STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Sub Part S: SMI Complaint #1541254/IL75571-F157 An extended survey was conducted.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 157	Continued From page 1	F 157		

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the Facility failed to timely notify the Physician of a significant change in condition for 1 of 22 residents (R20) reviewed for Physician Notification, in the sample of 22.

Findings include:

1. R20's April 2014 Physician Order Sheet (POS) documents R20 is a 91 year old female with a Diagnosis, in part; Transient Ischemic Attack (TIA) and Congestive Heart Failure.

R20's Minimum Data Set (MDS) of March 12, 2014 documents R20 has no cognitive impairment and required limited assistance of 1 for toileting.

R20's Nurses Notes of 4/13/14 at 12:30 PM, documents Certified Nurse Aide (CNA) reported R20 was on the commode and non-responsive. Upon assessment noted R20's skin was warm/dry to touch. Respirations even-non labored. R20 was transferred from the commode to the wheel chair and returned to bed. R20 resisted eyes being open and pulled cover to her chin. Vital Signs (VS) temperature (T) 98.8, pulse (P) 60, respiration (R) 18, (BP) blood pressure 155/70. Oxygen sats (saturation) 97% at room air. Z1, R20's Physician, was made aware of R20's condition with no new orders. Will continue to monitor. Z3, R20's Power of Attorney (POA),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 157	Continued From page 2	F 157		

and Z4, Granddaughter, were notified of change in condition.

The next Nurses Note written at 3 PM documents BP 158/78, T 96.2, P 71, R 18. In bed with eyes closed. Opens eyes on occasion and moves. Respirations even and unlabored.

The next Nurses Note written at 4:30 PM documents R20 resting in bed opens eyes occasionally. Oxygen 77% on room air. O2 (Oxygen) started at 2 L/M (liters per minute) per nasal cannula. Will monitor.

The next Nurses Note written at 5 PM documents R20's pulse oxygen was 83% on O2 at 2 L/M per nasal Cannula. B/P was 90/52, T 96.7, P 92, R 18. Z1 was called and gave orders to send to the Emergency Room (ER).

The Nurses Notes of 9:30 PM documents R20 was admitted to the hospital with diagnoses of acute CVA (Cerebrovascular Accident).

During interview with Z1, R20's Physician/Facility Medical Director on 3/12/15 at 2:45 PM, Z1 stated he would have expected the Nurse to call him when R20's Oxygen Saturation was 77%. Z1 stated the Nurse should have called him. He would have wanted to know and would have ordered R20 to be sent to the ER then. Z1 stated R20 had an extensive CVA with the left side affected. Z1 stated that R20 was 91 years old and if they would have called him earlier there would not have been a different outcome.

The Nurses Notes of 4/19/14 documents R20 expired at 3:12 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 311	Continued From page 3	F 311		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the Facility failed to provide restorative eating programming for 3 of 9 residents (R12, R15, R16) reviewed for restorative eating programs in the sample of 22. Findings include: 1. 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 one to two plus persons physical assistance with eating, upper and lower extremity functional limitation in range of motion and no restorative programing for eating. Interview of E5, MDS/CP (Care Plan) Coordinator, stated, on 3-13-2015 at 9:45 AM, did not have a restorative programming. During observation of R12's noon meal, on 3-8-2015 at 1:12 PM, R12 was served his noon meal and thickened liquids in a regular glass. R12 repeatedly asked for a straw and attempted to drink from his glass and place it to his lips after which E6, Certified Nursing Assistant (CNA), removed the glass from his hands and fed him both his meal and liquids. A "2 handled lidded	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 311	Continued From page 4	F 311		

cup with spout" was not provided.

R12's Diet Order & (and) Communication, dated 1-30-2015, documents, in part, "needs 2 handled lidded cup with spout."

Interview of E8, Restorative Nurse, on 3-10-2015 at 10:35 AM, E8 stated R12 could hold a cup. E8 also stated R12 was not in a restorative eating program during a review of the 200 Hall Restorative Book, dated March 2015.

The Facility's Rehabilitative Nursing Care Policy Statement, revised 2014), documents , in part, "Restorative/Rehabilitative nursing care care is provided for each resident admitted...the facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence."

2. R15's MDS, dated 11-5-14, documents moderately impaired cognition, supervision of set up help with eating and fluids and no restorative eating programing. R15's Care Plan, initiated 10-17-2014 and 11-19-2013, documents impaired vision function and at risk for dehydration related to blindness. It was also noted to assist with eating and encourage fluids.

During observation of R15's dining, on 3-8-2015 at 1:10 PM, R15 was served his noon meal with no verbal instructions as to what food and liquids he had nor the placement of the food items. R15's silverware was not unwrapped nor provided to him. R15 spilled one glass of fluids and dropped his bowl of cake without staff intervention.

During observation of R15's dining,on 3-9-2015 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 311	Continued From page 5 1:00 PM, R15 was not provided instructions for placement of his food or fluid items. R15's MDS, dated 2-5-15, documented his eating and fluid declined to supervision with one person physical assistance and no eating restorative programming. Interview of E8, Restorative Nurse, stated on 3-10-2015 at 10:35 AM, that the facility did not have a restorative eating program during review of the 200 Hall Restorative Book, dated March 2015. 3. R16 was fed lunch by E7, Certified Nurses Assistant (CNA), on 3/8/15, 3/9/15 and 3/10/15. E7 used built up utensils to feed R16. E7 did not offer R16 the chance to feed himself on 3/8/15, 3/9/15 or 3/10/15. R16's MDS, dated 12/9/14 documents R16 needs supervision with set up only. R16's MDS, dated 2/13/15, documents a decline in eating and documents R16 needs extensive assistance of one person physical assistance. The Facility's Dietary Progress Note for R16, dated 2/13/15, documents "(R16) is able to feed himself. " E3, Assistant Director of Nursing (ADON), stated on 3/9/15 that R16 has not fed himself for several months.	F 311		
F 323 SS=L	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 6	F 323		

prevent accidents.

This REQUIREMENT is 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.

This failure resulted in an Immediate Jeopardy.

While the immediacy was removed on 3/10/15 at 11:35 AM, the Facility remains out of compliance at Severity 2 as the facility continues to educate staff and evaluate and monitor the effectiveness of the Facility Policy and Procedure for Oxygen Administration and Oxygen Safety.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 7	F 323		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 8	F 323		

Residents, CMS 672, dated 3/9/15 documents that the facility has 109 residents living in the Facility.

The Immediate Jeopardy began on 3/10/15 at 11:35 AM when R17 was in the beauty shop with oxygen being administered and chemical nearby. E1 and E2 were notified of the Immediate Jeopardy on 3/10/15 at 4 PM.

On 3/11/15 the surveyors determined through observation and record review that the facility took the following action to remove the Immediacy:

1. E2, removed R17's oxygen from the beauty shop on 3/10/15 at 11:35 AM and told E4 they could not have oxygen in the beauty shop.

2. E4 was inserviced on 3/10/15 at 12:40 AM by E1 about not having any type of oxygen delivery in the beauty shop.

3. On 3/10/15 staff were educated on Oxygen Administration Policy, specifically not allowing residents receiving oxygen to enter the beauty shop. Completion date 3/11/15.
On 3/10/15 Residents and/or family members of residents receiving oxygen were educated on the facility oxygen administration policy with a focus on the safety requirements and prohibition of oxygen use in the beauty shop. Completion Date 3/11/15.

4. On 3/10/15, the Medical Director was notified of immediate jeopardy at 4:50 PM.

5. On 3/11/15 Facility oxygen administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 9	F 323		

policy was reviewed and revised.

6. E2 or Designee will perform random observations of beauty shop during open hours which is one business day per week for 12 weeks, to assure compliance and understanding of safety requirements. Results of the reviews will be discussed in the Quarterly Quality Assurance Meeting for 3 quarters with educational needs discussed as needed.

B. Based on observation, record review and interview, 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.

Findings include:

1. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 10	F 323		

had one fall since last review and R1 did not have 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 11	F 323		

wheelchair." The Fall Prevention Investigation listed, in part as, visually check resident every two 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 12	F 323		

keep patient in view of staff when up in wheelchair." 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 13	F 323		

light, toileting program, keep call light within 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 14	F 323		

doorway of her room. R1 fell forward out of her wheelchair. She hit her head on floor. She was 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 15	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 16	F 323		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 17	F 323		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 18	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 323	Continued From page 19 Report documents that R14 stood up from the wheelchair, and that staff were too far away to prevent fall. 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.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide adaptive equipment for eating in 2 of 2 residents (R12, R16) reviewed for use of special eating equipment and utensils in the sample of 22. Findings include: 1. R16 had a divided plate on 3/8/15. On 3/9/15 and 3/10/15, R16 had a scoop plate. On 3/8/15, during lunch, R16 was drinking from a "nosey" cup. On 3/9/15, during lunch, R16 was drinking from a regular cup.	F 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 369	Continued From page 20	F 369		

The Facility's Diet Order and Communication Sheet for R16, dated 2/11/15, documents "Nosey cups, scoop plate and curved utensils at every meal." The Facility's Dietary Progress Note for R16, dated 2/13/15, documents, "(R16) is able to feed himself. Continues to need his special plate, curved silverware and nosey cup." R16's dining card documents R16 needs "nosey cup at all times."

After lunch on 3/9/15, E7, Certified Nurses Aide (CNA), stated that R16 should have a nosey cup, but did alright without it today.

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 one to two plus persons physical assistance with eating, mobility, transfer and toileting and upper and lower extremity functional limitation in range of motion and no restorative programing for eating and/or swallowing.

R12's Diet Order & (and) Communication, dated 1-30-2015, documents, in part, "needs 2 handled lidded cup with spout."

During observation of R12 noon meal, on 3-8-2015, at 1:12 PM, R12 was served his noon meal and thickened liquids in a regular glass. R12 repeatedly asked for a straw and attempted to drink from his glass and place it to his lips after which E6, CNA, removed the glass from his hands and fed him both his meal and liquids. A "2 handled lidded cup with spout" was not provided.

Interview of E8, Restorative Nurse, on 3-10-2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	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) COMPLETION DATE
F 369	Continued From page 21 at 10:35 AM, E8 stated R12 could hold a cup. E8 also stated R12 was not in a restorative eating program during a review of the 200 Hall Restorative Book, dated March 2015. Interview of E5, MDS/CP (Care Plan) Coordinator, stated, on 3-13-2015 at 9:45 AM, R12 did not have a restorative programming.	F 369		