

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Mascoutah Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 201 South 10th Street Mascoutah, IL 62258	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to give resident showers to 3 of 5 residents (R2, R3, R5) reviewed for ADL (Activities of Daily Living) care provided for dependent residents in the sample of 5. Findings Include:1. R2's Face Sheet, undated, documents R2 has a diagnosis, in part, of Quadriplegia.R2's MDS (Minimum Data Set), dated 10/12/25, documents R2 is cognitively intact and is dependent upon staff for showers.R2's Care Plan, dated 6/3/25, documents R2 has an ADL self-care deficit and requires 1-2 assist with showers.R2's Shower Sheets, fails to show any documentation of a shower given/offered from 9/9/25 until 9/22/25 and none documented in 11/2025On 12/2/25 at 10:35 AM, R3 stated they don't have enough CNAs (Certified Nursing Assistant), and when you don't have enough CNAs, you don't get your showers.2. R3's Face Sheet, undated, documents R3 has a diagnosis, in part, of Cerebral Infarction with Hemiparesis/Hemiplegia.R3's MDS, dated [DATE], documents R3 is cognitively intact and requires partial/moderate assist with showers.R3's Care Plan, dated 10/20/21, documents R1 has an ADL self-care performance deficit, requires one staff participation with bathing, and to shower Monday/Thursday on day shift and as needed.R3's Shower Sheets, fails to show any documentation of a shower given/offered from 11/1/25 until 11/12/25 and none documented after 11/19/25.On 12/2/25 at 10:30 AM, R5 stated she is not getting her showers.3. R5's Face Sheet, undated, documents R5 has a diagnosis, in part, of Fibromyalgia and Congestive Heart Failure.R5's MDS, dated [DATE], documents R5 has moderate cognitive impairment and requires set up / clean up assistance with showers.R5's Shower Sheets, fails to show any documentation of a shower given/offered from 10/16/25 until 11/5/25.On 12/4/25 at 8:50 AM, V1, Administrator, stated showers are being given. Some of the residents will be offered a shower on their shower day, refuse and then want it at a different time and they do their best to accommodate. V1 stated she assists with showers. V1 stated V2, DON, interviewed the residents on their preferred date, shift, for showers and made a new shower schedule based on their preferences and it's been working out, it's that some refuse and then want it at a different time, so they might have to wait, but they do get their showers. The Shower Care Policy, dated 11/24/20, documents it is the policy of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues.</p>

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
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