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	09/11/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review, the facility failed to ensure a resident was positioned in a safe manner for one of three residents (R1) reviewed for safety in the sample of three. This failure resulted in R1 experiencing a fall which required sutures and resulted in R1 obtaining a small subdural hematoma. The findings include: R1's Face Sheet shows he was admitted to the facility on [DATE], with diagnoses including alcohol abuse, fall from bed, mood disorder, vascular dementia, generalized anxiety disorder, Parkinson's disease, and malnutrition. R1's Fall Risk assessment dated [DATE], shows that R1 is at risk for falls. R1's Significant Change in Status Minimum Data Set, dated dated dated [DATE], shows R1 is not cognitively intact, has an impairment on both upper and lower extremities, is dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on staff for toileting, personal hygiene, putting on/taking off footwear, sit to lying, and lying to sitting on the side of the bed. R1's Progress Notes dated August 10, 2024; shows he was transferred to the local emergency room after a fall. R1's Progress Notes dated September 4, 2024; shows he experienced another fall while ambulating. R1's Care Plan initiated February 26, 2024, shows R1 is resistant to ADL (Activities of Daily Living) care such as dressing and changing. He is also combative, hitting, pushing, holding onto and punching staff during care. This generally occurred almost daily. He has a diagnosis of dementia. Work in pairs when providing care if necessary for safety of resident or staff. R1's Care Plan initiated February 26, 2024, and revised September 9, 2024, shows R1 is at risk for falls related to confusion, incontinence, poor communication/comprehension. Falls were noted on April 29, 2024, May 20, 2024, June 16, 2024, August 2, 7, and 10, 2024, September 4, 2024, and September 7, 2024. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Facility Reported Incident shows that on September 7, 2024, at approximately 9:00 AM, [R1] fell from the edge of his bed while in a seated position. R1 returned from the local emergency room . CT (computed tomography) of the brain showed a possible tiny subdural hemorrhage. The emergency room physician spoke to the power of attorney (POA) and discussed goals of care. The POA declined treatment and wanted the resident transferred back to the facility. The resident has sutures in place on the left side of his forehead with order to remove in seven days. Conclusion: The CNA was next to the resident and was reaching for his shoes when the resident fell forward and sustained the fall but was unable to stop the fall. On September 10, 2024, at 10:11 AM, V5 CNA (Certified Nursing Assistant) stated she was the CNA taking care of R1 when he fell on [DATE]. V5 stated R1 was sitting on the side of the bed with his left hand holding the side rail. V5 stated R1 fell face first to the floor when V5 went to the foot of R1's bed to grab R1's shoes. V5 stated that R1 hit his head on the ground. V5 stated that when R1 wants to do something he will. V5 stated that R1 is impulsive. V5 stated that R1 tries to get out of the wheelchair by himself. V5 stated that prior to R1's recent fall, R1 was able to ambulate on his own. V5 stated that in the last month or so, R1 would cross his legs when he tried to stand up. V5 stated that R1's legs would get tangled. V5 stated that R1 has not really walked since his fall. V5 stated that when R1 fell forward from the bed, she immediately called for R1's nurse. V5 stated that R1 is pretty much nonverbal, but when R1 fell , he was moaning. V5 stated that R1 had a little blood coming from his forehead when he fell . V5 stated that R1 went to the hospital via 911. On September 10, 2024, at 10:29 AM, R1 was sitting in a high back wheelchair at the nurses' station. R1 had 5-6 sutures to his left forehead with fading bruising. R1 was nonverbal. On September 10, 2024, at 9:40 AM, V2 DON (Director of Nursing) stated that it was Saturday when R1 fell . V2 stated that R1 was sitting on the edge of the bed when V5 turned around to pick something up. V2 stated that R1 has been declining. V2 stated that R1 has agitative behaviors and is very cognitively not intact. At 11:34 AM, V4 RN (Registered Nurse) stated she was the nurse taking care of R1 the day he fell . V4 stated that R1 was on the floor when she came into R1's room. V4 stated that R1 had a bump on his head and there was a small amount of blood. V4 stated that R1 has severe dementia. V4 also stated that R1 is able to ambulate but does not have good balance. R1's Hospital Records dated September 7, 2024, shows, Impression: New small right temporal subdural hematoma likely subacute in nature. Patient's laceration was repaired using sutures. The facility's Fall Prevention Program policy revised on November 21, 2017, shows, 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 assistive devices are utilized as necessary. Safety interventions will be implemented for each resident identified at risk.