

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 01/08/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35156</p> <p>Based on interview and record review the facility failed to ensure all abuse investigations were reported to the designated representative and to other officials in accordance with State law, including State Survey Agency within five working days of the incident for 1 of 7 residents (R2) reviewed for reporting in the sample of 10.</p> <p>Findings include:</p> <p>On 1/2/2025 at 12:28 PM, V1, Administrator stated (V6), Licensed Practical Nurse LPN) was the nurse working the day (R2's) wet sheets were changed and the male certified nursing assistant (CNA) was (V7). V7 was the one who was working (R2's) hall. V1 stated, I did not get any statements or have any allegations of abuse related to (R2). I know the family was upset about (R2's) bed being wet but I do not have any statements or anything in writing voicing any other concerns, and nothing related to any abuse allegations.</p> <p>All abuse investigations for the past six months were requested and reviewed and there was no abuse investigation provided for R2.</p> <p>On 1/2/2024 at 12:43 PM, V7, Certified Nursing Assistant (CNA) stated, I laid (R2) gently on the bed and moved her feet over, covered her up and left the room. I never threw her on the bed or threw water at her. I tried to go back and clean up the water but (V6, LPN) told me not go into her room.</p> <p>On 1/3/2025 at 8:33 AM, R2 stated, I was good at the (Facility) until that staff member picked me up, slid me on the bed, swung my feet around and spilled water all over me and left me. I was afraid of him. He was rough with me. I was very upset, so I immediately called (V5, Family of R2) and told her what had happened. Nobody should be treated the way he treated me. I was scared to tell him about the water because of the way he was treating me. I feel like I was abused by him.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/3/2025 at 8:39 AM, V5, Family of R2 stated, I remember getting the call from my mom because she was frantic, and I asked her what was going on and she asked me to please come to the (Facility). It took me over an hour before I got there but when I got there my mom was still upset. When I walked into the room there was water all over the floor. I started cleaning up the water on the floor because I did not want anyone to fall. Then my mom told me a staff member threw her on the bed and spilled water all over her and left her. Now mind you, it took me an hour to get to my mom because I had to wait on my cousin, and here she is and when I went over to her the bed was soaked with water. I started stripping the bed and I went and got (V6, the nurse) and told him my mom was afraid of (V7) and he had me write everything down in a statement and he told me that staff member (V7) would not be providing care anymore to my mom. (V7) started to come into my mom's room and he told me he was going to finish cleaning everything but (V6) told him he could not go back into my mom's room. (V7) told me he had spilt the water I could see my mom shaking and I was happy (V7) was not going to provide care to my mom. But, then the next day (V7) was on the floor the next day giving care to my mom, so nothing happened. I did not want (V7) going into my mom's room after that incident because my mom was so upset and said she felt abused, and nobody should be treated the way (V7) treated her that day.</p> <p>On 1/3/2025 at 12:44 PM, V7, Licensed Practical Nurse (LPN) stated, I remember the family member (V5) coming to me and she was upset and told me there was water in her mom's room on the floor that she had cleaned up and her bed was wet. I went into the room and there was not any water on the floor but (R2's) bed was wet and damp. They told me they were upset with (V7's) care and did not want (V7) providing any care to (R2) and I told them to write down a statement. I called (V2) and she told me to call (V1). I called (V1) and I put the statement under (V1's) door because she was not here. I told both (V1) and (V2) that the family was upset and did not want (V7) providing care to (R2). I told (V7) he could not work (R2's) hall. Nobody asked me any other questions.</p> <p>R2's Medical Records were reviewed and there was no documentation related to any allegations of abuse made by R2.</p> <p>On 1/3/2025 at 3:07 PM, V1, Administrator stated she did not complete an investigation on (R2) and or put anything in place for (R2) or collect evidence to determine what actions the facility must follow, and or put in place for the protection of the residents in the facility. V1 also stated she did not report it because she stated she did not get any statements, and nothing was put under her door and did not realize it was not customer service.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>The Facility Resident Abuse/Neglect/Exploitation Policy with a revision date of 7/23 documents, To provide guidelines for identifying, investigation, and reporting resident abuse/neglect and exploitation including any reasonable suspicion of a crime toward the resident. It is the responsibility of the Administrator of each resident to monitor compliance of this policy. Department Managers and Supervisors must know, understand, and enforce this policy. All employees of (Facility) must know, understand, and abide by this policy. Every resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Resident must not be subject to abuse by anyone, including, but not limited to, resident staff, other residents, consultants or volunteers, other agencies serving the individual, family members or legal guardians, friends, or other individual. The Elder Justice Act of 2009 has mandated enhanced reporting requirements for crimes that occur in LTC (Long term Care) facility which are outlined in this policy. Any covered individual who received an allegation or suspects that there is a situation of abuse, neglect, or exploitation of a resident including a potential or actual criminal action shall immediate disrupt all perceived or observed abuse by yelling for help, activating the call lights and/or telling the person involved to stop. A covered individual may also contact the appropriate State agency- Department of Health and Senior Services (DHSS) Complaint Registry Unit. The Administrator will direct staff to complete an incident report and initiate investigation process. An investigation shall be initiated immediately. Any allegations must be fully investigated and self-reported to an appropriate State Agency. Upon receiving al allegation of abuse, the alleged perpetrator will be suspended/removed immediate from the resident, pending the investigation. Nursing Management or the Administrator will initiate the investigation and complete the Resident Abuse/Neglect Complaint Investigation Report.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35156</p> <p>Based on interview and record review the Facility failed to ensure all abuse allegation were thoroughly investigated for 1 of 5 residents (R2) reviewed for investigation of abuse in the sample of 10.</p> <p>Findings include:</p> <p>On 1/2/2025 at 12:28 PM, V1, Administrator stated, (V6, Licensed Practical Nurse LPN) was the nurse working the day that (R2's) wet sheets were changed and the male certified nursing assistant (CNA) was (V7). V7 was the one who was working (R2's) hall. V1 stated, I did not get any statements or have any allegations of abuse related to (R6). I know the family was upset about (R2's) bed being wet but I do not have any statements or anything in writing voicing any other concerns, and nothing related to any abuse allegations.</p> <p>All abuse investigations for the past six months were requested and reviewed and there was no abuse investigation provided for R2.</p> <p>On 1/2/2024 at 12:43 PM, V7, stated (R2) was very slow in her movements. (R2) did not like to move a lot, I helped her to transfer from her recliner to her wheelchair, and then her wheelchair to her bed, when I turned around a saw water on the floor. I did not see any water on (R2) nor did I see (R2) was wet. If I thought, she was wet I would have changed her right then. I always tried to be gentle with her and had no issues with her. I laid her gently on the bed and moved her feet over, covered her up and left the room. I never threw her on the bed or threw water at her. I tried to go back and clean up the water but (V6) told me not go into her room.</p> <p>On 1/3/2025 at 8:33 AM, R2 stated, I was good at the (Facility) until that staff member picked me up, slid me on the bed, swung my feet around and spilled water all over me and left me. I was afraid of him. He was rough with me. I was very upset, so I immediately called (V5) and told her what had happened. Nobody should be treated the way he treated me. I was scared to tell him about the water because of the way he was treating me. I feel like I was abused by him. I am afraid to go back to the facility.</p> <p>(continued on next page)</p>		

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