Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6009435 | A. BUILDING: ______ B. WING ______ | C 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ALTA REHAB AT WAUCONDA** | **176 THOMAS COURT WAUCONDA, IL 60084** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of 09-07-2024/IL177801 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. | S9999 | | |

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

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 June 9, 2023, 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 August 10, 2024, shows that R1 is at risk for falls.

R1's Significant Change in Status Minimum Data Set dated August 6, 2024, 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

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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.

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

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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 September 7, 2024. 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

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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."

(A)