STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145887	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Wauconda	176 Thomas Court Wauconda, IL 60084

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review the facility failed to supervise residents receiving medications and failed to administer medications as ordered for seven of ten residents (R1, R2, R3, R7, R8, R9, R10) reviewed for medication administration in the sample of ten. The findings include: 1. R10's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including unspecified right bundle branch block, constipation, cellulitis of right lower limb, unstable angina, edema, asthma, hypertension, and pain. R10's Weights and Vitals summary shows R10's blood pressure was 120/54. R10's pulse is not documented. R10's Order Summary Report shows an order for losartan 100 mg (milligrams) one time daily related to high blood pressure hold if blood pressure is less than 110/60. R10's Order Summary Report shows an order for metoprolol succinate 50 mg ER (Extended Release) one time a day related to high blood pressure. There are no parameters for when to hold the metoprolol. R10's Order Summary Report shows an order for senna with docusate sodium 8.6/50 MG give one tablet by mouth two times a day related to constipation. On April 10, 2024 at 10:07 AM, V4 LPN (Licensed Practical Nurse) was performing a morning medication pass for R10. V10 stated that she is holding R10's ordered metoprolol and losartan because her blood pressure was 120/54. V4 administered sennosides 8.6 MG instead of the ordered senna with docusate sodium 8.6/50 MG. On April 10, 2024, at 1:26 PM, V8 RN (Registered Nurse) stated R10's physician orders show that there were no parameters to hold R10's metoprolol. V8 stated she would have called the nurse practitioner to obtain parameters before she held the medication. V8 stated R10's losartan had ordered parameters to hold the medication if R10's blood pressure was less than 110/60. V8 stated she would have given R10 her losartan if her blood pressure was 120/54. V8 stated that senna with docusate sodium has an extra stool softener in it. (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On April 10, 2024, at 9:32 AM, R2 stated that the nurse drops off her medications in the morning but does not watch her take them. R2 stated the nurse comes back later to ask her if she took her medications. At 9:40 AM, V7 R1's daughter was sitting at R1's bedside. V7 stated that R1's nurse just came in and handed her a cup of medications and told R1 to take them but did not watch R1 take her medications. On April 10, 2024, at 9:53 AM, R3 stated that the nurse drops off her medications. R3 stated that the nurse does not watch her take her medications because the nurse knows that R3 will take them. R3 state she takes 21 medications in the morning. On April 10, 2024, at 1:35 PM, R8 stated that the nurse drops off her medications. R8 stated the nurse only watches her take her medications sometimes but not all the time. On April 10, 2024, at 1:37 PM, R7 stated that the nurse does not always watch her take her medications. There are times when the nurse just drops off her medications. On April 10, 2024, at 1:43 PM, R9 stated that she is usually at breakfast when the nurse is performing medication pass, so the nurse drops off her medications on her tray in her room. R9 stated she takes her medications when she gets back to her room after she's done eating in the dining room. R1-R3 and R7-R9 did not have a self-administration of medications assessment in their electronic medical records prior to April 10, 2024. On April 10, 2024, at 11:18 AM, V3 LPN (License Practical Nurse) stated I think I have left medications at residents bedside once to help someone somewhere else. V3 said she has not been counseled in regards to leaving medications at residents' bedside. V3 said there was a time when she went to give R1 her medications and R1 was sleeping so V3 left R1's medication at her bedside to prepare medications for another resident. V3 said R1's family (V6) approached V3 and told V3 that R1 has a tendency of trying to put medications in her coke can and not taking them. [R1] has a tendency of pocketing medications. V3 said she wasn't sure if R1 does it all the time. V3 said that R1's family asked V3 to make sure staff watches R1 to make sure she is taking her medication. V3 said it is important to watch residents take their medications so that the medications are effective. V3 said if certain medications are not taken, the blood pressures could go higher, or behaviors could escalate. V6 (R1's Daughter) said that the nurse that worked on Easter Sunday (March 31, 2024-V3) dropped off R1's medications and did not watch her take them. V6 said she brought the medication cup back to the nurse and told her that R1 is throwing the medications out and that staff need to watch R1 take her medications. V6 said the same nurse that worked Easter Sunday (V3) left R1's medications again on April 6, 2024. V6 said she saw R1 put the medications in R1's pop can. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 10, 2024, at 2:38 PM, V2 DON (Director of Nursing) said R1's family noticed that R1 was not taking her medications. V2 said she put in an order for the nurses to ensure R1 was taking her medications. V2 said she does not recall R1's family bringing up concerns in regard to R1's medications being left at R1's bedside, but V2 said she told R1's family that she was shocked that nurses were leaving medications at bedside. V2 said that nurses should follow up with the resident to ensure they are taking their medications. V2 said, staff can leave the medication on residents' tables and the staff should follow up with the resident in five minutes or so. When V2 was asked if staff are not visually watching the residents taking their medications, then how do staff know that the resident is taking their medications? V2 said That is a good question. V2 said that the staff is trusting the resident to take their medications. The facility Pharmaceutical Services policy revised December 2015 shows, It is the policy of this facility to provide assistance with medication administration as needed or requested. Residents may keep and use prescription and non-prescription medication in their apartment after being evaluated for safety in self-administration of medications and must keep their apartment locked at all times when unattended. Residents must keep medications secured from other residents. Over the counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.