	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		IL6002877	B. WING		10/10/2024	
IAME OF PR	OVIDER OR SUPPLIER	1	DDRESS, CITY, STATE	, ZIP CODE		
	MORIAL REHAB & THI	ERAPY	LLEGE AVENUE			
-		ALTON, I	L 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure He	ealth Survey				
S9999	Final Observations		S9999			
	Statement of Licensure Violations (1 of 3):					
	300.610a) 300.1210b) 300.1210c) 300.1210d)4)A)					
ę	Section 300.610 Res	sident Care Policies				
	procedures governin facility. The written p be formulated by a R Committee consisting administrator, the ad medical advisory cor of nursing and other policies shall comply					
	Section 300.1210 Ge Nursing and Persona	eneral Requirements for al Care				
	care and services to practicable physical, well-being of the resi each resident's comp plan. Adequate and care and personal ca	hall provide the necessary attain or maintain the highest mental, and psychological ident, in accordance with orehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident.				
	ent of Public Health	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE
	ally Signed					10/24/24
TE FORM			6899 65	JQ11	If contin	uation sheet 1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		IL6002877	B. WING		10/10/2024	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ALTON M	EMORIAL REHAB & TH	ERAPY	DLLEGE AVENUE IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
S9999	 c) Each direct c and be knowledgeab respective resident c d) Pursuant to s nursing care shall ind following and shall be seven-day-a-week based 4) Personal care 24-hour, seven-day-a include, but not be lind A) Each resident personal attention, indonal attention, indonal	are-giving staff shall review le about his or her residents' are plan. subsection (a), general clude, at a minimum, the e practiced on a 24-hour,	S9999			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		II 6002877	IL6002877 B. WING		10	0/10/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		//10/2024
		1251 CC	DLLEGE AVENUE			
ALTON M	EMORIAL REHAB & THE	ERAPY ALTON,	IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page	Continued From page 2 R23's Minimum Data Set, dated 8/20, documents R23 is alert and oriented x4, occasionally incontinent of urine, and requires assistance from staff for toileting.				
	R23 is alert and orier incontinent of urine, a					
	care. R23 was incom back covers and ope V5's incontinent brief urine. V5 then cleans area. V5 then assiste side. R23's gown, inc pad and sheets were sheets were soaked removed the soiled ir multiple deep, red inc cleansed R23's left b urine soak sheets fro beneath R23. V5 the seated position on th R23's clothes and as wheelchair. V5 did no	broviding R23 incontinent tinent of urine. V5 pulled aned R23's incontinent brief. was heavily soiled with sed R23's peri and groin ed R23 over onto her right continent brief, incontinent e soaked with urine. R23's up to her upper back. V5 incontinent brief revealing dentations in skin. V5 then buttock. V5 then removed the own the bed and rolled in assisted R23 into the e side of the bed and put on				
	to know why the girl of her last night. R23 st night. R23 stated the water last night but n her. R23 stated she t changed. R23 stated chair and able to use stated at night when all sense of control. F feel dirty, angry and she doesn't want to b	AM, R23 stated she wanted did not come in and change ated she has been wet all girl came in and gave her ever checked her or cleaned told the girl she needed to be in the day she is up in her the toilet with help. R23 she is in the bed, she loses R23 stated this makes her embarrassed. R23 stated ay in her own filth all night t to stink because of it. R23				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		IL6002877	B. WING		10	1/10/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE)/10/2024
		1251 C	OLLEGE AVENUE			
ALION ME	EMORIAL REHAB & THE	ALTON	IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page	e 3	S9999			
	Assistant, that cleans stated the others rem another on you witho she shouldn't have to they don't have enou- wet all night. R23 stat had to have her room bedpan and clean he R23 stated she comp done. R23 stated she nothing. On 10/7/2024 at 9:06 was informed (R23) of stated she thought it heavy wetter at night On 10/101/2024 at 1 Supervisor, stated (R V18 stated if (R23) stated is felt like a fool and fel an accurate statement stated (R23) laying in soiled up to her head On 10/10/2024 at 11 Practical Nurse, stated x4. V23 stated (R23) stated if (R23) stated if (R23) stated if (R23)	1:03 AM, V18, Nurse (23) is alert and oriented x4. tated said she was laying wet e accurate statement. V18 she was embarrassed, angry, t pain from this this would be nt of how (R23) felt. V18 n urine all night and being				
	long time, she would stated if (R23) stated be accurate.	d if she laid in urine for a feel nasty and dirty. V23 this is how she felt it would				
		M, Resident Council was R24, R31, and R33 voiced				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		IL6002877	B. WING		10	/10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ALTON MI	EMORIAL REHAB & THE	ERAPY	OLLEGE AVENUE , IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page 4		S9999			
	multiple concerns wit of incontinent care du	h lack of staff and timeliness uring this meeting.				
	facility does not have she has laid in wet pa because she could n clean her up. R23 sta former CNA and R24 getting on the bedpa throughout the night any staff to answer th frequently must sit w of time due to staff no staff saying they will then they don't return voices her complaint just blow smoke up h complaints. 2. R13's Care Plan, n	cil President, stated the e enough staff at night and ants multiple times all night ot get any employees to ated her roommate R24 is a has assisted her with n and has cleaned her up because they could not get ne call light. R23 stated she ith wet pants for long periods of answering her call light or be back to change her, and n. R23 stated she frequently is to administration, and they her butt in response to her				
	care, incontinent of b peri care after episod	owel and bladder. Provide les of incontinent remain nimize the risk of skin				
	R13's MDS, dated 7/ moderately cognitive	28/2024, documents R13 is ly impaired, incontinent of nd requires assistance from				
	and V24, LPN, perfor treatment. R13 was i bowel. V23 and V24 brief V24 rolled it bet	AM, observed V23, LPN, rmed incontinent care and ncontinent of urine and opened R13's incontinent ween R13's legs. V23 and on her right side. V24 rolled				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		IL6002877	B. WING		10/10/2024	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		J/10/2024
		-DADY 1251 C	OLLEGE AVENUE			
	EMORIAL REHAB & THE	ALTON	I, IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page 5		S9999			
	between R13's right wiped the same area then changed her glo treatment to R13's publitock. V24 then pla under R13. V23 and side and removed the from beneath R13. V R13's brief and place On 10/10/2024 at 11 Supervisor, stated sh all wet areas. V18 st her back and neck the as part of peri care. V performed, and the re bowel and bladder the care and then comple The facility's Perinea documents Purpose: performing perineal of to be done as needer residents who are un Perineal care is done prevent growth of ba breakdown and prom Standard precautions technique will be use Policy: Perineal Care incontinence for resid perform self-care. Per cleanse the perineun bacteria, prevent skin good personal hygien from the cleanest are clean from urethra to	and left buttocks. V24 then with a wet washcloth. V24 oves and performed ressure ulcer on right aced a clean incontinent brief V24 rolled R13 onto her left e soiled incontinent brief 23 and V24 then fastened ad cover over R13. :03 AM, V18, Nurse he expects the staff to clean ated if a resident is wet up to nose areas are to be cleaned /18 stated if a treatment is esident is incontinent of he staff are to perform peri- ete the treatment. I Policy, dated 10/22, To provide guidelines for care. Policy: Perineal care is d for incontinence for hable to perform self-care. to cleanse the perineum to cteria, prevent skin note good personal hygiene. s and sound aseptic d when performing peri-care. to be done as needed for dents who are unable to erineal care is done to in to prevent growth of in breakdown and promote he. Practice: 10. Always work ea to the dirtiest. Therefore, the anal area (front to back)				
	anal area to the vagi	er from spreading from the na or urethra using clean ently "pat" dry (no scrubbing).				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		IL6002877	B. WING		10	0/10/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE DLLEGE AVENUE	, ZIP CODE		
ALTON ME	EMORIAL REHAB & THE	ERAPY	IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page 6 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.		S9999			
	and hemiparesis follo affecting right domina aphasia following cel	print date of 10/9/24, s diagnoses of hemiplegia owing cerebral infarction ant side, dysphagia and rebral infarction, depression, ilepsy, and hypertension.				
	R24's MDS dated 10 cognitively intact.	/4/24 documented R24 is				
	depends on a wheel	/4/24 documented R24 chair for mobility and requires ssistance to ambulate 10				
	R24 agreed that she	ne Resident Council meeting helps her roommate (R23) t night and cleans her up due g the call light.				
	neoplasm of prostate cerebral infarction, p	print date of 10/9/24, s diagnoses of malignant e, dysphasia following ulmonary hypertension, hysema, spinal stenosis,				
	cognitively intact, alw has an indwelling uri	16/24 documented R31 is vays incontinent of bowels, nary catheter, and requires al assistance with toileting				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			 В. WING			10/10/0001	
		IL6002877	ET ADDRESS, CITY, STATE		10	/10/2024	
	ROVIDER OR SUPPLIER	1251		, ZIP CODE			
ALTON MI	EMORIAL REHAB & THE	ERAPY	N, IL 62002				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From pag	e 7	S9999				
	hygiene.						
	R31 stated that there of the shifts and that R31 stated that he ha	he Resident Council meeting is not enough staff on any the night shift is the worst. as been dirty all night several nnot get the CNAs to change					
	R33 has diagnoses of chronic kidney disea	lated 10/9/24 documented of benign hypertensive heart, se, congestive heart failure, , atrial fibrillation, anemia, abetes mellitus.					
	cognitively intact, alw	18/24 documented R33 is vays incontinent of bowel and s substantial to maximal ing hygiene.					
	R33 stated that she of diaper due to the stat or answering it, statin change her, and then stated she recently of changed at 7 am beot stated she would be	he Resident Council meeting often must sit in her wet adult ff not answering her call light ng they will be back to in they don't return. R33 alled for assistance to be cause she was wet. The CNA back to change her, and she is to change her adult diaper					
	stated that sometime	kimately 2 PM, V5, CNA s she does find residents th urine when she comes on					
	stated that she would staff to answer reside	AM, V18, Nurse Supervisor d expect the facility nursing ent call lights within 5 expect the nursing staff to					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		IL6002877	B. WING		10	10/10/2024	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 10		
		1251 C	OLLEGE AVENUE				
	EMORIAL REHAB & THE	ALTON	, IL 62002				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From page	Continued From page 8					
	and stated that it is a	e residents with care needs bsolutely not okay for a ng up another resident.					
	Statement of Licensu	Statement of Licensure Violations (2 of 3):					
	300.610a) 300.1210b) 300.1210c) 300.1210d)1)2)						
	Section 300.610 Res	ident Care Policies					
	procedures governing facility. The written p be formulated by a R Committee consisting administrator, the ad medical advisory com of nursing and other policies shall comply						
	Section 300.1210 Ge Nursing and Persona	eneral Requirements for al Care					
	care and services to practicable physical, well-being of the resi each resident's comp plan. Adequate and p care and personal ca	nall provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with orehensive resident care properly supervised nursing ire shall be provided to each total nursing and personal					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		IL6002877	B. WING		10)/10/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
ALTON M	EMORIAL REHAB & THE	ERAPY	OLLEGE AVENUE , IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
S9999	Continued From page 9		S9999			
		are-giving staff shall review le about his or her residents' are plan.				
	nursing care shall inc	ubsection (a), general clude, at a minimum, the e practiced on a 24-hour, asis:				
	-	including oral, rectal, ous and intramuscular, shall ered.				
		s and procedures shall be red by the physician.				
	These requirements by:	were not met as evidenced				
	are free from significa 6 (R195) residents re administration in a sa days in getting the ar as ordered by the Ph R195 to become con	record review, and ty failed to ensure residents ant medication errors for 1 of eviewed for medication ample of 33. A delay of 6 ntibiotic started to treat UTI sysician Assistant caused fused, have abdominal pain, nd missed some therapy				
	Findings include:					
	9/17/24 with diagnos intertrochanteric frac subsequent encounter	as admitted to the facility on es of displaced ture of right femur, er for closed fracture with ren syndrome with peripheral lvement, Parkinson's				

Illinois Department of Public Health STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		IL6002877	B. WING		10	/10/2024
IAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE	, ZIP CODE		//10/2024
	EMORIAL REHAB & THE	ERAPY	COLLEGE AVENUE			
		ALTO	DN, IL 62002			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page	e 10	S9999			
	rheumatoid arthritis.					
	(um Data Set) dated 9/4/24, mildly cognitively impaired.				
	(Physician Assistant) documented, "TI (uri					
	documents, "urine cu pneumoniae ESBL. \ report start ciprofloxa	Report dated 9/26/24 Ilture positive for klebsiella /31, PA documented on this acin 500 mg 1 tab (tablet) po times a day) for times 7 days ate of 9/27/24."				
	3:41 PM documents, to MD 9/27/24 with o Order entry was dela	ess Note dated 10/2/24 at "UA (urinalysis) results sent rder returning to start Cipro. ayed until 10/2/24 for ABT amily aware. ABT started at				
	note dated 9/18/24 d participated in gait tra	aining and ambulated 50 feet uard assist)/Min assist using a FWW (front				
	documented, "(R195 using front wheeled w	rapy Note dated 9/19/24) participated in gait training walker, CGA, and ambulated //c (wheelchair) follow."				
	R195's Physical The documented, "patien	rapy Note dated 9/24/24 t with decreased				

	epartment of Public He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	
		IL6002877	B. WING		10/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STATE	E, ZIP CODE		
		1251	COLLEGE AVENUE			
	EMORIAL REHAB & THE	ALTO	DN, IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From page	e 11	S9999			
	this date to drain fluid abdomen. Patient red	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."				
	documented, "patient secondary to having and following automa and concerned. Patient Patient requiring incr complete tasks. Patient assist to don bilatera					
	following instructions with front wheeled wa assist to complete SF bed to wheelchair. No	itting balance. Patient not to complete transfer to chair alker. Patient required mod PT (stand pivot transfer) from urse informed of status and regular labs and has a call				
	documented COTA (Therapy Assistant) re from patient. This clir wife appearing distre antibiotic for UTI was started. Wife also rep abnormal labs, but on hemoglobin. Wife rep removed but was rein	apy note dated 10/2/24 Certified Occupational eports increased confusion nician arrived at patient with ssed. Patient's wife reports ordered 9/27 but was never ports she was told there were nly had the report for ports catheter had been nserted. Spoke with nurse to ing seen. Nurse said to				
	return later as she ne (catheterization) patie (minimal) assist for s leg lifter during sit to rails. Verbal instruction ease of transfer. CG/ with verbal instruction	eeded to straight cath ent and scan bladder. Min upine to sit with assist using supine. Patient utilizing bed on for hand placement for A for sit to stand from bed n for correct hand placement. documented patient walked				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002877	B. WING		10)/10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		-DADY 1251 CC	DLLEGE AVENUE			
	EMORIAL REHAB & THE	ALTON,	IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
S9999	Continued From page	e 12	S9999			
	zero feet when R195 received physical therapy on 10/2/24".					
	the facility did not get when it was order for a delay of 6 days in g and R195 was confu- increased leg pain, a sessions due to the U ordered by the Physi she met with V2 DON V2 stated there was the antibiotic not gett ordered. On 10/9/24 at 10:40 was a medication err due to miscommunic the Physician Assista complete a medicatio	m R195's wife V28 stated t R195's antibiotic started a UTI. V28 stated there was getting the antibiotic started sed, having abdominal pain, nd missed some therapy JTI not being treated as cian Assistant. V28 stated N (Director of Nursing) and a miscommunication causing ing administered when it was am V2 DON stated there or with R195's cipro order ation between the nurse and ant. V2 stated the facility did on error report and a QAPI Performance Improvement) n error.				
	of 10/8/24, documen was discovered by th	•				
	had an order for oxyo every 4 hours on adr MARS documented F oxycodone on 9/23/2 10/2/24 when R195 v UTI. R195's MAR da	cation administration and 10/24 documented R195 codone 5mg prn (as needed) nission 9/17/24. These R195 only received the e4, 9/27/24, 10/1/24, and was exhibiting symptoms of a ted 10/1/24 documented ciprofloxacin was ordered on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6002877		B. WING		10	0/10/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ALTON ME	EMORIAL REHAB & THE	ERAPY	OLLEGE AVENUE			
		ALTON	, IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pag	e 13	S9999			
	9/27/24 was not adm	inistered until 10/2/24.				
	On 10/0/24 at 10:45	am V28 (R195's wife) stated				
		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 w	ould be more prepared to go				
		vould have been treated				
	when it was ordered.					
	On 10/9/24 at 11:05	am V26 PTA (Physical				
		tated she has been treating				
		n and there was a period				
		participate in therapy due to				
	an increase in pain a	nd confusion.				
		am V27 PT (Physical				
	Therapist)/Therapy Manager stated R195 did not					
	have any pain when she completed his initial					
		/27 stated then there were a				
		ave a lot of pain and some /as not doing very well in				
		participate in therapy during				
	\ldots					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		IL6002877 B. WING			10/10/2024	
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, Z		10/10/2024	
		1251	COLLEGE AVENUE			
ALION M	EMORIAL REHAB & THE	ALTC	DN, IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
S9999	Continued From pag	e 14	S9999			
	9/23/24, was walking R195 had decreased urine, and abdomina 9/26/24 R195 compla could not participate stated she spoke to I requested a doppler until the results came doppler results came and R195 did receive but R195 was unable 9/27/24. V27 stated I 10 feet in therapy on 10/1/24 R195 was st walked 30 feet in the R195 had increased walk in therapy, and to a UTI. V27 stated 10/3/24 and could no R195 was better on 75 feet. V27 stated F confusion on 10/7/24. The facility Nursing F Procedure dated 1/2 establish guidelines f physician orders and Scope: Level 2 policy personnel. Responsi the licensed nurse to this procedure. It is the manager to maintain procedure. It continu orders should be doo electronic medical re	ng good in therapy up until g 175 feet, then on 9/24/24 I performance, blood in his I distention. V27 stated on ained of a lot of pain and in therapy on this day. V27 R195's nurse on 9/26/24 and study and held off on therapy e back. V27 stated the back negative on 9/27/24 et o walk in therapy on R195 was only able to walk 9/30/24. V27 stated on ill having pain and only rapy. V27 stated on 10/2/24 confusion, was unable to only participated a little due R195 was still confused on ot due therapy on this day but 10/4/24 and was able to walk R195 did not have any and he had a great day in Practices Policy and 4 documented Purpose: To for properly obtaining I processing these orders. y affecting licensed nursing bility: It is the responsibility of o understand and comply with he responsibility of the nurse , enforce and monitor the es, telephone and verbal cumented in the resident's cord then read back to the dependent practitioner for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002877	 B. WING)/10/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		10/10/2024	
	EMORIAL REHAB & THE	ERAPY 1251 C	OLLEGE AVENUE			
		ALTON	, IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pag	e 15	S9999			
	Statement of Licensu	re Violations (3 of 3):				
	300.625a) 300.625b)					
	Section 300.625 Identified Offenders					
	· ·	nall review the results of the ground checks immediately checks.				
	all steps necessary to residents while the re background check or are pending; while th waiver of a fingerprin	hall be responsible for taking o ensure the safety of esults of a name-based a fingerprint-based check e results of a request for a tt-based check are pending; tified Offender Report and pending.				
	These requirements by:	are NOT MET as evidence				
	failed to initiate chirp R100, R101, R102, a	nd record review the facility for 5 of 10 residents (R99, and R103 reviewed for checks in the sample of 33.				
	Findings include:					
	admission date at 10 Police (ISP) Bureau	formation sheet documents /3/2023. R99's Illinois State of Identification documents check done 10/9/2024.				
	admission date of 10	nformation sheet documents /3/2024. R100's ISP Bureau ments criminal back ground				

STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6002877		B. WING		10	/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, Z	ZIP CODE	• •	
ALTON M	EMORIAL REHAB & TH	ERAPY	OLLEGE AVENUE , IL 62002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
\$9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 check done on 10/9/2024. 3. R101's Resident Information sheet documents admission date of 10/4/2024. R101's ISP Bureau of identification documents criminal back ground checks done on 10/7/2024. 4. R102' s Resident information sheet documents date of 10/4/2024. R102's ISP Bureau of identification documents criminal back ground check done on 10/7/2024. 5. R103's Resident Information sheet documents admission date of 10/3/2024. R103's ISP Bureau of identification documents criminal back ground check done on 10/7/2024. 0n 10/9/2024 at 2:00 PM V1, Administrator stated the registration last updated by system is the actual admission date and time. The facility policy client/resident Mistreatment, Neglect and Abuse Prohibition/Prevention dated, last revised 5/19 documents Screening: The facility screens potential covered individuals for a history of abuse, neglect or mistreating of		S9999	DEFICIENC	ΣΥ)	
	Sex offender, Reside Illinois practice: Illino to run criminal backg seeking admission to admission. Administr Identified offenders of	nployee dated revised 12/16 ent-documents Addendum for bis requires nursing facilities pround checks on all persons o facility within 24 hours of rative Code section 300.625 d) documents the facility shall cable provisions contained in				

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