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	01/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to communicate and document a fall incident in a timely manner, failed to a complete a post fall assessment or perform any subsequent assessments following a fall, and failed to implement interventions to prevent any future incidents. This failure affects one of three residents (R1) reviewed for falls in the sample of 3.The findings include:R1's face sheet documented an admission date of 01/06/2026 from an acute care hospital where she was hospitalized from [DATE] through 01/06/2026. Her past medical history upon admission included but not limited to seizures, anemia, hypertension, anxiety, osteoarthritis to left wrist, and chronic kidney disease. (Review of R1's census record indicates she is on hospital leave.)R1's fall risk assessment with effective date 01/06/2026 (same day as admission) documented score of 8 which indicated R1 is not at risk for falls. Assessment with effective date of 01/08/2026 (signed on 01/16/2026) documented score of 14 and indicated that R1 is at risk for falls. R1's care plan documented she is at risk for falls as evident by scoring tool with date initiated of 01/08/2026 that was revised on 01/14/2026.Final facility reported incident report submitted to Illinois Department of Public Health (IDPH) with incident date of 01/12/2026 indicated that R1 was admitted to the facility on [DATE] for short-term rehab. R1 noted with discoloration on right side of face. Patient's family reports that patient sustained a fall. Physician made aware. Patient was unable to be interviewed due to cognitive deficits. Staff assigned to the patient were interviewed. V7 (Certified Nursing Assistant/CNA) reported that when he was assigned to the patient on 01/08/2026, patient did sustain a fall. V7 stated that R1 fell from the right side of her bed. V7 stated that the patient's bed was in the lowest position and landing (floor) pads were in place. V7 stated that he reported the incident to the nurse (V6-Registered Nurse/RN) and that another CNA (V3) was also present. V3 (CNA) and V6 (RN) were both interviewed and confirmed V7's statement. They both reported that R1 did sustain a fall in which she fell from the right side of her bed. All staff members stated that they did not, nor did they witness anyone be physically inappropriate toward the patient. (Per V1-Acting Administrator, incident date of 01/04/2026 on IDPH report was incorrect date.)R1's unwitnessed fall report (#761) with incident date of 01/08/2026 at 08:06 PM (20:06) indicated that R1 rolled off the right side of her bed and was found on the landing pad. Resident was restless and hard to redirect. Resident unable to describe what happened due to her cognition and that no injuries observed at time of incident. Report had no documentation under the agencies/people notified section. (Date incident report was completed was not documented.)Fall report (#761) showed V7's witness statement dated 01/13/2026 that documented he put R1 to bed and lowered bed to lowest position, set up landing (floor) pads. Did not remember exact time but when V7 went back to check on R1, she was noted on the right side of the bed, and it appeared that R1 fell or rolled off her bed onto the landing pad. Another aide (V3) was there to assist. They called the nurse right away and the nurse assessed the patient.Fall report (761) also showed V6's witness statement dated (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

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	01/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/13/2026 that documented she was informed by V7 that R1 was noted on the landing (floor) pad. She went in and assessed patient. V6 indicated interventions were in place but they were not specified on report.Interdisciplinary Team note dated 01/13/2026 at 01:56 PM (13:56) documented that after further investigation, the team discovered that the resident sustained an unwitnessed fall on 01/08/2025 which could have caused facial discoloration due to the use of anticoagulant (blood thinner).On 01/17/2026 at 01:12 PM, V1 (Acting Administrator) said on 01/10/2026, R1 was noted by R1's daughter and V5 (Registered Nurse) with discoloration to her right side of face that looked like a new bruise. R1 also displayed altered mental status. Per V5, the night shift nurse (V6) had reported R1 was wandering, restlessness, and trying to get up during the previous night. V5 (RN) contacted R1's primary care physician on 01/10/2026 and updated him regarding facial bruising. Physician concluded bruising was likely due to the behaviors and use of a blood thinner but ordered R1 be sent to the hospital for evaluation of her altered mental status. V1 added that during further investigation into R1's facial bruising, V1 was informed by V7 (CNA) that R1 had a fall on 01/08/2026 and V7 had informed V6 (RN) of the fall. V1 added that V6 assessed R1 but did not document her assessment or complete a report, then said it was clear the nurse failed to report the incident. V1 also said from after the fall on the 8th until the morning of the 10th, R1 had no discoloration or bruising to her face; was first noted on 01/10/2026.On 01/17/2026 at 02:04 PM, V3 (Certified Nursing Assistant) said on 01/08/2026 she was working the evening shift with V7 (CNA). R1 was put R1 into bed after supper around 6-6:30 PM. Then around 08:00 PM while walking past R1's room with V7, he saw R1 had fallen out of bed onto the floor mats. It looked like she rolled out of bed. V3 went to get the nurse while V7 stayed with R1.On 01/17/2026 at 02:30 PM, V5 (Registered Nurse) said on morning of 01/10/2026 around 08:30 AM, R1 was sitting with her daughter and husband in the main dining room by nurses' station on the 700 unit. V5 was told that R1 was not acting like herself, was not talking to the daughter and noted with a new discoloration to the side of her head. V5 said R1 was admitted a few days prior with bruising to her upper and lower extremities. V5 called the physician and informed him of the bruising upon admission, new facial bruise, and the mental status changes. Was told by physician that the bruising is most likely from her behaviors and blood thinner (Lovenox) but to send R1 out for the altered mental status to rule out infection. V5 added that R1 constantly tries to transfer herself, get up by herself, and is unstable when standing. V5 also said the night shift reported R1 was restless and made multiple attempts to get up and transfer herself the previous night (01/09/2026).On 01/17/2026 at 02:51 PM, V6 (Registered Nurse) said on 01/08/2026 at approximately 08:06 PM, she was informed by V3 (CNA) that R1 was on the landing pad (floor mat) in her room. V6 went to assess her and did not see any injury at that time or any bruising. V6 then said that she totally forgot to document the fall and my assessment. V6 was called by management on the 12th because they were investigating the facial bruising to R1's to periorbital area. V6 said she informed them at this time that R1 had an unwitnessed fall that she forgot to document and did not inform the oncoming nurse. V6 said it slipped my mind. V6 added that she was disciplined for non-documentation. V6 said she should have reported the incident, contacted family and physician, documented her assessment/vitals/neurological checks and completed an incident report that would have resulted in continued post fall assessments for R1.On 01/17/2026 at 03:07 PM, V7 (CNA), said on 01/08/2026, he and V3 put R1 into bed about 6:00 PM. V7 said they lowered the bed to the floor and placed mats to both sides. V7 then said at around 8:00 PM, R1 was on the floor mat on the right side. It looked like she had rolled out of bed. V7 said he did not see any injury, redness or bruising. V7 stayed with R1 while V3 went to get the nurse. V6 (RN) came to the room and assessed R1. After she was assessed, V7 and another aide put R1 back into (continued on next page)

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	01/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed.Fall Prevention Program policy last revised 11/21/2017 provided by facility on 01/17/2026 reads in part: purpose is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.The Fall Prevention Program includes the following components but not limited to: assessment time frames, use and implementation of professional standards of practice, immediate change in interventions that were successful, notification of physician, family/legal representative, communication with direct care staff members, documentation requirements.Care plan incorporates included: addresses each fall, interventions are changed with each fall, as appropriate and preventative measures.Standards included: fall risk assessment will be performed upon admission, quarterly and with each significant change in mental or functional condition and after any fall incident; safety interventions will be implemented for each resident identified at risk.