

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Alton Memorial Rehab & Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  1251 College Avenue Alton, IL 62002	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interview and record review the facility failed to ensure a safe transfer for 1 of 3 residents (R2) reviewed for falls in the sample of 13. This failure resulted in R2 sustaining a large, abrasion/laceration on her right calf while being transferring without the use of a gait belt and needing wound care.</p> <p>Findings include:</p> <p>R2's Physician Order Sheet for May, 2024 documents a diagnosis of abnormal weight loss, hereditary hemochromatosis, unspecified severe protein calorie malnutrition, alcoholic hepatitis without ascites, chronic obstructive pulmonary disease, disorder of iron metabolism, irritable bowel syndrome with diarrhea, body mass index 19.9 or less, adult, arthropathic psoriasis, monoclonal gammopathy, ankylosis, spondylitis lumbar region.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact for decision making of activities of daily living. I use a wheelchair and a walker and have no impairment on my upper and/or lower extremities.</p> <p>R2's Resident Profile Page dated 4/5/2024 documents, I have a goal of increasing my independence. I am at risk for falls. I require assistance with transfers and ambulation. My goal is to reduce the risk factors that contribute to my fall risk and to minimize the risk of injury related to my fall throughout this review. My goal is to discharge home independently with home health. I am five foot seven and weigh 87 pounds. I have a risk for skin breakdown. I have a risk for skin breakdown. I received skin tear to right lower leg from transfer. Treatment orders in place and improvement noted at discharge.</p> <p>R2's Physician Note SBAR (Situation, Background, Assessment and Recommendation) dated 4/1/2024 at 10:00 AM, documents, I was called to patients' room at approximately 9:30 AM, because she was yelling in pain. The CNA informed me that her skin on her right leg got bumped during transfer. DON assisted me down to her room and patient's right calf had skin tear 7 x 4 cm (centimeters) in size. CNA informed me that she was transferring her from the wheelchair to the bed and the patient started to slide out of her wheelchair and she was able to put her on the bed before she slid on the floor. Patient stated she felt as if her leg hit the footboard and blood was spotted there. I assisted the DON with wrapping the patient's leg to control drainage. Patient is lying in bed, call light in reach. Incident report made.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R2's Wound Assessment Report dated 4/2/2024 documents wound length 9.9 x 5 (width) x 0.2 cm3 (depth) for right calf. L (length) x w (width) = 49.5. The facility photograph dated 4/2/2024 was reviewed and shows a large area or chunk of skin that was affected and discolored, taking up a large portion of the leg.</p> <p>R2's Progress Note dated 4/18/2024 at 10:20 PM, documents, I was called to a patient's room at approximately 9:30 PM, because she was screaming in pain. The CNA (certified nursing assistant) informed me that her skin on her leg ripped and was bleeding tremendously. DON (Director of Nursing) assisted me down to her room and patient right calf has skin peeling and hanging off. CNA informed me that she was transferring her from the wheelchair to the bed and the patient started to slide out of her wheelchair and she was able to put her on her bed before she slid on the floor. Patient stated that she felt as if her leg hit the footboard and blood was spotted on her. I assisted the DON with wrapping the patient's leg to control drainage.</p> <p>On 5/7/2024 at 3:07 PM, V4, Registered Nurse (RN) stated, (R2) was very pleasant, but she was not here very long. She fell before I started my shift. (R2) I believe had the incident with her calf on the day shift. (R2's) skin was very fragile. (R2) did have a good size wound to her calf. On top of that, she was very tiny, hardly weighed anything and was a smoker which are all things that contribute to healing of wounds. I believe she left here shortly after and was still getting wound treatment.</p> <p>On 5/7/2024 t 3:51 PM, V8, Nurse Practitioner stated, (R2's) skin was paper thin and there was an incident that she did sustain an injury from a transfer. I would expect all transfers to be safe and I am not sure what or how it happened, but she got a bad skin tear/abrasion on her leg. I would expect all things to be clear, so no resident is injured when being transferred.</p> <p>On 4/9/2024 at 3:00 PM, V9, Certified Nursing Assistant (CNA) stated, I gave (R2) a shower, and then put her in the wheelchair and took her into her room. (R2) is a one assist. I then I put the walker in front of her and she stood and then (R2) started to fall, and I grabbed her leg where she would not fall on the ground, and I yanked her, and she hit her leg on the side of bed. I guess (R2) hit the bed frame with her leg, because there was blood there on the bedframe at the end of the bed. (R2) did not give me chance to get a gait belt. I did not use a gait belt on (R2) when I was transferring her.</p> <p>On 5/9/2024 at 9:51 AM, V6, Licensed Practical Nurse (LPN) stated, I remember the aid (V9) came and got me and told me that while she was transferring (R2) from the chair to the bed, she hit her leg and got a skin tear to her right calf, and the skin was peeling. (R2) had hit her left at the bottom of the bed and her leg had scraped the foot board. I went and got (V2) and it was bleeding profusely, and we stopped the bleeding and bandages the area. We did not take a photo because of the blood but I believe the NP saw her the next day and they took a photo.</p> <p>R2's Wound Assessment Report dated 4/2/2024 documents wound length 9.9 centimeters x 5 (width) cm x 0.2 cm3 (depth) for right calf. LxW= 49.5).</p> <p>R2's Wound Report dated 4/18/2024 at 10:33 AM, documents wound 9.0 length x 4.7 x 0.1 cm3 (L x W = 42.3)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/9/2024 at 3:11 PM, V2, Director of Nursing stated, I would expect staff to follow the facility policy for transfers and for staff to use a gait belt for transferring all residents unless there was a medical contradiction for the use of a gait belt. (R2) did not have a medical contraindication. (R2) should have been transferred with a gait belt. I was not told a gait belt was not used on (R2) when she had the injury. I would have expected staff to dress her after her shower and use the gait belt to transfer her.</p> <p>The Gait Belt/Transfer Policy with a revision date of 5/2023 documents, To provide guidelines to facilitate the safe transfer and ambulation of the resident and prevent injury to the resident or employee. It will be the responsibility of all nursing staff to follow this policy and procedure. It is the policy of (Facility) to provide gait/transfer belts to nursing staff responsible for transfers and ambulation and for staff to use them when appropriate.</p>		