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	08/22/2025

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 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. (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that grievances were identified, documented, and addressed in accordance with facility policy. This applies to 1 of 4 residents (R1) reviewed for grievances. The Findings Include: Review of the Electronic Medical Record (EMR) showed that R1, a [AGE] year-old male, was admitted to the facility on [DATE], from a hospital following a fall. R1's documented diagnoses included, but were not limited to: dementia, repeated falls, ataxia, muscle wasting, lack of coordination, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), cirrhosis, protein-calorie malnutrition, and depression. The Minimum Data Set (MDS) dated [DATE], identified R1 as having moderately impaired cognition and requiring substantial to maximum assistance with activities of daily living (ADLs).An admission skin assessment dated [DATE], documented the following impairments: -Left elbow skin tear measuring 0.5 cm x 0.5 cm x 0.1 cm with 100% bright pink tissue and light serous drainage -Deep tissue injury (DTI) to sacrum measuring 3.0 cm x 2.5 cm with 100% dark maroon tissue --Bruise to left hip measuring 2 cm x 2 cm x 0 cmFurther initial assessment observations by the Wound Nurse (V3) included: -multiple bruises to upper arms, lower legs, right chest, right foot, and ankle; edema in the upper arms; scabbing to the right knee and anterior lower leg. Facility-acquired skin tears were documented as follows: -Left shoulder - Identified August 1,2025 : measured 2 cm x 0.1 cm -Right shoulder - Identified August 1,2025 : measured 1.45 cm x 1.0 cm x 0.1 cm -Right forearm - Identified August 4,2025: measured 15 cm x 13 cm x 0.1 cm with light bloody drainage. -Lesion to top of head - Identified August 1,2025: measured 0.5 cm x 0 cm with scant serosanguinous drainage and 100% slough/necrotic tissue.On August 20, 2025, at 2:30 P.M., the Wound Care Nurse (V4) stated that she performed a dressing change on the right forearm wound on August 6, 2025 at approximately 6:45 A.M. She observed significant bloody drainage and used four ABD pads and Kerlix wrap for coverage. However, she did not notify the physician or Nurse Practitioner (V6) despite the change in wound status.On August 20, 2025, at 12:22 P.M., V8 (Social Service Director) stated that V7 (R1's spouse) had voiced concerns regarding poor wound care on August 4, 2025, citing dried blood leaking through R1's shirt. V7 subsequently requested R1's transfer to another facility. V8 acknowledged that she did not report this grievance to either the Administrator (V1) or the Assistant Director of Nursing (V2).During a phone interview on August 20, 2025, at 1:00 P.M., V7 stated: They butchered my husband. what they called a ‘skin tear' was a huge wound, bleeding, and extending from the wrist almost to the elbow. No one told me how bad it was until I saw it at the other facility. He was immediately sent to the hospital and is now in hospice. Review of the facility's grievance documentation showed no record that V7's concerns were reported, investigated, or resolved.On August 20, 2025, at 4:40 P.M., both the Administrator (V1) and the Assistant Director of Nursing (V2) confirmed that they had not received any report of a grievance related to R1's wound care from V8 or other facility staff.Review of the facility's Grievance Policy (dated November 20, 2012) stated: The purpose of this policy is to ensure prompt resolution of all grievances related to care and treatment provided or not provided, staff and resident behavior, and other concerns during the resident's stay.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment for a skin tear as ordered by the physician. The facility also failed to reassess a worsening skin impairment, did not notify the physician of its changes to ensure timely and appropriate interventions, and lacked a care plan outlining specific interventions to manage multiple skin impairments.This applies to 1 of 4 residents (R1) reviewed for skin impairments. The Findings Include:The Electronic Medical record (EMR) showed that R1, a [AGE] year-old male admitted to the facility on [DATE], from a hospital following a fall. R1's diagnoses included, but were not limited to, dementia, repeated falls, ataxia, muscle wasting, lack of coordination, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), cirrhosis, protein-calorie malnutrition, and depression.The Minimum Data Set (MDS) dated [DATE], identified R1 as having moderately impaired cognition and requiring substantial to maximum assistance with activities of daily living (ADLs).The admission skin assessment dated [DATE] documented the following skin impairments: 1) Left elbow skin tear measuring 0.5 cm x 0.5 cm x 0.1 cm with 100% bright pink tissue and light serous drainage. Treatment Order: Cleanse with normal saline, pat dry, apply Adaptic and dry dressing three times per week (M/W/F). 2) Deep tissue injury (DTI) to sacrum measuring 3.0 cm x 2.5 cm with 100% dark maroon tissue. Treatment Order: Cleanse with saline, pat dry, apply Venelex and dry dressing daily. 3) Bruise to left hip measuring 2 cm x 2 cm x 0 cm.Review further of the initial assessment showed that additional observations by the Wound Nurse (V3) on admission included multiple bruises to the upper arms, lower legs, right chest, right foot and ankle, edema in the upper arms, and scabbing to the right knee and anterior lower leg.Subsequent wound records showed R1's facility-acquired skin tears as follows: 1) Left shoulder (identified August 1,2025): 2 cm x 0.1 cm. 2) Right shoulder (identified August 1,2025): 1.45 cm x 1.0 cm x 0.1 cm. 3) Right forearm (identified August 4,2025): 15 cm x 13 cm x 0.1 cm with light bloody drainage. Treatment Order: Adaptic dressing, ABD pads, Kerlix wrap, 3x/week (M/W/F) 4) Lesion to top of head (identified August 1, 2025): 0.5 cm x 0 cm, with scant serosanguinous drainage and 100% slough/necrotic tissue. The manufacturer specification for the ABD showed that this kind of dressing (Army Battle Dressing) is a type of wound dressing used to absorb fluids from large or heavily draining wounds. During a group interview on August 20, 2025, at 2:30 P.M., with the Assistant Director of Nursing (V2), Wound Care Coordinator (V5), and Wound Nurses (V3 and V4), the following information was obtained: -V3 said that while she observed the wounds on admission, she did not notify the physician or obtain specific orders. Instead, she implemented standard treatment protocols. -V4 stated she performed a dressing change on the right forearm wound on August 6, 2025, at approximately 6:45 A.M. She noted significant bloody drainage and used four ABD pads and Kerlix wrap for coverage. Despite observing increased drainage, V4 did not notify the physician or Nurse Practitioner (V6). -V2, V3, and V5 confirmed there was no documentation of treatment on August 4, 2025, when the right forearm skin tear was first identified. The also validated that their facility protocol was to document provided treatment into the ETAR (Electronic Treatment Administration Record). Review of the ETAR for the month of August 4, 2025, wound notes, and progress notes for showed no documentation of treatment being administered to R1's right forearm skin tear on August 4, 2025.The care plan dated July 21, 2025, lacked specific interventions to address R1's fragile skin or prevent further deterioration of skin integrity, despite multiple skin injuries and diagnoses increasing risk for skin breakdown.On August 20,2025 at 12:22 P.M., V8 said that V7 (R1's spouse) reported concerns to regarding poor wound care and draining wounds on August 4, 2025. V8 said that V7 noted a dried blood that leaked through R1's shirt. As a result, V7 requested a transfer to another facility.In a phone interview on August 20, 2025, at 1:00 P.M., V7 stated: They butchered my husband. what they called a 'skin tear' was a huge wound, bleeding, and extending from the wrist almost to the elbow. No one told me how bad it was until I saw it at the other facility. He was immediately sent to the hospital and is now in hospice.On August 20,2025 at 1:05 P.M., V9 and V10 (Admissions and Executive Director at the receiving facility), R1 arrived on August 6, 2025, around noontime, was assessed by nurse (V11), and transferred to the hospital via 911 due to deep wounds and significant pain.On August 21,2025 at 6:30 P.M., V11 said that when she immediately assessed R1 upon arrival to their facility. V11 said that V7 was present during the assessment. V11 described that R1 was a poor historian, now aware of what happened to his impaired skin integrity. V11 said she noted that R1's large bandage wrapped around R1's forearm that had extended from the wrist to the elbow. V11 said that the outer bandage was a mixed of