controlled substance scripts without it. On 7/8/2026 at 10:53 AM V8 (NP) stated, she is aware that R1 was unable to get her prescribed pain medication of Oxycodone 5 MG 2 tablets by mouth every 4 hours as needed for pain. V8 stated, it was her understanding that there were issues with the pharmacy delivering R1's pain medication to the facility which caused missed doses of her pain medication. V8 stated, she is aware that R1 had been without her Lorazepam 1 MG tablet every 8 hours by mouth for anxiety from 6/29/2026 until 7/1/2026. V8 stated, it was her understanding that R1's Lorazepam was not available in the facility and there had not been any in the emergency kit to pull from. V8 stated, she is aware that there are ongoing issues with the new pharmacy on getting resident's medication and supplies to the facility in a timely manner. V8 stated, it is her expectation that the facility has resident's medications and supplies on hand. On 7/8/2026 at 12:49 PM V1 (Administrator) stated, she was not aware of what had happened prior to 6/11/2026 when she returned to the facility from being off. V1 stated, she had been made aware on 6/11/2026 that there had been problems with the new pharmacy and R1's pain medication. V1 stated, she did not know until today that R1 had been out of her Lorazepam from 6/29/2026 through 7/1/2026. V1 stated, V11 ([NAME] Director) physician group does not have electronic signatures set up and the local retail pharmacies will not accept controlled substance scripts without it. V1 stated, there is still on-going issues with the pharmacy delivering medications in a timely manner to the facility. V1 stated, it is her expectations that the facility has residents' medication available in a timely manner. On 7/8/2026 at 1:47 PM V9 (RN) stated, the facility started with a new pharmacy company on 6/1/2026 and there have been issues with getting medications delivered to the facility timely. V9 stated, R1 had not gotten her pain medication since her dose on 6/9/2026 and had requested her pain medication V9 stated, she did contact the pharmacy to follow up on why R1's pain medication had not been received by the facility. V9 stated, she was told by a pharmacist that the R1's Oxycodone 5 MG had been dispensed and sent the evening of 6/9/2026. V9 stated, I explained to the pharmacist that the facility still had not received R1's pain medication at this time. V9 stated, the pharmacist was supposed to return a call back to her with more information but did not. V9 stated, she still had not received any update from the pharmacy, hours later, so she notified V2 (DON). V9 stated, V2 contacted the pharmacy company to follow up as well but not sure where things ended from that call. V9 stated, any time she had called the pharmacy she would be transferred to different areas in different states and then put on hold while the pharmacist attempts to verify what is going on with another pharmacist in another state. V9 stated, she did attempt to pull the Oxycodone 5 MG 2 tablets from the emergency kit on 6/11/2026 at 10:16 and 10:17 AM, but the count was off and there was no Oxycodone in the emergency kit. V9 stated, R1 had run out of her Lorazepam 1 MG by mouth every 8 hours as needed on 6/29/2026 through 7/1/2026. V9 stated, she arrived at work on 7/1/2026 with R1 requesting her (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam and notifying her that she had not had it in a few days. V9 stated, when she contacted the pharmacy about R1's Lorazepam 1 MG refill, she said the pharmacist told her that it was sent the night before on 6/30/2026. V9 stated, she is not sure what happened but later found out that the Lorazepam supply had missed being delivered on 6/30/2026 by driver. V9 stated, there was no Lorazepam to pull from the emergency kit either. V9 stated, she feels the pharmacy has too many stops and exchanges of medication with drivers prior to getting the residents medication to the facility.V10's (Director of Pharmacies) electronic mail dated 6/12/2026 at 1:11 PM documented.So many fails, expected and unexpected, occurred, and I take full responsibility for them.the medication from the pharmacy was originally delayed due to the tornadoes and storms last night in and around Illinois.because this medication is a scheduled II narcotic, we cannot just send it back up like we would a furosemide order. We need to have the doctor send a new script to the retail pharmacy and have it filled that way.In hindsight, I should have had this medication sent stat yesterday after the original fiasco occurred with only having a paper signature and no medication, which I sincerely apologize for.R1's Progress Note dated 6/12/2026 at 10:58 AM by V13 (RN) documented R1 complained of significant pain related to foot amputation. Unable to receive oxycodone due to pharmacy issues.R1's Progress Notes dated 6/10/2026 at 12:16 AM by V4 (Registered Nurse/RN) documented R1 had been requesting as needed oxycodone 5mg 2 tabs .V4 contacted pharmacy on call and was notified that the max amount that could have been pulled from the emergency kit was administered on dayshift by V3 (LPN) and there was no more available to pull.R1 notified and was noted to be upset about the situation.R1's local hospital Nurse's Notes dated 7/1/2026 at 9:10 AM documented under Presentation: R1 complaint of nursing home out of her lorazepam so she is having chest pain. Has not had a dose in 3 days.R1's local hospital Physician Documentation dated 7/1/2026 at 12:30 PM documented under History of Present Illness (HPI): R1 is transported to the emergency department via ambulance for local skilled nursing facility (SNF). R1 states that she has not had her anxiety mediations (Lorazepam) for several days because the SNF has run out.R1's Medication Administration Record (MAR) dated June 2026 documented an order for Oxycodone HCL Oral tablet 5 MG , Give 2 tablets by mouth every 4 hours as needed for pain with a start date of 6/9/26. R1's MAR document R1 receiving a dose 6/9/2026 at 4:37 PM by V3 (LPN) and did not receive another dose until 6/11/2026 at 5:57 PM by V5 (RN). R1's MAR documented and order for Lorazepam 1 MG by mouth every 8 hours as needed for anxiety with a start date of 6/9/26. R1's MAR does not document R1 received any doses on 6/29/2026 and 6/30/2026. The facility's Pharmacy Name Policy and Procedure (dated 5/2024) documented under Section 5.1 Drug Administration - General Guidelines.Procedure: 2. Medications are administered in accordance with written orders of the attending physician. If an unusual dose is ordered, considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition; the physician is contacted for clarification prior to the administration of the medication. The pharmacist is also available for consultation for drug therapy concerns or questions. This interaction with the physician is documented in the nursing notes and elsewhere in the medical records as appropriate.		