

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Alta Rehab at Fairmont		STREET ADDRESS, CITY, STATE, ZIP CODE 5061 North Pulaski Road Chicago, IL 60630	
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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>45002</p> <p>Based on interview and record review, the facility failed to follow their policy to update family on their grievance regarding insulin ordering issues for 1 (R4) out of three residents reviewed for grievance.</p> <p>Findings include:</p> <p>On 09/24/2024 at 12:00 PM, R4 was seen sitting in his room. R4 state he was not sure about his insulin being monitored.</p> <p>On 09/24/2024 at 11:32 AM, V2 (Director of Nursing) stated, the doctor will order the insulin then it will be confirmed by the nurse. After the nurse confirms the order, it goes to the pharmacy. The pharmacy will dispense on their next delivery. We request from the pharmacy exactly what the doctors' order. Pharmacy said that when it is ready to refill, they will dispense a new order.V2 was informed that R4 has a lot of insulin being billed to him. Lyumjev was the name of the insulin. Even though R4 doesn't take it, we have to discard it after 28 days. R4 is private pay. The pharmacy is charging the family extra. V2 stated we are talking to pharmacy but we are not sure if R4's insulin issue has been taken care of. V2 stated that this issue was not addressed in the care plan meeting on 09/23/2024.</p> <p>On 09/24/2024 at 11:47 AM, V8 (Minimum Data Set Care Plan Coordinator) states that she is familiar with R4. V8 stated that R4's son emailed her regarding the insulin that has been charged to them. Once the doctor changes the dose of the insulin, the nurse's order another set of insulin. The nurses should not be doing that. V8 stated that they should be changing the dose from what was previously dispensed insulin from pharmacy. Pharmacy will send the insulin when the nurse's click 'send'. This has been addressed to the nurses and I have no idea why they still keep doing it. V8 stated that they had a quarterly meeting yesterday. Care plan consisted of more insulin. We did not give them an update about this issue.</p> <p>On 09/24/2024 at 12:31 PM, V7 (R4's Financial Power of Attorney) stated that he wasn't aware of the meeting that took place yesterday 09/23/2024. V7 stated he notified V2 and V8 back in July about his grievance with this insulin issue for R4 and still has not received any update.</p> <p>(continued on next page)</p>		

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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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/24/2024 at 1:42 PM, V1 (Administrator) stated that they had a care plan meeting yesterday with the whole family where they addressed R4's full plan of care. After yesterday's meeting, the family had no concerns about that meeting. V1 stated that he was not aware of the situation with insulin. V1 stated that V2 did not mention to him about that issue. If he knew he would have addressed it immediately. V1 stated that they had a care plan meeting on 09/23/2024, but this issue was not brought up because the family did not bring it up. V1 spoke to the son and we are trying to find who ordered the extra pens. V1 and V2 are also trying to find out if the pharmacy credited some amount back to the patient. We try to get them an update on any grievances as soon as possible. As soon as I hear about it, I go with our business office manager and that's where I follow up. I try to follow up as soon as possible; at least within 24 hours.</p> <p>Facility's Grievance Policy (09/25/2017) documents in part: Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days. Under certain circumstances, additional time may be needed to complete an investigation and implement measures to resolve the grievance. In such cases resident or complainant should be notified of the extension.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>15301</p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to prevent development of deep tissue injuries (DTIs) for one of three residents (R6) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R6's Face Sheet documents resident was admitted to the facility on 7.10.2023 with diagnoses including but not limited to: Displaced fracture of greater trochanter of right femur (hip fracture), Chronic obstructive pulmonary disease, Hypertension, and Hypothyroidism.</p> <p>R6's MDS (Minimum Data Set, dated dated dated 7.10.2024) documents the following - BIMS: 14 (cognitively intact).</p> <p>On 9.24.2024 at 12:45 PM, R6 was observed awake and alert. R6 was sitting up in bed with head of bed elevated. R6 had pillows under her legs, with her legs externally rotated. R6 said she developed pressure ulcers to her ankles after staff crossed her legs (at the ankles) during care. Staff did not reposition ankles when they were through providing care. R6 said my legs stayed like that for maybe eight hours. I told the nurse. They uncrossed my legs and some skin came off. Resident not observed moving legs during interview/observation.</p> <p>On 9.24.2024 at 11:59 AM, V5 (Wound Nurse/LPN-Licensed Practical Nurse) said R6 has two facility acquired DTIs (Deep Tissue Injuries) to left lateral ankle and anterior right ankle. V5 said per R6, she developed DTIs after staff left R6's legs crossed at the ankles. That's the only way that I think it could have happened. V5 said R6 is unable to cross/uncross legs by herself.</p> <p>On 9.25.2024 at 10:44 AM V23 (RN-Registered Nurse/Wound Nurse) reviewed progress note of 8.29.204 at 1:39 PM, acknowledged she is the author of the note. V23 said, I was notified by the CNA (Certified Nursing Assistant) who was responsible for R6's care that day. R6 was up in the chair that day; she wanted me to look at R6's ankles. I noticed R6 had discoloration (maroon in color) to the right medial ankle and the left lateral ankle. The skin was intact at that time. I notified V31 (Wound Coordinator) and V30 (In-house Nurse Practitioner). Initially we (V23 and V30) thought they might be venous or arterial ulcers, but then we heard R6 say that her legs were crossed, we (V23 and V30) determined that pressure was the cause of the DTIs (Deep Tissue Injuries).</p> <p>Nurses Note dated 8.29.2024 at 1:39 PM documents in part: Wound Care the resident was seen by the wound care team per the CNA request. There are skin alterations noted to the right medial and left lateral ankles. Skin is intact. No erythema or s/s (signs/symptoms) indicative of infection.</p> <p>8.29.2024 at 4:01 PM Nurses Note documents in part: Wound care staff was informed by CNA that there was skin changes noted to the right and left ankle. Resident stated that she has a habit of crossing her legs, while ankles typically rest on top of each other. Resident stated that there is increased pain during digital palpitation.</p> <p>Wound Assessment Details Report documents:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Wound: Right ankle inner</p> <p>-Assessment Date: 8.29.2024 at 1:06 PM</p> <p>-Type: Pressure</p> <p>-Classification: Ulceration</p> <p>-Source: Facility-acquired</p> <p>-Clinical Stage: Deep Tissue Pressure Injury</p> <p>-Deep Maroon=100%</p> <p>-Size: 1.50 x 1.20 x Unknown (L x W x D)</p> <p>Wound Assessment Details Report documents:</p> <p>-Wound: Left ankle outer</p> <p>-Assessment Date: 8.29.2024 at 1:07 PM</p> <p>-Type: Pressure</p> <p>-Classification: Ulceration</p> <p>-Source: Facility-acquired</p> <p>-Clinical Stage: Deep Tissue Pressure Injury</p> <p>-Deep Maroon=100%</p> <p>-Size: 1.00 x 0.80 x Unknown (L x W x D)</p> <p>R6's care plan documents I have pressure ulcer right medial and left lateral ankles related to history of ulcers and immobility (revised 8.29.2024). R1's care plan documents the following intervention: Follow facility's policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Pressure Ulcer Prevention Policy (Revisions 1.15.2018) documents: 11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shear from heels, toes, and malleoli as indicated.</p>