STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002877	A. BUILDING: _____ B. WING _____	10/22/2021

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ALTON MEMORIAL REHAB & THERAPY	1251 COLLEGE AVENUE ALTON, IL 62002

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Annual Licensure and Certification Survey STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210)b 300.1210d)5) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations were not met as evidenced by: Based on interview, observation and record review, the facility failed to timely identify, treat, and provide timely repositioning for pressure ulcer treatment and prevention for 4 of 7 residents (R14, R31, R107, R108) reviewed for pressure ulcers in the sample of 48. This failure has resulted in R108 sustaining an unstageable, painful, necrotic 3.5 centimeter (cm) x 4 cm pressure ulcer to the left calf and a stage III coccyx pressure ulcer. Findings include: 1. R108's Physician Order Review/Renewal, print date of 10/20/21, documents R108's date of birth	S9999		

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S9999	Continued From page 2 of 07/10/1917 was admitted on 10/4/21 with diagnoses of Displaced Bicondylar fracture of left tibia, subsequent encounter for closed fracture with routine healing, Congestive Heart Failure and Mild Cognitive Impairment (so stated). R108's Minimum Data Set (MDS), dated 10/11/21, documents R108 in independent in decision making for daily tasks, requires limited assistance of 2 staff members for bed mobility, transfers, toileting and limited assistance of 1 staff member for personal hygiene. This MDS also documents R108 utilizes a wheelchair for mobility, is always incontinent of bowel and bladder, is at risk of developing a pressure ulcer and has no pressure ulcers at this time. R108's Physician Order Review/Renewal, print date of 10/20/21, documents: Start date 10/4/21. Skin Evaluation. q (every) week. Start date 10/14/21. Pressure Reducing Mattress or Overlay. Constant Order. Start date 10/12/21. Wound Care TAR (Treatment Administration Record). Pressure Ulcer, Coccyx, Bilateral, Coccyx, Foam, q (every) 3 days, PRN (as needed), cleanse area to coccyx, apply foam dressing q 3 days and PRN. R108's Hospital Discharge Paperwork, dated 10/4/2021, documents, "Other instructions: Partial weight bearing to left leg, immobilizer on at all times when up." R108's Braden Score Flow Sheet, print date of 10/20/21, documents on 10/4/21, R108's Braden Score was 15, on 10/10/21 it was 14, on 10/11/21 it was 14 and on 10/15/21 it was 13. The Braden scale for risk of pressure ulcers is 13- 14 a moderate range and 15- 18 a mild range of acquiring a pressure ulcer.	S9999		

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S9999	Continued From page 3 R108's Nurse Wound Assessment Detail Report documents, "10/12/21. Where is skin problem? Coccyx. Origin: Acquired in facility. Wound Type: Pressure Injury . Pressure Injury Staging: Stage II. Length of measurements in cm: 1. Width of measurements in cm: 3 Depth of measurements in cm: 0.1. Describe drainage: No drainage. Describe wound: Pink, uninvolved. Comprehensive wound note: Resident has pressure injury to coccyx, measuring 1 cm x 3 cm, superficial in depth." R108's Nurse Wound Assessment Detail Report documents, "10/18/21. Where is skin problem? Coccyx. Origin: Acquired in facility. Wound Type: Pressure Injury . Pressure Injury Staging: Stage III. Length of measurements in cm: 1.1. Width of measurements in cm: 2 Describe drainage: Sero-sanguineous drainage scant. Describe wound: Slough. Comprehensive wound note: Cont (continue) foam dressing to bottom q3d (every three days) and PRN. education about off loading given to family and will work with therapy to off load as much as possible and have up in chair around meals times to allow therapy sessions and off loading." R108's Care Plan, print date of 10/20/21, documents, "Skin. I am at risk for alteration in skin appearance secondary to my deficits with self-performance bed mobility. Assist me with daily repositioning as needed. Monitor my skin with daily care task assistance for any changes in skin appearance or skin integrity. Report any changes. Open area to coccyx. TX (treatment) as ordered, assist w (with)/ turning and repositioning, PT OT (Physical Therapy and Occupational Therapy) as ordered to increase ADL (activities of daily living) function. I wear a brace to my left leg	S9999		

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only when I am up and the nurses will check my skin daily, if any changes the MD (Medical Doctor)/ POA (Power of Attorney) will be notified."

On 10/19/21 at 10:28 AM, R108 was sitting in her wheelchair in her room asleep with the left leg immobilizer on and her leg extended with her heel on the floor. R108 remained in her wheelchair positioned the same way until 3:30 PM without the benefit of repositioning or incontinence care based on 15 minute or less observation intervals. At 3:30 PM, V4, Physical Therapist, assisted R108 to bed to do transfer training, therapy exercises and education with R108 and R108's daughter.

On 10/20/21 at 9:45 AM, R108 was lying in bed with a soft left leg immobilizer on which started mid thigh and ended mid calf. V5, Certified Nursing Aide (CNA), and V12, CNA, performed incontinent care for R108. R108's coccyx dressing was soiled with urine and at this time a large necrotic pressure ulcer could be seen under R108's left leg immobilizer on R108's calf. V3, Assistant Director of Nurses (ADON)/ Wound Nurse, was told of the need for a new coccyx dressing.

On 10/20/21 at 10:40 AM, V3 stated that R108 has a coccyx wound that is a facility acquired pressure ulcer and that the wound opened on 10/12/21 measuring 1 cm x 3 cm x 0.1 cm and that on 10/18/21 the wound measured 1.1 cm x 2 cm that it was slough with scant drainage. V3 stated that the wound is treated with cleansing the wound with normal saline and then placing a foam dressing over the wound. V3 stated, "(R108) has preventative measures in place of a low air loss mattress and offloading her often. R108 is 104 years old sometimes she doesn't

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want to lay on her back. She is 104 she can do what she wants." V3 was then told of the observation of the extended period of time that R108 stayed in the same position the day before, V3 stated, "I will have to do education that should not have happened."

On 10/20/21 at 10:45 AM, V3 changed R108's soiled coccyx dressing and measured the wound. R108's coccyx wound measured 2 cm x 0.5 cm, the wound bed was white, the peri-wound was intact and slightly red. The old dressing had greenish brown drainage on it. At this time, a large necrotic pressure ulcer could be seen under R108's left leg immobilizer on R108's calf.

On 10/20/ 21 at 10:46 AM, V3 was asked what treatment was in place for the pressure wound on R108's left calf, V3 stated, "I did not know she had that." V3 unfastened the Velcro straps of the brace and then assessed, measured and treated the pressure ulcer to R108 calf. R108 would yell out in pain anytime the area was touched. The bottom of the brace had green/brown/black drainage on it. V3 stated, "The wound measures 3.5 cm x 4 cm, the wound bed is necrotic, it is unstageable, the edges of the wound are inflamed, it is open at the top with slough and it is obviously painful." V3 further stated, "The staff should be checking under the brace at least once a day for skin breakdown. I did her coccyx dressing Monday and that brace is new she did not have that wound or the brace on then."

On 10/20/21 at 10:47 AM, V5 CNA, stated, "(R108) has had that brace since she was admitted. I think it came from the hospital." V5 also stated that the brace comes off for showers and she has never seen the wound under it.

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S9999	Continued From page 6 On 10/20/21 at 10:50 AM, V4, Physical Therapist, stated, "(R108) has always had the brace. She has a leg fracture. It always stays on." On 10/20/21 at 1:30 PM, V7, Registered Nurse (RN), stated, "If someone has a brace, we look under the brace at least once a day and chart on it under the skin assessment." On 10/20/21 at 1:50 PM, V23, RN, stated, "I have only taken care of (R108) two times this Monday and Tuesday. I did not look under her brace. I did not know that she had a large pressure wound under it. If someone does have a brace, we will chart on it under the skin assessment tab." On 10/20/21 at 1:55 PM, V12, CNA, stated, "(R108) has always had the brace, and I have never taken it off. I didn't know she had a wound under it." On 10/20/21 at 2:15 PM, V3 stated, "The nurses should have been charting on looking at the brace. Under the skin assessment tab, it will have an area for braces, but for that to be there (show up), there needs to be an order for it to show up. I did not see that it got ordered. The wound doctor will see her tomorrow by teleconference." On 10/20/21 at 2:30 PM, V3 stated, "I misspoke she did have the leg brace on. I talked with her daughter because she was in there when I did it (the coccyx dressing) Monday and (R108) had sweat pants on. When I did her dressing to the coccyx, she had sweat pants on and I did not see her whole leg. She was admitted with the brace." On 10/21/21 at 1:06 PM, V3 stated, "The wound doctor did see (R108) today and she said she expects the wound to get much worse	S9999		

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S9999	Continued From page 7 considering her advanced age. She requested that we notify the orthopedic doctor which we have done and maybe we can get a different brace for her since this one is causing pressure. We have not heard back from the orthopedic doctor." On 10/21/21 at 1:26 PM, V2, Director of Nurses (DON), stated, "The nurses were doing skin assessments but it doesn't show anything other than they did it. They were not documenting specifically on the brace." On 10/21/21 at 2:50 PM, V25, Wound Doctor, stated, "I did see (R108's) wound on her calf by teleconference today. It was hard to get a good look at it, but it is obviously it is a pressure wound caused by the leg brace. Which I see too many of those. It is necrotic and unstageable due to the necrotic area. I recommended that they contact ortho (orthopedic doctor) to see if she needs the brace still and if she does, is there a different brace she could use. That wound will not heal with the brace that she has because it is causing pressure. I cannot say what the outcome will be or how long she has had that wound. I do know that it is very sad, she is 104 years old and to get a wound like that it is just sad." V25 further stated, "The nurses should have been checking under that brace at least once a day for wounds at least." 2. R107's Physician Order Review/ Renewal, print date of 10/20/21, documents R107 was admitted on 9/2/21 with diagnoses of Aftercare following joint replacement surgery, Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, Encounter for after care, Pedestrian on foot injured in collision with car, pick up truck or van in nontraffic	S9999		

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S9999	Continued From page 8 accident. R107's Physician Order Review/ Renewal, print date of 10/20/21, documents, Start Date 9/2/21. Skin Care Protocol. Start Date 10/17/21. Wound Care TAR. Abrasion, Heel, Right, Heel, Foam, q3days, PRN, Cleanse right heel, apply foam dressing q3days and PRN. R107's Nurse Wound Assessment Detail Report, print date of 10/20/21, documents R107 did have bilateral heel wounds that were documented as healed on 10/5/21. R107's Braden Score Flow Sheet, print date of 10/20/21, documents on 10/7/21 it was 16. The Braden scale for risk of pressure ulcers is 15- 18 a mild range of acquiring a pressure ulcer. R107's MDS, dated 9/9/21, documents R107 is cognitively intact and is at risk for pressure ulcers. R107's Care Plan, print date of 10/20/21, documents, "Skin. I am at risk for impaired skin, interventions are to off load my heels as much as possible and notify my nurse of any changes to my skin integrity." On 10/18/21 at 11:00 AM, R107 stated, "I have a sore on my right heel. I got it here. They weren't checking my heels. It started as a blister then the skin got really hard. They had the wound doctor come in and he pulled it off. That really hurt. I put oil and a bandage on it but the nurses don't do anything with it. I asked over the weekend multiple times for a nurse to look at it because it hurts. I bought shoes this weekend because walking with socks was really hurting. The nurses never came and looked at it."	S9999		

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S9999	Continued From page 9 On 10/20/21 at 2:10 PM, R107's feet were assessed by V3, ADON. R107's right upper heel area measured 1 cm x 0.8 cm. R107's flinched and stated the right heel hurt upon assessment. R107's left heel was assessed to be a large callous area. On 10/20/21 at 2:15 PM, V3 stated, "The right heel is mushy and has drainage. I would stage it as a deep tissue injury. I wish someone would have let me know about it. I will have to figure out who she told. The left heel is just a callous area. She was admitted with them and we healed them up a couple of weeks ago." 3. R14's MDS dated 9/18/21, documents that R14 is cognitively intact and requires extensive assist from two staff members for bed mobility, requires extensive assistance from one staff member for toileting and personal hygiene, and is totally dependent on two staff members for transfers. R14 has a functional limitation to one side and is always incontinent of bowel and bladder. R14's Care Plan, dated 10/19/21, documents R14 is a total assist for bathing and bed mobility, an extensive assist for dressing and transferring by use of mechanical lift. It continues with R14 is incontinent of both bowel and bladder. It continues with R14 sits in a geriatric reclining chair, turn and reposition routinely. It continues with R14 has an unstageable wound to the right hip. It continues with R14 is at risk for skin breakdown. Assist with repositioning frequently. Interventions: Turn and reposition as needed, provide incontinent care as needed, keep skin dry, wheelchair cushion, low air loss mattress, treatments as ordered.	S9999		

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S9999	Continued From page 10 On 10/18/21 at 10:02 AM, R14 was sitting in the dining room in her geriatric reclining chair. R14 stated, "I have a sore on my butt. I think it's on my right side." On 10/19/21 at 9:30 AM, R14 was sitting in her geriatric reclining chair, leaning to her left side and eating breakfast. On 10/19/21 at 10:00 AM, R14 continued to sit in her geriatric reclining chair in the dining room. She was now facing the TV and continued to lean to her left side. On 10/19/21 at 11:00 AM, R14 was sitting in the dining room by herself in the same position and continued to lean to her left side. On 10/19/21 at 11:50 AM, R14 remained sitting in dining room in her geriatric reclining chair leaning to the left. R14 was asked if she had been there since breakfast, R14 stated "Well, I was over by the TV and now I'm by the table." R14 was asked if anyone has changed her or checked on her R14 stated, "No, no one has done anything yet." On 10/19/21 at 12:00 PM, R14 remained in her geriatric reclining chair at the dining room table and staff served her lunch. On 10/19/21 at 12:45 PM, V13, CNA, pushed R14 out of the dining room and left her in the hallway. At this time, V13 stated, "They are helping someone else get into bed now and will get with R14 shortly." On 10/19/21 at 12:55 PM, R14 was placed in her room and transferred to her bed. Perineal care was provided. R14's incontinent brief was soiled	S9999		

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with both urine and stool. R14's dressing dated 10/18/21 on R14 right hip had moved and was not over the open area. V14, CNA, stated, "The nurse will have to come and change that dressing" then continued with the perineal care. R14 was pulled up in bed. R14 was positioned that R14 remained on R14 left side.

The wound management log documents on 10/19/21 R14's pressure ulcer to her right hip as a stage 4 wound measuring 0.5 X 0.5 X 1.8 cm. The previous measurement (unsure of date) documents a measurement of 0.4 X 0.7 X 1.3 cm.

On 10/20/21, at 2:00 PM, V19, Licensed Practical Nurse (LPN), stated "We try and put (R14) back to bed to rest after every meal and get R14 up for the next meal."

4. R31's MDS dated 8/15/21, documents that R31 is cognitively intact and requires extensive assistance from one staff member for toileting, bathing, and dressing. R31 is incontinent of bowel and bladder.

R31's Care Plan, dated 9/26/21, documents R31 requires extensive assist with most ADL's. It continues with R31 is incontinent of urine and bowel. It continues with R31 has skin breakdown that includes a pressure ulcer (PU). It continues with R31 is incontinent and requires assistance with turning and repositioning. Intervention: provide perineal and skin care as needed and after episodes of incontinence.

On 10/18/21 at 9:30 AM, R31 was sitting in her wheelchair requesting to get into bed. R31 stated, "I have been up since before breakfast." V13, CNA, transferred R31 from her wheelchair

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to her bed and left R31 on her back with Head of Bed (HOB) elevated in bed.

On 10/18/21 at 11:00 AM, R31 remained in bed on her back with HOB elevated. R31 stated, "I should be getting lunch soon."

On 10/18/21 at 12:35 PM, R31 remained in bed on her back with HOB elevated. R31 stated, "I told them I was wet and needed changed and was told I would have to wait until after lunch was over."

On 10/18/21, at 1:15 PM, R31 was sitting upright on her back in bed and had not been cleaned up from her previous incontinent episode. V18, R31's son, stated, "They are so short staffed here. She (R31) does not get the same care on the weekends as she normally gets during the week."

On 10/18/21 at 2:00 PM, R31 stated, "They finally came in around 1:30 (PM) and changed me and was done by 1:45 (PM)." R31 was is in bed resting on her back with HOB elevated.

On 10/19/21 at 9:15 AM, R31 was s resting in bed on her back, HOB elevated and without complaints at this time.

On 10/19/21 at 12:30 PM, R31 remains wasn bed on her back with HOB elevated.

On 10/20/21 at 8:50 AM, R31 was sitting up in her wheelchair at the side of her bed and was finishing her breakfast.

On 10/20/21 at 12:10 PM, R31 was resting in bed, just finished lunch, turned to her left side. Stated "They just rolled me over to my side."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002877	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON MEMORIAL REHAB & THERAPY	1251 COLLEGE AVENUE ALTON, IL 62002

(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
S9999	Continued From page 13 On 10/20/21, at 2:00 PM, V19, LPN, stated "The aides are supposed to turn and reposition each resident every two hours. If I'm doing care on a resident, I will turn and reposition them at that time because I'm not sure when they were done last." On 10/21/21, at 2:15 PM, V3, ADON, stated "The pressure ulcer situation is a case by case issue. Each one has specific reasons why they're not getting any better." On 10/21/21, at 2:20 PM, V3, ADON, stated "I'm constantly on the floor, and I honestly can't say the staff are turning the residents every two hours." The facility's Skin Integrity, Assessment and Prevention of Wounds / Other Skin Conditions policy and procedure, dated 5/2019, documents, "II> Prevention. A. Residents at risk should have a visual skin inspection daily, paying particular attentions to bony prominences and pressure caused by ill - fitting shoes or medical devices such as splints, braces, cast, compressions stocking, oxygen cannulas, pommel cushions, etc (et cetera). CNAs will report report any abnormal finding to a nurse." The policy continues, "3. Activity and Mobility. For limited mobility, implement the following. a. For bed bound residents, individualized turning schedule with a minimum of turn every 2 hours. b. For chair bound residents, individualized repositioning schedule. Develop plan of care for scheduled rest periods in bed." The policy continues, "7. Medical Devices. Pressure injuries may develop at sites from positioning or use of medical devices. Examples: Ear lobes. Side of head from oxygen cannulas/masks. Nares, urinary meatus, and	S9999		

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	IL6002877	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON MEMORIAL REHAB & THERAPY	1251 COLLEGE AVENUE ALTON, IL 62002

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S9999	Continued From page 14 extremities caused by tubes, casts, orthotic devices (braces, splints, boots), cervical collars, pommel cushions or other medical devices. Ill-fitting shoes may cause blisters or pressure on the feet. Note: Orthotic devices such as boots, braces and splints require diligent checking to ensure proper fit and positioning. Consider also consultation and evaluation from Rehab (rehabilition) when using these devices. Careful observation and appropriate interventions relative to all medical devices is important and should be care planned and communicated to all caregivers." (B)	S9999		