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 _____	C 01/18/2023

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 Investigation of Facility Reported Incident of 12/29/22/IL155302 F689 Cited	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. 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.	S9999	**Attachment A** Statement of Licensure Violations	

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 _____	C 01/18/2023

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 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 record review and interview the facility failed to provide adequate assistance during toileting for one resident (R2) of 3 residents reviewed for falls in the sample of 3. This failure resulted in R2 being sent to the hospital with head laceration, requiring 6 sutures, and subdural hematoma. Findings include: 1. R2's Resident Admission History dated 12/21/22 documents R2 admitted from an acute care hospital for skilled services. R2's history documents a diagnosis in part traumatic subdural hemorrhage without loss of consciousness, history of falls. R2's Minimum Data Set (MDS) dated 12/28/2022 documents that R2 is moderately cognitively impaired with a Behavior Interview of Mental Status (BIMS) of 8. R2's MDS documents that R2 requires limited assistance and one-person physical assistance for transfers, and toileting.	S9999		

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 _____	C 01/18/2023

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 2 R2's undated Resident Profile Report documents ADL's (Activity of Daily Living) requires min/mod assist with cares. R2's profile report documents R2 is at risk for falls due to history of falls. R2's report documents that R2 had a fall on 12/22/22 with no injuries. Intervention bed in lowest position with thick black mat next to bed. R2's report documents that R2 fell on 12/27/22 and sent to the emergency room for evaluation and returned. Intervention: moved closer to nurses' station for better supervision. R2's Post fall evaluation dated 12/22/22 documents that R2 has an unwitnessed fall on 12/22/22 at 14:30 PM. R2's evaluation documents that nurse heard R2 yelling for help. R2's post fall evaluation documents that R2 was on the floor parallel to the bed. R2 stated she slid of the side of her bed. R2's evaluation documents that R2 had no injuries. IDT reviewed fall and R2 was trying to get up from bed to sit in wheelchair and slid off the bed which was in the lowest position, no injuries. Intervention: thick black mat placed next to bed with bed in lowest position. R2's post fall evaluation documents mental status: forgets limitations. Morse Fall Risk score 75. R2's Post Fall Evaluation dated 12/29/22 documents on 12/27/22 at 13:47PM R2 was heard screaming for help from bathroom. R2 was lying face first on the bathroom floor. R2's evaluation documents that R2 was bleeding from forehead sent to emergency room for evaluation. R2's evaluation documents R2 stated was reaching for toilet paper. R2's emergency department notes dated 12/27/22 documents that R2 received 6 sutures to laceration to forehead. Cat Scan of head	S9999		

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 _____	C 01/18/2023

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 3 documents small acute right sided subdural with stable left sided subdural. R2's emergency department notes document the physician spoke with neurosurgery who recommended Levetiracetam 500 Milligram (MG) twice a day and repeat Cat scan in 6 hours with transfer to trauma center. Notes document local hospital closed to all transfers including trauma. Notes document the physician contacted neurosurgery at another trauma center, who stated given well appearance and small bleed think reasonable to get repeat cat scan in 6 hours and if no changes discharge with outpatient neurosurgery follow up assuming no changes. Notes document repeat cat scan did not document any changes so R2 discharged back to the nursing home. On 1/17/2023 at 9:30AM V5, Certified Nursing Assistant (CNA) stated that she had taken R2 into the bathroom. V5 stated that she left R2 in the bathroom. V5 stated that R2 was to be assist of one with gait belt for toileting. V5 stated that she did not find R2 on the floor. V5 stated that she was not aware that R2 had a previous fall. On 1/17/2023 at 9:52AM, V4, Nurse Practitioner stated she was at the facility at the time of R2's fall. V4 stated that R2 was lying on the floor in the bathroom, with a cut to her head and her head bleeding. V4 stated that R2 was conscious and sent to the hospital for evaluation. V4 stated that R2 received sutures and did have a subdural hematoma. On 1/17/2023 at 11:51AM V6, Physical Therapist stated she had worked with R2 one or two times after admission. V6 stated R2 had balance issues and very forgetful. V6 stated R2 did not have good safety skills. V6 stated she worked with R2 on a transfer due to a fall she had when reaching	S9999		

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 _____	C 01/18/2023

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 4 for toilet paper. V6 stated that R2 did not have the range of motion to lift her arms up and could not reach the toilet paper. V6 stated that she assumed staff stayed with her in the bathroom due to the lack R2's balance, and safety skills. On 1/17/2023 at 11:58AM V8, CNA stated she would not leave a resident in the bathroom alone if resident identified high risk for falls. On 1/17/22 at 1:09 PM V3, Director of Nursing (DON) stated that every resident has a fall assessment on admission. V3 stated that R2 was not on a fall reduction program. On 1/17/2023 at 2:48PM V1, Administrator stated she would expect the facility to follow policies and procedures in regards to fall prevention. V1 stated she would not expect residents identified at high risk for falls that require assistance to be left in the bathroom alone. On 1/18/2023 V10, Physician stated "as a general rule if a resident has had falls and is at a high risk for falls, fall precautions have to be in place." V10 stated R2 should have provided physical assistance in the bathroom. The facility policy dated 3/19 revised, documents appropriate safety interventions, including potentially being place in a fall reduction program, will be implemented. The facility policy documents a score above 45, the resident is identified at high risk of falls. A fall reduction program will be initiated. The policy documents in addition, a resident may be place in the Fall management/Reduction program at any time the Fall IDT or nursing supervisor feels it would be beneficial such as if there is a change in condition that may increase a resident's fall risk. Update	S9999		

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 _____	C 01/18/2023

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 5 the care plan accordingly. The policy documents the Fall Management /Reduction Program (a score above 45) requires the following: to alert staff to the increased fall risk by communication in shift reports and in the care plan. It is also denoted in the resident's electronic record denoting high fall risk status. Other safety interventions specific to the individual resident will be implemented as deemed appropriate by the nurse or supervisor and added to the care plan. (A)	S9999		