

Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0058560</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>12/14/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALTA REHAB AT OAK BROOK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521</b>                           |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                          | Initial Comments<br><br>Facility Reported Incident of 10/28/2025/ 266369<br><br>Survey is Past Non Compliance - No POC or revisit is<br>required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         | S0000               |                                                                                                                          |  | 12/19/2025                                      |  |
| S9999                                                          | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall be<br>formulated by a Resident Care Policy Committee<br>consisting of at least the administrator, the advisory<br>physician or the medical advisory committee, and<br>representatives of nursing and other services in the<br>facility. The policies shall comply with the Act and<br>this Part. The written policies shall be followed in<br>operating the facility.<br><br>Section 300.1210 General Requirements for Nursing and<br>Personal Care<br><br>b) The facility shall provide the necessary care and<br>services to attain or maintain the highest practicable<br>physical, mental, and psychological well-being of the<br>resident, in accordance with each resident's<br>comprehensive resident care plan. Adequate and properly<br>supervised nursing care and personal care shall be<br>provided to each resident to meet the total nursing and |                                                                         | S9999               |                                                                                                                          |  | 12/19/2025                                      |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0058560</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                           |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>12/14/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>ALTA REHAB AT OAK BROOK</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2013 MIDWEST ROAD , OAK BROOK, Illinois, 60521</b> |                                                                                                                          |                                                 |                            |
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| S9999                                                          | <p>Continued from page 1<br/>personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a resident's foot was supported during wheelchair transport which resulted in a fracture of the lower leg. This past noncompliance occurred from October 27, 2025, through October 29, 2025.</p> <p>This applies to 1 of 3 residents (R1) reviewed for accidents in the sample of 6.</p> <p>The findings include:</p> <p>R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on July 29, 2020, with multiple diagnoses including multiple sclerosis, spastic hemiplegia affecting the right dominant side. Paraplegia, fracture of both the right and left femurs with surgical repair, diabetes mellitus, dementia, and left tibia fracture added October 27, 2025.</p> <p>R1's MDS (Minimum Data Set) dated November 26, 2025, showed R1 was cognitively intact and required assistance with ADLs including set up assistance with eating, partial assistance with oral hygiene, substantial assistance with upper body dressing and dependent on staff for lower body dressing, toileting, bathing, bed mobility and transfer.</p> <p>The facility sent a report to the department dated October 28, 2025, showed that R1 sustained a fracture to her left lower leg, while a therapy assistant was</p> |                                                                         |  | S9999                                                                                          |                                                                                                                          |                                                 |                            |

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| S9999                                                          | <p>Continued from page 2<br/>transporting R1 in a wheelchair from the therapy room to R1's room, and R1's leg was abruptly placed on the floor.</p> <p>On December 12, 2025, at 2:05 PM, V2 (Physical Therapy Assistant), stated on October 27, 2025, V2 was transporting R1 in the wheelchair both to and from therapy using only one footrest on the wheelchair.</p> <p>On December 13, 2025, at 1:35 PM, V5 (NP-Nurse Practitioner) stated on October 27, 2025, V5 was in the facility when R1 was injured, and alerted by staff that R1 was complaining of left leg pain. V5 stated she examined R1 and stated R1 was in pain and had limited ROM (Range of Motion) to the left leg and ordered X-rays of R1's entire left leg due to a history of previous fractures. V5 stated the injury was caused by R1's left leg not being supported by a footrest while being transported in a wheelchair, when R1's leg was caught under the wheelchair. V5 stated staff informed her that the staff was unable to find the second footrest for R1's wheelchair, and proceeded to transport R1 without the footrest, resulting in the fracture.</p> <p>R1's Xray result dated October 27, 2025, showed R1 sustained an acute nondisplaced fracture of the proximal left tibia.</p> <p>Prior to the survey entrance date of December 12, 2025, the facility had taken the following action to address the noncompliance.</p> <ol style="list-style-type: none"> <li>1. The Facility held an emergency QA (Quality Assurance) meeting, on October 28, 2025, that was attended by the Medical Director and the interdisciplinary team, to develop a plan to address the noncompliance.</li> <li>2. The Facility found R1's wheelchair footrest and did a 1:1 training regarding supporting feet during wheelchair transport with V2.</li> <li>3. The Facility in serviced the therapy department staff and nursing staff on October 28, 2025, regarding the use of footrests while transporting residents in their wheelchairs.</li> <li>4. The facility did a facility wide audit of residents who use wheelchairs for transport to ensure footrests were available and their care plans were updated.</li> <li>5. The Facility developed a QA Audit tool to ensure compliance. The facility had completed the audit tool</li> </ol> | S9999                                                                   |                                                                                                                          |                                                                                                |  |                                                 |  |

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| S9999                                                       | Continued from page 3<br>in accordance with their plan of 5 random residents per<br>week for 2 months. The initial audit was completed on<br>October 29, 2025, and the most recent audit tool was<br>completed on December 12, 2025. (B) |                                                                      |  | S9999                                                                                       |                                                                                                                          |                                              |                            |