

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 08/21/2024
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.			
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34314</p> <p>Based on interview and record review the facility failed to notify a physician prior to and after holding a blood pressure medication. This applies to 1 of 27 residents (R84) reviewed for notification of changes in the sample of 27.</p> <p>The findings include:</p> <p>R84's August 2024 Medication Administration Record (MAR) shows, Hydrochlorothiazide 12.5 mg (milligrams), give 1 tablet by mouth one time a day related to essential hypertension (high blood pressure) and Lisinopril 20 mg tab, give 1 tablet by mouth one time a day related to essential hypertension. The same report shows, both medications were held on August 1st, 5th & 18th, 2024.</p> <p>R84's electronic medical record shows, her physician was not notified on August 1st, 5th or 18th, 2024 of her blood pressure medication being held.</p> <p>On August 19,2024 at 10:17 AM, V16 LPN stated, whenever they hold a medication, they contact the doctor and let them know.</p> <p>The facility's physician-family notification-change in condition dated November 13, 2018 shows, Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. Guidelines: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: .A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e. g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., use of any medical procedure, or therapy that has not been used on that resident before.) .</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on observation, interview, and record review the facility failed to implement pressure ulcer prevention interventions for a resident who is at risk for developing pressure ulcers for 1 of 5 residents (R9) reviewed for pressure ulcers in the sample of 27.</p> <p>The findings include:</p> <p>On 8/19/24 at 10:12 AM, R9 was laying in bed. R9 did not have blankets on and R9's heels were observed directly on her mattress (not a low air loss mattress). R9 stated that she is not sure if she has wounds on her heels or not, but they are a little tender. R9 also stated that she is supposed to wear pressure relieving boots but sometimes they do not put them on. R9's pressure relieving boots were sitting in the chair in R9's room. At 11:45 AM, R9's heels were still directly on the bed and her boots were still in her chair.</p> <p>On 8/20/24 at 1:03 PM, V20 (Wound Registered Nurse) stated R9 is at risk for developing pressure ulcers and should have her heels offloaded to prevent pressure ulcers. V20 stated that R9's heels should not be directly on the bed.</p> <p>R9's Physician's Order Sheet printed on 8/21/24 shows an order dated 5/14/24 to keep both heels off loaded when in bed, may use pillows every shift and as needed.</p> <p>R9's Pressure Ulcer Risk assessment dated [DATE] shows that she is at moderate risk for acquiring pressure wounds.</p> <p>R9's Skin Integrity Care Plan shows, Elevate heels off the bed.</p> <p>The facility's Pressure Ulcer Prevention Policy revised on 1/15/18 shows, Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34314</p> <p>Based on observation, interview, and record review the facility failed to follow occupational therapy recommendations for a resident with a contracted hand. This applies to 1 of 4 residents (R70) reviewed for range of motion/restorative in the sample of 27.</p> <p>The findings include:</p> <p>R70's face sheet lists his diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>On August 19, 2024, at 10:30 AM, R70 was lying in bed. All 4 of his fingers were bent in a fist like shape on his right hand. He stated, he can open his fingers some but not all the way. His hand was not like that when he came to the facility and has gotten worse. He tries to do hand exercises. The facility does not do any exercises/anything with his hand.</p> <p>On August 20, 2024, at 9:20 AM, R70 was lying in bed. His hand was in the same position as the day before.</p> <p>On August 21, 2024, at 9:34 AM, V17 Occupational Therapy (OT) Assistant stated, R70 has a non-fixed contracture to his right hand. They were working on exercises, range of motion and weight bearing exercises when he was doing therapy. He has been discharged from OT. His recommendation to the nurse was to have a rolled-up towel in his right hand and to continue to do range of motion exercises.</p> <p>R70's restorative observations dated July 10, 2024, shows, he does not have any contractures, no ROM (range of motion) or braces/splints.</p> <p>R70's occupational discharge summary dated July 26, 2024, shows, Discharge Recommendations: 24/7 care and restorative. Restorative Program Established/Trained = Restorative Range of Motion Program. Range of Motion Program Established/Trained: BUE (bilateral upper extremity) AROM (active range of motion) . Prognosis to Maintain CLOF (current level of functioning) = Excellent with consistent staff support . Patient will be discharged to this LTC (long term care) with therapy recommendations for 24-hour care and restorative.</p> <p>On August 21, 2024, at 10:05, V18 Restorative Aide stated, there are 3 restorative aides for the residents/facility. He does R70's hallway. He does not see R70. R70 is not on any restorative program at this time.</p> <p>R70's electronic medical record does not show any orders or documentation for restorative therapy.</p> <p>R70's Minimum Data Set, dated dated [DATE] shows, he is not receiving any restorative therapy.</p> <p>R70's care plan does not show any plans of care for restorative or range of motion.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's restorative nursing program policy dated January 4, 2019 shows, Purpose: To promote each resident's ability to maintain or regain the highest degree of independence as safely as possible. Includes, but is not limited to, programs in waling/mobility, dressing and grooming, eating and swallowing, transferring, bed mobility, communication, splint or brace assistance, amputation care and continence programs.</p> <p>Guidelines: Appropriateness for a restorative program will be determined by the interdisciplinary team as needed and/or may be determined as a continuation of care following a course of physical, occupational and/or speech therapy . Each resident involved in a restorative program will have an individualized program with individualized goals and measurable objectives documented on the plan of care.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232</p> <p>Based on observation, interview, and record review the facility failed to safely transfer a resident by preventing the resident's head from hitting the mechanical lift, failed to safely transport a resident and failed to update a resident's care plan after a fall. This applies to 2 of 27 residents (R19 and R5) reviewed for safety in the sample of 27.</p> <p>The findings include:</p> <p>1. R19's Face Sheet showed R19 was a [AGE] year-old female with the diagnoses of dementia and anxiety.</p> <p>On 08/19/24 at 10:10 AM, R19 was sitting in her wheelchair. R19 had bruising to the left side of her forehead. The bruising started at R19's hairline and extended down to her left eyebrow. The bruising was about the width of R19's eyebrow/eye. The bruised area had a darker purple area about the size of a quarter near R19's hairline.</p> <p>R19's Skin- Other Skin Condition Report dated 8/14/24 showed R19 hit her forehead on a mechanical lift resulting in a red area to R19's forehead and ice was applied.</p> <p>On 08/20/24 at 09:01 AM, V4 (Certified Nursing Assistant- CNA) stated she and V6 (CNA) transferred R19 on 8/14/24 when R19 hit her head on the mechanical lift during resulting in the bruised forehead. V4 said R19 got, excited during the transfer. V4 explained R19 raised her head during the transfer hitting her head on the mechanical lift. V4 added R19 had a history of getting agitated and moving her head during transfers.</p> <p>On 08/20/24 at 01:33 PM, V6 said he and V4 were transferring R19 with a mechanical lift. V6 said they accidentally hit R19's head with the mechanical lift when the sling was being unhooked.</p> <p>08/20/24 at 12:32 PM, V7 (CNA) said a resident's head should not hit the mechanical lift during a transfer.</p> <p>R19's Care Plan showed she was at risk for developing bruises. Listed under interventions was, Extreme care with resident handling: when assisting with transfers, mobility, dressing, and bathing.</p> <p>34490</p> <p>2. R5's Minimum Data Set assessment dated [DATE] shows that she uses a wheelchair and needs substantial/maximal assistance to wheel 50 feet with two turns and is dependent on staff to wheel 150 feet.</p> <p>On 8/19/24 at 12:33 PM, R5 was laying in bed. R5 had a bruise under her right eye, forehead, and bilateral knees.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's Fall-Initial Occurrence Form dated 8/10/24 shows, Was being wheeled down to dining room by CNA (Certified Nursing Assistant) and she put her foot down and fell forward off of chair. Braced her fall by putting her arms out but still hit her face on the ground.</p> <p>R5's Fall Committee Meeting Notes dated 8/13/24 shows, Resident was up in her wheelchair and staff was wheeling resident when she put her feet down and she fell out of her wheelchair .What interventions were in place at the time of the fall? Make sure to apply wheelchair footrest prior to transporting .What interventions were put in place immediately after the fall to prevent further falls? Applied foot rest What new interventions and/or changes are suggested by the IDT at this time? Refer to therapy for evaluation Care Plan reviewed and updated with new interventions the Yes box checked.</p> <p>On 8/20/24 a 1:28 PM, V6 (Certified Nursing Assistant) said that around breakfast time he was wheeling R5 in her wheelchair to the dining room. V6 said that R5 then put her foot down and went forward out of her wheelchair and fell to the ground. V6 said that R5 is typically transported to the dining room by staff. V6 said that R5 did not have foot rests on her wheelchair at the time of the fall.</p> <p>On 8/20/24 at 2:12 PM, V19 (Therapy Director) said that if staff are pushing a resident's wheelchair, they should have foot pedals on. V19 stated that it is a safety hazard if not. V19 said that their feet could get stuck under the wheelchair and they could fall.</p> <p>On 8/21/24 at 11:35 AM, V3 (Assistant Director of Nursing) said that R5 is forgetful at times. V3 stated that they educated all of the staff after R5's fall that if they are transporting a resident, they should have foot pedals on.</p> <p>On 8/21/24 at 11:48 AM, V19 said that he hears about resident falls during the morning meetings or from the nurses and likes to do an evaluation of the resident within 24-48 hours after the fall to see if they would benefit from therapy services to prevent future falls. V19 said that he was not aware that R5 had had a fall prior to yesterday (8/20/24).</p> <p>R5's Fall Care Plan provided on 8/21/24 does not document any new interventions after her fall on 8/10/24.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232</p> <p>Based on interview and record review the facility failed to ensure a resident received their routine medication for 1 of 27 residents (R2) reviewed for pharmacy services in the sample of 27.</p> <p>The findings include:</p> <p>A facility assessment done on 6/14/24 showed R2's cognition was intact.</p> <p>R2's Order Summary Report showed R2 had an order for morphine (pain medication) to be given three times a day scheduled for pain.</p> <p>On 08/19/24 at 09:45 AM, R2 said the facility ran out of her morphine because they did not reorder the medication in time. R2 said she missed two doses of the morphine.</p> <p>R2's August 2024 Medication Administration Record (MAR) showed she was to receive morphine at 5:00 AM, 1:00 PM and 9:00 PM. The MAR showed on 8/5/24 R2 was not given her 1:00 PM or 9:00 PM doses.</p> <p>V5 (Licensed Practical Nurse- LPN) was the nurse that documented R2 did not received the 8/5/24 1:00 PM dose. On 08/19/24 at 11:57 AM, V5 could not recall why R2 did not receive her scheduled morphine.</p> <p>A progress note entered by V5 dated 8/5/24 at 1:36 PM, 36 minutes after the 1:00 PM dose of morphine was due, that a script for morphine was sent to the pharmacy.</p> <p>A progress note dated 8/5/24 at 9:25 PM, 25 minutes after the 9:00 PM dose of morphine was due, showed the morphine was not available and the facility was waiting for morphine to be delivered.</p> <p>R2's morphine Controlled Drug Administration Record dated 7/26/24 - 8/5/24 showed R2 received a dose on 8/5/24 at 5:00 AM and had no remaining doses on hand.</p> <p>On 08/19/24 at 02:17 PM, V15 (Pharmacy Technician) said the pharmacy received a script to refill R2's morphine on 8/5/24 and it was delivered to the facility on [DATE] at 4:24 AM.</p> <p>On 08/20/24 at 12:28 PM, V8 (Registered Nurse) said medications should be reordered to ensure they do not run out of a resident's medication.</p> <p>R2's Care Plan showed she was at risk for alteration in comfort related to pain. Listed under interventions was to administer pain medication as ordered.</p> <p>The facility's Pharmaceutical Services policy showed, Refill prescription drugs when needed, in order to prevent interruption of drug regimens.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47552</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents receiving a pureed diet received a 5.33-ounce (oz) portion of the pureed stuffed shells. This applies to 2 of 2 residents (R390, R81) reviewed for pureed diets in the sample of 27.</p> <p>The findings include:</p> <p>Facility provided Diet Type report dated 8/19/24 shows that R390 and R81 receive a pureed diet.</p> <p>On 8/19/24 at 11:31 AM, V11 (dietary aide) began to check temperatures and prepare for the lunch service on the 500, 600, and 700 units. V11 asked V12 (dietary aide) to grab the pureed meals and a few requested alternates from the kitchen. V12 returned from the kitchen at 11:45 AM with three pre-plated puree plates that were wrapped and covered along with the requested alternate items.</p> <p>On 8/19/24 at 11:53 AM, V12 removed the cover to the first puree plate which included a pre-plated serving of pureed stuffed shells and a pre-plated serving of pureed zucchini already on the plate. V12 then scooped a serving of mashed potatoes and gravy onto the plate before handing it to the nursing staff. V12 proceeded to serve the second puree plate right after the first following the same process.</p> <p>Facility provided diet spreadsheet shows the serving size for the pureed cheese stuffed shells was supposed to be a #6 scoop, which provides 5.33 total ounces.</p> <p>On 8/19/24 at 11:45 AM, V12 stated he was the one who pre-plated the pureed plates. V12 said he used a #8 scoop for the pureed stuffed shells, which provides 4 total ounces: 1.33 ounces less than the required portion size.</p> <p>On 8/20/24 at 9:24 AM, V9 (Food Service Director) said staff can use the diet spreadsheet found in the kitchen to confirm the scoop sizes to be used at service. V9 said the cook on duty usually pre-plates the puree plates before sending them to the units. If the incorrect scoop is used, a resident may not receive the correct amount of nutrients which may lead to malnutrition.</p> <p>Facility Pureed Food Preparation policy dated 2020 states, Pureed foods will be prepared using standardized recipes to ensure quality, flavor, palatability, and maximum nutritive value . Procedure: . 5. Serve with appropriate scoop number or divide equally to provide an equal number of portions. All of the pureed food must be used in order to deliver the correct nutrient density to each resident.</p>		