Illinois Department of Public Health

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 10/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2268324/IL152380	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to operationalize guiding policies on the provision of resident care by neglecting to: provide cardiac medications (for 18 days) and notify the physician when cardiac medications were continuously held; obtain residents weights,	S9999		

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monitor oral intake, determine the reason for inability to chew foods, and notify the physician of R1's refusal of meals; and assess or provide interventions as a significant decline in residents function from baseline occurred. These failures affect one (R1) of three residents reviewed for death on the sample list of 6. These failures resulted in serious harm and danger to R1's health contributing to R1's death. These failures also resulted in severe weight loss in which R1 lost 30 pounds in a five-week time frame (11.65 % of his body weight).

Findings include:

R1's Nurse's note, dated 9/9/2022 at 6:17 PM, documents R1 was admitted to the facility.

R1's Careplan, dated with a review date of 10/3/22, documents R1 was admitted to the facility on 9/9/22 with the diagnoses of Essential (Primary) Hypertension, Congestive Heart Failure, and Left Ventricular Failure, Dilated Cardiomyopathy, and Chronic Kidney Disease.

1. R1's Physician's Orders documents orders, dated 9/9/22, for Amlodipine Besylate (Calcium Channel Blocker) 81 milligram (mg) once a day, Lisinopril (Ace Inhibitors) 20 mg 1 tab by mouth one time a day, and Carvedilol (Alpha Beta Blocker) 25 mg 1 tab by mouth twice a day.

R1's Medication Administration Record for September 2022 and October 2022 documents R1's Amlodipine was not administered on 9/21, 9/24, 9/26, 9/27, 9/29, 10/6, 10/10, 10/11, 10/13, 10/14, and 10/15. R1's Lisinopril was not administered on 9/16, 9/18, 9/22, 9/23, 9/24, 9/26, 9/27, 9/28, 9/29, 10/5, 10/6, 10/10, 10/11,

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10/13, 10/14, and 10/15. And R1's Carvedilol was held on 9/10 (am dose), 9/16 (am dose), 9/18 (both doses), 9/21 (both doses), 9/22 (am dose), 9/23 (am dose), 9/24 (am dose), 9/26/22 (am dose), 9/27/22 (am dose), 9/28/22 (am dose), 9/29/22 (am dose), 10/5 (both doses), 10/6 (am dose), 10/10 (am dose), 10/11 (am dose), 10/13 (am dose), 10/14 (both doses), and 10/15 (am dose).

V9's Physician Order's sheet signed by V9 on 5/10/21 documents under the heading Hypotension states, "Hold blood pressure (B/P) medication if B/P is below 120/60."

On 10/19/22 at 10:30 AM, V6, Licensed Practical Nurse (LPN), stated, "(R1's) blood pressure fluctuated quite a bit. On the days that (R1) was low, we (nurses) would hold his cardiac medications if he was lower than 120/60. We have standing orders from (V9, Physician) to hold them." V6 stated Amlodipine Besylate 10 milligrams was held by V6 on 9/21/22 and 9/24/22. V6 stated the Lisinopril was held by V6 on 9/16/22, 9/21/22, and 9/24/22. V6 stated the Carvedilol was held by V6 on 9/21/22, 9/23/22, and 9/24/22. V6 stated on 9/16/22 his blood pressure was 118/78, on 9/21/22 it was 105/74, on 9/23/22 it was 116/66, and on 9/24/22 it was 108/60. V6 stated she did not notify V9 (Physician) she was holding the medications. V6 stated she held medications that she felt affected his blood pressure. On 10/5/22, V6 stated, "I didn't give the Lisinopril or Carvedilol because his blood pressure was 112/70."

On 10/20/22 at 8:40 AM, V11, LPN, stated on 9/29/22 she held R1's doses of Amlodipine Besylate 10 mg, his morning dose of Carvedilol, and his Lisinopril. V11 stated she held them

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because of his blood pressure being 103/58. V11 stated she didn't notify V9 about holding his medications or his low blood pressure. V11 stated she doesn't know the facility's policy about holding the medications.

On 10/20/22 at 9:01 AM, V12, LPN, stated, "I would hold his cardiac medications when his blood pressure was low. I took his B/P every time before giving his medications. When I was being trained, they taught me to do that. I wasn't trained which cardiac medications should be held for low blood pressure." V12 stated she didn't ever notify the physician she was holding his medications.

On 10/20/22 at 2:33 PM, V8, Nurse Practitioner, stated R1 has been a patient of hers since 2017. V8 stated R1 was receiving the cardiac medications for Coronary Artery Disease, Heart Failure, and Hypertension. V8 stated the facility should have notified the physician before holding R1's medications. V8 stated all three medications worked together for R1's diagnosis of Heart Failure. V8 stated R1's Carvedilol not only helped with Hypertension, but also helped decrease his cardiac workload. V8 stated the Lisinopril helps with Hypertension, but also helps protect his kidneys and his heart. V8 stated, "(R1) had chronic kidney disease. It is an issue that they didn't notify anyone."

On 10/20/22 at 10:39 AM, V10 (V9's nurse) stated V9 (R1's physician) stated he expects the nursing staff to call after holding medications the first time that they are held, and not giving R1's cardiac medications as scheduled put R1 at the risk for significant harm and danger.

On 10/19/22 at 9:50 AM, V7, County Coroner,

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S9999	Continued From page 5 stated R1 had a heart attack due to Carotid Artery Disease. V7 stated he thinks R1 not getting his cardiac medications could have contributed to his death. V7 stated, "In my eyes, it is a significant failure." 2. R1's hospital discharge orders, dated 9/9/22, documented an order to weigh resident daily. R1's weight summary record documents R1's weight as 259.2 pounds on 9/9/2022, this weight summary record does not document any other weights. R1's Health Status Note, dated 10/5/2022 at 11:24 AM, documents staff concerned with lack of appetite and only wanting to eat ice cream. R1's meal intake sheet documents R1 refused supper on 10/8/22, 10/9/22, 10/10/22, 10/11/22, 10/12/22, 10/14/22, and 10/15/22. This sheet documents R1 ate less than 25 percent on 10/13/22. There is no documentation of what R1 ate for breakfast or lunch from 10/8/22 through 10/15/22. R1's medical record does not document R1's intakes were monitored, or that the physician was notified of R1's meal refusals, with the exception of 10/12/22, after R1 was seen by V8, Nurse Practitioner. This medical record does not document R1's meal intakes were monitored, or the physician was notified after R1 was seen by the physician on 10/12/22. R1's medical record does not document the physician was notified R1's cardiac medications were being held. R1's physician visit summary, dated 10/12/22, documented by V8, Nurse Practitioner, documents R1's weight as 229 pounds. This visit summary documents an order for a dietary	S9999		

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S9999	Continued From page 6 consult with daily meal supplements as "he has lost a significant amount of weight." During interviews on 10/19/22 at 10:27 AM and 10/20/22 at 2:33 PM, V8, Nurse Practitioner, stated: R1 has been a patient of hers since 2017. He was admitted to the facility for therapy and he was seen by the facility's physician (V9) while at the facility. Prior to his admission to the facility he could walk with a walker. V13 reached out to her due to V13's concern for his declining condition. "When (R1) was seen in the office, it took three staff members to transfer him. (R1) looked like a completely different man as he had lost so much weight. He weighed 229 pounds. (V8) was shocked when she saw him and his decline was very concerning." V8 stated, "The facility should have called the physician about his intakes, him only eating ice cream, and should have weighed him. This could have caused an electrolyte balance and killed him. (R1's) cardiac medications were not only for Hypertension, but worked together to decrease his cardiac workload and to protect his heart and kidneys. The physician should have been notified before holding these medications. It is an issue that they didn't notify anyone." R1's Plan of Care Note, dated 10/14/2022 at 10:52 AM, documents, "care meeting held today. (R1) agrees to see speech therapy and requested to have food (consistancy) down graded to puree to see if this helps him eat more. (V13) would like to see if appropriate for nutritional drinks. . All parties agree to revisit discharge plans at a later date to give (R1) time to work on appetite and gain strength." On 10/20/22 at 9:23 AM, V14, Care Plan Coordinator, stated, "We had a care plan meeting	S9999		

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S9999	Continued From page 7 with the family (V13) due to his deterioration with therapy. They also had a huge concern that he wasn't eating. He was only wanting to eat ice cream. Sometimes he would eat a cheeseburger. (R1) stated he ate ice cream because it was easier to chew it. The CNAs chart his intakes and if his intake is below 50 percent it should come up on the dashboard." V14 stated, "Weekly weights should be done for four weeks after being admitted to the facility. The Dietary Manager or the Director of Nursing should be monitoring his weights. They haven't been having weight meetings lately." On 10/19/22 at 3:00 PM, V2, Director of Nursing (DON), stated she started working at the facility at the end of September. V2 stated she was out of the building from 10/7/22 through 10/17/22. V2 stated she was not able to monitor R1's intakes or ensure weights were obtained. On 10/20/22 at 1:37 PM, V13, Power of Attorney/Former Home Care Aide, stated R1 was admitted to the facility for therapy and his goal was to return to home. V13 stated R1 could walk with a walker and had a good appetitive. V13 stated V8 (Nurse Practitioner) was R1's primary physician prior to admitting to the facility. V13 stated she wasn't impressed with the facility physician (V9), so she requested he be seen by V8. V13 stated she was "very concerned with his condition, and all he was eating was ice cream. We had concerns about him not standing. I was confused why he wasn't participating in therapy. He went to see (V8) on 10/12/22. She was really concerned about him when she seen him. "We set up a care plan meeting with the facility because he wasn't eating. He didn't like the food and they thought it would be easier to eat the food if it was pureed. He said he couldn't chew	S9999		

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the food."

On 10/20/22 at 9:29 AM, V1, Administrator, stated, "New admits should be weighed weekly times four weeks. The CNAs would obtain the weights. The nurses should ensure the weights are obtained. I am losing my managers and bringing in new managers so there is a transition. The DON would be responsible for the admission review. CNAs will track intakes. I knew (R1) was only wanting ice cream. I worked in the kitchen the last week (R1) was here, and all his (meal) tickets said ice cream." V1 stated she was not aware that he couldn't chew or that he had significant weight loss. V1 stated, "I guess maybe they didn't weight him. I wasn't aware the nurses were holding (R1's) medications. I am aware that they were holding them now. Not sure what the policy was. I would think it would pop up on the clinical screen. I would expect them (nurse managers) to look into it and see why it was being held and notify the physician."

On 10/20/22 at 10:39 AM, V10 (V9's nurse) stated V9 (R1's physician) stated he expects the nursing staff to call after holding medications the first time that they are held, and not giving R1's cardiac medications as scheduled put R1 at the risk for significant harm and danger. V9 felt the facility not monitoring R1's weight, food intake, and assessing the reason for eating only ice cream, put R1 at risk for significant harm and danger.

The facility's Administration of Medications, with a review date of 04/21, documents, "1. If for any reason a physician's order cannot be followed, the physician shall be notified as soon as is reasonable. A notation shall be made on the nurse's progress notes in the patient's clinical

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S9999	Continued From page 9 record." (AA)	S9999		

LTC07202

COMPLAINT DETERMINATION FORM

FAC. NAME: MOWEAQUA REHAB & HCC — COMPLAINT #: 0152380
LIC. ID #: 0053595
DATE COMPLAINT RECEIVED: 10/17/22 09:56:00

IDPH Code	Allegation Summary	Determination
131	RESIDENT INJURY	2
199	OTHER	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v, Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.