(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
		IL6006720	B. WING		04/1	, 1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALTA RE	HAB AT OAK BROOK		WEST ROAD OK, IL 6052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Survey:	2472752/IL171683				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210b) 300.1210b)4					
	Section 300.610 R	esident Care Policies				
	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.					
	Section 300.1210 ( Nursing and Persor	General Requirements for nal Care				
	and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/20/24 **Electronically Signed** 

TITLE

STATE FORM 6899 If continuation sheet 1 of 6 V0N911

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			c
		IL6006720	B. WING			11/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALTA RE	HAB AT OAK BROOM	(	WEST ROAD OOK, IL 6052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	care needs of the result of the prostrate, and sadmitted to the service of 2024, with multiple presence of left art of the prostrate, an sacrum.	esident.  onnel shall assist and its so that a resident's abilities living do not diminish unless he individual's clinical condition iminution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; ith, language, or other lication systems. A resident arry out activities of daily living ervices necessary to maintain oming, and personal hygiene. Its were NOT MET as  and record review the facility sidents received adequate assessment and assistance ent significant weight loss.  If a residents (R1) reviewed for ample of 4.  The inc Medical Record) showed of the facility on January 2, diagnoses including dementia, ifficial hip, malignant neoplasm dipressure ulcer of the	S9999	DEFICIENC		
	presence of left art of the prostrate, an sacrum.	ificial hip, malignant neoplasm				

Illinois Department of Public Health

STATE FORM 6899 V0N911 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
IL6006720		B. WING		C 04/11/2024		
			<u> </u>		04/1	1/2024
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ALTA REHAB AT OAK BROOK  2013 MIDV OAK BRO			OK, IL 6052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	2 Continued From page 2 2024, showed R1 was severely cognitively impaired and required assistance with ADLs including partial assistance with eating and dependent on staff for bed mobility, dressing, bathing, toileting and transfer.  R1's care plan for ADLs revised on March 27, 2024. showed per report, resident noted able to lift utensils and appear to place food in his mouth during meals but spills them to his clothes. Resident may benefit with staff feeding assistance with meals.  R1's weight record documentation showed:     January 3, 2024- 163.0 lbs. (Pounds)     January 16, 2024- 152.2 lbs.     February 6, 2024-152.6 lbs.     March 5, 2024-142.2 lbs.     March 14, 2024-134.0 lbs.     March 16, 2024-129.3 lbs.     March 31, 2024-128.2 lbs.     April 4, 2024-126.5 lbs.     April 10, 2024-127.1 lbs.  On April 9, 2024, at 2:30 PM, V3 (CNA) stated R1 used to go to the dining room and feed himself at meals but had a hard time holding the utensils and would spill the food a lot. V3 also stated now that the staff feed him on a 1:1 basis he eats 100%. of his meals. V3 was unsure how long R1 was receiving 1:1 feeding assistance but stated maybe a week.  On April 10, 2024, at 11:15 AM, V7 (CNA) stated she has been R1's caretaker since his admission to the facility. V7 stated prior to R1 being in contact isolation, R1 would eat his meals in the dining room and after the staff set up his meal tray R1 would feed himself. V7 stated when R1					

fed himself, there would be a lot of food spillage
Illinois Department of Public Health

STATE FORM 6899 V0N911 If continuation sheet 3 of 6

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6006720	B. WING		04/1	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALTA RE	HAB AT OAK BROOK		WEST ROAD OK, IL 6052			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
\$9999	and it seemed R1 woof food. V7 describes side while sitting in sure if that caused plate of food or not.  R1's physician order revised on March 2 texture, thin consist for contact precauti Resistant Staphyloc wound was initiated wound was initiated and revised of Eating, the ability bring food and or lie food, for February 2 on 22/29 days code Code 6-Independe Code 5-set up assisted Code 3- partial assistance with the change from baselind discharge recommens showed R1 required Assistance) globally discharge summary 2024, to include confeeding program.	would only see half of his plate ed R1 would also lean to the his wheelchair and wasn't R1 to reach only for half of his ers showed R1's diet order 7, 2024, General diet, regular ency, feeding assist. An order ons for MRSA (Methicillin coccus Aureus) of the sacral on April 8, 2024.  In Survey Report for the task of to use suitable utensils to quid to the mouth and swallow 2024, showed documentation and as follows: and, -7 days, stance provided -9 days. Son, verbal cues provided - 4 distance provided -2 days.  In Survey Report for the task of the mouth and swallow 2024, showed documentation and as follows: and the reposition of the mouth and swallow 2024, showed documentation and as follows: an	S9999			
	R1's EMR showed R1 had continued weight loss of 15.7 lbs. while receiving OT services. R1's weight was documented as 142.2 lbs. on March 5, 2024, and 126.5 lbs. on April 4, 2024.					

Illinois Department of Public Health

STATE FORM 6899 V0N911 If continuation sheet 4 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		IL6006720	B. WING		04/1	7 1/2024			
				TATE TIP 000F	1 0471	1/2021			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ALTA RE	ALTA REHAB AT OAK BROOK 2013 MIDWEST ROAD OAK BROOK, IL 60521								
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE			
S9999	Continued From pa	ge 4	S9999						
	Nurse) and V9 (Res	at 11:38 AM, V8 (Restorative storative Aide) both stated that restorative 1:1 feeding							
	On April 10, 2024, at 2:45 PM, V5 (RD, Registered Dietician) stated she has been the facility's RD since February 1, 2024, and was made aware of R1's weight loss in early February, however V5's initial assessment was completed on March 7, 2024. V5's progress note identified significant weight loss of 6.8% in one month and 12.8% weight loss in 2 months and made no recommendation. V5 stated she has access to the EMR and can look at intake records remotely but was unaware of R1's spillage of food during self-feeding. V5 stated the food spillage would affect R1's food intake and could contribute to weight loss.								
	stated when the die weight loss, he wou assessment be con of significant weight facility staff to moni and that food spillag the resident's meal to weight loss. V4 significant weight lo weight be taken ever supplements be given completed to determ loss as well as put in prevent further weight.								
	The Facility's policy titled "Unintentional Weight Loss", dated 2022, showed "Causes /Risk Factors of Unintentional Weight Lossfrequent								

Illinois Department of Public Health

STATE FORM 6899 V0N911 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		IL6006720	B. WING		l l	C <b>11/2024</b>
	PROVIDER OR SUPPLIER	2013 MID	DRESS, CITY, ST WEST ROAD OOK, IL 60521			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
\$9999	causes of unintentic inadequate oral foo Screening to Identif Unintentional Weiglindividuals at mealt identify people that	onal weight loss include d and beverage intake and	S9999			

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V0N911 If continuation sheet 6 of 6