STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145121	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alton Memorial Rehab & Therapy	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to notify the provider of a fall with injury for 1 (R2) of 3 residents reviewed for accidents.Findings include: R2's Resident Profile Report (Care Plan) dated 11/26/2025, documents R2 was at risk for all and requires assistance with transfers and ambulation. Please ensure my bed is at an appropriate height at all times and call light is within reach. R2's SBAR dated 12/22/2025 at 8:05 AM, V5, LPN (Licensed Practical Nurse) documents R2 had knees buckle approx. 12 hours ago where resident's face had come in contact with handrail in shower room resulting in dentures breaking. Resident has bleeding and pain noted to gums/mouth. NP (Nurse Practitioner) present and gave order to send R2 to ER for evaluation and treatment. R2 complained of mouth pain 8/10 on pain scale. Medications included Apixaban (blood thinner medication) 5 mg (milligrams) BID (twice a day.) On 12/23/2025 at 9:50 AM V5, LPN stated she worked day shift on 12/22/2025 and arrived at the facility at approximately 7:00 AM. V5 stated received nurse report that R2 fell in the shower she went to assess her. V5 stated R2 complained of mouth pain and assessed dry blood on R2's lip, V5 stated she notified the provider immediately and R2 was sent to the ER for further evaluation and treatment. V5 stated it was her understanding that the nurse (name unknown) didn't notify R2's provider that she hit her head when R2 fell on [DATE]. V5 stated when a resident falls at the facility the assigned nurse is to follow the facility's fall policy which includes assessing the resident and notifying the resident's provider of the fall immediately after the assessment then to document a post fall assessment and an SBAR if the resident goes to the ER. V5 stated she couldn't believe R2 wasn't sent to the ER after she fell because she is on a blood thinner, and she could have a brain bleed and needed to be assessed by a physician.R2's Nurse Practitioner (NP) Progress Note, dated 12/23/2025, documents this fall was not reported to the provider until the oncoming nurse received report the following morning. The incident was not documented in R2's electronic medical record in a timely manner, and no nursing notes were available for review. R2 is prescribed Eliquis. Any reported or suspected head strike while on an anticoagulation warrants immediate transfer to the emergency department for evaluation, and at a minimum a STAT head CT. At 7:24 AM orders were given to send R2 to the emergency department, she was transferred via EMS. On 12/23/2025 at 1:20 PM V8, NP stated she wasn't notified R2 fell and hit her mouth/head in the shower on 12/22/2025 and she would have expected staff to notify her of that because R2 was on a blood thinner and needed to be assessed by a physician. V8 stated when she assessed R2 on the morning of 12/22/2025 R2's mouth was bleeding, so she knew R2 had an injury and she transferred R2 to the ER after assessing her. The Facility's Reporting of Injuries Policy, revised 12/25 documents purpose: to provide an orderly process for reporting injuries involving residents. Serious incidents, i.e., head injuries are to be reported to the physician at the time of occurrence. Be prepared in using the SBAR format, to report to the physician results of the assessment, including pertinent information (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relative to items such as medications. All charting should include notification of doctor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow fall policy and procedures, and staff failed to use a gait belt when transferring a resident, for 1 (R2) of 3 residents reviewed for accidents. This failure resulted in a cognitively impaired resident (R2) being transferred to the emergency room after hitting her head. R2 had to get an EKG, blood work, head CT and chest x-ray. Using the reasonable person approach, this failure caused pain, discomfort and invasive interventions during an emergency room visit.Findings Include: R2's Resident Profile Report (Care Plan) dated 11/26/2025, documents R2 was at risk for falls and requires assistance with transfers and ambulation. The care plan states, Please ensure my bed is at an appropriate height at all times and call light is within reach. No documentation if gait belt should be used or how many staff to transfer R2 or mode of transfer. R2's Active Medication List documents Apixaban (blood thinner) 5 milligrams (mg) BID (twice a day) for treatment of AFIB. R2's Electronic Medical Record, dated 12/22/2025 no documentation of R2 fall in the shower or hitting her head on a handrail. R2's SBAR dated 12/22/2025 at 8:05 AM, V5, LPN (Licensed Practical Nurse) documents R2 had knees buckle approx. 12 hours ago where resident's face had come in contact with handrail in shower room resulting in dentures breaking. Resident has bleeding and pain noted to gums/mouth. NP (Nurse Practitioner) present and gave order to send R2 to ER (emergency room) for evaluation and treatment. R2 complained of mouth pain 8/10 on pain scale. Medications included Apixaban (blood thinner medication) 5 mg (milligrams) BID (twice a day.) On 12/23/2025 at 9:50 AM V5, Licensed Practical Nurse (LPN) stated she worked day shift on 12/22/2025 and arrived at the facility at approximately 7:00 AM. V5 stated received nurse report that R2 fell in the shower went to assess her. V5 stated R2 complained of mouth pain and assessed dry blood on R2's lip. V5 stated she notified the provider immediately and R2 was sent to the ER for further evaluation and treatment. V5 stated it was her understanding that the nurse (name unknown) didn't notify R2's provider that she hit her head when R2 fell on [DATE]. V5 stated when a resident falls at the facility the assigned nurse is to follow the facility's fall policy which includes assessing the resident and notifying the resident's provider of the fall immediately after the assessment then to document a post fall assessment and an SBAR if the resident goes to the ER. V5 stated she couldn't believe R2 wasn't sent to the ER after she fell because she is on a blood thinner, and she could have a brain bleed and needed to be assessed by a physician.On 12/23/2025 at 9:25 AM R2 sat up in a wheelchair in her room. V4, Certified Nurse Aide (CNA) pulled R2's shirt up for a skin assessed and a large purple bruise to right upper body was noted and a dried scab/abrasion to R2's right lip area as well. R2 stated she fell in the shower. R2 didn't recall what staff was in the shower when she fell or any specifics regarding the fall. R2 stated she hit her face on the rail, and she broke her teeth on the way down. R2 stated she was assessed at the hospital the next day and although her face hurt, she was ok. On 12/23/2025 at 10:04 AM V6, RN (Registered Nurse) stated she worked 7:00 AM to 11:00 PM on 12/21/2025 and was assigned to R2. V6 stated V7, CNA asked her to help transfer R2 from shower chair to her wheelchair in the shower room because V7 had attempted to multiple times but that R2's knees kept buckling and she needed assistance because R2 was weak. V6 entered the shower room and stood behind R2. V6 stated V7 stood R2 up and assisted her to stand to hold onto the grab bar and when she moved the shower chair from under R2 her knees buckled and her and V7 lowered R2 to the ground. V6 stated V7 didn't have a gait belt on R2 at the time of the transfer but she probably should have because R2 was so weak. V6 stated she assessed a small amount of blood on R2's mouth after they lowered her to the floor, but she didn't hear or see R2 hit her mouth on anything, and she was behind (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2 so she wouldn't have seen her hit her mouth on the rail. V6 stated R2's dentures were broken at that time, and she assumed R2 cut her mouth on her broken dentures when she plopped on the shower floor while they lowered her to the floor. V6 stated V7 didn't tell her that R2 hit her mouth on the handrail until an hour after that and she had already assessed R2 and cleaned her mouth of the blood. V6 stated she didn't notify the provider that R2 fell because she didn't fall. V6 stated her and V7 assisted R2 to the floor and she didn't know she hit her mouth at that time. After V7 reported to her that R2 hit her mouth on the rail she still didn't report that to the provider because there was no bruising or injury sustained. V6 stated hindsight she should have reported the resident being lowered to the floor and that she hit her head because R2 is on a blood thinner and could have had a brain bleed. V6 stated she didn't assess neurological status after the fall and didn't take her vital signs either. R2's Emergency Department Records dated 12/22/2025 documents patient is a pleasant [AGE] year-old female who presents at the emergency room for evaluation fall yesterday. Apparently hit head, face. Has had some weakness. Physical exam: Jaw: tenderness and pain on movement present. Assessment: abrasion to lip, bruising to right upper extremity. Clinical impressions: contusion to face and generalized weakness. Patient had 12 lead EKG, blood work, head CT and chest x ray done in the ER. On 12/23/2025 at 10:22 AM V1, Administrator stated she had concerns regarding R2's fall and the lack of assessment, notification and the lack of post fall documentation from when R2 fell on the evening of 12/21/2025 in the shower room. V1 stated when a resident falls the assigned licensed nurse is responsible for assessing the resident and documenting the assessment in the resident's electronic medical record on a post fall assessment form and to notify the provider of the fall as well. V1 stated even if staff lower a resident to the floor that is still considered a fall because the resident changed planes. V1 stated she expected the nurse to assess the resident, document the assessment and then document that the provider was notified of the fall and what was ordered, if anything. V1 stated she reviewed R2's electronic medical record for the 12/21/2025 shower room fall and there was the assigned nurse was V6, and she didn't document anything regarding the fall in R2's medical record. V1 stated she was very concerned that R2 wasn't sent to the ER until 12 hours post fall because she's on a blood thinner and even though she's not a nurse she knew R2 could have a brain bleed and needed to be assessed by a physician. V1 stated R2 was transported to the ER on [DATE] at approximately 7:00 AM and had a head CT done and it was negative for a brain bleed. V1 stated R2 sustained bruises, and her dentures were broken during the fall in the shower. V1 stated she expects staff to use a gait belt, and she expected V7 to use one on R2, especially since she noted R2 was weak prior to the transfer. R2's Progress Note, dated 12/23/2025 V8, Nurse Practitioner (NP) documented at 7:19 AM she was notified that R2 had a fall the previous evening in which her face struck a bar in the shower room, resulting in broken dentures. The report further noted dried blood present on R2's lips, with complaints of jaw and facial pain. R2 complained of pain to her head, face and mouth. On 12/23/2025 at 1:20 PM V8, NP stated she was notified that R2 fell in the shower the night before on the morning of 12/22/2025 and she assessed R2's mouth was bleeding and stated since R2 is on a blood thinner medication she should have been assessed and transferred to the ER at the time of the fall. V8 stated she expected staff to follow the fall policies and procedures at the facility and to use a gait belt when transferring residents. V8 stated she expected staff to document an assessment of the fall and stated there was no documentation of the fall in R2's electronic medical record and no post fall assessments. V8 stated she wasn't notified that R2 fell and hit her mouth/head in the shower on 12/22/2025 and she would have expected staff to notify her of that because R2 was on a blood thinner and needed to be assessed by a physician in the ER immediately to rule out a brain bleed. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility's Fall Management/Reduction Program Policy, revised 9/24, documents once a fall occurs, it is important that an assessment and investigation occur to determine possible cause of the fall utilizing the designated form within the resident's medical record. A post fall evaluation is to be completed after any resident fall. Additionally, neuro checks per neuro check policy will also be completed. Neuro checks are to be completed with any fall at the following intervals: all falls in which the head was struck initial assessment, every 15 minutes x4, every 30 minutes x2, every hour x2, then once per shift for 72 hours. The Facility's Use of Gait Belt Policy revised 5/23 documents policy purpose: to provide guidelines to facilitate the safe transfer of the resident and prevent injury to the resident. Responsibility: it will be the responsibility of all nursing staff to follow this policy and procedure. Nursing personnel must have gait belts on their person at all times.