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
	IL6002877	A. BUILDING: _____ B. WING _____	12/01/2022

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
S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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.	S9999		
	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.		**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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: Based on observation, interview and record review, the facility failed to ensure fall interventions are implemented and provide supervision for safety for 1 of 4 residents (R28) reviewed for falls in the sample of 29. This failure resulted in R28 sustaining multiple falls with multiple fractures. Finding includes:	S9999		
	R28's Morse Fall Risk Score, dated 10/30/2022, documented that she was at high risk for falls. R28's Minimum Data Set, dated 9/9/2022 documented that R28 was rarely or never understood cognitively, that she required limited to extensive assistance of 1 staff member for activities of daily living, and that her balance was not steady and that she was only able to stabilize with staff assistance while moving from seated to standing position.			

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S9999	Continued From page 2 R28's Post Fall Evaluation, dated 10/30/2022, documented, "Morse Fall Risk Score: 80." It continues, "Team Meeting Notes: Writer is notified about fall. Immediately, writer goes to see Patient. Writer sees patient laying with left side on the fall (sic) at the hallway. Patient is helped to stand with maximum assist. Patient is unable to explain situation; unable to confirm or decline head hitting the floor. Patient consistently complains of general pain; mad (sic)reference to shoulder and head upon assessment. No apparent skin injury gait is weak and unsteady. Patient is helped back to wheelchair. (Power of Attorney) is informed; Resident is transferred to ER (Emergency Room) for evaluation. (V14, R28's Physician) is notified." It continues, "Intervention: will notify family regarding recommendation for sitter. Resident will be monitored at the nurse's station for better supervision. (V14, R28's Physician and Power of Attorney) aware." R28's Post Fall Evaluation, dated 11/01/2022, documented, "Member was observed sitting on the floor facing the door looking down at floor. She was holding her forehead with her (left) hand and when (Nurse) assessed the area (Nurse) noted a hematoma to (left) forehead, involving eyebrow with a small laceration within the hematoma and a scant amount of blood present. No other injuries were noted. Resident was assisted up to her manual wheelchair per 1 assist and was able to bear weight with out (complaint of) pain." It continues, " She was brought to the nurse's station for supervision and an ice pack was applied to the hematoma." It continues, "Intervention: if resident becomes anxious and restless, place in recliner at the nurse's station for close supervision, thick black mat next to bed when in bed in the lowest position. (V14, R28's	S9999		

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S9999	Continued From page 3 Physician and Power of Attorney) aware." R28's Hospital Record, dated 11/01/2022 to 11/04/2022, documented, "(Computerized tomography) Pelvis (without) contrast. Result date 11/01/2022." It continues, "Impression: Non displaced fracture through the left lateral sacral body extending to the sacroiliac joint." R28's Care Plan, dated 11/15/2022, documented, "I am at risk for falls related to my (history) of falls. Please ensure my bed is at an appropriate height at all times. Ensure my call light is within reach when I am in my room. Round on me as needed to ensure I do not need assistance with ambulation. My goal is to reduce the risk factor that contribute to my fall risk and to minimize the risk of injury related to my falls throughout this review period." On 11/28/2022 at 12:31 PM, R28 was lying in bed asleep. The bed was in the lowest position but there were no floor mats on either side of the bed nor was her call light within reach. On 11/29/2022 at 09:18 AM, R28 was lying in bed asleep call light within reach and bed in the lowest position but there were no floor mats on either side of the bed. On 11/29/2022 at 12:27 PM, R28 was sitting up in wheelchair at the nurses station and V6, LPN, was sitting at the nurses station. On 11/30/2022 at 08:44 AM, R28 was not in her room or anywhere around the unit, V7, Registered Nurse (RN), stated that she was told that R28 was sent to the hospital last night because she fell and that they do not know if she will be returning. V7 stated that she did not know	S9999		

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S9999	Continued From page 4 what happened or how R28 fell. On 11/30/2022 at 10:00 AM, V11, Licensed Practical Nurse (LPN), stated that R28 was sitting up in her wheelchair across from the nurses station and that she (V11) was in another resident's room passing medications. When she (V11) exited the other resident's room, she saw R28 leaning forward like she was picking up something off of the floor and she couldn't get to her fast enough before she fell onto the floor, onto her left side. V11 continued to state that R28 complained of left arm pain so the doctor and the family was notified and V14, R28's Physician, ordered an xray of her left arm, which showed a fracture of her wrist and she was sent out to the hospital. V11 also stated that the CNA's (Certified Nursing Assistants) and the other nurse were in other rooms assisting other residents and there was no one sitting at the nurses station when R28 was in the hallway across from the nurses station. V11 continued to state that R28 was seen about 5 minutes prior to her fall. V11 stated that when R28 is up to her wheelchair she is parked in front of the nurses station because she is a high fall risk. On 12/01/2022 at 10:33 AM, V15, LPN, stated that she was in a room assisting another resident when R28 fell and that she was seen a few minutes prior to her fall but not by her. V15 also stated that they have tried everything with R28. On 11/30/22 at 12:30 PM, V14, R28's Physician, stated that R28 was very mobile and when she fell the 1st time, the facility started fall precautions. V14 stated yes that if R28 was sat out in front of the nurses station in her wheelchair, he would expect a nurse or a staff member to be there to observe her. When asked	S9999		

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S9999	Continued From page 5	S9999		

if the facility would have provided a 1 to 1 sitter or temporary sitter to sit with R28 would that have maybe prevented her from falling, V14 stated a temporary sitter would if it could be provided by the facility. V14 stated yes all safety protocols should be in place for R28.

R28's Post Fall Evaluation, dated 11/29/2022, documented, "Team Meeting Notes: Resident was sitting in (wheelchair) in hallway and this nurse was walking out of (R139's room) and noted resident leaning forward and to left of (wheelchair) and tried to get to resident and fell to left side of (wheelchair) and landed on left arm. (R28) states I hurt my arm. Assisted up with 2 assist to (wheelchair)." It continues, "Resident wanting to go to bed, assisted to bed with this nurse assist. (V14, R28's Physician) and and informed of fall and received orders to x-ray (left) wrist. Son informed of fall and apparent injury. (Mobile X-Ray Service) here to x-ray (left) wrist and showed (fracture). Son aware and resident being sent to (local hospital emergency department). Son here to go with resident. Report given to (Registered Nurse) in (Emergency Room)."

R28's Radiological Report, dated 11/29/2022, documented, "Reason: Fall with Pain and Mild Swelling. Procedure: 73110-Left Wrist, Complete, 3+ Views" It continues, "Impressions: Subacute distal radial and ulnar fractures."

V18's, CNA, written statement, dated 11/29/2022 at 10:30 PM documented, "I was taking (R19) to the bathroom commode the time that (R28) fell. When I was finish taking care of (R19) I went in her room and I heard (V11) talking to (R28)."

V17's, CNA, written statement, dated 11/29/2022

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S9999	Continued From page 6 at 9:35 PM, documented, " I was assisting a patient in the shower room. I didn't witness that patient falling. I didn't even know she fell until hours after." V19's, CNA, written statement, dated 11/29/2022, documented, " I (V19) was with another patient on East after dinner when (R28) fell, so I didn't see anything." On 11/30/2022 at 3:55 PM, V1, Administrator stated that the facility could not provide 1 to 1 supervision for R28 and that R28's son did not want it. When asked that when R28 was placed up at the nurses station to be supervised would she expect staff be there to supervise R28, V1 stated that there was always someone at the nurses desk and it was only a matter of 1 to 2 minutes when R28 wasn't supervised. The facility's policy, "Fall Management/Reduction Program", dated 09/2022, documents, "Appropriate safety interventions, including potentially being placed in a Fall Reduction Program, will be implemented. (A)	S9999		