| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **146162** | A. BUILDING _____ B. WING _____ | **08/06/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **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) |
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| F 0676<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview the facility failed to provide care oversight, assistance, and cueing to encourage self feeding and prompt dining assistance to three (R3, R5, R15) of four residents reviewed for dining assistance in the sample list of 15 residents. The findings include: On 8/4/20 from 12:00 pm until 12:30 pm, R3, R5, and R15 sat at dining room tables in the Main Assisted Dining room with covered food and drinks placed in front of them, before they received any staff assistance to uncover food, set up food or assist with dining. The examples include: 1. R3's annual Minimum Data Set (MDS), dated [DATE], documents R3 requires extensive assistance of one staff for eating. R3 receives a mechanically altered diet (pureed) and receives restorative program for eating seven days per week. R3's Care Plan, dated 6/7/20, states All About Me- Dietary - (R3) uses nosey cups, divided plate, and left handed bent spoon he is given that and a regular spoon. His brother states that he thinks that (R3) does better with a regular spoon so we give him the option of which spoon he wants to use. The Care Plan also states (R3) has a swallowing problem difficulty with thin liquids. Dysphasia. (R3) will have no choking episodes when eating through the review date. All staff to be informed of resident's special dietary and safety needs. The approach/intervention includes: Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. Instruct (R3) to eat in an upright position, to eat slowly, and to chew each bite thoroughly. When (R3) isn't feeding himself, staff is to assist. Sippy cup for liquids at meal time. R3's Restorative Care Plan, dated 6/7/20, states (R3) will be able to feed self all or part of meals with set up, supervision and cues through review date. RESTORATIVE PROGRAM - Eating- staff to set up tray, encourage (R3) to pick up spoon or hand spoon to him or hand over hand, encourage him to take bites and drinks, use supervision, cues and encouragement to as much for himself as possible assist more as needed. EATING: (R3) requires supervision, cues, encouragement participation to eat at times may need more assist. On 8/4/20 at 11:55 am, R3 was seated in wheelchair at a table in the main dining room. There were nine tables in the dining room set up for one resident each . At 12:00 pm, (R3) was given a clothing protector and a foam bowl of pureed cake with lid was placed on the table in front of him. A weighted curved handled spoon with a napkin was on the table. Certified Nurse Aide (CNA) V16 placed two regular glasses of thickened water and thickened tea on the table instead of in a nosey or sippy cup. R3's wheelchair was not close up to the table, and R3 did not attempt to open the bowl of pureed cake. At 12:05 pm, a closed foam clam shell container of food was placed on the table in front of R3. V16 did not open the container of food and dessert, did not offer R3 a drink, or tell R3 what was for lunch. V16 did not hand R3 the weighted curved spoon to encourage R3 to eat. On 8/4/20 at 12:10 pm there were four CNAs (V12, V14, V15, V16) seated beside four other residents giving 1:1 (one to one) feeding assistance. R3 remained seated at the table with food still covered. R3 was still just looking at it talking to self and appeared to be pointing and counting items on table. At 12:30 pm, V9, Licensed Practical Nurse (LPN), approached R3 and gave R3 medication on a spoon. V9 opened the dessert and foam container of pureed food. V9 pulled R3's wheelchair up to the table and gave R3 the weighted curved spoon and prompted him to eat stating, Use your spoon. R3 started self feeding using the built up spoon in his left hand to eat his pureed turkey. R3's disposable plate contained pureed turkey, zucchini and mashed potatoes. R3 ate slowly but was able to get food on spoon and bring to mouth. R3 continued to eat slowly with the built up spoon until 12:40 pm. On 8/4/20 at 12:40 pm, R3 was feeding self pureed turkey with the spoon. V16, CNA, came over to R3 and took the weighted spoon from R3's hand and set it aside. V16 stated, Let me help you or your food is going to be ice cold. V16 did not offer to warm up the food which had been sitting in front of R3 for 30 minutes. V16 used a plastic spoon to feed a R3 a bite of turkey. R3 reached for the curved spoon and V16 took the spoon and put it out of reach and started feeding R3 bites of food. V16 handed R3 a napkin to hold. V16 did not give R3 a drink of thickened liquids until after multiple bites of food. The thickened drinks were in regular glasses, not sippy or nosey cups. At 12:45 pm, V16 was still feeding R3 and did not use hand over hand or give R3 the opportunity to continue to feed self. V16 gave R3 eight spoonfuls of food before offering a drink instead of alternating liquids and solids as per R3's care plan. On 8/6/20 at 8:15 am, V5, Dietary Manager, stated that staff should have set up R3's tray when the food was delivered as R3 can feed self with set up and cueing. 2. R5's Minimum Data Set (MDS) MDS Annual, dated 7/10/20, identifies R5 has moderate cognitive impairment. R5 requires limited assistance of one staff to eat. R5 is 61 inches tall , weighs 100 pounds, and has a mechanically altered diet. R5's [DIAGNOSES REDACTED]. R5's Dietary Care Plan, dated 7/8/20, states, (R5) has an ADL (Activity of Daily Living) Self Care Performance Deficit- Dementia Aggressive Behavior, Confusion, Impaired balance, combative with care at times/resistive. (R5) will accept assistance with ADLs through next review. The approaches include EATING: The resident require set up, encouragement, supervision at least, at times due to cog (cognition) will need one staff participation to eat. Encourage to try and feed self, or place food on utensil and hand to resident, if she is unable to perform task feed her. Encourage (R5) to participate to the fullest extent possible with each interaction. On 8/4/20 at 11:40 am, R5 was seated in wheelchair in the bedroom. V13 Activity Aide offered a drink in a foam cup, dessert in a foam bowl and roll of silverware to roommate, R2, but not to R5. R5 stated, Where is my cake? V13 stated that R5 eats up front in Main Dining room and will get pureed cake and lunch at that time. On 8/4/20 at 11:55 am, R5 was seated at a table in main dining room in a wheelchair. There was a foam bowl of pureed cake with a lid and a roll of silverware plastic on table out of that was out of R5's reach. At 12:00 pm, Certified Nurse Aides (CNAs) V16, V12, V14 and V15 came into the dining room. There were two foam cups of water and tea on the table out of reach. No one offered R5 a drink. At 12:00 pm, a foam clamshell container of food was placed on the table, out of reach, and a tray with pitchers of tea and water and cups were also on R5's table. At 12:10 pm, R5 had arms stretched out trying to reach drink cups and dessert. R5 was rubbing hands all over the table. Two foam cups of drinks were just out of reach. R5 managed to get one cup of water and spilled it on the table. R5 kept bringing her hand to her mouth like she is hungry. On 8/4/20 at 12:30 pm, V12, CNA, sanitized her hands and walked over to R5 and gave R5 a drink while holding the foam cup for her. V12 then got a chair and sat by R5 and and opened the food container of pureed turkey, zucchini and mashed potatoes and began to feed R5 with a spoon. V12 did not offer to reheat food that had been sitting out for 30 minutes. At 12:35 pm, V12 poured R5 more drinks. R5 accepted the bites of food and drinks from V12. R5 kept reaching for cups but was not given a cup to hold. At 12:45 pm, V12 remained with R5 and fed the resident without encouraging R5 to self feed. On 8/6/20 at 8:15 am, V5, Dietary Manager stated that R5 has a tendency to dump drinks and food so the staff like to sit with her to assist with feeding. The staff should be encouraging R5 to participate in self feeding. V5 stated putting the food just out of reach was like teasing R5, they should have not had it on the table until they were ready to assist. 3. R15's Admission Minimum Data Set (MDS), dated [DATE], identifies R15 has severe cognitive impairment, requires extensive assist of one staff for eating. R15 has [DIAGNOSES REDACTED]. R15 is 65 inches tall, weighed 100 pounds on admission. R15's last recorded weight was 87.4 pounds (7/4/20) a significant weight loss. R15 had a stage two pressure ulcer on admission. R15 has a physician's diet order, |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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.

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| F 0676<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>dated 6/19/2020, for NAS (No Added Salt) diet, Pureed texture, Regular Liquid Consistency consistency R15's Care Plan, dated 7/8/20, states The resident has a swallowing problem Swallowing assessment results. The resident will have no choking episodes when eating through the review date. Diet to be followed as prescribed. The resident has impaired visual function. The resident has unplanned/unexpected weight loss Poor food intake. The resident will consume at least 50% at most meals. Monitor and record food intake at each meal. Offer substitutes as requested or indicated when she is not eating. On 8/4/20 at 11:55 am, R15 was seated at dining room table by self facing outside windows in the Main Dining Room. On 8/4/20 at 12:10 pm, R15 had a bowl of pureed cake with lid, had two foam cups of drinks, and had roll of plastic silverware. R15 took bowl of cake in two hands and managed to get the lid off per self. R15 tipped cup of water over on table. There were four Certified Nurse Aides (CNAs) in the dining room, however, they were sitting at tables assisting other residents. R15 had a foam container of pureed food that she had opened but was not eating much. R15 was stacking bowls and cups and wiping the table with a napkin. On 8/4/20 at 12:30 pm, V16, CNA, came over to R15 and stated, Did you make a mess and spill your drink (R15)? That's OK. V16 wiped up the spilled water and got resident new cup. At 12:35 pm, V16 CNA, warmed up R15's food in the microwave and then sat down beside to R15 help her eat. V16 offered bites of pureed turkey and mashed potatoes, which R15 accepted. V16 offered a bite of zucchini and R15 stated, I don't like zucchini. V16 did not offer a vegetable substitute to R15. At 12:37 pm, V9, Nurse, brought medication and small cup of water to R15. At that time R15 stated she was full. V16 got up from the table and performed hand hygiene, then went to assist another resident. On 8/4/20 at 12:50 pm, V19, Cook, stated they did not prepare a substitute vegetable for zucchini. V19 stated we have a tablet and residents that can choose select from the menu what they want to eat. On 8/6/20 at 8:15 am, V5, Dietary Manager, stated R15 is able to self feed depending on the day. The staff should have opened the dessert and the food and set R15 up to encourage self feeding. |
| F 0686<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to assess an existing Stage III pressure ulcer and failed to implement individualized, resident specific interventions for one resident (R1) of three residents reviewed for wounds in a sample of 15 residents. As a result of this failure, R1's existing Stage III pressure ulcer became significantly worse (Stage IV with visible muscle and bone), and R1 developed a new, facility acquired, unstageable pressure ulcer on his left heel. Findings include: R1's Care Plan, last updated 6/7/20, includes the following Diagnoses: [REDACTED]. R1's wound Care Plan, last updated 6/7/20, documents The resident has potential/actual impairment to skin integrity related to debridement of coccyx wound, immobility, dependent on staff for repositioning. A problem is documented on 6/7/2020: Stage 1 blister left heel. This description includes a blister which would indicate at least a Stage II as per current standard of practice. Wound clinic documentation, dated 6/17/20, documents this wound as unstageable. R1's Care Plan includes the following generic interventions: Wound clinic as ordered. Date Initiated: 06/09/2020 Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 03/04/2020 Follow facility protocols for treatment of [REDACTED]. to MD (medical doctor). Date Initiated: 03/04/2020 The resident needs pressure relieving/reducing mattress, pillows to protect the skin while in bed. Date Initiated: 03/04/2020 The resident needs pressure relieving/reducing cushion to protect the skin while up in chair. Date Initiated: 03/04/2020 Revision on: 06/07/2020 The resident needs protective heel boots Date Initiated: 06/07/2020 Wound vac (vacuum) as ordered Date Initiated: 06/09/2020. R1's Care Plan includes no additional interventions. R1's progress note, dated 3/3/20 at 4:02pm, documents that R1 was admitted on [DATE]. At that time, R1's skin assessment documents R1 as high risk for breakdown. The facility's Nursing Admission/Readmission Data Collection, dated 3/3/20, documents R1 was admitted with a stage III Pressure Ulcer measuring 6x3x3.5 centimeters (Length x Width x Depth) to his sacrum. There is no assessment of the appearance of the wound or whether there is any drainage from the wound or any odor. No wound assessment is documented until 3/5/20 at 2:08pm. No wound treatment is documented on Treatment Administration Sheet as completed until evening shift on 3/5/20. Wound Assessment on 3/5/20 at 2:08 pm, documents the measurements of R1's pressure ulcer on Sacrum as 6x4x1.5 centimeters (cm.) (length x Width x Depth). At that time a treatment order is received from physician and initiated for: Cleanse wound with normal saline, apply alginate to wound bed, and cover with foam border dressing. On 3/31/20, the wound assessment states the wound measures 3x2.5x2.5cm. A dressing is signed off the treatment sheet as done daily beginning 3/5/20. The wound is not assessed except for weekly wound sheets. On 4/21/20, even though the wound was improving at this point, the wound care order is changed to: Cleanse wound, apply Santyl ointment to wound bed, cover with Dakin's solution and dry dressing. Although the wound treatment is signed off on the treatment sheet as done daily, no assessment of the wound is completed except for the weekly wound tracking. On 5/20/20, R1 was seen by the local hospital wound clinic. The wound clinic documents the sacral wound measurements are 10 x 8 x 5.5 centimeters with 34%to 66% necrosis (eschar) and exposed muscle. At that visit, a [DEVICE] was ordered. The [DEVICE] is documented as placed on 5/21/20, at 125 millimeters of suction. At that time, the wound clinic ordered Low air loss mattress, inflatable cushion for wheelchair, turn and position every two hours, and float heels off bed and chair. However, R1's care plan was not personalized to include these interventions, and it is not documented whether they were initiated or not. From the time the [DEVICE] was placed, until 6/12/20 when R1 went for a surgical debridement of the sacral wound, there is no documentation of the appearance of the wound, how much drainage the [DEVICE] is collecting, or whether the wound vac is even functioning. On 6/7/20, the heel wound was documented on R1's progress notes. On 6/10/20, the wound clinic documented the wound on R1's Coccyx measured 10 x 9. x 5.9 centimeters, with exposed muscle and bone, had foul odor and 67-100% necrosis . On 6/10/20, the wound clinic documented the facility acquired heel wound had progressed to 4.5 x 5.5 x 0.1 and was documented at unstageable. On 6/17/20, the wound clinic documents the wound to R1's sacrum has increased to 11 x 14 x 5 centimeters following surgical debridement. On 8/5/20 V2, Director of Nursing (DON), verbalized R22, Registered Nurse (RN) former wound nurse, had been responsible for wound care until he ended his employment with the facility recently. The facility did not know how to contact R22. V2 stated, I thought he was doing a good job of wound care and documentation until I discovered his documentation was not up to my standards. I agree that there should have been better wound documentation. I realize our care plans aren't what they should be, and I am working with corporate to improve that. R1 was hospitalized during the onsite portion of this survey. On 8/5/20 at 12:45am, V20, Wound Care Nurse Manager at the wound clinic caring for R1's wound, verbalized that in her opinion R1 was not being off loaded as recommended related to the rapid deterioration of the sacral wound and the development of the unstageable heel wound. V20 stated, It's really sad. (R1) was positive and kidded around with us when he first came to us. But the last few times I've seen him, he just hangs his head and cries. I think there was some issue at the facility with the function of the [DEVICE]. I remember (V22) the wound nurse talking to us about having to get a replacement pump. On 8/5/20, V21, Wound Care Medical Doctor, stated, They (the facility) didn't take very good care of (R1). I can say that if (the facility) had followed the wound care recommendation that I made (R1's) sacral (Coccyx) wound would not have deteriorated as rapidly as it did, and if (the facility) had floated (R1's) heels on a low air loss mattress he would not have developed the second pressure area on his heel. |