

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2024
NAME OF PROVIDER OR SUPPLIER Alta Rehab at Wauconda		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<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>35541</p> <p>Based on interview and record review the facility failed to ensure a resident's opioid pain medication was administered as prescribed to avoid a significant medication error. This failure applies to 1 of 4 residents (R1) reviewed for medication administration errors in the sample of 4.</p> <p>The findings include:</p> <p>The Facility Reported Incident Report dated 6/4/24 showed, On 6/3/24 at approximately 11:30 AM, the patient (R1) was seen by the NP (nurse practitioner) due to increased confusion. Nurse continued to monitor the patient, reviewed his meds (medications), and noted that Norco 10/325 (opioid pain medication) PO (by mouth) 1 tablet was given 3 hours from last dose. Patient has an order for Norco 10/325 1 tablet PO every 6 hours as needed for pain. NP was notified and gave an order for 1x (on time) dose of Narcan (medication to reverse the effects of opioids) and if no improvement of mental status to send to a (local emergency room) . The report showed no significant change in R1's mental state after he was administered Narcan. R1 was sent to a local hospital for an evaluation. R1 was admitted to the hospital with diagnoses of urinary tract infection (UT1) and encephalopathy (altered mental state).</p> <p>R1's (physician) Order Summary Report dated 5/31/24 showed an order for R1 to receive Norco 10/325 mg (milligrams); one tablet by mouth every 6 hours as needed for moderate pain.</p> <p>R1's June 2024 (electronic/computerized) Medication Administration Record (MAR) dated June 2024 showed V7 Registered Nurse (RN) administered one tablet of Norco 10/325 mg to R1 at 9:27 AM on 6/3/24. The MAR showed no documentation R1 had been administered any doses of Norco from 12:00 AM-9:26 AM on 6/3/24.</p> <p>R1's Controlled Drug Administration Record (written/paper charting/narcotic log) for June 2024 showed V8 Licensed Practical Nurse (LPN) administered one tablet of Norco 10/325 mg to R1 at 6:45 AM on 6/3/24.</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 6/17/24 at 10:05 AM, V7 RN stated she was assigned to R1, from 7:00 AM-7:00 PM, on 6/3/24. V7 stated, I was passing morning medications when (R1) asked for a pain pill. I looked in the MAR on the computer and saw that no one had given him a Norco in a while, so I gave him one tablet around 9:30 AM. I didn't sign out or look at his narcotic log prior to giving him a Norco. I just checked the MAR . By noon, (R1) was definitely becoming more sleepy. He seemed a little off. That's when I checked the narcotic log and saw that the night nurse (V8 LPN) had already given him a Norco at 6:30 AM that morning. The night nurse (V8) signed off he gave the med in the narcotic book but didn't document it in the computer. I notified the nurse practitioner immediately. She gave an order to give Narcan. I gave it. There was really no change in (R1) so we sent him to the hospital for an eval/evaluation. I should have checked both, the MAR and the narcotic book, prior to giving (R1) a Norco.</p> <p>On 6/17/24 at 10:26 AM, V8 LPN stated he gave R1 one Norco tablet around 6 AM on 6/3/24 due to R1's complaint of pain. V8 stated he signed out that he gave R1 the Norco only on the narcotic book. V8 stated he did not sign out that he gave R1 a Norco in the MAR. V8 stated, That is my fault. I forgot to sign out that I gave (R1) a Norco on the MAR in the computer. I should have documented the administration in both places (MAR and narcotic log).</p> <p>On 6/17/24 at 11:46 AM, V3 Assistant Director of Nursing stated when staff administer opioid pain medications, staff are to document each administration in two places, the MAR and the narcotic logbook. V3 stated in the incident related to R1 on 6/3/24, both staff members involved made mistakes. (V8 LPN) did not document (R1's) Norco administration in the computer. (V7 RN) did not check both the MAR and the narcotic logbook prior to giving (R1) a Norco.</p> <p>On 6/17/24 at 10:07 AM, V6 (R1's Physician) stated he expects staff to follow physician orders and administer medications as he prescribes them. When V6 was asked if the extra Norco given to R1 on 6/3/24 caused the change in R1's mental status, V6 stated, It is difficult for me to ascertain the actual cause of (R1's) change in mental status. The UTI he was diagnosed with (on 6/3/24) could have caused his change in mental status just as much as the extra Norco could have .</p> <p>On 6/17/24 at 11:30 AM, V1 Administrator stated the facility did not have a medication administration policy related to the administration/documentation of opioid pain medications.</p>		