STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000621	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASCOUTAH REHAB AND NURSING	201 SOUTH 10TH STREET , MASCOUTAH, Illinois, 62258

(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) COMPLETION DATE
S0000	Initial Comments Complaint Survey: 2547275/2581027	S0000		08/20/2025
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)2)3 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to order a abdominal ultrasound, urinalysis/culture and sensitivity in a timely manner for 1 (R4) of 3 residents reviewed for timeliness of care in the sample of 3. This failure resulted in a nonverbal resident (R4) being transferred to the emergency room and diagnosed with a impacted stool in the intestine that was digitally removed from her	S9999		08/20/2025

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

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S9999	Continued from page 1 rectum, enema, IV hydration and intramuscular shot for the urinary tract infection and put on oral antibiotics. Using the reasonable person approach, this failure caused pain, discomfort and invasive interventions during a hospital visit. Findings include: R4's Undated Face Sheet documents she was initially admitted to the facility on 10/13/1983 with diagnoses including cerebral palsy, constipation and GERD. R4's Care Plan, dated 3/31/2025 documents focus bowel and bladder incontinence. Interventions: record bowel movements, frequency, and consistency. Assess any signs of discomfort, burning or itching around anus, loss of appetite, etc. No documentation of R4's diagnosis of constipation was addressed/documented on her care plan. Another focus: R4 has a communication problem, she is nonverbal. Goal: R4 will feel heard and understood, as reflected in her body language and facial expressions. Interventions: encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense or respond to the feeling resident is trying to express. Monitor/document for physical/nonverbal indicators of discomfort or distress and follow-up as needed. R4's Annual Minimum Data Set, dated 6/14/2025 documents she is severely cognitively impaired, no constipation present, both sides functional impairment in range of motion, wheelchair for mobility device, doesn't ambulate, dependent on staff for toileting, incontinent of bowel and bladder. R4's Physician's Order Sheet (POS), dated 12/2/2021 MiraLAX 17 grams by mouth every day for constipation. 12/2/2021 Senokot S 8.6 milligrams/50 mg two times a day for constipation and 1/27/2025 Bisacodyl 1 suppository rectally at bedtime every other night for constipation. R4's Medication Administration Record (MAR) dated 8/2025 staff documented physician prescribed medications to treat constipation were administered as ordered. R4's POS, dated 8/4/2025, documents a urinalysis and reflex culture (no reason for order) and an ultrasound abdomen and pelvis indication: mass in lower left quadrant. R4's Bowel and Bladder document, dated 8/3/2025 through 8/14/2025 staff documented R4 had a small bowel	S9999		

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S9999	Continued from page 2 movement on 8/3/2025, large bowel movement on 8/9/2025 and 8/11/2025 and a small bowel movement on 8/12/2025. R4's Nursing Progress dated 8/4/2025 through 8/7/2025 no documentation as to why a urinalysis and reflex culture was ordered and no documentation if either test was collected/completed. R4's Nursing Progress Note, dated 8/7/2025 at 1:33 AM, documents attempted to get urine per sterile technique without success. No documentation if the ultrasound abdomen and pelvis was completed. R4's Physician's Progress Note, dated 8/8/2025 at 7:00 AM documents urinalysis and reflex culture sent. R4's Medical Record dated 8/8/2025 through 8/11/2025 showed no urinalysis and reflex culture, or ultrasound abdomen and pelvis results were not uploaded in R4's Medical Record. R4's Physician's Progress Note, dated 8/11/2025 at 7:00 AM, documents the patient is a poor historian due to cerebral palsy and aphasia. The patient history is taken from her family and nursing staff. The patient has been restless and agitation for the past week. There was possible grimacing and complaint of pain witness by her family. Anxiety versus GI/GU (genitourinary/gastrointestinal) symptoms, continuing to await US (ultrasound) and UA (urinalysis)/UC (urine culture.) R4's Medical Record was reviewed for the UA/UC and abdominal/pelvic ultrasound on 8/12/2025 at 12:00 PM. The results were not uploaded in R4's electronic medical record at that time. On 8/12/2025 at 12:10 PM V1, Administrator and V2, Interim Director of Nursing stated he noted a day or so ago that R4's UA/UC was not collected yet and the abdominal/pelvic ultrasound was not completed yet and he had been on the phone with the ultrasound company all morning trying to figure out why it wasn't done yet. V2 stated the ultrasound company informed him that the physician's order verbiage was not correct, and it needed the word "limited" to be added to it so the ultrasound would be covered by insurance. V2 stated he didn't know why the physician ordered a UA/UC other than to rule out a UTI and the ultrasound abdomen/pelvis was ordered because R4's physician felt a mass in her abdomen. V2 wasn't aware the laboratory and ultrasound tests were not completed until the surveyor requested the test results, that's when he started making calls to see why the tests were not	S9999		

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S9999	Continued from page 3 completed. V1 stated when a physician orders a lab test and/or an ultrasound she expects the UA to be collected and sent off to the lab the next day and if it was attempted to be collected and unsuccessful, the nurse should report that to the oncoming nurse and that nurse should attempt to collect the specimen. If there are any issues getting a specimen i.e. urine collected and/or issues with getting an ultrasound completed nurses should notify the resident's physician within 24 hours and update them on why the tests were not done. V1 stated it was a breakdown of communication between nurses as to why these tests were not completed in a timely manner. R4's Nursing Progress Note, dated 8/12/2025 at 2:16 PM staff documented company here to do abd (abdominal) x ray for a mass to left quad. At 2:50 PM, staff documented, attempted to obtain UA sample via straight cath per sterile technique. Attempt was unsuccessful. Evening shift nurse notified that sample is needing to be collected, verbally understood. At 9:21 PM, staff documented x ray results received and faxed to MD (physician.) At 9:34 PM staff documented, urine obtained & in fridge in med room. Lab req filled out & faxed to lab. Lab to p/u (pick up) urine in the AM (morning.) R4's Laboratory Report, dated 8/12/2025 documents urine specimen collected on 8/12/2025. UA results: pending. UC results: Escherichila Coli (E-Coli.) R4's Ultrasound Patient Report, dated 8/14/2025 documents pelvis ultrasound findings: images of the bladder are unremarkable. Left lower quadrant images are unremarkable as well. There is no evidence of mass, cyst or fluid collection. Impression: unremarkable examination. R4's Ultrasound Patient Report, dated 8/14/2025 documents abdomen ultrasound findings: trace amount of ascites is noted in the left lower abdomen/pelvis. Peristalsing bowel loops are noted in the left lower abdomen early in the exam, measuring up to 2.3 centimeters in diameter. No discrete mass is identified. Impression: slightly dilated peristalsing bowel loops in the lower left abdomen. Correlate for enteritis versus small bowel obstruction. R4's After Visit Emergency Room Summary, dated 8/15/2025 documents, reason for visit: abdominal pain. Diagnoses: impacted stool in intestine, UTI and constipation. Instructions: Evaluated in the emergency department today with primary concern of possible constipation. Your workup was concerning for UTI as	S9999		

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S9999	Continued from page 4 well. Fecal disimpactation at bedside. Medications administered: Rocephin 1 gram injection (treatment of UTI), saline enema, sodium chloride 0.9% (intravenous fluid for hydration) and Iodamide. R4's POS, dated 8/15/2025, documents a new physician's order Cephalexin 500 mg twice a day for 7 days to treat UTI. On 8/19/2025 at 10:00 AM V1, Administrator and V2, DON stated R4 is a total care, she is incontinent of bowel and bladder and is dependent with all care and is nonverbal. V2 stated staff are expected to document when a resident has a bowel movement in the electronic medical record so they can ensure residents are not constipated. Staff documented R4 had a small bowel movement on 8/12/2025. R4 was transferred to the emergency room after R4's physician reviewed the abdominal ultrasound results on 8/15/2025 as she wanted to rule out a small bowel obstruction. The emergency room discharge paperwork documents she was impacted, and emergency room staff digitally removed the impaction at bedside. After an enema was administrated R4 had a large bowel movement, and she had another large bowel movement when she was readmitted to the facility. V2 stated R4 was also diagnosed a UTI and was administered an intramuscular shot of antibiotics in the emergency room and is continuing by mouth antibiotics at the facility to treat the UTI. V2 stated R4 didn't have a bowel obstruction and the constipation was resolved immediately after the enema was administered in the emergency room. On 8/19/2025 at 10:40 AM V19, R4's physician stated she ordered the abdominal ultrasound on 8/42025 due to feeling a mass in her abdomen but she was more concerned with her having a UTI at that time. R4 is nonverbal and therefore she can't voice pain but when she assessed her on 8/42025 V19 felt R4 was either in pain or experiencing anxiety so she ordered a UA/C&S and an abdominal ultrasound for the mass felt in her abdomen that day. V19 stated the tests were not done in a timely fashion and stated she comes to the facility on Mondays and Fridays and she expected to have both test results back that Friday, 8/8/2025 but she spoke to the floor nurses who were agency staff and they told her the tests were completed but the results weren't in R4's electronic medical record and the medical records employee was on vacation at that time so she had issues getting the test results. After the abdominal ultrasound was completed, she reviewed the results the next day and stated she sent R4 to the emergency room to rule out a small bowel obstruction and stated she reviewed the emergency room records and it was	S9999		

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S9999	Continued from page 5 determined R4 had impacted stool near the rectum which was digitally removed at bedside in the emergency room and R4 received an enema in the emergency room where she had 2 large stools right after. V19 stated it was determined that R4 has a UTI and she received an intramuscular shot of antibiotics in the emergency room and she is on a by mouth antibiotic at the facility to treat that. V19 stated she expected the facility to follow the policies and procedures to ensure physician ordered tests are completed in a timely fashion. On 8/19/2025 at 3:00 PM, V2 stated the facility doesn't have a policy or procedure that documents when a lab or ultrasound timeframe should be done. "B"	S9999		