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	03/21/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35267 Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care for residents who required staff assistance for toileting, repositioning, and bathing. This applies to 16 of 16 residents (R1-R16) reviwed for ADL (Activities of Daily Living) care in a sample of 16. The findings include: 1. Face sheet, dated 3/18/25, shows R3's diagnoses include senile degeneration of brain, Alzheimer's disease, bipolar disorder, history of seizures, depression, psychosis, and anxiety. MDS (Minimum Data Set), dated 1/7/25, shows R3 was severely impaired and required substantial assistance from staff for toileting. The MDS showed R3 was always incontinent of bowel and bladder. Bowel and bladder incontinence care plan, initiated 2/17/25, shows R3 was unable to make her needs known and needed assistance with toileting. The care plan shows R3's approaches include checking R3 every two hours and assisting with toileting her as needed. Advanced Practice Registered Nurse progress note, dated 2/18/25, shows R3 was recently treated for a urinary tract infection. On 3/18/25 at 10:11 AM, V5 (Restorative Aide) stated R3 required two staff for transfers and R3 would have her incontinence brief checked and changed after lunch. On 3/18/25 during continuous observation in the multipurpose room between 10:00 AM and 1:05 PM , R3 sat in the dementia unit multipurpose room in her wheelchair without her incontinence brief being checked/changed and without being repositioned. At 1:05 PM R3 was taken to her room by V7 (CNA-Certified Nursing Assistant) to have her incontinence brief changed and be placed in bed. V7 stated R3's incontinence brief was not wet but had a smear of bowel movement in the brief. On 3/18/25 at 1:10 PM, V5 stated the last time R3 had her incontinence brief checked/changed was when she got her up and out of bed at approximately 9:45-10:00 AM. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25 at 1:05 AM, V7 (CNA-Certified Nursing Assistant) stated she had not checked/changed R3's incontinence brief during her shift that day. On 3/18/25 at 2:00 PM, V5 (Restorative Aide) stated all incontinent residents were to be checked and changed every two hours. V5 stated if residents can not communicate if they wanted to go to the bathroom and were incontinent, the staff were to take them to their room and have their briefs checked/changed. V5 stated staff were expected to reposition residents every two hours or more often. On 3/18/25, V2 (Director of Nursing) stated incontinent residents were to have their incontinence briefs checked and changed every two hours. V2 stated residents were also to be repositioned every two hours. Facility Incontinence Care Policy, revised 1/16/18, shows the purpose of the policy was to prevent excoriation and skin breakdown, discomfort, and maintain dignity. The policy guidelines show incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or every two hours and provided perineal and genital care after each episode. 2. Face sheet, dated 3/18/25, shows R4's diagnoses included dementia and anxiety. MDS, dated [DATE], shows R4's cognition was severely impaired, R4 was dependent on staff for toileting, and R4 was frequently incontinent of bowel and bladder. R4's care plans show R4 required a mechanical lift and two staff for transfers and two staff for assistance with incontinence brief checks/changes. The care plan shows R4 was to be kept clean and dry and was to be repositioned every two hours. On 3/18/25 during continuous observation in the multipurpose room between 10:00 AM and 12:23 PM, R4 sat in her wheelchair in the multipurpose room with no repositioning and no staff checked/changed her incontinence brief. On 3/18/25 at 12:23 PM, V7 (CNA) stated she was assigned to R4 as her CNA and last toileted R4 when she got her up when she got R4 up for breakfast some time prior to 9:00 AM. V7 checked/changed R4's incontinence brief and stated the brief was not wet with urine but R4 had had a bowel movement. 3. Face sheet, dated 3/18/25, shows R2's diagnoses included fractured left femur, dementia, protein-calorie malnutrition, depression, and lack of coordination. MDS, dated [DATE], shows R2 was severely cognitively impaired, was dependent on staff for toileting, and R2 was occasionally incontinent of urine and frequently incontinent of bowel. R2's care plan, dated 3/11/25, shows R2 was dependent on two staff for transfers and incontinence brief checks and changes. R2's care plan, dated 3/10/25, shows R2 had a pressure injury to her right him related to immobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25 during continuous observation in the multipurpose room, R2 sat in her wheelchair from 10:00 AM to 10:31 AM when she was taken to therapy. At 11:02 AM, R2 was returned to the multipurpose room from therapy and V11 (Occupational Therapist) stated R2 was not toileted while in therapy. Between 11:08 AM and 11:14 AM R2 was removed briefly from the multipurpose room and returned without toileting. R2 continued to sit in her wheelchair in the multipurpose room from 11:14 AM to 12:42 PM when she was taken to her room by V7 for incontinence brief check/change and to be placed in bed. V7 stated R2's brief was dry when it was changed. On 3/18/25 at 12:42 PM, V7 stated R2 was assigned to V7 and V7 had not checked/changed R2's incontinence brief since before 9:00 AM. 4. Face sheet, dated 3/18/25, shows R1's diagnoses included dementia, morbid obesity, depression, and anxiety. MDS, dated [DATE], shows R1's cognition was moderately impaired, R1 required substantial/maximum assistance with toileting, and was always incontinent of bowel and bladder. Care plan, revised on 4/4/24, shows R1 required one staff to assist resident with incontinence brief check and changes. On 3/17/25 at 1:14 PM, V10 (Family) stated when she arrived to visit R1, R1 was in a soiled incontinence brief. V10 stated after visiting for 2.5 hours, no staff came to check/change R1's incontinence brief. V10 stated she checked R1's incontinence brief and it was soiled so she put the call light on for staff to come change the brief. V10 stated the prior week she arrived to visit R1 and R1's incontinence brief was so soiled it soaked through her clothes and through her bed linens. Review of R1's weekly skin observations and skin condition assessments, dated 2/25/25 to 3/11/25, show R1's sacrum was reported to have blanchable redness with skin intact as well as a fungal rash on her bilateral inner buttocks. On 3/18/25 at 1:39 PM, V9 (Wound Nurse) stated R1 has on and off fungal rashes on her buttocks. V9 stated R1 has chronic loose bowel movements that irritate her skin. V9 state R1's skin never opens and R1 is treated with antifungal powder and zinc ointment. 5. Grievance, dated 12/17/25, shows a concern was expressed that staff were very slow and not responding to R6's request for assistance. The grievance shows R6 waited 45 to 60 minutes for staff to respond to her request for assistance. Grievance, dated 1/20/25, shows R7 was found by family to be soaked through his incontinence brief and did not get any assistance feeding him lunch. The family reported that the resident did not get assistance with feeding at lunch a day they visited a week prior. The family expressed ongoing concerns regarding lack of assistance which was the reason the family visited often. The resolution showed a staff was assigned to provide feeding assistance and education was provided to the CNA about rounding and checking on residents with cognitive impairment. Grievance, dated 1/20/25, shows on 1/18/25 the family of R8 was requesting her incontinence brief to be changed and reported overhearing a CNA state that the resident had an upcoming shower on the 3/11 shift and would have her incontinence brief changed at that time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Grievance, dated 1/21/25, shows the family of R9 expressed concern that no CNA came in overnight to check and change the resident's incontinence brief. Grievance, dated 1/22/25, shows the family of R10 reported the resident was in need of an incontinence brief change. Grievance, dated 2/2/25, shows the family of R11 placed R11's call light on to use the bathroom and the daughter came out of the room twice to see if assistance was coming. The grievance shows the daughter spoke to staff who asked if she needed something and the family reported the resident needed to use the bathroom. The grievance shows the family was told the resident could walk to the toilet. Grievance resolution shows the resident requires one staff to transfer her while toileting and education was provided to staff. Grievance, dated 2/3/25, shows R12 expressed concern that he was experiencing long wait times at night for assistance toileting and that staff were not rounding overnight. The grievance resolution shows the resident required assistance with transfers and toileting. Grievance, dated 2/15/25, shows the family of R13 arrived to visit the resident on 2/14/25 at approximately noon and the resident was still in bed with her gown on and not up, dressed and out of bed. The grievance shows when the family asked for assistance to get the resident dressed and out of bed, staff responded they would not be able to assist until after lunch trays were finished. The grievance resolution shows the staff had a slow start due to staffing delays. Grievance, dated 3/6/25, shows the family of R14 visited the resident and found her with her incontinence brief overflowing with feces and R14 was attempting to clean herself with wipes and tissues she had available at the bedside. The family also expressed concerns that the resident was still in the same clothes as the day prior at 1:30 PM the following day. Grievance, dated 3/7/25, shows family expressed concerns that R15 did not receive a shower on his scheduled shower days. Grievance, dated 3/11/25, shows R16 expressed concern that she pressed her call light for assistance from staff to use the restroom for over 25 minutes while she heard staff talking outside the room near the nursing station. The grievance shows staff finally arrived, put R16's walker near her while sitting in a lift recliner, and told her she was in a lift recliner and could go to the bathroom herself without staff assistance. The resolution shows R16 would no longer be assigned that CNA. Resident council meeting minutes, dated 12/19/24, show a resident expressed concerns he was not getting him up early enough on the weekends. Resident council meeting minutes, dated 1/23/25, show that families of residents stated the CNAs have to wait to use the facility mechanical lift because it is in use and there are delays in resident care. Resident council meeting minutes, dated 2/20/25, show a request for the facility to purchase an additional mechanical lift, a resident reported that her roommate was left on the toilet for over 30 minutes, and multiple residents stated the CNA response time to call lights could improve.