

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 11/04/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34490</p> <p>Based on observation, interview, and record review the facility failed to assess and monitor a resident after a fall for 1 of 3 residents (R1) reviewed for quality of care in the sample of 3.</p> <p>The findings include:</p> <p>R1's Final Incident Report shows that R1 had an assisted fall on 10/11/14. R1 had an X-ray done on 10/14/24 that showed an acute nondisplaced oblique distal radial fracture with soft tissue swelling.</p> <p>On 11/4/24 at 9:19 AM, R1 was sitting in her wheelchair in her room. R1 had a brace on her left wrist and was unable to move her left arm.</p> <p>On 11/4/24 at 9:19 AM, R1 stated that she had a fall in the bathroom. R1 stated that she must have hit her left arm on the wheelchair when she fell . R1 stated that after she fell , the nurse came in and helped her back up into the wheelchair. R1 stated that it did not appear that the nurse did any type of assessment after the fall. R1 stated that she had pain and tingling in her left arm right after the fall.</p> <p>On 11/4/24 at 1:32 PM, V6 (Registered Nurse) stated that she was the nurse on duty when R1 fell . V6 stated that she was alerted by the Certified Nursing Assistant (CNA) that R1 was on the floor in the bathroom. V6 stated that she went into the bathroom and R1 was sitting on the floor and her left arm was holding her body up. V6 stated that she looked her over from head to toe and asked her if she hurt anything and she (R1) stated, no so they lifted her back into the wheelchair. V6 stated that she did not consider the incident a fall because the CNA stated that she was lowered to the ground. V6 stated that she did not notify the physician or the family of the incident.</p> <p>On 11/4/24 at 3:09 PM, V10 (Nurse Practitioner) stated that on 10/14/24 she was asked by V14 (R1's Spouse) to see R1 due to her having pain in her left wrist after a fall. V10 stated when she examined R1, she had tenderness to her wrist area when palpated. V10 stated the tenderness in her wrist area was new for R1 so she ordered an X-ray. V10 stated that the X-ray came back showing a fracture. V10 stated that R1 told her that her wrist had a constant ache ever since the fall.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Electronic Medical Record (EMR) does not document the fall incident that happened on 10/11/14 in the Nursing Notes. There was no initial assessment of the resident after the fall incident documented in R1's Nursing Notes. There was no documentation of assessments of the resident post fall until V10 (Nurse Practitioner) saw R1 on 10/14/24 in R1's EMR. There was no documentation in the Nursing Notes that R1's physician and family was notified immediately after the fall.</p> <p>On 11/4/24 at 3:00 PM, V3 (Assistant Director of Nursing) stated that a fall is when a resident has a change in elevation and did not get to their intended spot. V3 stated that even if a resident is assisted to the floor, it is still considered a fall. V3 stated that once a resident falls, the nurse should immediately do a full head to toe assessment, check range of motion, assess pain and do a full set of vitals. V3 stated the physician and the family should be notified of the fall and it should be documented in a Fall Occurrence Assessment Form in the EMR. V3 stated that after a fall, the resident is assessed by the nurse every shift for the following 72 hours to ensure there is not a change in condition. V3 stated that R1 did not have a Fall Occurrence Report done after her fall. V3 stated that she could not find an assessment documented of any type immediately after R1's fall. V3 stated that she could not find any documentation that the physician or family was immediately notified after the fall. V3 stated that she could not find any 72-hour post fall assessments in R1's EMR. V3 stated that she was aware that R1 had fallen after V10 saw R1 on 10/14/24.</p> <p>The facility's Fall/Incident Occurrence-Assessment and Documentation Guidelines revised on 1/4/16 shows, The following information needs to be documented in the service notes: Date and time of Incident; Change noted in resident's physical and mental condition; skin conditions including pain, swelling, change in temperature, site, size, depth, color and breaks; pain, site and intensity; Notification of resident's attending physician, responsible party and Administrative Staff;</p> <p>The facility's Incidents and Accidents Policy dated 11/28/12 shows, Documentation in nurses' notes to include A description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified. A minimum of seventy-two (72) hours (longer, if indicated) of documentation by all three shifts on resident status after the incident. Vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be documented.</p>		