STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. Section 300.1210 General Requirements for	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
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on observation, interview and record review, the Facility failed to ensure residents environment remains free of accident hazards by allowing residents with oxygen in the beauty shop near flammable hair chemicals and hair dryers. This has the potential to affect all of the 109 residents living in the Facility. Also the Facility failed to provide adequate supervision and safe transfers to prevent injuries for 3 of 11 residents (R1, R12, R14) reviewed for falls and fall prevention in the sample of 22 and one resident (R24) in the supplemental sample.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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	S9999		

Findings include:

1. Facility Policy and Procedure of 3/2004 for Oxygen Administration documents, "Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles etc.) from the immediate area where the oxygen is to be administered...Instruct the resident, his/her family, visitors and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the Oxygen Safety handout located in Appendex A."

Facility Oxygen Safety Policy and Procedure of 2001 documents, "For your safety and the safety of those around you, please observe the following safety precautions during your oxygen therapy!...Do not use flammable materials near oxygen. These include lotions, alcohol, oils, grease, nail polish remover, etc."

On 3/10/15 at 11:30 AM, R17 was observed in the beauty shop sitting in her wheel chair with an Oxygen tank and receiving Oxygen per nasal cannula. E4, Beautician, was cutting and blow drying R17's hair. At 11:35 AM, E1 Administrator and E2, Director of Nursing (DON), were informed of R17 being in the beauty shop with Oxygen. E2 ran and removed the Oxygen from R17 with R17's permission and instructed E4 that Oxygen was not allowed in the beauty shop. E4 was blow drying R17's hair at the time. E1, came into the beauty shop and stated R17 was a new resident and it was not facility policy to have oxygen in the beauty shop.

On 3/10/15 at 12:20 PM, there were multiple aerosol cans of hair spray, finishing spray, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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	S9999		

hair fix spray that labels had documentation, Warning flammable, avoid heat, fire, flame and smoking during use and until hair completely dry. There was an aerosol can of hair shine and texturing spray that documents, Warning: Flammable, do not use by fire, heat or smoking. Keep away from sources of ignition such as; any object that sparks. There was a bright pink sign on the wall of the beauty shop that documents, "No oxygen tanks at any time." E4 stated the sign was there when she started working at the facility. E1 stated E4 had been at the Facility for about 7 months.

2. The Resident Census and Conditions of Residents, CMS 672, dated 3/9/15 documents that the facility has 109 residents living in the Facility.

3. On 03/08/15 at 11:30 AM during tour of the 100 Hall, R1 was in her bed. R1's wheelchair was on the right side of her bed with a black cushion on top of a non-skid pad (Dycem) that was smashed and folded on one edge. At 1:00 PM, R1 was observed sitting in the wheelchair with her bottom on the cushion at a dining table during the lunch dining service. On 03/11/15 at 2:00 PM, R1 was in her bed and her wheelchair was out in the hall. E16, Activity Director confirmed that R1's wheelchair had a cushion on top of the non-skid pad.

The Minimum Data Set (MDS), dated 12/24/14, documents R1 has severe cognitive impairment with both short and long term memory deficits and requires extensive assistance of at least one staff for bed mobility, transfers, dressing, hygiene and toilet use. It also documents that R1 had only had one fall since last review and R1 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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	S9999		

any restorative programs or therapy. It also documents R1 was frequently incontinent of both bowel and bladder. The Care Plan, dated 10/23/14, documents R1 had impaired cognition related to Dementia and Alzheimer's Disease, has a self care performance deficit and a high risk for falls due to being unaware of safety needs and confusion. The interventions listed, in part, were to educate on use of call light and be sure call light is within reach, wait for staff for assistance, non-skid pad (Dycem) to wheelchair, keep in view of staff and therapy. The Fall Risk Assessment, dated 10/21/14, documents R1 as a high risk for falls.

On 07/14/14 at 8:00 AM, an Incident/Accident Report documented R1 was found lying on the bathroom floor on her back. It documents R1 sustained a 1 centimeter (cm) laceration to the back of the right hand. It documents R1 was alert with confusion. It documents additional steps taken to prevent recurrence as "Resident educated to wait for staff assistance and use call light. A Post Fall Investigation, dated 07/14/14, documents an alarm was not present, i.e. bed/wheelchair alarm. On a Fall Prevention Interventions sheet, wheelchair alarm, call bell within reach and visible, answer call light promptly, remind resident to request assistance and put in a supervised area was added.

On 07/18/14 at 11:00 AM, an Incident/Accident Report documented R1 "slid out of wheelchair, sustained abrasion to right knee. Resident holding on to hand rail while propelling self and pulled self out of wheelchair." It documented R1 was alert with confusion. The additional steps to prevent recurrence documented "Dycem to wheelchair." The Fall Prevention Investigation listed, in part as, visually check resident every two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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	S9999		

hours, or more frequently as determined by care team, chair alarm, answer call light promptly and remind resident to ask for assistance.

On 07/26/14 at 6:00 PM, an Incident/Accident Report documents R1 "stood up from wheelchair in dining room." The additional steps to prevent recurrence document "Dycem to wheelchair." The Fall Prevention Investigation listed, in part as, toilet every one to two hours, assistance with all transfers, remind resident to ask for assistance and reorient to call light.

On 09/14/14 at 2:15 AM, an Incident/Accident Report document R1 "going to bathroom, came back slipped on floor." It documents R1 sustained an abrasion to the right elbow. It also documents R1 was alert with confusion. The additional steps to prevent recurrence were "every one hour toileting and attempt to wear gripper socks at all times." A Nurse's Note, dated 09/14/14, documents R1 was "Instructed on proper way to use call light and wait for assistance and to keep bedroom door open when in bed. Resident voiced understanding but unable to properly demonstrate use of call light." The Fall Prevention Interventions were listed, in part as, instruct to call for help and call bell within reach, answer call light promptly and visible and put in supervised area.

On 09/27/14 at 6:30 AM, an Incident/Accident Report documents R1 "patient wheeled self to the dining room. And was later observed by staff sitting on the floor." It documents R1 was disoriented and had no injury. The additional steps to prevent recurrence were "attempt to keep patient in view of staff when up in wheelchair." The Fall Prevention Interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 6	S9999		

were listed, in part as, instruct to call for help and call bell within reach, answer call light promptly and visible and put in supervised area.

On 10/15/14 at 5:00 PM, an Incident/Accident Report documents R1 "sitting in wheelchair with feet propped up on bed, slid out of wheelchair onto floor on buttocks." It documents R1 was alert with confusion and sustained a laceration to the left middle finger of the left hand. The additional steps to prevent recurrence were listed as "place at nurses station at meal times to monitor; place Dycem in wheelchair." The Fall Prevention Interventions were listed, in part as, remind the resident to ask for assistance, reorient to call light, answer call light promptly, every 15 minute checks, remind resident to request assistance and keep call light within reach.

On 10/21/14 at 4:00 PM, an Incident/Accident Report documents R1 "was being transferred from bed to chair, gait belt buckle caught the arm." It documents R1 sustained a 1 inch skin tear to the left arm. The additional steps taken to prevent recurrence were listed as "attempt to have resident wear long sleeves when up."

On 10/25/14 at 12:30 PM, R1's Incident/Accident Report documents "Resident found sitting on bathroom floor on buttocks, alarm sounding, no injury." The additional steps to prevent recurrence listed were "hourly toileting until auto locks can be installed." The Post Fall Investigation, dated 10/25/14, documents "slid out of wheelchair-moved." The Fall Prevention Interventions were listed, in part as, remind the resident to ask for assistance. Reorient to call light, toileting program, keep call light within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 7 reach, answer call light promptly, non-slip footwear and wheelchair alarm. On 10/29/14 at 12:00 AM, an Incident/Accident Report documents R1 "trying to go to bathroom." It documents R1 was alert and oriented with confusion at times and no injuries. The additional steps taken to prevent recurrence were listed as "mat to floor by bed, physical therapy to evaluate and gripper socks in bed." The Fall Prevention Interventions were listed, in part as, ask the resident every one to two hours if she needs to use the bathroom, visually check the resident every two hours or more frequently, bed/chair alarm, remind resident to request assistance, keep call light within reach, answer call light promptly and non-slip footwear. On 11/22/14 at 5:30 PM, R1's Incident/Accident Report documented "Resident found on floor by special care exit door." It documents R1 was alert and oriented x 1 and sustained injuries to the back of the head and right elbow. The additional steps taken to prevent recurrence were listed as "attach alarm out of residents reach." The Post Fall Investigation documents R1 had taken off wheelchair alarm then attempted to get up unassisted to go to the bathroom. The Fall Prevention Interventions were listed, in part as, ask the resident every one to two hours if she needs to be toileted, remind resident to ask for assistance, reorient to call light, visually check the resident every two hours or more frequently, bed/chair alarm, keep call light within reach, answer call light promptly and non-slip footwear. On 12/03/14 at 4:40 PM, an Incident/Accident Report documents "sitting in wheelchair in doorway of her room. R1 fell forward out of her wheelchair. She hit her head on floor. She was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 8	S9999		

found laying in the doorway with her head in hallway." It documents R1 was confused and sustained a laceration over the right eye and was sent to the emergency department. The additional steps taken to prevent recurrence were listed as "attempt to keep resident in view of staff when up in wheelchair." The Post Fall Investigation, dated 12/03/14, documents R1 had removed the wheelchair alarm clip from her shirt prior to falling. The Fall Prevention Interventions listed, in part as, ask resident every one to two hours if she needs toileted, remind resident to ask for assistance, reorient to call light, answer call light promptly, visually check resident every two or more frequently, non-slip footwear and wheelchair alarm.

On 02/05/15 at 4:00 PM, R1's Incident/Accident Report documents "resident found by (CNA) lying on floor with a bloody nose and lip bit with blood on lip." It documents R1 sustained injuries to her nose, lip, left elbow and right forearm. The additional steps taken to prevent recurrence were listed as, "DON notified, neuro checks initiated and raised edge mattress." The Post Fall Investigation, dated 02/05/15, documents R1 had rolled out of bed and missed the mat on the floor. It documents the side rails were not up and the bed alarm had not sounded at the time of the fall. The Fall Prevention Interventions were listed, in part as, answer call light promptly, remind the resident to ask for assistance, reorient to call light, visually check the resident every one to two hours or more frequently, check battery on all alarms, night light, call bell within reach and visible and low mattress.

On 02/27/15 at 8:30 AM, R1's Incident/Accident Report documents, "called to 100 Hall. Noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 9	S9999		

resident laying on hallway floor in front of wheelchair. Noted laceration forehead 1 cm x 0.2 cm x 0.1 cm. wheelchair alarm sounding." It documents R1 was "alert with periods of confusion, minimal amount serosanguinous drainage. Left knee abrasion 1 cm x 1.2 x 0.1 cm area red with scant serosanguinous drainage. Range of Motion (ROM)done without difficulty. Resident assisted up x two to wheelchair and returned to bed. Resident denies any complaint of pain. Resident stated she fell from wheelchair while propelling wheelchair with feet." The additional steps taken to prevent recurrence were listed as "therapy to evaluate and treat."

On 03/02/15 at 1:00 PM, an Incident/Accident Report documents, "called to residents room per CNA, unwitnessed per CNA. Resident slid to floor from wheelchair did not hit head. Resident found sitting on buttocks on floor in from of wheelchair. Wheelchair alarm sounding." It documents, "ROM done without difficulty. Upon assessment noted two small areas to lower back, 0.3 cm x 0.1 cm x 0.1 cm and 0.2 cm x 0.1 cm x 0.1 cm. Red/pink, no drainage, no odor. Resident denies any complaint of pain. Resident assisted up to bed x two staff members, bed alarm intact. Call light within reach." The additional steps taken to prevent recurrence were listed as "therapy to evaluate and treat 02/27/15." The Fall Prevention Interventions listed, in part as, remind resident to ask for assistance, reorient to call light and resident to be more visible to staff when up in wheelchair.

The policy and procedure, titled "Fall Management" documents under "Policy: It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 10	S9999		

include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assuasive devices are utilized as necessary." And under, "Standards: #4...Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained."

On 03/13/15 at 12:20 PM, E2 acknowledged that R1's interventions were repetitive and ineffective, and stated that she felt that the facility had tried everything they could think of to prevent R1 from continuing to fall.

2. R12's Minimum Data Set (MDS), dated 10-22-14 and 1-21-15, documents diagnosis, in part as Cerebral Palsy, severe cognitive impairment, total dependence of two plus persons physical assistance with mobility and transfer and upper and lower extremity functional limitation in range of motion.

R12's Incident/Accident Reports, dated from 4-28-2014 to 3-9-2015, documented the following incidents: On 4-28-2014 at 10:30 PM, R12 received a 4.0 cm x 2.0 cm and multiple scratches 0.5 cm x 6.0 cm from rubbing his unpadded arm on his wheel chair: On 5-2-1014 at 7:30 AM, R12 received a 0.9 cm x 0.5 cm x 0.1 cm skin tear on his left upper posterior thigh from his adult diaper which unidentified staff were instructed not to use while he was in bed; On 6-18-2014 at 8:15 AM, R12 received a 5 inch long abrasion to the top of his head during care after which unidentified staff where educated to use safety while providing him care; On 1-10-2015 at 1:30 PM, R12 received a 1.0 cm x 1.0 cm skin tear on the outside of his left knee while he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 11	S9999		

being transferred with a mechanical lifting device: and, On 2-17-2015 at 7:15 AM, R12 incurred a 0.2 cm x 0.1 cm x 1.0 cm skin tear on his left elbow while he was being turned during showering.

R12's Care Plan, dated initiated 10-16-1014, documents R12 was at risk for falls related to his lack of safety awareness and that he was at risk for impairment to skin integrity related to fragile skin. R12 requires total assistance with transfers, to provide padding during transfers and to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces.

3. R24's MDS, dated 2-29-2015, documents severe cognitive impairment and extensive assistance of two plus persons physical assist with mobility and transfer. R24's Care Plan, revision date 10-22-2014, documents R24 was at risk for falls related to history of falls. R24 has a communication problem related to hearing deficit and to reapproach her at a later time when she becomes frustrated and agitated.

During observation of R24's transfer from bed to chair, E9 and E10 CNA's, placed a transfer belt around R24, while she was in bed, and transferred her from bed to chair. R24 was agitated, yelling and grabbing at E9 and E10's clothing and name tags. E9 and E10 did not lay her down and reapproach her. They transferred her from bed to chair supporting her weight with the transfer belt as R24's feet did not touch the floor.

The Facility's Repositioning, Lifts and Transfers policy, not dated, documents, in part, "Transfers are a procedure to assist a patient who can bear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 12 weight through one leg or both arms move from one surface to another...these include...transfer belts." 4. R14's Physician Order Sheet (POS), dated 2/27/15, documents that R14 has a diagnosis of Dementia and Psychosis. R14's Brief Interview of Mental Status (BIMS), dated 2/5/15, documents a 0, which indicates that R14 is rarely understood. R14's MDS, dated 2/5/15, documents that R14 requires extensive assistance and two plus physical assistance for transfers, requires extensive assistance and one person physical assistance with walking. R14's Fall Risk Prevention Assessment, dated 9/15/14, documents that R14 scored 13 (a score of 10 or above is a high risk for falls). R14's Care Plan, dated 10/17/14, documents that R14 is at a risk for falls related to history of falls, cognitive impairments, visual acuity impairments, decreased safety awareness, impulsiveness with attempt to stand or self transfer without staff assistance. R14's Fall Risk Prevention Assessment, dated 2/8/15, documents that R14 scored 16 (a score of 10 or above is a high risk for falls). R14's Incident/Accident Report, dated 1/24/15, documents that R14 was sitting up at side of bed, and slid to the floor. R14's Incident/Accident Report, dated 2/7/15, documents that R14 was found in room sitting on buttocks in front of wheelchair by bed with alarm sounding. R14's Incident/Accident Report, dated 2/16/15, documents that R14 was attempting to climb out of bed so CNA dressed R14 and sat in wheelchair for monitoring. The Incident/Accident Report documents that R14 stood up from the wheelchair, and that staff were too far away to prevent fall.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTON REHAB & NURSING CENTER	3523 WICKENHAUSER 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 13 On 3/13/15 at 11:10 AM E2 was interviewed and stated that interventions based on the investigation of falls is under additional comments on the front of the Incident/Accident Report. E2 stated that interventions in place for a person with falls will be reviewed if they are ineffective. The facility failed to analyze data to identify trends and patterns and perform root cause analysis of R14's falls. The facility failed to review interventions, and make changes based on investigation of R14's falls. B	S9999		