

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/23/2025
Form Approved OMB
No. 0938-0391

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 12/30/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 4.</p> <p>The findings include:</p> <p>The facility's Incident Report for R1 shows on 12/23/24 resident was overheard in the dining room (during breakfast) stating that she was abused by a CNA (certified nursing assistant) on the previous day. Social Service Designee interviewed the resident who claimed that the day before she overheard a CNA and an Activity Aide arguing in the hallway. According to the resident, she tried to intervene and tell them to stop, and the CNA allegedly pointed her finger in the resident's face and used profanity at her.</p> <p>On 12/30/24 at 9:47 AM, R1 was in her room re-arranging her things on her bed. R1 stated on 12/22/24 after breakfast, she heard yelling in her hall. R1 stated she went out of her room and as she got closer to the people yelling, she saw V6 Certified Nursing Assistant (CNA) was yelling at V5 Activity Aid. R1 stated V5 was pushing a resident down the hall from the nursing station and V6 was yelling at V5. R1 stated V5 wasn't saying anything and V6 was harassing V5 about how V5 was a little person on the grapevine and her position was on the bottom. R1 stated V6 was saying V5 was dumb and stupid and V5 just kept pushing the resident down the hallway and not saying anything back. R1 stated she got involved and told V6 to knock it off and to get out of here it wasn't her hall. R1 stated V6 yelled at me to back off and to shut up you b***h. R1 stated she felt bad for V5 and again told V6 to get out of here, you don't belong here. R1 stated she wanted V6 to leave V5 alone. R1 stated V6 was yelling at her and at V5 and pointing her finger at them. R1 stated at some point it went from V6 yelling B***h to her saying F*** You. R1 stated V5 was able to get away and she reported what happened to V7 Manager on Duty. R1 stated she talked to V4 Social Services about what happened the next day. R1 stated R2 saw and heard the yelling as well.</p> <p>(continued on next page)</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

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 12/30/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at 9:56 AM, R2 stated on that day (12/22/24), she was in her room watching TV and heard yelling in the hall. R2 stated it was loud, she heard it over the TV. R2 stated she wheeled herself to the hall and saw V6 yelling at V5. R2 stated she heard no words from V5. R2 stated V5 was pushing another resident down the hall and V6 was just raging calling V5 a B***h. R2 stated V5 kept pushing the resident down the hallway, trying to get away from V6. R2 stated she was not sure who the resident that was being pushed was. R2 stated V6 was getting so close to V5 that she thought it was going to get violent. R2 stated R1 was nearby, somewhat behind V5. R2 said V6 was yelling at R1 to go back to her room. R2 said V6 called V5 and R1 a B****. R2 stated R1 told V6 to get out of there and V5 again told R1 to go back to her room. R2 stated V6 kept on yelling at V5 about how V5 was just a little activity person, and she was a CNA. R2 said it was not right and she was going to call the state about it.</p> <p>On 12/30/24 at 10:24 AM, V1 Administrator stated V6 did get disciplinary action for swearing and leaving her assigned unit.</p> <p>On 12/30/24 at 10:39 AM, V6 stated she had a verbal disagreement with another staff member. V6 stated it started in the dining room and continued to the nurse's station and down the hallway. V6 stated the disagreement did get loud and R1 did come out of her room. V6 stated R1 was behind V5 who was pushing another resident down the hallway. V6 stated she did call V5 a B*** and R1 assumed that she was talking to her. V6 stated R1 kept propelling toward her, and she told R1 to back away. V6 stated she was not assigned to that unit and her assignment was in a hall on the other side of the building. V6 stated that the situation was not appropriate to do in the hallway with residents present.</p> <p>On 12/30/24 at 10:54 AM, V4 Social Services stated R1 reported to her (12/23/24) that two employees (V5 and V6) were fighting in the hallway, and she had tried to intervene. V4 stated R1 reported V6 swore at her and told her to stay out of it.</p> <p>On 12/30/24 at 11:04 AM, V5 stated V6 had approached her in the dining room and accused her of talking about V6 behind her back. V5 stated V6 followed her down the 200 hall to the 300 hall and then continued down the 300 hall while V5 was pushing R3. V5 stated V6 was calling me irrelevant and downgrading my job and her age. V5 stated she kept walking away and V6 kept on and was calling her a B***. V5 stated R1, R2, and R3 heard everything. V5 stated V6 yelled at R1. V5 stated you are not supposed to talk to residents that way. V5 stated she told V6 to go back to her unit and kept walking to try to get away from V6. V5 stated V6 finally left, and she called her supervisor who advised her to talk to V7. V5 stated she gave her statement to V7. V5 said she went and apologized to the residents. V5 stated V6 was very loud, and her tone was disrespectful to her and the residents. V5 stated V6 was very disrespectful to R1 and was using her hands and pointing at R1 while yelling at her.</p> <p>On 12/30/24 at 11:37 AM, R3 stated V5 was pushing her back to her room and the other one came up and started talking loudly about V5 talking about her behind her back, childish stuff like you do in school. R3 said V6 kept on and on down the hall and was yelling loud enough for people to hear. R3 said she couldn't remember all that was said and couldn't see behind her to know who else was there. R3 said V5 kept pushing her down the hall to her room and the other one went away.</p> <p>On 12/30/24 at 1:10 PM, V1 said residents should not be yelled at by staff.</p> <p>(continued on next page)</p>		

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 12/30/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>R1's Progress Note by V4 dated 12/24/24 shows Resident was overheard in dining room, stating a CNA was inappropriate. Said writer discussed with resident what had happened, R1 stated a CNA was inappropriate to an activity aide and R1 stated she asked the CNA to stop, and then CNA was verbally inappropriate to her. Said writer informed Administrator.</p> <p>R1's Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively intact.</p> <p>The facility's Statement from V5 regarding 12/22/24 incident shows As V6 was walking away she called a B**** and then returned and repeated her insults. Several residents witnessed the incident and urged her to stop and leave me alone. At one point, V6 yelled at a resident, telling them to mind their business.</p> <p>The facility's Abuse Prevention and Reporting Policy dated 10/24/22 shows Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.</p>		

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 12/30/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 4.</p> <p>The findings include:</p> <p>The facility's Incident Report for R1 shows on 12/23/24 resident was overheard in the dining room (during breakfast) stating that she was abused by a CNA on the previous day. Social Service Designee interviewed the resident who claimed that the day before she overheard a CNA and an Activity Aide arguing in the hallway. According to the resident, she tried to intervene and tell them to stop, and the CNA allegedly pointed her finger in the resident's face and used profanity at her.</p> <p>On 12/30/24 at 9:20 AM, V1 Administrator said the incident was determined to be a 2 staff verbal altercation witnessed by R1. V1 said the initial report said R1 used profanity at her, but as they interviewed staff, the profanity was toward the other staff and not the resident. V1 said they did not substantiate abuse.</p> <p>On 12/30/24 at 9:47 AM, R1 was in her room re-arranging her things on her bed. R1 said on 12/22/24 after breakfast, she heard yelling in her hall. R1 said she went out of her room and as she got closer to the people yelling, she saw V6 Certified Nursing Assistant (CNA) was yelling at V5 Activity Aid. R1 said V5 was pushing a resident down the hall from the nursing station and V6 was yelling at V5. R1 said V5 wasn't saying anything and V6 was harassing V5 about how V5 was a little person on the grapevine and her position was on the bottom. R1 said V6 was saying V5 was dumb and stupid and V5 just kept pushing the resident down the hallway and not saying anything back. R1 said she got involved and told V6 to knock it off and to get out of here it wasn't her hall. R1 stated V6 yelled at me to back off and to shut up you bitch. R1 said she felt bad for V5 and again told V6 to get out of here, you don't belong here. R1 said she was wanted V6 to leave V5 alone. R1 said V6 was yelling at her and at V5 and pointing her finger at them. R1 said at some point it went from V6 yelling B*** to her saying F*** You. R1 said V5 was able to get away and she reported what happened to V7 Manager on Duty. R1 said she talked to V4 Social Services about what happened the next day. R1 said R2 saw and heard the yelling as well.</p> <p>On 12/30/24 at 9:56 AM, R2 said on that day, she was in her room watching TV and heard yelling in the hall. R2 said it was loud, she heard it over the TV. R2 said she wheeled herself to the hall and saw V6 yelling at V5. R2 said she heard no words from V5. R2 said V5 was pushing another resident down the hall and V6 was just raging calling V5 a B***. R2 said V5 kept pushing the resident down the hallway, trying to get away from V6. R2 said she was not sure who the resident that was being pushed was. R2 said V6 was getting so close to V5 that she thought it was going to get violent. R2 said R1 was nearby, somewhat behind V5. R2 said V6 was yelling at R1 to go back to her room. R2 said V6 called V5 and R1 a B****. R2 said R1 told V6 to get out of there and V5 again told R1 to go back to her room. R2 said V6 kept on yelling to V5 about how V5 was just a little activity person, and she was a CNA. R2 said it was not right and she was going to call the state about it.</p> <p>(continued on next page)</p>		

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 12/30/2024
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at 11:37 AM, R3 said V5 was pushing her back to her room and the other one came up and started talking loudly about V5 talking about her behind her back, childish stuff like you do in school. R3 said V6 kept on and on down the hall and was yelling loud enough for people to hear. R3 said she couldn't remember all that was said and couldn't see behind her to know who else was there. R3 said V5 kept pushing her down the hall to her room and the other one went away.</p> <p>On 12/30/24 at 10:39 AM, V6 said she had a verbal disagreement with another staff member. V6 said the disagreement did get loud and R1 did come out of her room. V6 said R1 was behind V5 who was pushing another resident down the hallway. V6 said she did call V5 a B*** and R1 assumed that she was talking to her. V6 said R1 kept propelling toward her and she told R1 to back away. V6 said she was not assigned to that unit and her assignment was in a hall on the other side of the building. V6 said that the situation was not appropriate to do in the hallway with residents present. V6 said she was not sure if any other staff was present, but there were other residents in the doorways of the rooms.</p> <p>On 12/30/24 at 10:24 AM, V1 Administrator said V7 was home sick and was not available. V1 said V7 was the manager on duty that day and had started the interviews about the incident. V1 said V7 told her no other residents or staff were present and the incident happened at the nurse's station. V1 said she was told no one had overheard anything, so she did not interview anyone else based on V7's report of the situation. V1 said V6 did get disciplinary action for swearing and leaving her assigned unit. V1 was not aware of any other residents overhearing the incident nor that the incident continued down the resident hallway from the nurse's station.</p> <p>On 12/30/24 at 10:54 AM, V4 Social Services said R1 reported to her (12/23/24) that two employees (V5 and V6) were fighting in the hallway and she had tried to intervene. V4 said R1 reported V6 swore at her and told her to stay out of it. V4 said she had only talked to R1 and had not done any other interviews. V4 said R1 did not want to call the police.</p> <p>The facility's Statement from V5 regarding the 12/22/24 incident shows Several residents witnessed the incident and urged her to stop and leave me alone. At one point, V6 yelled at a resident, telling them to mind their business.</p> <p>The facility's Statement from V6 regarding the 12/22/24 incident shows walking and shouting down the hallway (not just at the nurse's station).</p> <p>The facility's Abuse Prevention and Reporting Policy dated 10/24/22 shows Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making necessary changes to prevent future occurrences. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.</p>		