(X6) DATE

Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
			A. BUILDING.			,
		IL6001051	B. WING			5/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALTA RE	HAB AT FAIRMONT		TH PULASK , IL 60630	I ROAD		
(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			
	Facility Reported In	cident of 12/20/24/IL184679				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210a) 300.3210t)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conforming and othe policies shall complicies the facility and shall	dvisory physician or the ommittee, and representatives in services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	a) Comprehen facility, with the part the resident's guard applicable, must de comprehensive car includes measurable meet the resident's	General Requirements for nal Care usive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the				

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

02/05/25 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6001051	B. WING		01/2	; 5/2025
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0=	<u></u>
ALTA RE	HAB AT FAIRMONT		TH PULASK , IL 60630	II ROAD		
(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
S9999	resident's compreh allow the resident to practicable level of provide for discharge restrictive setting be needs. The assess the active participate resident's guardian applicable. (Section Section 300.3210 of the subjected to phe psychological abuse misappropriation of these requirement by: Based on observation review, the facility for failures affected 2 or in R2 grabbing R1's R1 grabbing R2 in the scratches and pain section findings include: The final for FRI (Foccurred on 12/20/2 documents, in part, grabbed on to her saked (R1) to let loon not. (R2) reported sher shirt (R1) allebathroom, approactions.	ensive assessment, which a attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act) General shall ensure that residents are ysical, verbal, sexual or e, neglect, exploitation, or property. s were not met as evidenced on, interview and record ailed to protect the residents' m physical abuse. These residents (R1 and R2) resulting thumb causing R1 pain and the chest causing multiple to R2.	S9999	DEFICIENCY		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		IL6001051	B. WING		01/2	; 5/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AI TA REHAR AT FAIRMONT		TH PULASK , IL 60630	(I ROAD			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	(R1) reported to the her left thumb. The x-ray was ordered. is inconclusive due fractures and Xray rold ununited cortica of the base of the leprovider ordered acortho. Resident sch 12/30/2024." On 1/24/25 at 12:46 still broken." R1 shot thumb/hand. Survey thumb/hand without R1's left thumb app (R1) can't wear that don't feel right. It's ((left thumb) still humb/hand issues with her before me. (R2) is the bathroom complain Administrator). I (R1) can't ompose out of the bath verbally assaulted marm. I (R1) grabbed myself and she (R2) back and broke it. It I (R1) called her and deny that. The policities assaulting people."	ge 2 led her Later in the evening, a nurse that she had pain in doctor was notified, and an Diagnosis of an acute fracture to history of pathological report stating: acute versus I fracture at the ulnar margin off 1st metacarpal. The le bandage and follow up with eduled to see ortho on Spm, R1 said, "My thumb is browed surveyor R1's left yor observed R1's left a splint or ace wrap, and leared swollen. R1 stated, "I wrap for my thumb, it just ace wrap) not comfortable. It is lill (R1) tell you what leared swollen. (R2) was in the ling about the (V3, Assistant 1) was tired of listening to it, (R2) to shut up. She (R2) then hroom and physically and line. She (R2) bit me in the liner (R2) shirt to defend ly grabbed my thumb, bent it (R1's thumb) hurt like a b****! C-*-*-*! I (R1) am not going to be came and if I (R1) go to jail, I too. The truth hurts. I (R1) her (R2) here. She's (R2) cility physically and verbally suments, in part, diagnosis	\$9999			
		not limited to bipolar disorder;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	IL6001051	B. WING		01/2	5/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALTA REHAB AT FAIRMONT		TH PULASK , IL 60630	I ROAD		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
right ankle and foot, fracture with routine Immunodeficiency V Data Set (MDS), dat part, a brief interview score of 14 which indintact. R1's progress note p Nurse/RN), dated 12 documents, in part, "a physical altercation The patient stated the thumb but refused to checked in the hospi made aware of the swas made aware	sorder; age-related arrent pathological fracture, subsequent encounter for healing; and Human firus (HIV). R1's Minimum ted 10/24/24, documents, in wof mental status (BIMS) dicates R1 is cognitively Der V4 (Registered 2/20/2024 at 10:43pm, "9:20pm the patient (R1) had n with her roommate (R2). That she (R1) has a broken left to go with the ambulance to be ital. NP (nurse practitioner) situation. The administrator the situation" Der V4 (Registered 2/20/2024 at 10:45pm, "The patient (R1) refused to get her thumb checked. the er thumb but refused to be ation." Der V5 (Social Worker) dated in, documents, in part, friter checked in on pt as tearful and became upset altercation between her and the (R2). Pt reports to be in awaiting to have an x-ray friter sat with pt until she (R1) gan to ask if she'd be able to rom her old room with writer. that it would be best to allow (R1) belongings to keep	\$9999	DELITION OF THE PROPERTY OF TH		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			71. BOILDING.			,
		IL6001051	B. WING			5/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALTA RE	HAB AT FAIRMONT		TH PULASK , IL 60630	I ROAD		
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S9999	Continued From pa	ge 4	S9999			
	understanding. Wri	ter retrieved all pt's belongings n putting them away in her new				
	dated 12/26/2024 2 "Appointment for O made an appointment of December at 1:4 appointment. She (appointment, and stransportation arrar resident stated when	he (R1) also made her own ngements. This is what the en I (V6) went to ask her for about her appointment to				
	Nurse/LPN), dated documents, in part, appt and said, "no (R1) do it myself! I	per V7 (Licensed Practical 12/26/2024 6:35pm, "(R1) cancelled her Ortho one schedules my appt! I'll (R1) have my own doctor! I y doctors that's associated				
	documents, in part, Pt (patient/R1) scor Screening Assessing allegation of abuse hospital. According report was done but a complaint," with good "Pt (patient/R1) will and verbalize to stanglect through revinterventions that documents of the safety if feeling unsubstant of the safet	ocument, in part, "Ensure afe."R1's Care Plan, revision				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
		IL6001051	B. WING			C 25/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AI TA D	EHAB AT FAIRMONT	5061 NOR	TH PULASK	(I ROAD		
ALIAN	LIIADAI TAIKWONI	CHICAGO	, IL 60630			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
\$9999	educated on import still reluctant." R1's 10/22/24, documen psychotropic medic document, in part, "for target behavior s response to verbal violence/aggressior and document per f R1's "Abuse/Neglect (most recent asses physical altercation 12/20/24), documer "Abuse/Neglect Scr documents, in part, measure for likelihor mistreatment and/o symptoms related to Moderate = 3-4, Hig "Abuse/Neglect Scr following was answ and /or present mer psychotic symptoms hallucinations) and events and the intersheet documents, in but are not limited to depressive disorder health diagnosis. Al risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ would have a score Moderate risk for potential fur question was answ was an and potential fur question was an	ance of application however Care Plan, revision date ts, in part, "I (R1) use ation," with interventions that Monitor/record occurrence of symptoms (inappropriate communication, a towards staff/others. etc.) facility protocol." et Screening," dated 10/21/24 sment done prior to the between R1 and R2 on hts, in part, "Score:2." R1's reening," dated 10/21/24, "B. Risk measure. Risk bod for a history of previous/ or potential future problems/ o mistreatment. 0. Low= 0-2,	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		IL6001051	B. WING		1	5/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
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040.15	CLIMMA DV CTA			DDOVIDEDIC DI ANI OF CODDECTION	DNI .	0.5)
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
S9999	Continued From pa	ge 6	S9999			
	X-Rav of left thumb	due to pain/swelling."				
		1				
		umb, dated 12/21/24,				
		"acute versus old ununited				
	the 1st metacarpal.	he ulnar margin of the base of				
	the 1st metacarpai.					
	On 1/24/25 at 11:47	7am. R2 said, "(R1) was				
		o me while I (R2) was in the				
		ouldn't hear her (R1), so I (R2)				
		d on. When I (R2) came out of				
		e) went up to her (R1) and				
		ue (R1) was saying. (R1) then u think? I'm (R1) stupid." She				
		my shirt. I (R2) gave (R1) to				
	, ,	of my shirt. I (R2) counted to 3				
		are you going to do now, so I				
		R1) hand to stop her (R1) from				
		nd I (R2) must have hurt her				
		didn't mean to break it (left				
		lid intentionally grab her (R1) e. I (R2) grew up in a not so				
		l. I (R2) think she (R1) thought				
		g to stand there and let her				
	, , ,	hen (R1) told the nurses I (R2)				
		ould I (R2) bite someone with				
		nodeficiency Virus)? I'm (R2)				
		R1) a liar. She (R1) gave me				
		ny chest. Those scratches (R2) was attacked by a rabid				
	cat."	(112) was allacked by a labid				
		cuments, in part, diagnosis				
		not limited to anxiety disorder,				
		olar disorder. R2's Minimum				
		ated 10/18/24, documents, in				
		w of mental status (BIMS) ndicates R2 is cognitively				
	intact.	Idiodico INZ io obgrillively				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		IL6001051	B. WING			C 25/2025
	PROVIDER OR SUPPLIER	5061 NOR	DRESS, CITY, S RTH PULASK D, IL 60630	TATE, ZIP CODE I ROAD		
(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	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
S9999	R2's progress note Nurse/RN), dated 1 documents, in part, had a physical alter (R1). She (R2) was (R1) in the chest the She (R2) then grab so that she (R1) will roommate. Both pain different rooms. It Administrator made R2's progress note Nurse/LPN), dated documents, in part, on resident chest a R2's "Abuse/Negled (most recent asses physical altercation 12/20/24), document puts R2 at MODER abuse. R2's Care plan, rev documents, in part, abuse/neglect," very document, in part, abuse Observer peers." R2's Care plandocuments, in part, medication," with in part, "Monitor/documents,	per V4 (Registered 2/20/2024 at 10:48pm, "At 9:20pm, the patient (R2) reation with her roommate grabbed by her roommate at caused some scratches. It is her roommates (R1) hand I let go causes pain to the tients were separated and put NP (nurse practitioner) and a aware of the situation." per V10(Licensed Practical 12/21/24 at 7:20pm, " Scratch marks still noted	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		E SURVEY PLETED	
		IL6001051	B. WING		I	C 25/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ALTA RE	HAB AT FAIRMONT		RTH PULASKI), IL 60630	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
\$9999	12/20/24 and that F changed. V8 said, of thing since the mode of thing safe. I (V3) followed up wire (V3) asked them if they (R1 and R2) be on 1/24/25 at 2:44 Nursing/DON) said incident with (R1) as that (R1) was lying out of bathroom. (Rept talking and tall (R2) suddenly jumphad to defend herse separated right award called. They (R1 and feel most injuries cathan others." On 1/24/24, survey Nurse/RN) for an incall. On 1/24/25 at 3:15 process.	R1 and R2 rooms were I'lt was a he said she said type hinute it happened." Om, V5 (Social Worker) R1 and R2 were separated heir rooms were changed the physical altercation. V5 said, "I hat actually happened. They fferent stories" Om, V3 (Assistant , " The incident with (R1) hubstantiated because bothing different stories. The stories We (staff) ensured both were drup with both (R2) and (R1). I them (R1 and R2) feel safe and oth said yes."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		IL6001051	B. WING			25/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AI TA RE	HAB AT FAIRMONT		TH PULASK	KI ROAD		
ALIANE	TAIRMONT	CHICAGO	, IL 60630			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 9	S9999			
	(V9) don't follow the someone's hand or cause pain, V9 rep	em." When asked if grabbing scratching someone can lied, "Possibly." When asked if can cause pain or harm to				
		or called V4 (Registered nterview, but V4 did not pick up				
	Reporting- Illinois," documents, in part, of our residents to exploitation misapp deprivation of good mistreatment. This abuse neglect exploroperty and mistre to do so, the facility resident sensitive a environment. The passure that the faci control to prevent dexploitation misapp deprivation of good mistreatment of resestablishing an environment sensitivity, prevention of mistre means any physical assault inflicted upon accidental means (the willful infliction of confinement, intimine resulting physical has a resident (42 Cl the infliction of injurother than by accidents.)	d, "Abuse Prevention and revised date 10/24/22, "This facility affirms the right be free from abuse, neglect, propriation of property is and services by staff or facility therefore prohibits obtation, misappropriation of eatment of residents. In order or has attempted to establish a and resident secure ourpose of this policy is to dity is doing all that is within its occurrences of abuse neglect propriation of property, is and services by staff and sidents. This will be done by: vironment that promotes resident security, and eatment Abuse: Abuse alon a resident other than by 210 ILCS 45/1-103). Abuse is of injury, unreasonable dation, or punishment with arm, pain, or mental anguish FR 483.5) Physical Abuse is ry on a resident that occurs ental means and that requires 77 III. Adm. Code 300.330).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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S9999	Continued From pa	ge 10	S9999			
	Physical abuse incl pinching, kicking, a through corporal pure Interpretive Guideling altercations that incresults in physical in must be reported in Resident Assess life history on the accomprehensive car assessments, staff increased vulnerable exploitation, mistreamisappropriation of needs, triggers and conflict" Facility's policy titled Performance Improrevised date 10/24/ "Quality of care will in areas of resident."	udes hitting, slapping, nd controlling behavior unishment (42 CFR 483.12 nes) Resident-to-resident clude any willful action that njury, mental anguish or pain accordance with regulations ment: As part of the resident's dmission assessment, e plan, and MDS will identify residents with ility for abuse, neglect, atment, history of trauma or resident property, who have behaviors that might lead to d, "Quality Assurance overnent Program (QAPI)," (22," documents, in part, be monitored and evaluated a care and services at each ding but not limited to:				

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