

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/08/2025
NAME OF PROVIDER OR SUPPLIER  Alta Rehab at Oak Brook		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0551  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights.  (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:  145458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/08/2025
NAME OF PROVIDER OR SUPPLIER  Alta Rehab at Oak Brook		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that a resident representative was given accurate information regarding authorization to use an electronic monitoring device in the resident room, resulting in miscommunication and lack of informed consent related to resident rights. This applies to 1 of 3 residents (R1) reviewed for electronic monitoring device in the sample of 8. The findings include: R1 was admitted to the facility on [DATE] with multiple diagnoses including muscle wasting and atrophy, COPD (chronic obstructive pulmonary disease), acute bronchitis, and positive Covid 19, based on the face sheet. R1's admission observation record dated August 29, 2025 showed that the resident was alert and oriented x two (to person and place). R1's OT (occupational therapy) evaluation dated August 30, 2025 showed that the resident was moderately impaired with decision making. R1's OT treatment encounter notes dated September 1, 2025 showed, that the resident was confused. On September 4, 2025 at 9:58 A.M, V7 (daughter) stated she is the POA (Power of Attorney) for R1. V7 stated that on August 30 2025, she talked to V11 (RN (Registered Nurse)/ Supervisor) about installing a video surveillance camera inside R1's room. V7 stated that she was informed by V11 that according to V2 (Director of Nursing), video surveillance is not allowed. V7 stated that she had sent an email to V2 on September 1, 2025 for the follow up of video surveillance and V2 had not replied to the email. The facility's grievance/complaint form dated August 31, 2025 at 1:30 PM created by V11 (RN Supervisor) showed that R1's family would like to install camera in the room, emphasizing rights. On September 6, 2025 at 3:35 PM, V2 (Director of Nursing) stated that on Sunday, August 31, 2025 she received a call from V11 informing her that V7 (daughter) was requesting to have a surveillance camera inside R1's room. According to V2 she informed V11 that she believed the facility's policy prohibits the use of the camera in the resident room. V2 stated that after talking to V11 she requested a copy of the admission contract, which she received via text message (does not remember who among the administrative staff sent the text message). According to V2, she reviewed the facility's admission contract, which showed that video camera in resident room is prohibited. V2 stated that she called back V11 after reviewing the admission contract and told V11 that camera inside a resident room is prohibited. During the same interview, V2 admitted that when she read the admission contract she focused on the statement, Video cameras are prohibited in resident rooms and she did not noticed the following statement on the same admission contract that read, unless the resident and/or resident representative has followed the steps outlined under the law. V2 stated that she did not receive any email from V7, nor did she talk personally or over the phone to V7 with regards to video camera in R1's room. On September 6, 2025 at 4:02 PM, V14 (admission Assistant) stated that on Sunday, August 31, 2025 (not sure of the time), V2 requested a copy of the facility's admission contract, specifically the part regarding video camera in the resident room and also requested to show the specific part to V11. According to V14, she sent the requested copy to V2, and she showed R1's unsigned admission contract regarding video camera in the room to V11. After showing the said part of the admission contract to V11, she (V14) proceeded to R1's room to discuss the contract and have it signed by the resident. V14 stated that on August 31, 2025 between 1:00 PM and 2:00 PM, she arrived at R1's room and at that time V7 (daughter) was present. According to V14, the contract was discussed and signed by R1 in the presence of V7 and during the discussion, V7 asked about installing a camera inside R1's room. V14 stated that she showed the part of the admission contract regarding video camera to V7 while R1 was present. V14 stated that V7 made a comment, This tells me that I have to do certain procedures, but it is allowed as long as steps are followed to which she (V14) agreed. According to V14, V7 did not ask for any further question. R1's signed admission contract dated August 31, 2025 showed under electronic device policy, Cameras: Video Cameras are prohibited in resident rooms unless the resident and/or Resident Representative has followed the steps outlined under Illinois law Authorized Electronic Monitoring in Long Term Care Facilities. (210 ILCS 32/1, et seq.). This includes notifying the Facility of an intent to place the camera and obtaining consent from the Resident and Resident's Roommate, if any. Once the Facility has been notified of the intent to place a camera, the other aspects of the applicable law will be reviewed with the Resident and/or Representative to ensure compliance and to answer any questions. On September 6, 2025 at 4:13 PM, V11 stated that on Sunday, August 31, 2025 at around 1:30 PM, V7 (daughter) asked about putting a camera inside R1's room. According to V11, she told V7 that she was not familiar with the facility's policy regarding camera in the room, but she will find out. V11 stated that she called</p>		