STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146162	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moweaqua Rehab & Hcc	525 South Macon Street Moweaqua, IL 62550

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49492 Based on observation, interview, and record review, the facility failed to ensure a resident had adequate storage for personal belongings and space to accommodate a resident bed for one of three residents residents (R7) reviewed for environment on the sample list of seven. Findings Include: R7's Current Care Plan states R7 is dependent on staff for activities, cognitive stimulation, and social interaction related to impaired mobility, and R7 prefers to not be around others in social settings, with an initiated of 06/02/2024. On 9/30/24 at 11:50 AM, two boxes of R7's personal belongings were in the hallway outside R7's room, with R7's personal pillow laying on top of the boxes, exposed to anyone walking in and out the adjacent entry/exit door. On 9/30/24 at 11:50 AM, R7 stated there is not enough room for her personal belongings in the room, and the staff put her belongings in the hallway. R7 stated anyone can steal her belongings, and R7 would never know. R7 stated this makes her upset that she cannot keep track of her belongings. On 9/30/24 at 11:50 AM, R7 stated staff have to move her bed to close the door, and often times the door hits her bed and jolts her, making her uncomfortable when the staff try to close the door harder. R7 stated there is not enough room for the door to close when the bed is positioned straight. On 9/30/24 at 12:46 PM, V4, Corporate Registered Nurse, confirmed there are two bariatric beds in the room, and there is lack of space for personal belongings. On 9/30/24 at 12:50 PM, V1 confirmed the room cannot accommodate the resident's personal belongings, and R7 has personal belongings in the hallway and the wheelchair across from the room.

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview, and record review, the facility failed to provide bath/showers on a regular basis for three residents (R2,R5,R7) of three residents reviewed for hygiene in a sample list of seven residents. Findings Include: 1. R5's Progress notes document R5 was admitted to the facility 8/29/24. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is cognitively intact and totally dependent for shower or bath. R5's Plan of Care (POC) History for bathing, dated 9/1/24 to 10/1/24, does not document a bath or shower was provided for R5 during that time period. On 10/2/24 at 11:00AM, R5 was observed in a Bariatric bed receiving care. R5 stated, I have not gotten a full bath since I got here. I've not been out of bed. I didn't get up at home for a while either. I'd like to have my feet washed. On 10/1/24 at 2:00 PM, V3, Corporate Registered Nurse (RN), provided one hand written shower sheet that was dated 9/17/24, but stated, This is the only shower or bath I see documented since (R1's) admission. Upon request for a policy regarding Activities of Daily Living (ADLs) or bathing/showering for residents V1, Administrator stated, We don't have that policy. 49492 2. R2's Care Plan (current) documents BATHING: R2 requires one staff participation with bathing. Date Initiated: 07/25/2024 The Facility Resident Shower Schedule documents R2 is to receive showers on Tuesday and Friday on day shift. R2's Point of Care (POC) Bathing Record for September 2024 documents R2 has only received one shower in the month of September. On 9/30/24 at 11:50AM, R2 stated since admission on 7/25/24, R2 has only received one shower. 3. R7's Care Plan (current) documents BATHING: R7 is dependent on staff to provide a bath two times weekly and as necessary. Date Initiated: 05/28/2024 The Facility Resident Shower Schedule documents R7 is to receive showers on Monday and Thursday on day shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's POC Bathing Record for September 2024 documents R7 received one shower in the month of September (9/17/24). On 10/2/25 at 10:05AM, V4, Corporate Registered Nurse, stated all residents are to receive a minimum of two showers per week. V4 stated V4 is unable to provide shower sheets or proof of showers given.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on interview and record review, the facility failed to provide diabetic care for one resident (R1) of three residents reviewed for diabetic care in a sample list of seven residents. Findings Include: R1's face sheet documents R1 was admitted to the facility 8/14/24, with the diagnosis of Type II Diabetes Mellitus, Chronic Kidney Disease Stage III, Cardiomyopathy, and Cognitive Communication Deficit. R1's Progress note, dated 9/14/24 at 5:20PM, documents, (R1) noted diaphoretic, Altered Mental Status see current V/S (vital signs). Blood Glucose noted at 56. Nurse Practitioner on call for Patient Care Provider, gave new order Glucagon 1ml (milliliter), (IM) Intramuscular now. Recheck Blood sugar in 30 minutes. Resident noted [NAME] arms and legs. Writer phoned Wife she stated, 'I want him sent to emergency room at (hospital).' (nurse) phoned 911, 5:30PM first responders showed up (blood glucose) at this time 52. 6:30PM (Ambulance) here to transport resident, to (hospital). 6:30PM Report called to (hospital emergency room) spoke with Triage nurse, gave report. R1's Progress note, dated 9/15/24 at 4:08AM, documents, Hospital phoned for update on (R1). (R1) admitted to (hospital) for hypoglycemia. R1's Progress note, dated 9/23/24 at 4:13 PM, documents R1 was admitted to our community. See the Nursing Admission/Readmission Data Collection for additional information. There are no blood glucose levels documented for R1 on 9/23/24 or 9/24/24. R1's Physician's Orders document a physician's order initiated 9/25/24 for blood glucose checks before meals. R1's Medical Record does not include documentation of follow up with the physician to obtain an order for blood glucose monitoring before 9/25/24. On 10/2/24 at 9:45AM, V3, Corporate Registered Nurse (RN), confirmed, given R1's fluctuating blood glucose prior to R1's admission to the hospital, the admitting nurse should have notified the Physician or Nurse Practitioner upon admission to seek a physician's order for blood glucose monitoring.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37813 Based on interview and record review, the facility failed to seek a prescription for an ordered controlled pain medication prior to depleting supply for one resident (R5) of three residents reviewed for pain in a sample list of seven residents. Findings Include: R5's current Physician's Orders include a Physician's Order, initiated 8/29/24, for Tramadol 50 Milligrams by mouth for moderate pain. R5's Medication Administration Record (MAR) documents R5 did not receive Tramadol 9/6/24, 9/7/24, 9/8/24, 9/9/24, 9/10/24, or 9/11/24. During that time, R1's pain on a scale of 1-10 ranged from a low of 0 to a high of 8. On 10/2/24 at 11:00AM, R5 stated, I have pain most of the time and they were out of my pain pill for about a week. I really hurt and it was so bad I had trouble sleeping. R5's Progress note, dated 9/9/24 at 11:00PM, by V10, Nurse Practitioner, documents, Per nurse, Still need this script Prescription (Script) sent ASAP (R1) is out of Tramadol and unable to pull from stat (emergency supply) due to needing script. On 10/2/24 at 2:00 PM, V3, Registered Nurse (RN) Corporate Nurse, confirmed R5 was out of Tramadol from 9/6/24 to 9/11/24. V3 also confirmed R5 should have had Tramadol available, especially when R5 experienced pain level of 8/10. On 10/2/24 at 3:00 PM, V1, Administrator, stated the facility does not have a policy for pain control. V1 further stated the facility was in the process of updating policies and procedures with their new Medical providers, and do not have policies until this process is completed.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 49492 Based on interview and record review, the facility failed to provide laboratory services for two of three residents (R2 and R5) reviewed for laboratory services on the sample list of seven. Findings Include: 1. R2's progress note, dated 9/9/24 at 11:00PM, written by V10, Nurse Practitioner, documents an order for a urinalysis. R2's progress note, dated 9/10/24 at 1:54PM, by V8, Licensed Practical Nurse, documents a physician order was received for a urinalysis. R2's clinical physician orders do not document an active order was entered for a urinalysis to be completed. On 9/30/24 at 11:50AM, R2 stated R2 has felt like R2 has a urinary tract infection and staff have not collected a urine sample. On 10/2/24 at 10:05AM, V4, Corporate Nurse, stated V10 did enter a progress note with an order for a urinalysis 9/9/24. V4 then stated V8 entered a progress note documenting an order was given by the physician to obtain a urinalysis on 9/10/24. V4 confirmed there is no active order in R2's clinical physician orders for a urinalysis to be performed. On 10/2/24 at 10:05AM, V4 confirmed R2's urine was not collected for the urinalysis until 10/1/24, on the night shift. V4 confirmed there is no documentation of physician notification of a delay in completing the urinalysis. 50322 2. R5 admitted to facility on 8/29/24 from an acute care hospital for short stay rehab following covid 19 illness, as documented on hospital discharge date d 8/29/24. R5's face sheet, dated 10/1/24, documents a diagnosis of type 2 diabetes mellitus. R5's Physician order, sheet dated 10/1/24, documents a laboratory order for hemoglobin A1C (measures glucose in blood) on 8/29/24. Nursing progress notes, dated 9/3/24, document, lab (laboratory) not present. Nursing progress notes, dated 9/24/24, document not a lab day. R5's electronic medical record does not document any laboratory results completed. On 9/30/24 at 1:50 PM, R5 confirmed no one had taken any blood for labs from her during her stay at facility, and she was going home today. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 2:30 PM, R5's laboratory results for lab tests ordered on 8/29/24 were requested from V3, Regional Registered Nurse. On 10/2/24 9:30 AM, V1, Administrator, verified there were no labs on file for R5.