STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012322	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOWEAQUA REHAB & HCC	525 SOUTH MACON STREET MOWEAQUA, IL 62550

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S 000	Initial Comments Facility Reported Incident of August 28, 2022 IL150985	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 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 regulations were not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

Based on record review and interview, the facility failed to supervise two residents (R4 and R6) with known histories of repeated falls. These failures resulted in R4 falling from the commode while left unattended and sustaining a humerus fracture, and R6 falling multiple times when left unsupervised. R4 and R6 are two of three residents reviewed for falls in the sample list of three.

Findings include:

1. R4's Diagnosis Sheet (current) includes the following diagnoses: Dementia, Repeated Falls, Unsteady on Feet, Reduced Mobility and Convulsions.

R4's Minimum Data Set (MDS), dated 6/11/22, documents R4 as being severely cognitively impaired, and not steady, only able to stabilize with assistance when moving from a seated to standing position. R4 is also documented on this same MDS as needing the assistance of one person when toileting.

R4's Plan of Care (current) documents a focus area of "Falls" with a directive for Nursing staff: "Do not leave (R4) in the bathroom unattended", with initiation dated 9/30/21.

The facility's "Fall Log" dated March through September 2022, documents R4 with the following falls: 3/27/22 x 2 falls, 7/31/22, 8/17/22 and 8/28/22.

A Facility Incident Report, dated 8/28/22, for R4 documents the following: "fall in bathroom, (V3 Licensed Practical Nurse) left the room to find a clean brief as resident (R4) was incontinent. I (V3) heard (R4) scream from the hallway--When

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S9999	Continued From page 2 (V3) and CNA (Certified Nursing Assistant) entered the room (R4) was lying on (R4's) back, with (R4's) w/c (wheelchair) on top of (R4) in the next door neighbor's room. (R4) was in no distress on visual assessment, but upon ROM (Range of Motion) to upper extremities, (R4) screamed in pain when attempted to (Left) shoulder. Upon palpation (V3) felt 2 separate bones and visually on the verge of protruding through the skin. (V3) contacted (Emergency Services) for immediate transfer." On 9/7/22 at 10:15 am, V3 confirmed V3 had placed R4 on the commode in a shared bathroom, and left R4 unattended on the commode to retrieve a clean incontinence brief. V3 stated V3 was in the hall and heard R4 scream, and upon returning to the bathroom found R4 on the floor of the doorway leading to another resident's room. V3 stated the wheelchair was on top of R4, and confirmed the above assessment on R4's Left Arm/Shoulder area. V3 also confirmed at this time V3 had not read R4's Plan of Care. R4's Hospital Notes on 8/28/22 document the following: "Fall with pain and deformity of Left Shoulder. X-ray - Three views of the left shoulder performed. Separate Anterior, Posterior and Lateral views left humerus also obtained. Impression: 1. Oblique fracture of the proximal humerus involving the humeral neck. There is displacement and angulation present with some impaction or overriding present. No dislocation. 2. Degenerative changes." The X-ray findings are Electronically signed by V10, Radiologist. On 9/7/22 at 10:30 am, V1, Administrator, confirmed R4 should not have been left on the commode unattended, and R4's fractured Left	S9999		

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S9999	Continued From page 3	S9999		

arm was due to falling while unsupervised in the bathroom on 8/28/22. V1 also confirmed V3 should have had all necessary supplies with V3 when delivering care to R4.

2. R6's Diagnosis Sheet (current) includes the following diagnoses: Dementia with Behavioral Disturbances, Repeated Falls, Muscle Weakness, Vertigo, and Unsteady on Feet.

R6's MDS, dated 6/8/22, documents R6 as being Moderately Cognitively Impaired with Behaviors. This same MDS documents R6 needing extensive assist in transfers.

R6's Plan of Care (current) documents a focused area on "Falls", with a directive to Nursing staff: "(R6) is to be in supervised areas when up", with an initiation date of 3/03/22.

The facility's "Fall Log", dated April through September 2022, documents R6 with the following falls: 4/23/22, 4/29/22, 8/11/22.

The facility's "Incident Reports" on the above falls document the following:

4/23/22 at 9:20 am - R6 found on the floor in the common area by the dining room. R6's wheelchair was positioned by the arm of the couch and R6 stated "I was trying to get over there to the couch." R4 was positioned between the wheelchair and the couch facing the dining room. Unwitnessed fall.

4/29/22 at 1:10 pm - R6 found sitting on the floor in another resident's room. Confused. Unwitnessed fall.

8/11/22 at 8:00 pm - R6 in dining room and fell

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S9999	Continued From page 4 out of wheelchair. Unwitnessed fall. On 9/7/22 at 1:00 pm, V1 confirmed R6's above falls occurred when R6 was unsupervised. V1 also confirmed at this time, due to R6's history of repeated falls, R6's Plan of Care includes R6 is not to be left unsupervised in common areas when up. (A)	S9999		