STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001770	A. BUILDING: _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CISNE REHABILITATION & HEALTH CENTER	107 NORTH WATKINS STREET CISNE, IL 62823

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S 000	Initial Comments Facility Reported Incident of November 18, 2023/IL167273	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirments were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's wheelchair had foot rests in place when transporting a resident for 1 (R1) of 3 residents reviewed for accidents in a sample of 3. This failure resulted in R1 falling forward out of the wheelchair, sustaining a head laceration requiring R1 to be transferred to the hospital, and receiving sutures to close the wound. Findings include: 1. R1's face sheet documented an admission date of 11/14/23. R1's Cumulative Diagnosis Log documented diagnoses including: anemia, osteoarthritis, basal cell carcinoma of lower lip, history of falls, obesity, Parkinson's disease, history of stroke, dementia, intraventricular hemorrhage. R1's 11/18/23 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. R1's 11/18/23 MDS documented R1 used a wheelchair with supervision and touching assistance. R1's 11/17/23 Activities of Daily Living (ADL) Plan of Care documented identified safety risks of: poor safety awareness, fall history, gait, and balance. R1's 11/15/23 Physical Therapy Plan of Care	S9999		

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S9999	Continued From page 2 documented in part " ...being referred to skilled therapy due to recent hospitalization with diagnosis of intraventricular hemorrhage with significant decline in mobility. Patient is requiring increased time and cueing due to difficulty following commands ... due to weakness continues to require extensive assistance ... " On 12/7/23 at 11:26 AM, V3 (Certified Nursing Assistant/ CNA) said on 11/18/23 R1 was sitting in his wheelchair ambulating around the dining room. V3 said R1 was starting to get fidgety, and she was going to assist R1 to the nurse's station. V3 said she was pushing R1 down the hall in his wheelchair with no foot pedals present when R1 put his feet down and fell forward out of his wheelchair onto the floor. V3 said R1 was wearing a new pair of house shoes that had a good amount of grip. V3 said she called for a nurse to assess R1. V3 said R1 had a laceration to his forehead and was sent to the hospital. V3 said 11/18/23 was the first time she had cared for R1 and was not familiar with his needs. V3 said R1 was hard to understand and was not sure R1 could follow commands. On 12/7/23 at 12:40 PM, V10 (Registered Nurse/ RN) said on 11/18/23 she was standing at the nurse's station giving change of shift report when she heard a commotion in the hall. V10 said she found R1 to be lying in the floor in the hallway. V10 said she assessed R1 and found a laceration to R1's forehead. V10 said R1's forehead laceration was bleeding so she cleaned it with a washcloth and applied pressure. V10 said Emergency Medical Services (EMS) were called and R1 was transported to the hospital. V10 said if a resident does not propel themselves in the wheelchair they should have foot pedals on the wheelchair. V10 said R1 was propelling himself	S9999		

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S9999	Continued From page 3 around the facility earlier in the day and was seen abruptly stopping his wheelchair with his feet and grabbing the hand rails. On 12/7/23 at 11:37 AM, V4 (Physical Therapy Assistant) said she had evaluated R1. V4 said R1 was able to propel himself in his wheelchair. V4 said R1 sometimes was able to follow commands. V4 said if a resident was able to propel themselves, she would expect staff to remove the foot pedals from the wheelchair. V4 said if staff were propelling a resident she expected the foot pedals to be on the wheelchair. On 12/7/23 at 1:42 PM, V2 (Director of Nursing/ DON) said she had completed the investigation for R1's 11/18/23 fall. V2 said R1 was in the dining room blocking the exit and other residents were trying to get by. V2 said V3 (CNA) was assisting R1 out of the exit when R1 slammed his feet down and fell forward out of his wheelchair. V2 said she had reeducated all staff foot pedals were to be on the wheelchair with the resident's feet on the foot pedals if they are being propelled by staff. V2 said if R1 had foot pedals on his wheelchair on 11/18/23 the fall may not have happened. On 12/7/23 at 1:15 PM, V9 (Licensed Practical Nurse/ LPN) said she had cared for R1 once. V9 said R1 was oriented to self only and was not able to follow directions. R1's 11/18/23 at 6:00 PM Skilled Progress Note documented in part " ...Resident being assisted by CNA (V3) down the hall to the nurses station. Resident abruptly put his feet down which caused him to be propelled forward. Resident landed on the floor. Laceration above (left) eyebrow ... Wash cloth administered to slow bleeding ... 911	S9999		

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S9999	Continued From page 4 called ... resident bound for (hospital) ..." R1's 11/18/23 at 10:30 PM Skilled Progress Note documented in part " ... Brain bleed found via CT (Computerized Tomography) scan. Resident being flown to a larger hospital ..." R1's 11/18/23 hospital record Physician Documentation documented in part " ... reports injury, a laceration, 5 cm (s), complex irregular, ragged, left eyebrow and left eyelid, pain, swelling, tenderness .... Resulted from a fall ... impacting a hard surface ... Pertinent positives: headache, injury. Severity of symptoms: At their worst the symptoms were severe, just prior to arrival ... Wound Repair of 5cm (2.0 inch) subcutaneous laceration to left upper eyelid and left supraordital ridge. Profuse bleeding noted ... Skin closed with 12 4-0 Ethilon using Simple sutures ... (CT scan of head without contrast) ... Impression: Small amount of interventricular hemorrhage (IVH). Recommend clinical correlation follow-up as clinically warranted ...Diagnosis: Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness ... laceration without foreign body of left eyelid and periocular area ..." R1 was then transferred to another hospital for a higher level of care. R1's 11/19/23 Neurosurgery Consult documented in part " ... recent admission to (hospital) 11/7/23 - 11/14/23 with (Intraventricular Hemorrhage) who presented to the hospital after sustaining a fall ... The patient was seen in consultation ... during his recent admission. Findings were non-surgical and patient was advised to hold his (aspirin) for 7 days ... The patient returns to the hospital after sustaining a fall at his nursing home. He has a laceration to his forehead ... CT head was completed redemonstrating blood in the right	S9999		

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S9999	Continued From page 5 lateral ventricle slightly increased in size, thus the reason for neurosurgical consultation ..." R1's 11/19/23 History and Physical documented in part " ... reportedly had a fall at the nursing facility where he resides. He did hit his head ... He was previously on (aspirin) and Plavix, but has been on hold for 2-3 days, per report. Trauma evaluation ... revealed IVH. He has a laceration to the left forehead, sutured ... He was recently admitted to (hospital) after sustaining a fall and found to have IVH. He was evaluated by Neurosurgery, findings were found to be non surgical. He was to hold (aspirin) for 7 days. CT on 11/7/23 with no significant changes and trace amount of layering hemorrhage with the right lateral ventricle persists ..." On 12/8/23 at 11:04 AM, V6 (Neurosurgery Nurse Practitioner) said she had completed the consult for R1 on 11/19/23 after R1 ' s hospital admission. V6 said it would be very difficult to determine if the worsening of the intraventricular hemorrhage was caused by R1 ' s 11/18/23 fall or the use of blood thinners. R1's 11/18/23 Investigation Report for Falls documented in part " ... Root Cause Analysis: Resident's feet went under the (wheelchair) and it caused (R1) to fall out when (R1) put feet down suddenly causing chair to abruptly stop ... What new intervention was implemented to prevent any further falls? (Wheelchair) to have foot pedals be placed and being utilized (at) all (times) while being propelled in (wheelchair) ..." The facility's 11/20/23 QAC Progress Notes documented in part " ... (Interdisciplinary team) discussed (R1) incident (with) significant injury. All documentation reviewed with root cause of fall	S9999		

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S9999	Continued From page 6 determined. Care plan reviewed and updated with new interventions. (Administrator) and DON to continue internal investigation ..." (B)	S9999		