

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Moweaqua Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380</p> <p>Based on observation, interview, and record review, the facility repeatedly failed to maintain the dignity of four residents (R4, R7, R11, R3) out of four residents reviewed for dignity in a sample list of eleven residents.</p> <p>Findings include:</p> <p>1. R11's Care Plan, dated 10/22/24, documents actual skin impairments to skin integrity related to incontinence and has areas of pressure to left hip, right Ischium, and right hip. This same Care Plan, with a date of 6/17/24, documents resident has bladder and bowel incontinence and to check and change every two hours and as needed.</p> <p>On 10/24/24 at 12:13 PM, R11 was lying in bed with the top sheet mostly covered with a light brown substance that has fading brown color towards the edges of the sheet. R11 was lying on a bed pad that is covered with a light brown substance that has fading brown color towards the edges of the pad. At this same time, R3, who is the roommate of R11, stated no one has been into change R11 at all this morning. R3 and R11's room has an odor of urine and bowel movement.</p> <p>On 10/24/24 at 12:16 PM, V7, Regional Clinical Nurse, stated V7 does smell an odor and noticed the color of the top sheet and bed pad as being brown. V7 stated R11 needs incontinent care, and it needs to be addressed.</p> <p>On 10/24/24 at 12:22 PM, V26, Certified Nursing Assistant (CNA), stated V26 has not gotten to changing R11. V26 stated V26 came in for V26's shift at 6:00 AM this morning. V26 stated the residents should be checked every two hours and changed as needed. V26 stated the residents should be checked in the morning coming on shift to see if the resident is incontinent. V26 stated R11 is incontinent of bowel and bladder. V26 stated V26 is aware of the impact on skin with incontinent residents.</p> <p>41970</p> <p>2. R4's undated Face Sheet documents R4's medical diagnoses as Right Femur Fracture, Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes Mellitus Type II, Acute Kidney Failure, Adult Failure to Thrive, Asthma, Atrial Fibrillation, Dysphagia, Repeated Falls, Metabolic Encephalopathy, Chronic Heart Failure, Muscle Weakness, Age Related Physical Debility.</p> <p>(continued on next page)</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R4's Minimum Data Set (MDS), dated [DATE], documents R4 as moderately cognitively impaired. This same MDS documents R4 requires moderate assistance with toileting, dressing, bathing and supervision when moving from a sitting position to a standing position.</p> <p>R4's Care Plan intervention, dated 12/12/2023, documents R4 requires one assist bathing, transfers and toileting.</p> <p>The undated facility shower schedule documents R4 is to receive a shower on Wednesday and Saturdays on dayshift.</p> <p>R4's Electronic Medical Record (EMR) does not document any refusals or follow ups to R4 refusing her showers. R4's EMR documents R4 was not provided a shower on 9/4/24, 9/7, 9/11, 9/14, 9/18, 9/21, 9/25, 9/28, 10/2, 10/5, 10/16, 10/19 and 10/23/24.</p> <p>On 10/23/24 at 2:20 PM, R4 had ungroomed facial hair with food debris in it. R4's fingernails were packed with unknown brown substance.</p> <p>3.) R7's undated Face Sheet documents medical diagnoses of Alzheimer's Disease, Abnormal Posture, Muscle Weakness, Unsteadiness on Feet, Morbid Obesity, and History of Falls.</p> <p>R7's Minimum Data Set (MDS), dated [DATE], documents R7 as severely cognitively impaired. This same MDS documents R7 requires moderate assistance with eating and dependant on staff for personal and oral hygiene.</p> <p>R7's Care plan intervention, dated 10/31/2022, documents R7 prefers to be shaved on her shower days. This same Care plan documents an intervention, dated 7/22/22, to check R7's nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.</p> <p>On 10/22/24 at 3:20 PM, R7 was in her wheelchair in a reclining position. R7 has multiple pieces of food debris on her face and on the front of her shirt. All of R7's fingernails were packed with dark brown unknown substance. R7 lifted her hand to her face touching her fingernail area to her lips. R7 had overgrowth of chin hairs approximately a half inch long.</p> <p>On 10/22/24 at 3:21 PM, R7's floor was cluttered with food and unknown debris. R7's garbage can was overflowing with soiled incontinence briefs. R7's room smelled of urine.</p> <p>On 10/23/24 at 2:40 PM, R7 was in her wheelchair in a reclining position. R7 had multiple pieces of cheesy pasta on the front of her shirt, and yellow cheese on the sides of her mouth. R7's fingernails were unchanged with dark brown unknown substance. R7 had overgrowth of chin hairs approximately a half inch long.</p> <p>On 10/24/24 at 10:40 AM, R7 was in her wheelchair reclined back in her room. R7 has multiple pieces of food debris including pieces of yellow egg on her face and on the front of her shirt.</p> <p>On 10/24/24 at 10:42 AM, V24, Certified Nurse Aide (CNA), stated R7 is fully dependent on staff for help with eating. V24 stated, I made sure everyone had on clothing protectors in the dining room this morning, but whoever took (R7) out of the dining room should have made she sure was cleaned off instead of rolling her through the hallway looking like this.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/24/24 at 10:45 AM, V3, Assistant Director of Nurses (ADON), stated the staff should make sure that residents are cleaned up after eating. V3 stated, You can clearly see the food all over (R7). I don't know why (R7) wasn't cleaned up. I have a lot of teaching to do here.</p> <p>On 10/24/24 at 12:00 PM, V7, Regional Clinical Nurse, stated the facility does not have a policy to make sure staff are assisting residents with hygiene after meals. V7 stated the standard of care is to make sure all residents are assisted with cares. V7 stated cares includes washing a resident's face and hands after meals, making sure residents are wearing clean clothing and fingernails are kept clean.</p> <p>The State of Illinois Department of Aging facility handout titled Residents' Rights for People in Long-term Care Facilities revised on October 2014 documents residents have the right to a dignified existence. Residents will be treated with consideration, respect and dignity recognizing each resident's individuality.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview, and record review, the facility failed to maintain a clean environment for four (R3, R4, R7, R9) residents out of five residents reviewed for cleanliness of environment in a sample of eleven residents.</p> <p>Findings include:</p> <p>The facility Resident Council report, dated 9/10/2024, documents, Description: Residents would like the rooms cleaned better. Wipe down room, sweep, mop. Summary/Findings: Some rooms needed more attention, but for the most part rooms have been cleaned. Action Taken: Housekeeping Supervisor will do spot checks to ensure cleanliness of rooms and hallways.</p> <p>The facility Resident Council Report, dated 10/9/12024, documents, Description: Would like rooms cleaned and wiped down, sweep and mop. Action Taken: Bedrooms should be cleaned daily and residents should assist us in keeping clutter down in their rooms by allowing staff to assist them in straightening.</p> <p>1.) R3's Minimum Data Set (MDS), dated [DATE], documents R3 as cognitively intact. This same MDS documents R3 requires maximum assistance with toileting, bathing, dressing and dependent on staff for transfers.</p> <p>On 10/23/24 at 9:32 AM, R3 was laying in her bed in high position. R3's floor had multiple/dozens of pieces of unknown debris and food particles.</p> <p>On 10/23/24 at 9:35 AM, R3 stated R3's room is cleaned twice a week on average. R3 stated, Look at this mess. There is stuff all over the floor. That draws bugs. I can't get up and clean it or I would. I don't want to live in this mess.</p> <p>2.) R4's Minimum Data Set (MDS), dated [DATE], documents R4 as moderately cognitively impaired. This same MDS documents R4 requires moderate assistance with toileting, dressing, bathing and supervision when moving from a sitting position to a standing position.</p> <p>On 10/22/24 at 3:44 PM, R4's floor in his room was cluttered with debris. R4's bed was not made. Incontinence briefs were sitting out on top of R4's dresser.</p> <p>On 10/23/24 at 9:41 AM, R4's floor in his room had multiple pieces of debris and food particles on the floor. R4's bed was not made.</p> <p>On 10/24/24 at 11:01 AM, R4 was laying on his bed with food particles on his bed linens and all over R4's floor.</p> <p>3.) R7's Minimum Data Set (MDS), dated [DATE], documents R7 as severely cognitively impaired. This same MDS documents R7 requires moderate assistance with eating, and dependant on staff for personal and oral hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/22/24 at 3:21 PM, R7's floor was cluttered with food and unknown debris. R7's garbage can was overflowing with soiled incontinence briefs. R7's room smelled of urine.</p> <p>On 10/23/24 at 2:42 PM, R7's floor had food debris scattered around R7's floor. R7's garbage can was overflowing with garbage with soiled incontinence wipes laying on the floor next to R7's garbage can.</p> <p>4.) R9's Minimum Data Set (MDS), dated [DATE], documents R9 as severely cognitively impaired. This same MDS documents R9 as requiring maximum assistance with eating and dependant on staff for all other cares including personal hygiene, bathing, transfers and dressing.</p> <p>On 10/22/24 at 2:15 PM, R9's floor of her room had multiple pieces of food debris and unknown debris all of her floor. R9's garbage can was overflowing with garbage with soiled tissues on the floor next to R9's garbage can. R9 had multiple pillows and her bath basin sitting on the floor.</p> <p>On 10/22/24 at 2:20 PM, R9 stated, My room is always dirty. I guess they (facility) thinks it's ok to live like pigs.</p> <p>On 10/23/24 at 10:02 AM, V13, Housekeeper, stated the facility does not have a Housekeeping Supervisor and has housekeeping on day shift only. V13 stated, There are times when I come in and can tell the resident rooms have not been cleaned, but sometimes we (staff) get called to do room moves or have deep cleans and then the resident rooms just don't get cleaned either.</p> <p>On 10/23/24 at 10:07 AM, V14, Housekeeper, stated some of the housekeepers do clean the resident rooms including sweeping. V14 stated, Not everyone can bend over to see what is under a resident bed or under their chairs. So there are a lot of times the resident rooms may just get their garbage changed or just the middle of the room swept but nothing else.</p> <p>On 10/23/24 at 10:15 AM, V25, Maintenance Director, stated the facility does not have a Housekeeping Supervisor, and V25 is not in charge of anything to do with housekeeping. V25 stated, I can see that the rooms need cleaned, but I have enough to do with trying to fix all the broken stuff here.</p> <p>On 10/23/24 at 3:00 PM, V7, Regional Clinical Nurse, stated the facility does not have a separate policy on cleaning of the rooms. V7 confirmed the facility does not have a Housekeeping Supervisor. V7 stated the expectation is that all resident rooms and bathrooms are cleaned daily. V7 stated once the housekeeping staff has cleaned the room, the nursing staff would be responsible for cleaning up any nursing related incidents.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 35380</p> <p>Based on observation, interview, and record review, the facility failed to provide planned showers for five residents (R2, R3, R4, R5 R6) out of seven residents reviewed for showers in a sample list of eleven residents.</p> <p>Findings include:</p> <p>1.) R2's Minimum Data Set (MDS), dated [DATE], documents R2 is not cognitively intact. This same MDS documents R2 requires substantial/maximal assist with bathing.</p> <p>R2's Care Plan, dated 8/28/24, documents R2 has an Activities of Daily Living (ADL) self care deficit related to impaired mobility and right sided Hemiparesis.</p> <p>R2's documented bathing ADL log documents R2 received three showers/baths (on 8/19/24, 8/20/24, 8/29/24) out of eight monthly baths R2 should have received. This same type of log for R2's baths for September 2024, documents R2 received a shower/bath on 9/2/24. R2's Shower Sheets document R2's refusals on 9/5/24 and 9/18/24. There is no further documentation in R2's medical record stating if R2 was offered or given shower/baths on other days, and no documentation as to staff further interventions offered.</p> <p>R2's bathing ADL log for October 2024, does not have any showers/baths as given to R2. R2's shower/bath sheets, dated 10/4/24 and 10/9/24, document R2 refused showers/baths. There is no further documentation in R2's medical record stating if R2 was offered or given shower/baths on other days and no documentation as to staff further interventions offered.</p> <p>2.) R5's MDS, dated [DATE], documents R5 is not cognitively intact. This same MDS documents R5 requires substantial/maximal assist with bathing.</p> <p>R5's Care Plan, dated 9/3/24, documents R5 has an ADL self care deficit related to weakness and contractures.</p> <p>R5's bathing ADL log for August 2024, documents R5 received 3 showers/baths out of eight that should have been given for this month. R5's bathing ADL log for September 2024, documents R5 received one of eight showers/baths that should have been given during this month. R5's Shower sheets for September 2024, document R5 received two showers on 9/5/24 and 9/13/24 for this month. According to these documents, R5 received three of eight showers that should have been given during the month of September 2024. There is no further documentation in R5's medical record stating if R5 was offered or given shower/baths on other days and no documentation as to staff further interventions offered.</p> <p>3.) R6's MDS, dated [DATE], documents R6 is not cognitively intact. This same MDS documents R6 requires substantial/maximal assist with bathing.</p> <p>R6's Care Plan, dated 8/12/24, documents R6 has limited physical mobility related to Cerebral Vascular Accident (CVA).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's bathing ADL log for August 2024, documents R6 received two of eight showers (8/18/24, 8/31/24) that should have been given for this month. R6's bathing ADL log and shower sheets for September 2024, document R6 received four of eight showers (9/4/24, 9/7/24, 9/11/24, 9/18/24) that should have been given for this month. R6's bathing ADL log and shower sheets for October 2024, document R6 received four of six showers (10/5/24, 10/9/24, 10/16/24, 10/23/24) that should have been given for this month. There is no further documentation in R6's medical record stating if R6 was offered or given shower/baths on other days and no documentation as to staff further interventions offered.</p> <p>On 10/22/24 at 11:55 AM, V7, Regional Clinical Nurse, stated residents should be getting 2 showers a week.</p> <p>41970</p> <p>4.) R3's undated Face Sheet documents medical diagnoses as Encephalopathy, Neuropathy, Dysphagia, Major Depressive Disorder, Obstructive Sleep Apnea, Morbid Obesity, Chronic Pain Syndrome, Rheumatoid Arthritis, Need for Assistance with Personal Care, Abnormalities of Gait and Mobility, Lack of Coordination, and History of Respiratory Failure with Hypoxia.</p> <p>R3's Minimum Data Set (MDS), dated [DATE], documents R3 as cognitively intact. This same MDS documents R3 requires maximum assistance with toileting, bathing, dressing, and dependent on staff for transfers.</p> <p>R3's Care Plan intervention, dated 5/28/2024, documents R3 requires two staff members to provide a bath twice a week and as necessary.</p> <p>The undated facility shower schedule documents R3 is to receive a shower on Tuesday and Fridays on dayshift.</p> <p>R3's Electronic Medical Record (EMR) does not document any refusals or follow ups to R3 refusing her showers. R3's EMR documents R3 was not provided a shower on 9/3/24, 9/10/24, 9/13/24, 9/17/24, 9/20/24, 10/1/24, 10/4/24, 10/8/24 and 10/15/24.</p> <p>On 10/23/24 at 9:37 AM, R3 stated, I haven't had a shower in a long time before yesterday (10/22). I smelled so bad. I don't know why they (staff) won't give me a shower. I don't like to smell. They (staff) tell me I refuse. I don't refuse the shower or bedbath. They (staff) don't even ask me. They just mark me down as refused.</p> <p>5.) R4's undated Face Sheet documents R4's medical diagnoses as Right Femur Fracture, Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes Mellitus Type II, Acute Kidney Failure, Adult Failure to Thrive, Asthma, Atrial Fibrillation, Dysphagia, Repeated Falls, Metabolic Encephalopathy, Chronic Heart Failure, Muscle Weakness, Age Related Physical Debility.</p> <p>R4's Minimum Data Set (MDS), dated [DATE], documents R4 as moderately cognitively impaired. This same MDS documents R4 requires moderate assistance with toileting, dressing, bathing, and supervision when moving from a sitting position to a standing position.</p> <p>R4's Care Plan intervention, dated 12/12/2023, documents R4 requires one assist bathing, transfers, and toileting.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The undated facility shower schedule documents R4 is to receive a shower on Wednesday and Saturdays on dayshift.</p> <p>R4's Electronic Medical Record (EMR) does not document any refusals or follow ups to R4 refusing her showers. R4's EMR documents R4 was not provided a shower on 9/4/24, 9/7/24, 9/11/24, 9/14/24, 9/18/24, 9/21/24, 9/25/24, 9/28/24, 10/2/24, 10/5/24, 10/16/24, 10/19/24 and 10/23/24.</p> <p>On 10/23/24 at 2:20 PM, R4 had ungroomed facial hair with food debris in it. R4's fingernails were packed with unknown brown substance.</p> <p>On 10/23/24 at 3:00 PM, V2, Assistant Director of Nurses (ADON), stated the staff need to do a better job getting residents clean. V2 stated the residents should have their face and hands washed after every meal and should not be wearing clothing with food on it. V2 stated there is not a facility policy that states the residents should get showers twice per week. V2 stated residents should receive the standard of care, which is two baths per week. V2 stated, I have a lot of teaching to do with the staff at this facility.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview, and record review, the facility failed to implement fall interventions for one (R4) resident out of three residents reviewed for falls in a sample list of eleven residents.</p> <p>Findings include:</p> <p>R4's undated Face Sheet documents R4's medical diagnoses as Right Femur Fracture, Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes Mellitus Type II, Acute Kidney Failure, Adult Failure to Thrive, Asthma, Atrial Fibrillation, Dysphagia, Repeated Falls, Metabolic Encephalopathy, Chronic Heart Failure, Muscle Weakness, and Age Related Physical Debility.</p> <p>R4's Minimum Data Set (MDS), dated [DATE], documents R4 as moderately cognitively impaired. This same MDS documents R4 requires moderate assistance with toileting, dressing, bathing, and supervision when moving from a sitting position to a standing position.</p> <p>R4's Fall Risk Assessment, dated 8/8/24, documents R4 as a high fall risk.</p> <p>R4's Care Plan intervention, dated 8/18/24, instructs staff to re-direct R4 to a common area or activities when noted to be wandering in his wheelchair. Staff to intervene immediately if they see R4 attempting to stand up from his wheelchair when he is wandering throughout facility. This same Care Plan documents an intervention, dated 8/22/24, for R4's furniture in his room to be rearranged.</p> <p>R4's Nurse Progress Note, dated 8/22/24 at 5:47 PM, documents R4 had an unwitnessed fall while self ambulating in room.</p> <p>R4's Fall Investigation, dated 8/22/24, documents R4 was walking independently in his room when he fell . This same investigation documents R4's fall was unwitnessed and was incontinent at the time of the fall.</p> <p>R4's Nurse Progress Note, dated 9/20/2024 at 9:03 PM, documents, Staff did not witness fall. (R4) was last toileted before supper at 5:30 PM-6:00 PM.</p> <p>R4's Fall Investigation, dated 9/20/24, documents R4 had an unwitnessed fall at 8:45 PM in his room. This same investigation documents R4 was yelling I fell . I fell and was found laying between his wheelchair and bed on his Right side. This same investigation stated R4 stated he was bending over messing with his sheets on his mattress. This same investigation documents R4 was incontinent at the time of his fall.</p> <p>On 10/22/24 at 3:43 PM, R4 was walking independently in his room from bathroom to his bed with no staff present. R4 was leaned over while walking and grabbing onto furniture.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Moweaqua Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/22/24 at 3:45 PM, V21, Licensed Practical Nurse (LPN), was sitting at nurses station when V21 was informed R4 was walking independently in his room. V21 walked into R4's room and stated, (R4) you are not supposed to be up. You could fall. That is not safe. I don't know where all the staff are, but they should be watching you.</p> <p>On 10/23/24 at 9:40 AM, R4 was sitting in his wheelchair in his room. R4 grabbed the siderail on his bed and stood up and began to walk the length of his bed. There were no staff present.</p> <p>On 10/24/24 at 11:00 AM, R4 was laying sideways in his bed with his feet on the floor and head laying over the opposite side of his bed. There were no staff present.</p> <p>On 10/24/24 at 11:15 AM, R4 was standing in his room independently. No staff present.</p> <p>On 10/23/24 at 9:45 AM, V2, Assistant Director of Nurses (ADON), walked into R4's room and stated, (R4) is busy today. (R4) is always on the move. We (staff) can't keep up with him.</p> <p>On 10/23/24 at 9:50 AM, V17, Certified Nurse Aide (CNA), stated the facility had mentioned moving R4's furniture around in his room due to his falls. V17 stated, They (facility) never did move anything. It was just talk. (R4) falls a lot. We (staff) can't keep up with him.</p> <p>On 10/23/24 at 1:00 PM, V7, Regional Clinical Nurse, stated R4 has fallen multiple times. V7 stated the staff are supposed to monitor R4 to help prevent falls. V7 stated when a resident falls, the assigned floor nurse is to initiate an intervention. V7 stated the Interdisciplinary Team (IDT) meets after that, and reviews the fall and interventions. V7 stated R4's Careplan does state R4 should be re-directed to the common area, and that R4's room was to be rearranged to help prevent falls.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35380</p> <p>Based on interview and record review, the facility failed to administer antibiotics as ordered by the physician for two of four residents (R2, R10) reviewed for antibiotic medication administration in the sample list of eleven.</p> <p>Findings include:</p> <p>1. R2's August 2024 Electronic Medical Administration Record (e-MAR) documents an order for Doxycycline Monohydrate oral tablet 100 milligrams (mg) - give one tablet two times a day for Pneumonia until 8/30/24, start date 8/20/24. This same e-MAR documents the antibiotic Doxycycline Monohydrate was not given on 8/21/24 (AM dose), due to R2's refusal, and not given on 8/23/24 (PM dose) due to other-see progress note. Both 8/21/24 and 8/23/24 dates have no documentation of the physician being notified of R2 not receiving the antibiotic, or any reasoning for the refusal and just not being given in R2's medical record.</p> <p>2. R10's e-MAR dated August 2024, documents an order for Augmentin 500-125 mg one twice a day by mouth. This same e-MAR documents the following: August 21, both AM and PM doses as 6; August 22, AM dose documents 5 and August 22 PM dose 6; August 23, both AM and PM doses as 6; August 24, both AM and PM doses as 6; and August 25, AM dose as 6. According to the Chart Code on this same e-MAR, 5 stands for hold-see progress notes and 6 stand for other-see progress notes. There is no further documentation as to why these medications were not administered in R10's medical record.</p> <p>On 10/22/24 at 3:36 PM, V7, Regional Clinical Nurse, stated if a resident refuses a medication, the doctor should be notified, and V7 does not see any rational documented for these antibiotics not being given in the residents' medical records.</p> <p>The facility's Administration of Medications, dated Revised 07/24, documents if for any reason a physician's order cannot be followed, the physician shall be notified and a notation should be made on the nurse's progress notes in the patient's clinical record. This same policy documents the facility should check the Physician's Order Sheet and Medication Administration Record against the current Physician's Orders to assure proper administration of medications to the residents.</p>		