

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058560		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/05/2025	
NAME OF PROVIDER OR SUPPLIER ALTA REHAB AT OAK BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521			
(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		S0000				
	Complaint Investigation 2656854/25710629						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	Section 300.610 Resident 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.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	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.						

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058560		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/05/2025	
NAME OF PROVIDER OR SUPPLIER ALTA REHAB AT OAK BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521			
(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
S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 requirements were not met as evidenced by: Based on the interview and record review, the facility failed to transfer a resident using a mechanical lift safely. This failure caused R1 to be dropped from mechanical lift resulting in an ankle fracture. This applies to one of three (R1) reviewed for falls in the sample of 7. This past non-compliance occurred from May 16, 2024, to June 2, 2024. The findings include: On 10/31/2025 at 11:30 AM, V10 (R1's family) said R1 was dropped from the mechanical lift on 05/16/2024 due to only one staff member attempting the transfer and without properly applying the sling. V10 stated the fall broke R1's ankle. V10 said R1 was transferred to the hospital the next day. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility with diagnoses of dementia, atrial fibrillation, congestive failure, and pain. A physician order dated 05/06/2024 showed R1 was admitted to hospice care. Minimum Data Set dated 05/15/2024 showed R1 was severely cognitively impaired. The care plan dated 04/18/2024 showed R1 required two assist transfers per mechanical lift. The progress notes dated 05/16/2024 by V13 (Registered Nurse-former employee) stated V14 (Agency Certified Nursing Assistant [CNA]- former employee) reported R1 had fallen from the mechanical lift while being transferred to bed and slings were not appropriately			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058560		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/05/2025	
NAME OF PROVIDER OR SUPPLIER ALTA REHAB AT OAK BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521			
(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	
S9999	Continued from page 2 applied. The nursing notes dated 5/17/24 at 12:12 PM stated the hospice nurse visited the facility and arranged for R1 to be transported to the hospital for an evaluation. The hospital physician's progress notes dated 5/17/24 showed R1 was sent to the emergency room after a fall from a mechanical lift, and the x-ray report dated 5/17/24 showed a displaced fracture to the distal tibia and fibula (lower leg bones). The facility's incident report dated 5/16/24 showed R1 required two people's assistance and had a fall while a former Certified Nursing Assistant transferred R1 via mechanical lift, and that staff were in-serviced on mechanical lift transfers. The facility policy for manual gait belt and mechanical lifts with a revision date of 1/19/18 in part showed to protect the safety and wellbeing of the staff and residents, and to promote quality care. This facility will use mechanical lifting devices. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the mechanical lift with two caregivers. On 10/31/2025 at 3:00 PM, V1 (Administrator) and V2 (Director of Nursing) stated the facility had an ownership change survey with an exit date of 05/23/2024, and the facility was cited for R1's fall and a plan of correction was submitted and accepted. V2 Director of Nursing said two staff should be present during mechanical lift transfers, and the staff should ensure the sling is attached adequately prior to lifting the resident. V2 said all staff were provided with in-services and training has been ongoing. The facility's accepted Plan of Correction (POC) showed their date of completion as June 2, 2024. (B) -A whole-house transfer audit was conducted. -The training binder showed the facility provided in-services beginning on 5/17/24, indicating the appropriate number of staff assistants for mechanical lift transfers is two and sling pads must be securely placed before transfers. -Signs were in place as reminders to have two assists for mechanical lift transfers. -The Nursing Observation Audit Tool was used to track compliance for number of staff used for mechanical lift transfers with no concerns. (B)		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058560		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/05/2025	
NAME OF PROVIDER OR SUPPLIER ALTA REHAB AT OAK BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521			
(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
S9999				S9999			