

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  02/13/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</b></p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders when administering medications including multiple doses of intravenous antibiotics for two (R7, R8) residents out of three residents reviewed for medication administration in a sample list of eight residents.</p> <p>Findings include:</p> <p>1. R7's Electronic Medical Record (EMR) documents medical diagnoses as Multiple Sclerosis, Heart Failure, Epilepsy, Acute Osteomyelitis, Sacral Pressure Ulcer, Need for Personal Care, and Bacteremia.</p> <p>R7's Minimum Data Set (MDS), dated [DATE], documents R7 as cognitively intact.</p> <p>R7's Physician Order Sheet (POS), dated February 2025, documents a physician order starting 2/1/25 for Ertapenem Sodium one Gram (GM) every 24 hours intravenously for wound infection until 2/3/25. This same POS documents a physician order starting on 2/3/25 for Ertapenem Sodium one gram (gm) every 24 hours intravenously for wound infection until 2/11/25. Notify Physician if medication is missing.</p> <p>R7's Medication Administration Record (MAR), dated February 2025, documents R7 was not administered Ertapenem Sodium One GM on 2/1/25, 2/2/25, 2/5/25, 2/8/25 and 2/10/25.</p> <p>R7's Nurse Progress Notes do not document R7's Ertapenem Sodium One Gram (GM) not being administered on 2/1/25, 2/2/25, 2/5/25, 2/8/25 and 2/10/25. R7's Nurse Progress Notes do not documents notifications being made to R7's Physician, R7, nor R7's Power of Attorney (POA).</p> <p>R7's Medication Error Report, dated 2/3/25, documents R7's Ertapenem Sodium One GM was not administered on 2/1/25 and 2/2/25 due to staff not being able to locate the medication.</p> <p>The facility was unable to provide medication error reports due to R7's Ertapenem Sodium not being administered on 2/5/25, 2/8/25 and 2/10/25.</p> <p>On 2/11/25 at 1:00 PM, R7 was laying in his bed with a Peripherally Inserted Central Catheter (PICC) line in place in his Left Upper arm.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 1:05 PM, R7 stated the nurses are 'hit an miss' administering his Ertapenem Sodium One Gram (GM) via his PICC (peripherally inserted central catheter) line. R7 stated, Sometimes they (staff) are good about it and other times I have to wait for hours. Then I ask about it and they tell me they will get it. No one ever returns to give me the antibiotic. That is the entire reason I have to have this PICC line. If they (staff) aren't going to give it to me, then I should not have to have this PICC line. Now I was told that I have to have it (IV antibiotic) for more days due to the staff didn't give it right. That isn't right.</p> <p>On 2/11/25 at 1:45 PM, V7, Agency Registered Nurse (RN), stated she worked on 2/1/25 and 2/2/25 as R7's nurse. V7 RN stated she looked for R7's Ertapenem Sodium IV antibiotic, but was not able to find it. V7, RN, stated she did not give R7's antibiotic on those two days, and did not notify the Physician. V7, RN, stated she was told later that the facility has a back up medication storage system, which did include the antibiotic, which was onsite that weekend. V7, RN, stated, I guess I should have called somebody, but I can't be expected to give something I can't find. I should not have to call the doctor every time someone doesn't get their medication.</p> <p>2. R8's Electronic Medical Record (EMR) documents medical diagnoses of Epilepsy and Dementia.</p> <p>R8's Minimum Data Set (MDS), dated [DATE], documents R8 as severely cognitively impaired.</p> <p>R8's Physician Order Sheet (POS), dated December 2024, documents a physician order starting 12/6/24 for Briviact Oral Tablet 50 milligram (MG). Give 50 mg by mouth two times a day for Epilepsy.</p> <p>R8's Medication Administration Record (EMR), dated December 2024, documents R8 received the scheduled doses of Briviact 50 mg in the morning and evening of 12/17/24.</p> <p>R8's Nurse Progress Note, dated 12/17/24 at 8:04 PM, documents R8 was given the wrong dose of Briviact (anti-epileptic) medication. This same note documents, (R8) was mistakenly given two doses from a card of another resident with 100 milligram (mg) Briviact, though (R8) is ordered 50 mg of Briviact.</p> <p>R8's Medication Error Report, dated 12/17/24, documents R8 received the wrong dose of Briviact. This same report documents R8 was ordered 50 mg Briviact twice daily and was mistakenly given Briviact 100 mg on 12/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 3:00 PM, V5, Nurse Practitioner (NP), stated R7's Intravenous (IV) antibiotic Ertapenem Sodium One GM was ordered daily for R7's Sacral Pressure Ulcer, which is infected. V5, NP, stated Ertapenem would be considered a critical medication necessary for R7's wound healing. V5, NP, stated V5 is not aware R7 had any side effects from the staff not administering this medication, but 'absolutely could have'. V5, NP, stated there is no excuse for V7, Agency Registered Nurse (RN), to not call V5, NP, on 2/1/25 to report R7's medication could not be located. V5, NP, stated the facility did in fact have R7's Ertapenem, which was in the Stat Safe medication storage system. V5, NP, stated she found out R7 did not have his Ertapenem on 2/3/25. V5, NP, stated V5 is onsite five days per week for half days, which is during the time R7 is scheduled to receive his IV antibiotic through his PICC line. V5, NP, stated the staff could have notified her while she was in the building, and she would have addressed the situation immediately. V5, NP, stated R8 has Briviact 50 mg ordered twice daily for his Seizure Disorder. V5, NP, stated all residents medications should be administered as ordered by the prescriber. V5, NP, stated V6, Agency Licensed Practical Nurse (LPN), mistakenly administered Briviact 100 mg to R8. V5, NP, stated R8 did not have any significant medical complications due to this error. V5, NP, stated, (R8) was lucky to not have any significant issues due to this error. It could have been much worse. Overdosing the resident's neurological symptoms could cause ill effect.</p> <p>On 2/13/25 at 10:05 AM, V1, Administrator, stated the facility does not have a policy or guidelines on medication errors. V1 stated it is the expectation for nursing staff to follow the physician orders, and if there a reason a resident does not get their medication or gets the wrong dose, then the staff should reach out to the provider.</p>		