STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058528	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTA REHAB AT WAUCONDA	176 THOMAS COURT , WAUCONDA, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Findings: (1 of 4) 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by: Based on interview and record review the facility failed to notify the department (Illinois Department of Public Health/IDPH) following an incident resulting in	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 a resident (R1) sustaining fractures to the 4th and 5th metatarsals, for 1 of 1 resident reviewed for reporting in the sample of 19. On 2/9/26 at 11:17 AM, R1 was on the memory care unit sitting in a reclining wheelchair with her right foot wrapped in an ace bandage. V19 (Licensed Practical Nurse) said R1 recently had a fall and broke a couple bones in her right foot. R1's progress notes show on 1/13/26 at 3:15 AM, R1 was found on the floor in her room next to her bed. R1 was unable to recall what happened and was assisted back to bed. At 3:30 AM, R1 was complaining of pain to her right foot which is a new "acute problem" and an order for a stat X-ray was obtained. R1's progress notes at 3:24 PM on 1/13/26 show the X-ray results revealed displaced fractures to her 4th and 5th metatarsal. R1's right foot is documented as bruised with swelling and she was complaining of pain. R1 was sent to a local Emergency Room for splinting and evaluation by orthopedics. R1's nursing progress note at 8:59 PM on 1/13/26 shows that R1 was admitted to the hospital for diagnoses including acute fall and fractures to the 4th metatarsal and base of the fifth metatarsal and for a urinary tract infection. On 2/10/26 at 11:20 AM, V2 (Director of Nursing) verified that R1's fractures were not reported to the department because R1's X-Ray report mentions the fractures were "pathological" even though she had a fall and began to complain of pain after the fall. R1 said going forward they will be reporting all fractures even if it indicates it is a "pathological" fracture. The facility provided X-Ray report makes no mention of R1 having a fall and lists the indication as for "pain." The same report also mentions there is a suspicious fracture to the head of the 5th metatarsal and another fracture is identified in base of the 5th metatarsal. The facility provided Incident and Accident policy dated 12/17/25 shows that an accident is "any happening	S9999		

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S9999	Continued from page 2 not consistent with the routine operation of the facility that results in bodily injury." The policy also shows that the IDPH should be notified within 24 hours of a serious incident or accident that results in a resident injury. (C) (2 of 4) 300.696b) 300.696d) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. d)Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to implement policies to prevent and control infection for 4 of 19 residents(R3,R4,R6,R7) reviewed for infection control in the sample of 19. The findings include:	S9999		

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S9999	Continued from page 3 1..On 02/09/2026 at 11:03AM, R7 was lying in bed. R7 complained to pain to the bottom. V4 CNA-Certified Nursing Assistant and V5 CNA removed R7's pants and brief. R7 was incontinent of stool. V4 CNA cleaned the stool from R7's rectal area. V4 CNA did not remove their gloves. V4 CNA with V5 CNA's assistance placed a clean incontinent brief on R7. V4 positioned R7's indwelling urinary catheter as they pulled up R7's pants. V4 positioned R7 in the bed. V4 CNA with gloved hands pulled the sheet and blanket up around R7's neck and face area. On 02/09/2026 at 11:47AM, R7's door had an isolation sign. V6 Wound Nurse and V7 Wound Nurse assisted R7 to roll back and forth to remove clothing and expose a coccyx dressing. V6 and V7's upper garment and lower garments touched R7's bed as they helped. V6 removed R7's old dressing, performed the treatment and applied a clean dressing. V6 Wound Care Nurse and V7 Wound Care Nurse did not wear an isolation gown. On 02/09/2026 at 11:47AM, V6 Wound Nurse said, the two open areas are treated as one wound. On 02/10/2026 at 11:41AM, V2 DON-Director of Nursing said, staff should change gloves after cleaning poop before touching clean items. The facility glove policy revised 11/28/2018 shows, gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface. The sign on R7's door shows, Enhanced Barrier Precautions, Staff must wear gloves and a gown for the following high-contact resident care activities… …Wound Care. 2. On 2/9/26 at 11:10 AM, R4's room had no EBP or other isolation precautions sign on or around her door and no PPE outside or just inside of her room. On 2/9/26 at 12:34 PM, there was still no EBP sign on or around R4's door and no PPE outside of her room. R4's Admission Record dated 2/10/26 shows R4 was admitted to the facility on 2/4/26. R4's diagnoses include, but are not limited to infection due to	S9999		

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S9999	Continued from page 4 internal left hip prosthesis and methicillin resistant staphylococcus aureus (MRSA) infection as the cause of diseases. R4's Order Summary Report dated 2/10/26 shows an active order written on 2/4/26 for EBP and treatment orders (clean with normal saline, apply alginate and medihoney and cover with foam dressing three times a week and as needed) for a coccyx wound. The facility's Resident Matrix printed 2/9/26 shows R4 has a Stage 3 pressure ulcer. The facility's census dated 2/9/26 shows R4 is marked as being on EBP. 3. On 2/9/26 at 1:58 PM, R6's room had no EBP sign on or around her door and no PPE outside or just inside of her room. R6 said she has a bed sore on her coccyx, and she gets dressing changes every couple of days. R6 said staff do not wear gowns when they provide care. V13, Certified Nursing Assistant (CNA), entered R6's room to change her brief. V13 put on gloves but did not put on a gown and began to prepare R6 for incontinence care. R6's Admission Record dated 2/10/26 shows R6 was admitted to the facility on 2/28/25. R6's Order Summary Report dated 2/10/26 shows an active order written on 1/11/26 for treatment (cleanse with normal saline, MH (? Medihoney), foam dressing every Monday, Wednesday, Friday, and as needed) to her left buttock pressure wound. The facility's Resident Matrix printed 2/9/26 shows R6 has a Stage 3 pressure ulcer. R6's (Wound) Visit Report for 12/10/25 shows R6 was seen that day for an initial visit from the wound nurse practitioner, V20, for wounds to her coccyx which was present since 12/5/25. R6 was diagnosed with a pressure ulcer of sacral region, stage 3. The wound was debrided that day. Photos of R6's coccyx wound show an open area. R6's Wound Assessment Details Report dated 2/10/26 shows R6 has an active, Stage 3 pressure wound of her coccyx. On 2/10/26 at 11:00 AM, V6, Wound Care Nurse, said staff know if a resident is on isolation because there are signs on their door and PPE carts outside their room. V6 said they also check the residents' chart; if a resident is on isolation or EBP, it should be on the banner in their EMR (electronic medical record). V6 said the Infection Prevention nurse initiates EBP/isolation for a resident. The facility's Enhanced Barrier Precautions Policy (reviewed/revised 5/7/24) shows EBP refer to an	S9999		

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S9999	Continued from page 5 infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with infection with an MDRO when contact precautions do not otherwise apply or chronic wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Examples of chronic wounds include pressure ulcers and unhealed surgical wounds. High contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care. 4.) On 2/10/2026 at 9:15 AM, R3 was sitting in the dining area finishing breakfast. Outside of R3's room there was no sign to indicate she was on Enhanced Barrier Precaution and there was no bin containing PPE. On 2/10/26 at 9:29 AM, V12 (CNA) said that R3 has a wound on her heel but she is not on any isolation or precautions for that. R3's wound assessment shows on 11/15/25 she was found to have a blister on her right heel. R3 's wound assessment completed on 1/28/26 by V20 (Nurse Practitioner) shows the wound (blister) to her right heel blister is deteriorating and had opened. Treatment order for medical honey and bordered gauze dressing with changes 3 times a week was obtained. On 2/10/26 at 11:00 AM, V6 (Wound Care Nurse) said residents who have pressure ulcers with open areas requiring treatment should have EBP precautions in place and staff should wear gowns and gloves when providing direct care. On 2/10/26 at 11:25 AM, V2 (Director of Nursing) verified that R3 did not have EBP precautions or orders in place and she "100% should have them." V2 said she thinks what happened was R3's wound was classified as a blister still and should have been changed once the wound opened and EBP precautions should have been added. 5.On 02/09/2026 at 11:03AM, R7 was lying in bed. R7 complained to pain to the bottom. V4 CNA-Certified Nursing Assistant and V5 CNA removed R7's pants and brief. R7 was incontinent of stool. V4 CNA cleaned the stool from R7's rectal area. V4 CNA did Not remove the gloves. V4 CNA with V5 CNA's assistance placed a clean incontinent brief on R7. Positioned R7's indwelling urinary catheter as they pulled up R7's pants.	S9999		

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S9999	Continued from page 6 Positioned R7 in the bed. V4 CNA with gloved hands pulled the sheet and blanket up around R7's neck and face area. (B) (3 of 4) 300.2090a) Section 300.2090 Food Preparation and Service a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the protein for the puree residents, noon meal, was portioned according to the recipe for 4 of 19 residents (R2,R7,R18,R19) reviewed for food preparation in the sample of 19. The findings include: The facility Diet Type Report dated 02/10/2026 shows, R2,R7,R18,R19 as pureed diet texture. On 02/10/2026 at 9:30AM, V18 Cook used a spoon to scoop ground breaded chicken into a food processor, then added chicken broth and thickener. V18 did not weigh the protein prior to processing. On 02/10/2026 at 9:30AM, V18 Cook said, I am making 10 servings for the noon meal. The facility recipe for 02/10/2026 Lunch shows, Ground Breaded Chicken Thighs with Gravy: chicken thigh, boneless skinless 4 ounces. 10 servings: 2.5 pounds of chicken. Weigh a cooked boneless chicken thigh to be sure 3 ounces of protein is being served.	S9999		

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S9999	Continued from page 7 Puree Breaded Chicken 10 servings: 2.75 pounds of chicken, 1 tablespoon of chicken base, 3.5 cups of water. The facility Standardized Recipes policy dated 2025 shows, weight or volume of each ingredient- This is the required amount of each ingredient in the recipe. (C) (4 of 4) 300.1060f) 300.1060g) Section 300.1060 Vaccinations f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were screened for risk factors associated with hepatitis B and C, and HIV, their hepatitis B vaccination status, and failed to offered the hepatitis B immunization within 10 days of admission for 2 of 5 residents (R4,R5) reviewed for immunizations in the sample of 19. The findings include: On 02/10/26 at 11:41 AM, V2, Director of Nursing, said she checks the state immunization registry to see if residents have had the hepatitis B immunization series for her own knowledge, but it does not get recorded in their Electronic Medical Record, they don’t offer the hepatitis B vaccinations, and she does not screen	S9999		

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S9999	Continued from page 8 residents for the hepatitis B vaccines or risk factors. On 2/10/26 at 12:34 PM, V2 said they don't screen residents for hepatitis B. On 2/10/26 at 11:58 AM, V1, Administrator, said they do not have a policy regarding hepatitis B for residents. On 2/10/26 at 2:19 PM, V17, Regional Nurse Consultant, said they just implemented Social History/Initial assessment six months ago, however, the facility was unable to provide documentation that the assessment was completed for R4 and R5. R4's Immunizations list dated 2/10/26 does not list hepatitis B or any information regarding her hepatitis B vaccination status. R5's Immunizations list dated 2/10/26 does not list hepatitis B or any information regarding his hepatitis B vaccination status. The facility was unable to provide documentation that R4 and R5 were screened for hepatitis B and hepatitis C and HIV risk factors and whether they have received and/or would like to receive the hepatitis B vaccination series. (C)	S9999		