

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/10/2024
NAME OF PROVIDER OR SUPPLIER  Alta Rehab at Oak Brook		STREET ADDRESS, CITY, STATE, ZIP CODE  2013 Midwest Road Oak Brook, IL 60521	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</b></p> <p>Based on interview and record review, the facility failed to follow physician orders to administer antihypertensive and pain medications to a resident (R1) with diagnoses of hypertension, recent back surgery, and chronic back pain.</p> <p>This applies to 1 of 4 residents (R1) reviewed for significant medications in the sample of 4.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed that R1, a [AGE] year-old with diagnoses that includes spondylosis with radiculopathy, lumbar region, encounter for orthopedic after care, hypertension, hyperlipidemia, GERD (gastro-esophageal regurgitation disease), hypothyroidism, anemia, protein calorie malnutrition, lactose intolerance, s/p (status post) L5/S1 (lumbar and sacral) laminectomy on October 8, 2024, and chronic back pain. R1 was admitted to the facility on [DATE] at 1:36 P.M., and was discharged home against medical advice on October 11,2024. R1 left the facility at 9:45 A.M.</p> <p>The POS (Physician Order Sheet) for the month of October 2024 showed physician orders dated October 10, 2024 for the following antihypertensive and pain medications that included but not limited to:</p> <p>-Gabapentin 100 mg. 1 capsule by mouth every evening for pain scheduled to be given 6:00 P.M. daily</p> <p>-Losartan Potassium -HCTZ (hydrochlorothiazide) 100-12.5 mg., 1 tablet a day for hypertension scheduled to be given 8:00 A.M.</p> <p>The pharmacy delivery manifesto showed that R1's medications were delivered to the facility on [DATE] at 3:42 A.M. The medications that were delivered included Losartan Potassium- HCTZ 100-12.5 mg. with total of 14 tablets; and Gabapentin 100 mg with total of 14 tablets.</p> <p>The nurses notes dated October 11,2024 at 7:58 A.M., which was documented by V7 (LPN/Licensed Practical Nurse) showed that R1 was upset and wanted her medications, before she eats breakfast, immediately. V7 noted then that R1's blood pressure was 184/95 at 8:08AM. V7 documented that V10 (physician) was notified and ordered to give R1 her morning medications and added a new medication and directed V7 to check the blood pressure again. V7's notes document that R1 called her son and he picked her up at 9:25AM and R1 left the facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On November 8,2024 at 1:20 P.M., V7 stated that R1 was upset on October 11,2024 around 8:00 A.M. V7 said that R1 was asking for the blood pressure medications. V7 said that upon checking R1's vital signs, R1 blood pressure was high. V7 said the BP was 184/95. V7 said that R1's antihypertensive medications were not available, so she called V10 for an alternate medication. V7 said that at 8:10 A.M., she was able to get an order from V10 for an alternate medication for hypertension and was to be given one time, and immediately and to resume the original order for antihypertensive medications when it arrives from pharmacy. V10 said that the alternate medications were Amlodipine 5 mg. 1 tablet and Losartan Potassium 50 mg. 1 tablet. V7 said that EMAR is to be always utilized to show that medications were administered. V7 had no explanation why R1's EMAR was not signed that she gave the alternate medications Amlodipine and Losartan Potassium 50 mg.)</p> <p>The EMAR (Electronic Medication Administrator Record) for the month of October 2024 showed Gabapentin was not given to R1 as ordered on October 10,2024 at 6:00 P.M. The EMAR also showed that Losartan Potassium HCTZ 100-12.5 mg. and or the alternate Amlodipine 5 mg and Losartan Potassium 50 mg. as ordered by the physician were not given to R1.</p> <p>On November 8,2024 at 1:30 P.M. the EMAR for October 2024, nurse's notes dated October 11,2024 pharmacy manifesto dated October 11,2024, list of medications available in the convenience box at the facility were reviewed with V2 (Director of Nursing). V2 said that R1's medications including the antihypertensive (Losartan-Potassium 100 mg-12.5 mg.) and pain medication (Gabapentin 100 mg) were delivered to the facility on [DATE] at 3:35 A.M. V2 added that R1's original order for antihypertensive medication which was the Losartan Potassium combined with HCTZ was delivered but was not administered to R1. V2 also said that the Gabapentin for pain was also not given as ordered. V2 also said that V7 must have not able to find R1's delivered medications but can take the alternate medications from the facility's convenience box.</p> <p>On November 8,2024 at 1:45 P.M., V10 (R1's Attending Physician) said that she saw R1 the day of admission which was October 10,2024 in the afternoon. V10 said that R1 expressed going home because her specific brand of antihypertensive medication was not available in the facility. V10 said that the morning of October 11,2024 around 8:00 A.M., the nurse in the facility had updated her because R1's blood pressure was high so V10 had given an alternate medication to be given while waiting for the right medications. V10 added that she had expected that these alternate medications for hypertension was administered so R1's blood pressure will go down. V10 also added that the antihypertensive medication (Amlodipine, Losartan) and pain medication (Gabapentin) were significant medications since it can cause a significant result if medications were omitted.</p> <p>The facility's policy for medication administration dated September 2019 shows:</p> <p>Policy: Medications administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .</p> <p>Procedure:</p> <p>7. The medication administration record (MAR) is always employed during medication administration.</p> <p>Documentation including electronic:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.</p>		