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	03/19/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to determine the residents' wishes upon admission for advanced directives. This applies to one of three residents (R1) in the sample of seven reviewed for advanced directives.The surveyor confirmed by observation, interview and record review that the deficiency practice occurred on [DATE] and was corrected on [DATE], prior to the start of this survey and was therefore past noncompliance.The findings include:The facility face sheet for R1 shows she was admitted to the facility on [DATE] and discharged on [DATE]. The diagnoses for R1 include but are not limited to metabolic encephalopathy, urinary tract infection and Type 2 Diabetes Mellitus. The section of the face sheet for advanced directive is blank. The admission observation form dated [DATE] shows R1 was alert and orientated to person, place, time and situation.A nursing note dated [DATE] shows R1 was admitted to the facility with altered mental status and was alert and oriented but was forgetful. No mention of advanced directives being discussed with the resident or her family.A nursing note dated [DATE] for R1 shows at 9:10AM, a nurse (V5) was summoned to R1's room with the report of being unresponsive. The nurse documented R1 was unresponsive with absent respirations and carotid pulse. The nurse then documented that she checked R1's medical record and saw an order for a full code, so CPR (Cardiopulmonary Resuscitation) was started and 911 was called. The note goes on to show CPR continued until EMS (Emergency Medical Services) arrived. The note shows at 10:05 AM, per lead Paramedic, a pulse was regained, and the resident was transferred to the hospital.On [DATE] at 4:30 PM, V8 (R1's son in law) was called and he said R1 was in the hospital, and it was decided by R1 and her daughter, R1 would be a DNR (Do Not Resuscitate). R1 had a wrist band on her wrist showing she was a DNR when she got to the facility. V8 said the admitting nurse at the facility cut off the wristband and settled R1 into her room. V8 said he and his wife stayed at the facility about an hour after R1 was admitted making sure she was settled and no staff ever asked him or his wife what R1's wishes were regarding advanced directives. V8 said the hospital told him the form showing advanced directives would be sent with R1 to the facility.On [DATE] at 9:50AM, V5 RN (Registered Nurse) said she really did not remember much about that shift when R1 coded. V5 said she was called to R1's room when other staff found her unresponsive. V5 said she checked for a pulse and respirations on R1 and when none were found, she checked R1's medical record and saw she was a full code, so she began CPR and 911 was called. V5 said it is important for the staff who admit a resident to ask about advanced directives on admission. V5 said if the resident is not aware enough, the family should be asked. V5 said the hospitals are not very good at sending advanced directives with the resident from the hospital.On [DATE] at 10:07 AM, V6 RN said she was working the morning R1 stopped breathing. V6 said CPR was being done and EMS arrived at the facility. V6 said R1 did have a heartbeat and was transferred to the hospital. V6 said when a resident is admitted to the facility, advanced directives needs to be determined so the residents wishes are granted.On [DATE] at 10:35 AM, V2 DON (Director Of Nursing) said she was notified of CPR being performed on R1 that morning. V2 said the nurse that called her said the medical record was checked to see what R1's wishes were before CPR was started and an order for a full (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	code was noted. V2 said upon admission to the facility, the staff need to talk to the residents and their family about advanced directives.On [DATE] at 1:40PM, V7 RN said she was the nurse who admitted R1 to the facility, but she does not remember her specifically. V7 said she admitted a lot of residents to the facility. V7 said it is the protocol for the facility to ask the residents on admission what their wishes are for advanced directives, but she does not remember if she did this for R1 when she was admitted .On [DATE] at 1:49AM, V3 ADON (Assistant Director of Nurses) said the nurses must ask all residents and families on admission what their wishes are for advanced directives and it must be documented.On [DATE] at 2:16PM, V1 Administrator said after this incident he completed an in-service and audits on advanced directives. V1 said the facility needs to have a consistent process in place for advanced directives, it needs to be addressed and documented in the medical record. V1 said if the admitting nurse does not see advanced directive from the hospital, they should not assume the resident is a full code.The discharge summary from the hospital dated [DATE] shows code status on discharge as DNR. The discharge summary was a part of R1's facility medical record.The Physician Order Sheet dated [DATE] shows an order for a full code.The facility policy with a revision date of [DATE] for Advance Directive shows at the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law.Prior to the survey date of [DATE], the facility had taken the following action to correct the noncompliance:On [DATE] an in-service was completed regarding code status being verified on admission with the resident and if the resident is not able to make that decision, confirm with the POA (Power of Attorney).On [DATE] a whole house audit was completed for advanced directives.On [DATE] a Quality Assurance action plan was made to continue chart audits for advanced directives.The facility was able to demonstrate monitoring of the corrective action and sustained compliance.