STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145458	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Oak Brook	2013 Midwest Road Oak Brook, IL 60521

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to follow their policy ensure resident and family grievances are promptly resolved. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for assistance with ADLs (Activities of Daily Living) in the sample of 4. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including, lymphedema, hypertension, morbid obesity, polyosteoarthritis, bursitis of right shoulder, depression, noncompliance with medical treatment, candidiasis of skin and nails, uterine cancer, and functional urinary compliance. R1's MDS (Minimum Data Set) dated July 8, 2024 shows R1 is cognitively intact, requires setup assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, and is dependent on facility staff for toilet hygiene, showering, lower body dressing, bed mobility,, and transfers between surfaces. R1 is always incontinent of bowel and bladder. On September 16, 2024 at 9:31 AM, R1 was lying in bed in a bariatric bed in her room. R1 said her incontinence brief had not been changed since 2:00 AM and was wet with urine. R1 continued to say she has not received a shower since being admitted to the facility. R1 said facility staff provide her with bed baths, and occasionally use a shampoo cap to wash her hair in the bed. On September 16, 2024 at 11:20 AM, R1 was lying in bed in her room. R1's call light was illuminated and audibly alarming. R1's call light continued to be illuminated and audibly alarm for 26 minutes and 24 seconds before facility staff came to the room to meet R1's needs. R1 said her incontinence brief was still wet and no staff had changed her brief since 2:00 AM. V5 (Agency CNA-Certified Nursing Assistant) said she reported for duty at the facility at 9:30 AM, was assigned to care for R1, and had not changed her incontinence brief during the time she had been on duty. V6 (CNA) and V7 (WCN-Wound Care Nurse/RN-Registered Nurse) entered the room to assist with R1's incontinence care. The sheets under R1 were soaking wet, with a dark brown dry ring on the outside the circle of wetness. The circle of wetness under R1 was approximately four feet in diameter. R1's gown and incontinence brief were also soaking wet and V5 (Agency CNA) said the incontinence brief, resident gown, and sheets were soaked with urine. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Oak Brook	2013 Midwest Road Oak Brook, IL 60521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR shows R1 should receive showers on Mondays and Thursdays. The facility does not have documentation to show R1 had received a shower/bed bath twice a week as shown in their policy. The facility does not have documentation to show R1's hair was shampooed more than twice during the 30-day look back period. 2. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, metabolic encephalopathy, sepsis, UTI (Urinary Tract Infection), acute pyelonephritis, acute cough, hemiplegia, and hemiparesis following cerebral infarction, diabetes, aphasia following cerebral infarction, heart disease, dementia, lack of coordination, and cognitive communication deficit. R2's MDS dated [DATE] shows R2 is rarely/never understood, has moderate cognitive impairment, is dependent on facility staff for all ADLs (Activities of Daily Living), and is always incontinent of bowel and bladder. On September 16, 2024 at 12:50 PM, V8 (Activity Aide) placed R2 and her wheelchair in R2's room and left the room. R2's left hand was in a splint and her left arm and hand were resting on R2's left groin area. The bilateral groin areas of R2's pants was soaked, and a strong urine odor was present. R2 was unable to answer questions regarding her incontinence due to her medical condition. V9 (CNA) entered R2's room and said he was responsible for caring for R2. V9 said, I got [R2] out of bed at 9:30 AM, and that was the last time I checked her incontinence brief and changed her. She is a heavy wetter. V9 used a gait belt to lift R2 from the wheelchair and onto her bed. As V9 lifted R2 from her wheelchair, the back side of R2's pants became visible in the buttocks area. The entire backside of R2's pants was soaked, approximately 12 to 18 inches in diameter. The padding under R2's buttocks on her wheelchair was also soaked, and a strong urine odor was present. V9 (CNA) removed R2's incontinence brief. V9 said the brief was soaked with urine. V9 turned R2 onto her left side in the bed. Stool was present on R2's lower back and buttocks from the top of the incontinence brief towards R2's perineal area. The stool was caked on R2's skin and V9 had to use a peeling motion to remove the incontinence brief that appeared stuck to R2's skin because of the amount of stool present. V9 then provided incontinence care to R2. On August 26, 2024, V12 (Son of R2) submitted a Concern Form. The Concern Form dated August 26, 2024 shows: Family members visited [R2] on August 26, 2024 at 8:00 PM and discovered [R2] in bed wearing a urine-soaked [incontinence brief]. The urine had soaked through onto clothing and bed sheets. Family members were concerned about the body band [R2] wears, which seems to be dirty often and has an odor. On September 17,2024 at 9:51 AM, V12 (Son of R2) said he filled out the concern form after finding R2 soaked in urine and had hoped the incidents had resolved after filing the grievance. The EMR shows R2 should receive showers on Wednesdays and Saturdays. The facility does not have documentation to show R2's hair was shampooed during the 30-day look back period. 3. The EMR shows R3 was admitted to the facility on [DATE]. R3 was sent to the local hospital for lethargy on September 3, 2024 and returned to the facility on [DATE]. R3 has multiple diagnoses including, metabolic encephalopathy, UTI, cerebral infarction, sepsis, pneumonitis, dysphagia, pancreatitis, Covid-19, abnormal gait, acute respiratory failure, anemia, acute kidney failure, and heart disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Oak Brook	2013 Midwest Road Oak Brook, IL 60521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's MDS dated [DATE] shows R3 has no speech, is rarely understood, and has moderately impaired cognition. R3 requires partial/moderate assistance with personal hygiene, substantial/maximal assistance with oral hygiene and eating, and is dependent on facility staff for all other ADLs. R3 is always incontinent of bowel and bladder. On September 16, 2024 at 3:30 PM, V8 (Activity Aide) said R3 had been sitting in the dining room in her wheelchair since lunchtime and no staff had taken her to her room for incontinence check or change. On September 16, 2024 at 3:42 PM, V10 (CNA) and V11 (CNA) used a mechanical lift to transfer R3 from her wheelchair to the bed and provided incontinence care to R3. R3 was not able to be interviewed due to her medical condition. V10 and V11 said they reported for duty at 3:00 PM and had not checked R3 for incontinence. V10 removed R3's incontinence brief. Stool was present in R3's brief. A pressure ulcer was visible on R3's sacrum. No dressing was covering the pressure ulcer. On August 5, 2024, V15 (Sister of R3) submitted a Concern Form. The concern form shows: [R3's] wheelchair was very pissy and smelled very bad. Her clothes were wet, and her sweater was wet as well. I want the CNA to check on her and make sure she's not wet. Just take care of her please. On September 17, 2024 at 10:16 AM, R4 said she is the Resident Council President. Resident Council meeting minutes for the period May 1, 2024 to present were reviewed with R4. R4 confirmed the concerns shown on the Resident Council meeting minutes had been discussed. R4 continued to say call light response times, showers, and timely incontinence care is an ongoing issue and frequently discussed at Resident Council meetings without any resolution. Resident Council meeting minutes dated May 16, 2024 show residents had concerns regarding being left in feces for hours and leaving residents in soiled briefs until the next shift. Concerns were also documented regarding residents being left in their wheelchairs for more than two hours. Resident Council meeting minutes dated June 20, 2024 show residents had concerns regarding the response time for answering call lights and CNAs, especially agency CNAs, on the weekends, come into answer lights, shut them off and never return. Another resident voiced concerns with waiting more than 20 minutes for a call light to be answered while soiled. Resident Council meeting minutes dated August 15, 2024 show a family member stated a resident was found soiled in her chair, and the CNA did not clean the chair. Another family member speaking on behalf of a resident stated that the CNAs do not do a two hour check and change, and all others agreed with same. The facility's Grievance Policy revised 9-25-17 shows: Purpose: To ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus. Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days (excludes weekends and holidays). Under certain circumstances, additional time may be needed to complete an investigation and implement measures to resolve the grievance. In such cases, the resident or complainant should be notified of the extension.

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Alta Rehab at Oak Brook	2013 Midwest Road Oak Brook, IL 60521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to follow their policy to develop resident-centered care plans. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for resident rights and policy and procedure in the sample of 4. The findings include: 1. On September 16, 2024 at 11:20 AM, R1 was lying in bed in her room. R1 said her incontinence brief was wet and no staff had changed her brief since 2:00 AM. V5 (Agency CNA-Certified Nursing Assistant) said she reported for duty at the facility at 9:30 AM, was assigned to care for R1, and had not changed her incontinence brief during the time she had been on duty. V5 continued to say she had never worked with R1 and was not familiar with R1's care preferences, including if R1 requires assistance with turning in the bed, or has incontinence or skin care concerns. V6 (CNA) and V7 (WCN-Wound Care Nurse/RN-Registered Nurse) entered the room to assist with R1's incontinence care. R1 was very particular regarding her positioning during the incontinence care episode as well as the technique used by V5 (Agency CNA), and frequently corrected V5 and spoke loudly towards V5 when R1 became upset with V5 for not knowing R1's care needs. V5 repeated multiple times this was the first time she had cared for R1 and was not familiar with her care needs or preferences. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including, lymphedema, hypertension, morbid obesity, polyosteoarthritis, bursitis of right shoulder, depression, noncompliance with medical treatment, candidiasis of skin and nails, uterine cancer, and functional urinary compliance. R1's MDS (Minimum Data Set) dated July 8, 2024 shows R1 is cognitively intact, requires setup assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, and is dependent on facility staff for toilet hygiene, showering, lower body dressing, bed mobility, and transfers between surfaces. R1 is always incontinent of bowel and bladder. R1's care plan initiated April 4, 2024 shows R1 has, ADL self-care deficit or potential: Needs assistance or is dependent in oral/dental care, bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, and bathing. R1's care plan shows multiple interventions initiated April 4, 2024 including Provide adaptive/safety equipment: (Specify: wheelchair, walker, other). The intervention does not clearly specify which adaptive/safety equipment should be used by R1. R1's care plan does not show R1 requires bed baths only and the use of a shampoo shower cap for hair hygiene due to the fact the facility does not have a bariatric shower chair/bed that will fit through the door to enable R1 to take showers, and therefore requires bed baths only. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions for R1's ADL self-care deficit do not address R1's inability to move her lower limbs without staff assistance. R1's ADL interventions also show to Provide only the amount of assistance/supervision that is needed with ADLs (Specify: Stand-by, contact guarding, cueing/prompting, hands-on, hand-over-hand). R1's care plan does not specify the amount of assistance/supervision that is needed. R1's care plan is not resident-centered or specific to R1's care needs. The green care card posted on the wall in R1's room did not detail R1's specific care needs to alert staff to R1's specific care needs. 2. On September 16, 2024 at 12:50 PM, V9 (CNA) entered R2's room and said he was responsible for caring for R2. V9 said, I got [R2] out of bed at 9:30 AM, and that was the last time I checked her incontinence brief and changed her. She is a heavy wetter. V9 used a gait belt to lift R2 from the wheelchair and onto her bed. V9 did not ask other staff to assist him with R2's transfer. The green care card posted in R2's room was smudged, and R2's transfer status was illegible. V9 (CNA) removed R2's incontinence brief. V9 said the brief was soaked with urine. V9 turned R2 onto her left side in the bed. Stool was present on R2's lower back and buttocks from the top of the incontinence brief towards R2's perineal area. The stool was caked on R2's skin and V9 had to use a peeling motion to remove the incontinence brief that appeared stuck to R2's skin because of the amount of stool present. V9 then provided incontinence care to R2. On September 17, 2024 at 9:00 AM, R2 was sitting up in bed. R2 had a splint on her left hand and her left hand and arm were resting in her lap. R2 was attempting to feed herself pureed foods from the plate on her overbed table. R2 had a cup with thickened liquids located on the left side of R2's meal tray, out of R2's reach. No staff were present in the room helping R2 eat. No staff were present ensuring slow rate of eating, small bites/drinks or providing one-to-one feeding assistance. V9 (CNA), the CNA assigned to care for R2, was observed entering and exiting the resident room across the hall from R2 but was not in R2's room assisting R2 with eating. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, metabolic encephalopathy, sepsis, UTI (Urinary Tract Infection), acute pyelonephritis, acute cough, hemiplegia, and hemiparesis following cerebral infarction, diabetes, aphasia following cerebral infarction, heart disease, dementia, lack of coordination, and cognitive communication deficit. R2's MDS dated [DATE] shows R2 has unclear speech, is rarely/never understood, has moderate cognitive impairment, is dependent on facility staff for all ADLs (Activities of Daily Living), and is always incontinent of bowel and bladder. As of September 17, 2024 at 11:49 AM, the EMR showed the following order for R2 dated July 10, 2024: Low-concentrated sweets diet, puree texture, honey-thick liquids consistency, 1:1 feeding assist, upright at 90 degrees, slow rate, allow for extra swallows, small bites/drinks, 1/2 teaspoon bites, no straws, stop if patient coughing. R2's ADL care plan, initiated and revised on August 21, 2024 shows R2 requires assist with oral/dental care, bed mobility, transfer, walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's ADL care plan shows just two ADL interventions, each initiated on August 21, 2024: Provide 2 person assist with transfer. PT/OT (Physical Therapy/Occupational Therapy) evaluation and treatment as per MD orders. R2's care plan does not show interventions to address R2's one-to-one feeding assistance, the type of 2-person transfer required, such as a mechanical lift device or stand and pivot transfer, bathing assistance needed, or the need for incontinence care. The facility did not have documentation to show a care plan for R2's unclear speech, or how staff should communicate with R2. 3. On September 16, 2024 at 11:15 AM, V5 (Agency CNA-Certified Nursing Assistant) said she reported for duty at the facility at 9:30 AM and was assigned to care for R3. V5 said she was not familiar with R3's care needs and had never taken care of R3. V5 said she was not aware if R3 could speak or had incontinence issues. On September 16, 2024, R3 was intermittently observed sitting in the dining room from 1:00 PM to 3:42 PM. No staff were observed checking R3 for incontinence. R3's position was not changed during the observation period. On September 16, 2024 at 3:30 PM, V8 (Activity Aide) said R3 had been sitting in the dining room in her wheelchair since lunchtime and no staff had taken her to her room for incontinence check or change. On September 16, 2024 at 3:42 PM, V10 (CNA) and V11 (CNA) used a mechanical lift to transfer R3 from her wheelchair to the bed and provided incontinence care to R3. V10 and V11 were asked how they were aware of R3's need for mechanical lift transfer. V10 said there is usually a green care card posted in each resident's room with some of their care needs, but R3 did not have a care card posted in her room. V10 said she made the assumption R3 required mechanical lift transfer because the resident was sitting on a mechanical lift transfer sling in her wheelchair. R3 was not able to be interviewed due to her medical condition. V10 and V11 said they reported for duty at 3:00 PM and had not checked R3 for incontinence. V10 removed R3's incontinence brief. Stool was present in R3's brief. A pressure ulcer was visible on R3's sacrum. The EMR shows R3 was admitted to the facility on [DATE]. R3 was sent to the local hospital for lethargy on September 3, 2024 and returned to the facility on [DATE]. R3 has multiple diagnoses including, metabolic encephalopathy, UTI, cerebral infarction, sepsis, pneumonitis, dysphagia, pancreatitis, Covid-19, abnormal gait, acute respiratory failure, anemia, acute kidney failure, and heart disease. R3's MDS dated [DATE] shows R3 has no speech, is rarely understood, and has moderately impaired cognition. R3 requires partial/moderate assistance with personal hygiene, substantial/maximal assistance with oral hygiene and eating, and is dependent on facility staff for all other ADLs. R3 is always incontinent of bowel and bladder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's ADL care plan initiated on September 6, 2024 and revised on September 10, 2024 shows R3 has an ADL self-care/mobility performance deficit that may fluctuate, and R3 needs assistance or is dependent in oral/dental care, bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, and bathing. R3's ADL care plan does not specify the type of assistive mobility device needed by R3, R3's incontinence issues or type of toileting assistance, dressing needs, or bed mobility needs. The facility does not have documentation to show R3 has a care plan to address R3's lack of speech, or that she is rarely understood, and what interventions are in place to enable staff to communicate with R3. On September 17, 2024 at 9:41 AM, V13 (ADON-Assistant Director of Nursing) reviewed resident care plans and said R1, R2, and R3's care plans did not show specific care plan interventions to address resident's care needs. V16 continued to say green care cards should be posted in each resident room to show resident care needs. On September 17, 2024 at 10:16 AM, R4 said she is the Resident Council President. R4 said, Agency staff are not prepared to care for us. They don't know what level of assistance we need. For instance, they don't know that I need help putting on my socks and shoes. This is the topic of discussion at Resident Council quite frequently. On September 17, 2024 at 11:46 AM, V16 (Restorative Manager/RN-Registered Nurse) said R2 receives tube feeding and a pureed diet. [R2] needs one-to-one feeding assistance. I am supposed to update the care plans. Whenever there are therapy changes, they have to give restorative an update and update the green card in the resident's room The facility's Comprehensive Care Plan Policy revised 11-17-17 shows: Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to promptly respond to call lights when a resident required assistance, failed to provide timely incontinence care, failed to provide feeding assistance as ordered by the physician, and failed to provide showers/bed baths as shown in the facility's policy. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for assistance with ADLs (Activities of Daily Living) in the sample of 4. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including, lymphedema, hypertension, morbid obesity, polyosteoarthritis, bursitis of right shoulder, depression, noncompliance with medical treatment, candidiasis of skin and nails, uterine cancer, and functional urinary compliance. R1's MDS (Minimum Data Set) dated July 8, 2024 shows R1 is cognitively intact, requires setup assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, and is dependent on facility staff for toilet hygiene, showering, lower body dressing, bed mobility, and transfers between surfaces. R1 is always incontinent of bowel and bladder. R1's care plan initiated April 4, 2024 shows R1 has, ADL self-care deficit or potential: Needs assistance or is dependent in oral/dental care, bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, and bathing. R1's care plan initiated June 6, 2024 shows R1 has, Potential for impairment to skin integrity related to decreased mobility, fragile skin, impaired mobility, and incontinence. Interventions dated June 6, 2024 include: Keep skin clean and dry. Use lotion on dry skin. On September 16, 2024 at 9:31 AM, R1 was lying in bed in her room. R1 said her incontinence brief had not been changed since 2:00 AM and was wet with urine. R1 continued to say she has not received a shower since being admitted to the facility. R1 said facility staff provide her with bed baths, and occasionally use a shampoo cap to wash her hair in the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On September 16, 2024 at 11:20 AM, R1 was lying in bed in her room. R1's call light was illuminated and audibly alarming. R1's call light continued to be illuminated and audibly alarm for 26 minutes and 24 seconds before facility staff came to the room to meet R1's needs. R1 said her incontinence brief was still wet and no staff had changed her brief since 2:00 AM. V5 (Agency CNA-Certified Nursing Assistant) said she reported for duty at the facility at 9:30 AM, was assigned to care for R1, and had not changed her incontinence brief during the time she had been on duty. V6 (CNA) and V7 (WCN-Wound Care Nurse/RN-Registered Nurse) entered the room to assist with R1's incontinence care. V5, V6, and V7 turned R1 to her side in the bed. A pungent urine odor was present in the room as R1 was turned to her side. The sheets under R1 were soaking wet, with a dark brown, dry ring around the perimeter of the circle of wetness. The circle of wetness under R1 was approximately four feet in diameter. R1's gown and incontinence brief were also soaking wet and V5 (Agency CNA) said the incontinence brief, resident gown, and sheets were soaked with urine. On September 16, 2024 at 1:37 PM, V14 (WCC-Wound Care Coordinator) said the facility is unable to provide a shower for R1 due to her obesity. V14 said the facility does not have a shower chair or shower bed that will fit through the door of the resident's room or shower room to provide R1 with a shower. V14 continued to say she was standing out in the hallway at 11:20 AM while incontinence care was provided to R1, and the pungent smell of urine was noticeable in the hallway outside of R1's room. On September 16, 2024 at 1:32 PM, V2 (DON-Director of Nursing) said all showers and hair washing should be documented in the EMR. V2 said residents are supposed to receive two showers a week. V2 continued to say the facility does not document showers on paper shower sheets. The EMR shows R1 should receive showers on Mondays and Thursdays. The EMR shows the following documentation for R1 for showering/bed baths and shampooing hair for the 30-day look back period of August 19, 2024 to September 17, 2024: Monday, August 19, 2024 - bed bath provided, no documentation of hair shampooing Thursday, August 22, 2024 - no documentation of bed bath/shower or hair shampooing Monday, August 26, 2024 - bed bath provided, no documentation of hair shampooing Thursday, August 29, 2024 - refused bed bath, no documentation of hair shampooing Friday, August 30, 2024 - bed bath provided; hair shampooed Monday, September 2, 2024 - bed bath provided, no documentation of hair shampooing Thursday, September 5, 2024 - no documentation of bed bath/shower or hair shampooing Monday, September 9, 2024 - no documentation of bed bath/shower or hair shampooing Thursday, September 12, 2024 - bed bath provided, no documentation of hair shampooing Saturday, September 14, 2024 - bed bath provided; hair shampooed (continued on next page)

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	145458	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Oak Brook	2013 Midwest Road Oak Brook, IL 60521

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility does not have documentation to show R1 had received a shower/bed bath twice a week as shown in their policy. The facility does not have documentation to show R1's hair was shampooed more than twice during the 30-day look back period. 2. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, metabolic encephalopathy, sepsis, UTI (Urinary Tract Infection), acute pyelonephritis, acute cough, hemiplegia, and hemiparesis following cerebral infarction, diabetes, aphasia following cerebral infarction, heart disease, dementia, lack of coordination, and cognitive communication deficit. R2's MDS dated [DATE] shows R2 is rarely/never understood, has moderate cognitive impairment, is dependent on facility staff for all ADLs (Activities of Daily Living), and is always incontinent of bowel and bladder. R2's care plan initiated August 21, 2024 shows R2, Requires assist with oral/dental care, bed mobility, transfer, walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. R2's care plan initiated July 26, 2024 shows R2 has A potential for impairment to skin integrity related to fragile skin, impaired mobility. Interventions initiated July 26, 2024 include: Keep skin clean and dry. Use lotion on dry skin. Turn and reposition with care, every two hours, per individualized turn schedule. On September 16, 2024 at 12:50 PM, V8 (Activity Aide) was pushing R2 in a wheelchair towards R2's room. V8 continued to say she is responsible for pushing R2 in her wheelchair from the dining room to her room after lunch is finished. V8 placed R2 and her wheelchair in R2's room and left the room. R2's left hand was in a splint and her left arm and hand were resting on R2's left groin area. The bilateral groin areas of R2's pants were soaking wet, and a strong urine odor was present. R2 was unable to answer questions regarding her incontinence due to her medical condition. V9 (CNA) entered R2's room and said he was assigned to care for R2. V9 said, I got [R2] out of bed at 9:30 AM, and that was the last time I checked her incontinence brief and changed her. She is a heavy wetter. V9 used a gait belt to lift R2 from the wheelchair onto her bed. As V9 lifted R2 from her wheelchair, the back side of R2's pants became visible. The entire backside of R2's pants was soaked, approximately 12 to 18 inches in diameter, on her buttocks area. The padding under R2's buttocks on her wheelchair was also soaked, and a strong urine odor was present. V9 (CNA) removed R2's incontinence brief. V9 said the brief was soaked with urine. V9 turned R2 onto her left side in the bed. A large amount of stool was present on R2's lower back and buttocks from the top of the incontinence brief towards R2's perineal area. The stool was caked on R2's skin and V9 had to use a peeling motion to remove the incontinence brief that appeared stuck to R2's skin because of the amount of stool present. V9 then provided incontinence care to R2. On August 26, 2024, V12 (Son of R2) submitted a Concern Form. The Concern Form dated August 26, 2024 shows: Family members visited [R2] on August 26, 2024 at 8:00 PM and discovered [R2] in bed wearing a urine-soaked [incontinence brief]. The urine had soaked through onto clothing and bed sheets. Family members were concerned about the body band [R2] wears, which seems to be dirty often and has an odor. On September 17,2024 at 9:51 AM, V12 (Son of R2) said he filled out the concern form after finding R2 soaked in urine and had hoped the incidents regarding lack of timely incontinence care had resolved after filing the grievance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On September 17, 2024 at 9:00 AM, R2 was sitting up in bed. R2 had a splint on her left hand and her left hand and arm were resting in her lap. R2 was attempting to feed herself pureed foods from the plate on her tray table. R2 had a cup with thickened liquids located on the left side of R2's meal tray, out of R2's reach. No staff were present in the room to help R2 eat. Food was falling from R2's fork onto her lap and tray table. No staff were present ensuring slow rate of eating, small bites/drinks or providing 1:1 feeding assistance. V9 said he was assigned to care for R2. V9 was observed entering and exiting the resident room across the hall from R2 but was not in R2's room assisting R2 with eating. As of September 17, 2024 at 11:49 AM, the EMR showed the following active order for R2 dated July 10, 2024: Low-concentrated sweets diet, puree texture, honey-thick liquids consistency, 1:1 feeding assist, upright at 90 degrees, slow rate, allow for extra swallows, small bites/drinks, 1/2 teaspoon bites, no straws, stop if patient coughing. The EMR shows R2 should receive showers on Wednesdays and Saturdays. The EMR shows the following documentation for R2 for showering/bed baths and shampooing hair for the 30-day look back period of August 19, 2024 to September 17, 2024: August 21, 2024 - Shower, no documentation of hair shampooing August 24, 2024 - Shower, no documentation of hair shampooing August 28, 2024 - Shower, no documentation of hair shampooing August 31, 2024 - No documentation of shower or hair shampooing September 4, 2024 - Shower, no documentation of hair shampooing September 7, 2024 - Shower, no documentation of hair shampooing September 11, 2024 - Shower, no documentation of hair shampooing September 14, 2024 - No documentation of shower or hair shampooing The facility does not have documentation to show R2's hair was shampooed during the 30-day look back period. 3. The EMR shows R3 was admitted to the facility on [DATE]. R3 was sent to the local hospital for lethargy on September 3, 2024 and returned to the facility on [DATE]. R3 has multiple diagnoses including, metabolic encephalopathy, UTI, cerebral infarction, sepsis, pneumonitis, dysphagia, pancreatitis, Covid-19, abnormal gait, acute respiratory failure, anemia, acute kidney failure, and heart disease. R3's MDS dated [DATE] shows R3 has no speech, is rarely understood, and has moderately impaired cognition. R3 requires partial/moderate assistance with personal hygiene, substantial/maximal assistance with oral hygiene and eating, and is dependent on facility staff for all other ADLs. R3 is always incontinent of bowel and bladder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan initiated June 6, 2024, and revised on September 10, 2024 shows R3 has an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day due to decreased activity tolerance, impaired balance. Needs assistance or is dependent in oral/dental care, bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, bathing. R3's care plan initiated June 6, 2024 for potential for impairment to skin integrity related to fragile skin and impaired mobility shows multiple interventions dated June 6, 2024, including, Keep skin clean and dry. Use lotion on dry skin. Minimize pressure over boney prominences. Turn and reposition with care every two hours. On September 16, 2024, R3 was intermittently observed sitting in the dining room from 1:00 PM to 3:42 PM. No staff were observed checking R3 for incontinence. R3's position was not changed during the observation period. On September 16, 2024 at 3:30 PM, V8 (Activity Aide) said R3 had been sitting in the dining room in her wheelchair since lunchtime and no staff had taken her to her room for incontinence check or change. On September 16, 2024 at 3:42 PM, V10 (CNA) and V11 (CNA) used a mechanical lift to transfer R3 from her wheelchair to the bed and provided incontinence care to R3. R3 was not able to be interviewed due to her medical condition. V10 and V11 said they reported for duty at 3:00 PM and had not checked R3 for incontinence. V10 removed R3's incontinence brief. Stool was present in R3's brief. A pressure ulcer was visible on R3's sacrum. No dressing was covering the pressure ulcer. On August 5, 2024, V15 (Sister of R3) submitted a Concern Form. The concern form shows: [R3's] wheelchair was very pissy and smelled very bad. Her clothes were wet, and her sweater was wet as well. I want the CNA to check on her and make sure she's not wet. Just take care of her please. On September 17, 2024 at 10:16 AM, R4 said she is the Resident Council President. Resident Council meeting minutes for the period May 1, 2024 to present were reviewed with R4. R4 confirmed the concerns shown on the Resident Council meeting minutes had been discussed. R4 continued to say call light response times, showers, and timely incontinence care are ongoing issues and frequently discussed at Resident Council meetings with no resolve. Resident Council meeting minutes dated May 16, 2024 show residents had concerns regarding being left in feces for hours and leaving residents in soiled briefs until the next shift. Concerns were also documented regarding residents being left in their wheelchairs for more than two hours. Resident Council meeting minutes dated June 20, 2024 show residents had concerns regarding the response time for answering call lights and CNAs, especially agency CNAs, on the weekends, come into answer lights, shut them off and never return. Another resident voiced concerns with waiting more than 20 minutes for a call light to be answered while soiled. Resident Council meeting minutes dated August 15, 2024 show a family member stated a resident was found soiled in her chair, and the CNA did not clean the chair. Another family member speaking on behalf of a resident stated that the CNAs do not do a two hour check and change, and all others agreed with same. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Call Light Policy revised 2-2-18 shows: Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner.2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. The facility's Bathing - Shower and Tub Bath Policy, revised 1-31-18 shows: Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: A shower, tub bath or bed/sponge bath will be offered according to the resident's preference two times per week or according to the resident's preferred frequency and as needed or requested.Document bathing task and assistance provided in the electronic record, including pertinent observations. The facility's Incontinence Care Policy revised 4-20-21 shows: Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.