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	10/10/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, and interview the facility failed to ensure a resident was treated with dignity and had needs met timely for 1 of 3 (R23) residents in a sample 33 observed for dignity. Findings include: R23's Care Plan, noted dated, documents R23 is able to make her needs known, pleasant to talk to and can communicate needs with staff. R23's Minimum Data Set, dated dated ,d+[DATE], documents R23 is alert and oriented x4 occasionally incontinent of urine and requires assistance from staff for toileting. On 10/7/2024 at approximately 9:00 AM, observed V5, CNA, providing R23 incontinent care. R23 was incontinent of urine. V5 pulled back covers and opened R23's incontinent brief. V5's incontinent brief was heavily soiled with urine. V5 then cleansed R23's peri and groin area. V5 then assisted R23 over onto her right side. R23's gown, incontinent brief, incontinent pad and sheets were soaked with urine. R23's sheets were soaked up to her upper back. V5 removed the soiled incontinent brief revealing multiple deep, red indentations in skin. V5 then cleansed R23's left buttock. V5 then removed the urine soak sheets from the bed and rolled beneath R23. V5 then assisted R23 into the seated position on the side of the bed and put on R23's clothes and assisted R23 into the wheelchair. V5 did not cleanse all areas of incontinence. V5 did not cleanse R3's inner thighs and back. On 10/7/2024 at 8:50 AM, R23 stated she wanted to know why the girl did not come in and change her last night. R23 stated she has been wet all night. R23 stated the girl came in and gave her water last night but never checked her or cleaned her. R23 stated she told the girl she needed to be changed. R23 stated in the day she is up in her chair and able to use the toilet with help. R23 stated at night when she is in the bed, she loses all sense of control. R23 stated this makes her feel dirty, angry and embarrassed. R23 stated she doesn't want to lay in her own filth all night and she doesn't want to stink because of it. R23 stated it hurts laying in one position wet all night. R23 stated there is only 1 CNA, Certified Nurse Assistant, that cleans you when you are wet. R23 stated the others remove the depend and put another on you without cleaning you. R23 stated she shouldn't have to live like that. R23 stated they don't have enough staff. R23 stated she laid wet all night. R23 stated there was a time she had to have her roommate take her off the bedpan and clean her. R23 stated no one came. R23 stated she complains about it, but nothing is done. R23 stated she feels like a fool, like she is nothing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/2024 at 9:08 AM, V5, CNA, stated she was informed (R23) did not void all night. V5 stated she thought it was odd because (R23) is a heavy wetter at night. On 10/101/2024 at 11:03 AM, V18, Nurse Supervisor, stated (R23) is alert and oriented x4. V18 stated if (R23) stated said she was laying wet all night this would be accurate statement. V18 stated if R23 stated she was embarrassed, angry, felt like a fool and felt pain from this this would be an accurate statement of how (R23) felt. V18 stated (R23) laying in urine all night and being soiled up to her head is a dignity problem. On 10/10/2024 at 11:47 AM, V23, Licensed Practical Nurse, stated (R23) is alert and oriented x4. V23 stated (R23) will tell you the truth. V23 stated if (R23) stated she was wet all night, and they didn't have staff this would be an accurate statement. V23 stated if she laid in urine for a long time, she would feel nasty and dirty. V23 stated if (R23) stated this is how she felt it would be accurate. The facility's Resident Handbook, dated March 2020, documents Resident Rights: These are your rights as a resident of a Long-Term Care Community in Illinois as provided by the centers for Medicare and Medicaid Services (CMS) and the Illinois Department of Public Health (IDPH). You have the right to privacy in medical treatment, personal care, telephone and mail communications, visits with family and meetings in groups. You should be treated with consideration and respect, with full recognition of your dignity and individuality.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on record review and interview, the facility failed to complete the periodical comprehensive Minimum Data Set Assessments in the required time frame for 3 of 3 (R16, R23, R28) residents reviewed for resident assessments in a sample of 33. Findings include: 1. R28's Face Sheet, not dated, documents that R28 was admitted [DATE]. R28's Minimum Data Set (MDS), dated [DATE], documents Quarterly Assessment. Signed 8/23/2024. The facility provided a form that documents (R28) Target date: 8/9/2024, Submission and Processing date:10/8/2024. Warnings: Record submitted late. The submission date is more than 14 days after Z0500B on this new assessment. 2. R23's Face Sheet, not dated, documents that R23 was admitted [DATE]. R23's Minimum Data Set (MDS), dated [DATE], documents Quarterly Assessment. Signed 9/4/2024. The facility provided a form that documents (R23) Target date: 8/20/2024, Submission and Processing date: 10/8/2024. Warnings: Record submitted late. The submission date is more than 14 days after Z0500B on this new assessment. 3. R16's Face Sheet, not dated, documents that R16 was admitted [DATE]. R16's Minimum Data Set (MDS), dated [DATE], documents Quarterly Assessment. Signed 9/4/2024. The facility provided a form that documents (R28) Target date: 8/21/2024, Submission and Processing date: 10/8/2024. Warnings: Record submitted late. The submission date is more than 14 days after Z0500B on this new assessment. On 10/9/2024 at 1:32 PM, V29, MDS Coordinator stated that she is not sure why the assessments are indicating that they are overdue. On 10/9/2024 at 1:40 PM V30, Corporate Director of Reimbursement stated that the assessments were submitted late and this is why it was indicated that the assessments were overdue. The facility's Minimum Data Set Protocol, dated 10/23, documents Purpose: to provide directions for the completion of Resident Assessment Instrument (RAI) in a consistent, accurate manner that complies with the requirements set forth in the Long-Term Care Facility Resident Assessment Instrument User Manual. This includes the Minimum Data Set (MDS), Version 3.0, Submission: Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 +14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B +14 days).

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on interview and record review the facility failed to provide timely and complete incontinent care for 5 of 5 residents (R13, R23, R24, R31, R33) reviewed for incontinent care in a sample of 33. This failure resulted in R23 laying in urine all night, feeling dirty, like a fool and embarrassed. Findings include: 1. R23's Care Plan, not dated, documents R23 is occasionally incontinent of urine of bladder and continent of bowel. Please provide frequent toileting and peri care after each incontinent episode, requires extensive assist with ADL's (activities of daily living), R23's Minimum Data Set, dated dated ,d+[DATE], documents R23 is alert and oriented x4, occasionally incontinent of urine, and requires assistance from staff for toileting. On 10/7/2024 at approximately 9:00 AM, observed V5, CNA, providing R23 incontinent care. R23 was incontinent of urine. V5 pulled back covers and opened R23's incontinent brief. V5's incontinent brief was heavily soiled with urine. V5 then cleansed R23's peri and groin area. V5 then assisted R23 over onto her right side. R23's gown, incontinent brief, incontinent pad and sheets were soaked with urine. R23's sheets were soaked up to her upper back. V5 removed the soiled incontinent brief revealing multiple deep, red indentations in skin. V5 then cleansed R23's left buttock. V5 then removed the urine soak sheets from the bed and rolled beneath R23. V5 then assisted R23 into the seated position on the side of the bed and put on R23's clothes and assisted R23 into the wheelchair. V5 did not cleanse all areas of incontinence. V5 did not cleanse R3's inner thighs and back. On 10/7/2024 at 8:50 AM, R23 stated she wanted to know why the girl did not come in and change her last night. R23 stated she has been wet all night. R23 stated the girl came in and gave her water last night but never checked her or cleaned her. R23 stated she told the girl she needed to be changed. R23 stated in the day she is up in her chair and able to use the toilet with help. R23 stated at night when she is in the bed, she loses all sense of control. R23 stated this makes her feel dirty, angry and embarrassed. R23 stated she doesn't want to lay in her own filth all night and she doesn't want to stink because of it. R23 stated it hurts laying in one position wet all night. R23 stated there is only 1 CNA, Certified Nurse Assistant, that cleans you when you are wet. R23 stated the others remove the depend and put another on you without cleaning you. R23 stated she shouldn't have to live like that. R23 stated they don't have enough staff. R23 stated she laid wet all night. R23 stated there was a time she had to have her roommate take her off the bedpan and clean her. R23 stated no one came. R23 stated she complains about it, but nothing is done. R23 stated she feels like a fool, like she is nothing. On 10/7/2024 at 9:08 AM, V5, CNA, stated she was informed (R23) did not void all night. V5 stated she thought it was odd because (R23) is a heavy wetter at night. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 10/101/2024 at 11:03 AM, V18, Nurse Supervisor, stated (R23) is alert and oriented x4. V18 stated if (R23) stated said she was laying wet all night this would be accurate statement. V18 stated if R23 stated she was embarrassed, angry, felt like a fool and felt pain from this this would be an accurate statement of how (R23) felt. V18 stated (R23) laying in urine all night and being soiled up to her head is a dignity problem. On 10/10/2024 at 11:47 AM, V23, Licensed Practical Nurse, stated (R23) is alert and oriented x4. V23 stated (R23) will tell you the truth. V23 stated if (R23) stated she was wet all night, and they didn't have staff this would be an accurate statement. V23 stated if she laid in urine for a long time, she would feel nasty and dirty. V23 stated if (R23) stated this is how she felt it would be accurate. On 10/8/24 at 1:30 PM, Resident Council was conducted, and R23, R24, R31, and R33 voiced multiple concerns with lack of staff and timeliness of incontinent care during this meeting. R23, Resident Council President, stated the facility does not have enough staff at night and she has laid in wet pants multiple times all night because she could not get any employees to clean her up. R23 stated her roommate R24 is a former CNA and R24 has assisted her with getting on the bedpan and has cleaned her up throughout the night because they could not get any staff to answer the call light. R23 stated she frequently must sit with wet pants for long periods of time due to staff not answering her call light or staff saying they will be back to change her, and then they don't return. R23 stated she frequently voices her complaints to administration, and they just blow smoke up her butt in response to her complaints. 2. R13's Care Plan, not dated, documents R13 and requires extensive too dependent of ADL care, incontinent of bowel and bladder. Provide peri care after episodes of incontinent remain clean and dry and minimize the risk of skin breakdown thru this next review period. R13's MDS, dated [DATE], documents R13 is moderately cognitively impaired, incontinent of bladder and bowel, and requires assistance from staff for toileting. On 10/9/2024 at 8:00 AM, observed V23, LPN, and V24, LPN, performed incontinent care and treatment. R13 was incontinent of urine and bowel. V23 and V24 opened R13's incontinent brief V24 rolled it between R13's legs. V23 and V24 then turned R13 on her right side. V24 rolled the soiled incontinent brief under R13. Using soap and water V24 wiped the stool from between R13's right and left buttocks. V24 then wiped the same area with a wet washcloth. V24 then changed her gloves and performed treatment to R13's pressure ulcer on right buttock. V24 then placed a clean incontinent brief under R13. V23 and V24 rolled R13 onto her left side and removed the soiled incontinent brief from beneath R13. V23 and V24 then fastened R13's brief and placed cover over R13. On 10/10/2024 at 11:03 AM, V18, Nurse Supervisor, stated she expects the staff to clean all wet areas. V18 stated if a resident is wet up to her back and neck those areas are to be cleaned as part of peri care. V18 stated if a treatment is performed, and the resident is incontinent of bowel and bladder the staff are to perform peri care and then complete the treatment. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	The facility's Perineal Policy, dated 10/22, documents Purpose: To provide guidelines for performing perineal care. Policy: Perineal care is to be done as needed for incontinence for residents who are unable to perform self-care. Perineal care is done to cleanse the perineum to prevent growth of bacteria, prevent skin breakdown and promote good personal hygiene. Standard precautions and sound aseptic technique will be used when performing peri-care. Policy: Perineal Care is to be done as needed for incontinence for residents who are unable to perform self-care. Perineal care is done to cleanse the perineum to prevent growth of bacteria, prevent skin breakdown and promote good personal hygiene. Practice: 10. Always work from the cleanest area to the dirtiest. Therefore, clean from urethra to the anal area (front to back) to prevent fecal matter from spreading from the anal area to the vagina or urethra using clean technique. Always gently pat dry (no scrubbing). Female Perineal Care 2. Expose perineal area. Gently cleanse the inner legs and outer peri area along the outside of the labia. 3. Cleanse outer labia from front to back. 4. Cleanse inner labia from front to back. 5. Gently open all skin folds and cleanse from front to back. 6. Cleanse and dry anal area. -- 3. R24's face sheet, print date of 10/9/24, documented R24 has diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia and aphasia following cerebral infarction, depression, multiple sclerosis, epilepsy, and hypertension. R24's MDS dated [DATE] documented R24 is cognitively intact. R24's MDS dated [DATE] documented R24 depends on a wheelchair for mobility and requires partial to moderate assistance to ambulate 10 feet. On 10/8/24, during the Resident Council meeting R24 agreed that she helps her roommate (R23) get on the bed pan at night and cleans her up due to staff not answering the call light. 4. R31's face sheet, print date of 10/9/24, documented R31 has diagnoses of malignant neoplasm of prostate, dysphasia following cerebral infarction, pulmonary hypertension, pleural effusion, emphysema, spinal stenosis, and atrial fibrillation. R31's MDS dated [DATE] documented R31 is cognitively intact, always incontinent of bowels, has an indwelling urinary catheter, and requires substantial to maximal assistance with toileting hygiene. On 10/8/24, during the Resident Council meeting R31 stated that there is not enough staff on any of the shifts and that the night shift is the worst. R31 stated that he has been dirty all night several times because he cannot get the CNAs to change him. 5. R33's face sheet dated 10/9/24 documented R33 has diagnoses of benign hypertensive heart, chronic kidney disease, congestive heart failure, morbid obesity, gout, atrial fibrillation, anemia, hypertension, and diabetes mellitus. R33's MDS dated [DATE] documented R33 is cognitively intact, always incontinent of bowel and bladder, and requires substantial to maximal assistance with toileting hygiene. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24, during the Resident Council meeting R33 stated that she often must sit in her wet adult diaper due to the staff not answering her call light or answering it, stating they will be back to change her, and then they don't return. R33 stated she recently called for assistance to be changed at 7 am because she was wet. The CNA stated she would be back to change her, and she could not get anyone to change her adult diaper until 11:30 am. On 10/8/24 at approximately 2 PM, V5, CNA stated that sometimes she does find residents that are saturated with urine when she comes on duty in the mornings. On 10/10/24 at 11:06 AM, V18, Nurse Supervisor stated that she would expect the facility nursing staff to answer resident call lights within 5 minutes She would expect the nursing staff to immediately assist the residents with care needs and stated that it is absolutely not okay for a resident to be cleaning up another resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on record review, and interview, facility failed to ensure sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner promotes each resident's rights, physical, mental, and psychosocial well-being. This failure has the potential to affect all 33 residents residing in the facility. R23's Care Plan, not dated, documents R23 is occasionally incontinent of urine of bladder and continent of bowel. Please provide frequent toileting and peri care after each incontinent episode, requires extensive assist with ADL's (activities of daily living), R23's Minimum Data Set, dated dated ,d+[DATE], documents R23 is alert and oriented x4 occasionally incontinent of urine and requires assistance from staff for toileting. On 10/7/2024 at approximately 9:00 AM, observed V5, CNA, provide R23 incontinent care. R23 was incontinent of urine. V5 pulled back covers and opened R23's incontinent brief. V5's incontinent brief was heavily soiled with urine. V5 then cleansed R23's peri and groin area. V5 then assisted R23 over onto her right side. R23's gown, incontinent brief, incontinent pad and sheets were soaked with urine. R23's sheets were soaked up to her upper back. V5 removed the soiled incontinent brief revealing multiple deep, red indentations in skin. V5 then cleansed R23's left buttock. V5 then removed the urine soak sheets from the bed and rolled beneath R23. V5 then assisted R23 into the seated position on the side of the bed and put on R23's clothes and assisted R23 into the wheelchair. V5 did not cleanse all areas of incontinence. V5 did not cleanse R3's inner thighs and back. On 10/7/2024 at 8:50 AM, R23 stated she wanted to know why the girl did not come in and change her last night. R23 stated she has been wet all night. R23 stated the girl came in and gave her water last night but never checked her or cleaned her. R23 stated she told the girl she needed to be changed. R23 stated in the day she is up in her chair and able to use the toilet with help. R23 stated at night when she is in the bed, she loses all sense of control. R23 stated this makes her feel dirty, angry and embarrassed. R23 stated she doesn't want to lay in her own filth all night and she doesn't want to stink because of it. R23 stated it hurts laying in one position wet all night. R23 stated there is only 1 CNA, Certified Nurse Assistant, that cleans you when you are wet. R23 stated the others remove the depend and put another on you without cleaning you. R23 stated she shouldn't have to live like. R23 stated they don't have enough staff. R23 stated she laid all night. R23 stated there was a time she had to have her roommate take her off the bedpan and clean her. R23 stated no one came. R23 stated she complains about it, but nothing is done. R23 stated she feels like a fool, like she is nothing. On 10/8/24 at 1:30 PM, Resident Council was conducted, and R23, R24, R31, and R33 voiced multiple concerns with lack of staff and timeliness of incontinent care during this meeting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23, Resident Council President, stated the facility does not have enough staff at night and she has laid in wet pants multiple times all night because she could not get any employees to clean her up. R23 stated her roommate R24 is a former CNA and R24 has assisted her with getting on the bedpan and has cleaned her up throughout the night because they could not get any staff to answer the call light. R23 stated she frequently must sit with wet pants for long periods of time due to staff not answering her call light or staff saying they will be back to change her, and then they don't return. R23 stated she frequently voices her complaints to administration, and they just blow smoke up her butt in response to her complaints. On 10/7/2024 at 9:08 AM, V5, CNA stated she was informed (R23) did not void all night. V5 stated she thought it was odd because (R23) is a heavy wetter at night. On 10/101/2024 at 11:03 AM, V18, Nurse Supervisor stated (R23) is alert and oriented x4. V18 stated if (R23) stated said she was laying wet all night Because no one came in and there were no staff this would be accurate statement. V18 stated if (R23) stated she was embarrassed, angry, felt like a fool and felt pain from this this would be an accurate statement of how (R23) felt. V18 stated (R23) laying in urine all night and being soiled up to her head is a dignity problem. On 10/10/2024 at 11:47 AM, V23 stated (R23) is alert and oriented x4. V23 stated (R23) will tell you the truth. V23 stated if (R23) stated she was wet all night, and they didn't have staff this would be an accurate statement. 49494 On 10/8/24 at 1:30 PM, Resident Council was conducted. R23, R24, R31, and R33 voiced multiple concerns with lack of staff during this meeting. R24's face sheet, print date of 10/9/24, documented R24 has diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia and aphasia following cerebral infarction, depression, multiple sclerosis, epilepsy, and hypertension. R24's MDS dated [DATE] documented R24 is cognitively intact. R24's MDS dated [DATE] documented R24 depends on a wheelchair for mobility and requires partial to moderate assistance to ambulate 10 feet. On 10/8/24, during the Resident Council meeting R24 agreed that she helps her roommate R23 get on the bed pan at night and cleans her up due to staff not answering the call light. R31's face sheet, print date of 10/9/24, documented R31 has diagnoses of malignant neoplasm of prostate, dysphasia following cerebral infarction, pulmonary hypertension, pleural effusion, emphysema, spinal stenosis, and atrial fibrillation. R31's MDS dated [DATE] documented R31 is cognitively intact, always incontinent of bowels, has an indwelling urinary catheter, and requires substantial to maximal assistance with toileting hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24, during the Resident Council meeting R31 stated that there is not enough staff on any of the shifts and that the night shift is the worst. R31 stated that he has been dirty all night several times because he cannot get the CNAS to change him. R33's face sheet dated 10/9/24 documented R33 has diagnoses of benign hypertensive heart, chronic kidney disease, congestive heart failure, morbid obesity, gout, atrial fibrillation, anemia, hypertension, and diabetes mellitus. R33's MDS dated [DATE] documented R33 is cognitively intact, always incontinent of bowel and bladder, and requires substantial to maximal assistance with toileting hygiene. On 10/8/24, during the Resident Council meeting R33 stated that she often must sit in her wet adult diapers due to the staff not answering her call light or answering it, stating they will be back to change her, and then they don't return. R33 stated that she recently called for assistance to be changed at 7 am because she was wet, the CNA stated she would be back to change her, and that she could not get anyone to change her adult diaper until 11:30 am. On 10/8/24 at approximately 2:00 PM, V5, CNA stated that sometimes she does find residents that are saturated when she comes on duty in the mornings. On 10/10/24 at 11:06 AM, V18, Nurse Supervisor stated she would expect the facility nursing staff to answer resident call lights within 5 minutes, she would expect the nursing staff to immediately assist the residents with care needs and stated that it is absolutely not okay for a resident to be cleaning up another resident. (continued on next page)

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	145121	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alton Memorial Rehab & Therapy	1251 College Avenue Alton, IL 62002

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility staff plan policy and procedure dated 3/20 documented the purpose is to establish written guidelines to assist nursing management in determining adequate staffing to provide safe resident care. It is the responsibility of all nursing management (Director of Nursing, Assistant Director of Nursing, Supervisors and Nurse Managers) to understand and enforce this policy. Responsibility: It is the responsibility of this community to provide sufficient staff with appropriate competencies and skills to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Policy: The provision of safe care to every resident should be the focus for determining the number and competency level of direct caregivers based on the resident's needs within the community and to make sure staffing information is readily available in a readable format to residents and visitors at any given time. The community census, acuity and diagnosis of the resident population will be considered based on the facility assessment. Basic staffing guidelines will be followed for assigning direct care nursing staff on each shift of duty. The need for additional staff should be assessed using established guidelines that are reflected in the practice statement of this policy. It continues, direct care staffing: 1. The staffing plan should be based upon general staffing guidelines. The staffing schedule is developed by the nursing office and available to the staff at least two weeks in advance. 2. Each shift staffing is determined by staffing guidelines using resident acuity, census and staff availability. Nursing Supervisors will evaluate upcoming shift staffing to ensure adequate staffing. 3. The information shall reflect staff absences on that shift due to call outs and illnesses. The actual hours will be updated on the staffing sheet after the start of each shift. It continues, 7. If the acuity for a specific nursing unit requires adjusted staffing, examples of acuity measures to be considered are: a. Number of residents that require full assistance. b. Number of residents with continuous monitoring devices, c. Number of new admissions within the past twenty-four hours. It continues, 11. Providing care includes, but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to residents' needs.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview, record review, and observation the facility failed to ensure residents are free from significant medication errors for 1 of 6 (R195) residents reviewed for medication administration in a sample of 33. A delay of 6 days in getting the antibiotic started to treat UTI as ordered by the Physician Assistant caused R195 to become confused, have abdominal pain, increased leg pain, and missed some therapy sessions. Findings include: R195's face sheet, print date of 10/8/24, documented R195 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, Sjogren syndrome with peripheral nervous system involvement, Parkinson's disease, anemia, obstructive sleep apnea, and rheumatoid arthritis. R195's MDS (Minimum Data Set) dated 9/4/24, documented R195 is mildly cognitively impaired. R195's Physician Progress Notes by V31 PA (Physician Assistant) dated 9/27/24 at 8:51 AM documented, TI (urinary tract infection). Urine cx (culture) growing out ESBL (extended spectrum beta-lactamase). 9/27 - 1 week course of ciprofloxacin ordered. R195's Urine Culture Report dated 9/26/24 documents, urine culture positive for klebsiella pneumoniae ESBL. V31, PA documented on this report start ciprofloxacin 500 mg 1 tab (tablet) po (by mouth) BID (two times a day) for times 7 days for UTI with a start date of 9/27/24. R195's Nurse Progress Note dated 10/2/24 at 3:41 PM documents, UA (urinalysis) results sent to MD 9/27/24 with order returning to start Cipro. Order entry was delayed until 10/2/24 for ABT (antibiotic). MD and family aware. ABT started at this time. R195's Physical Therapy Treatment Encounter note dated 9/18/24 documented, patient participated in gait training and ambulated 50 feet with CGA (contact guard assist)/Min assist (minimal assistance) using a FWW (front wheeled walker) with cues. R195's Physical Therapy Note dated 9/19/24 documented, (R195) participated in gait training using front wheeled walker, CGA, and ambulated 250 feet with close w/c (wheelchair) follow. R195's Physical Therapy Note dated 9/24/24 documented, patient with decreased performance with blood in urine and procedure this date to drain fluid as patient had distended abdomen. Patient required increased assistance this date due to fatigue. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R195's Occupational Therapy Note dated 10/2/24 documented, patient seen extended time today secondary to having difficulty attending to task and following automatic instructions. Wife present and concerned. Patient alert and oriented x 1. Patient requiring increased time to initiate and complete tasks. Patient required max to near total assist to don bilateral tie shoes. Patient demonstrated poor sitting balance. Patient not following instructions to complete transfer to chair with front wheeled walker. Patient required mod assist to complete SPT (stand pivot transfer) from bed to wheelchair. Nurse informed of status and reports patient has irregular labs and has a call out to MD. R195's physical therapy note dated 10/2/24 documented COTA (Certified Occupational Therapy Assistant) reports increased confusion from patient. This clinician arrived at patient with wife appearing distressed. Patient's wife reports antibiotic for UTI was ordered 9/27 but was never started. Wife also reports she was told there were abnormal labs, but only had the report for hemoglobin. Wife reports catheter had been removed but was reinserted. Spoke with nurse to ask about patient being seen. Nurse said to return later as she needed to straight cath (catheterization) patient and scan bladder. Min (minimal) assist for supine to sit with assist using leg lifter during sit to supine. Patient utilizing bed rails. Verbal instruction for hand placement for ease of transfer. CGA for sit to stand from bed with verbal instruction for correct hand placement. This progress notes documented patient walked zero feet when R195 received physical therapy on 10/2/24. On 10/7/24 at 9:15 am R195's wife V28 stated the facility did not get R195's antibiotic started when it was order for a UTI. V28 stated there was a delay of 6 days in getting the antibiotic started and R195 was confused, having abdominal pain, increased leg pain, and missed some therapy sessions due to the UTI not being treated as ordered by the Physician Assistant. V28 stated she met with V2 DON (Director of Nursing) and V2 stated there was a miscommunication causing the antibiotic not getting administered when it was ordered. On 10/9/24 at 10:40 am V2 DON stated there was a medication error with R195's cipro order due to miscommunication between the nurse and the Physician Assistant. V2 stated the facility did complete a medication error report and a QAPI (Quality Assurance Performance Improvement) on R195's medication error. The facility medication incident report, print date of 10/8/24, documented R195's medication error was discovered by the facility on 10/2/24 for R195's antibiotic was ordered to be started on 9/27/24. This incident report documented antibiotic delayed start for UTI. R195's MARS (medication administration records) dated 9/24 and 10/24 documented R195 had an order for oxycodone 5mg prn (as needed) every 4 hours on admission 9/17/24. These MARS documented R195 only received the oxycodone on 9/23/24, 9/27/24, 10/1/24, and 10/2/24 when R195 was exhibiting symptoms of a UTI. R195's MAR dated 10/1/24 documented R195's first dose of ciprofloxacin was ordered on 9/27/24 was not administered until 10/2/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 10/9/24 at 10:45 am V28 (R195's wife) stated R195 is going home tomorrow because the insurance company will not pay for anymore therapy services. V28 stated she filed an appeal with the insurance company, and it was denied. V28 stated the 6-day delay in R195 receiving the antibiotics for the UTI due to the miscommunication caused R195 to miss therapy for multiple days because R195 was having pain, confused, and unable to participate in therapy. V28 stated instead of treating the UTI due to the miscommunication with the antibiotics the facility nurses were just administering oxycontin to R195 for pain. V28 stated the oxycontin caused R195 to be zoned out. R195 stated he was having pain in his lower abdomen and his upper leg during this time, and he was unable to do therapy. V28 stated she is very upset because R195 did not receive as much therapy as he needed due to the delay in getting the antibiotic started. V28 stated she believes R195 would be more prepared to go home if R195's UTI would have been treated when it was ordered. On 10/9/24 at 11:05 am V26 PTA (Physical Therapy Assistant) stated she has been treating R195 since admission and there was a period R195 was not able to participate in therapy due to an increase in pain and confusion. On 10/9/24 at 11:06 am V27 PT (Physical Therapist)/Therapy Manager stated R195 did not have any pain when she completed his initial therapy evaluation. V27 stated then there were a few days R195 did have a lot of pain and some confusion so R195 was not doing very well in therapy or unable to participate in therapy during those day. V27 stated the therapy documentation shows R195 was doing good in therapy up until 9/23/24, was walking 175 feet, then on 9/24/24 R195 had decreased performance, blood in his urine, and abdominal distention. V27 stated on 9/26/24 R195 complained of a lot of pain and could not participate in therapy on this day. V27 stated she spoke to R195's nurse on 9/26/24 and requested a doppler study and held off on therapy until the results came back. V27 stated the doppler results came back negative on 9/27/24 and R195 did received some therapy on 9/27/24 but R195 was unable to walk in therapy on 9/27/24. V27 stated R195 was only able to walk 10 feet in therapy on 9/30/24. V27 stated on 10/1/24 R195 was still having pain and only walked 30 feet in therapy. V27 stated on 10/2/24 R195 had increased confusion, was unable to walk in therapy, and only participated a little due to a UTI. V27 stated R195 was still confused on 10/3/24 and could not due therapy on this day but R195 was better on 10/4/24 and was able to walk 75 feet. V27 stated R195 did not have any confusion on 10/7/24 and he had a great day in therapy on 10/7/24. The facility Nursing Practices Policy and Procedure dated 1/24 documented Purpose: To establish guidelines for properly obtaining physician orders and processing these orders. Scope: Level 2 policy affecting licensed nursing personnel. Responsibility: It is the responsibility of the licensed nurse to understand and comply with this procedure. It is the responsibility of the nurse manager to maintain, enforce and monitor the procedure. It continues, telephone and verbal orders should be documented in the resident's electronic medical record then read back to the ordering physician/independent practitioner for verification.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42108 Based on observation, interview, and record review, the facility failed to properly store medications and ensure expired medications were discarded when appropriate. This has the potential to affect all 45 residents living in the facility. Findings include: On 10/7/2024 at 9:43 AM, the facility's East Wing Medication Storage Room was inspected. The refrigerator in the medication room contained the following medication: 1. A Dulcolax suppository with expiration date 1/20/2023. 2. Two Acetaminophen 650mg suppositories with expiration date 4/2024. The East Wing medication room also had the following medication: 3. A large bottle of stool softener with expiration date 3/2022. On 10/7/2024 at approximately 9:50 AM, V4, Licensed Practical Nurse, LPN stated the medication in the storage rooms is stock medication. V4 stated the Dulcolax and Acetaminophen suppositories and the stool softeners are stock medication and can be used for everyone as long as they have an order and no allergies. V4 stated expired medications are not to be used and are to be destroyed. On 10/10/24 at 10:06 AM, V32, LPN stated the medicine room and medication storage room stores the stock, over the counter medication. V32 stated the Senna tablets, Acetaminophen and Dulcolax suppositories are stock medication and can be used for all residents. V32 stated if the medication is expired it is destroyed immediately. V32 stated they have a person stocks the medication, and they check the expiration date. On 10/10/2024 at 11:03 AM, V18, Nurse Supervisor stated (V33), Central Supply, is the central supply person. V18 stated at the end of last month, she has helped with checking the meds. V18 stated she is not sure of why the expired meds were there. V33 stated she is not sure if the medication was taking out of the cart and placed on the shelf or what. V33 stated the nurses check the carts and V33 checks the medicine room and medication room when he stocks. V18 stated he checks all the meds for expired medication at time. V18 stated when the medications are expired, he alerts the nurse, and they destroy them. On 10/10/2024 at 11:47 AM, V23, LPN stated when medications are expired on the cart they are removed and destroyed. V23 stated the medication is not placed back in the medication rooms they are destroyed. V23 stated the pharmacist checks the carts and the medication guy checks the medication rooms for expiration medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Pharmacy Services and Procedure Manual, dated 12/1/22, documents Procedure: 4. The facility should ensure medications and biologicals: (1) have an expired date on the label; (2) have been retained longer than manufacture or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. The CMS Long-Term Care Facility Application for Medicare and Medicaid dated 10/7/2024, documents total residents 45.