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 01/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Fairmont	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on observation, interview and record review, the facility failed to protect the residents' rights to be free from physical abuse. These failures affected 2 residents (R1 and R2) resulting in R2 grabbing R1's thumb causing R1 pain; and R1 grabbing R2 in the chest causing multiple scratches and pain to R2. Findings include: The final for FRI (Facility Reported Incident) that occurred on 12/20/24, dated 12/24/24, documents, in part, . (R2) alleged that (R1) grabbed on to her shirt. (R2) reported that she asked (R1) to let loose of the shirt, but she would not. (R2) reported she removed (R1's) hand from her shirt . (R1) alleged that (R2) came out of the bathroom, approached her bed, made contact with her head, bit her arm and then grabbed her thumb. (R1) reported grabbing (R2's) shirt and accidentally scratched her . Later in the evening, (R1) reported to the nurse that she had pain in her left thumb. The doctor was notified, and an x-ray was ordered. Diagnosis of an acute fracture is inconclusive due to history of pathological fractures and Xray report stating: acute versus old ununited cortical fracture at the ulnar margin of the base of the left 1st metacarpal. The provider ordered ace bandage and follow up with ortho. Resident scheduled to see ortho on 12/30/2024. On 1/24/25 at 12:46pm, R1 said, My thumb is still broken. R1 showed surveyor R1's left thumb/hand. Surveyor observed R1's left thumb/hand without a splint or ace wrap, and R1's left thumb appeared swollen. R1 stated, I (R1) can't wear that wrap for my thumb, it just don't feel right. It's (ace wrap) not comfortable. It (left thumb) still hurts. I'll (R1) tell you what happened with (R2). (R2) violated me. She (R2) had issues with her (R2) previous roommate before me. (R2) is the problem. (R2) was in the bathroom complaining about the (V3, Assistant Administrator). I (R1) was tired of listening to it, so I (R1) told her (R2) to shut up. She (R2) then came out of the bathroom and physically and verbally assaulted me. She (R2) bit me in the arm. I (R1) grabbed her (R2) shirt to defend myself and she (R2) grabbed my thumb, bent it back and broke it. It (R1's thumb) hurt like a b****! I (R1) called her a C-*-*-*! I (R1) am not going to deny that. The police came and if I (R1) go to jail, she (R2) goes to jail too. The truth hurts. I (R1) don't feel safe with her (R2) here. She's (R2) going around the facility physically and verbally assaulting people. (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: 145867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2025

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

R1's face sheet documents, in part, diagnosis that include but are not limited to bipolar disorder; major depressive disorder; age-related osteoporosis with current pathological fracture, right ankle and foot, subsequent encounter for fracture with routine healing; and Human Immunodeficiency Virus (HIV). R1's Minimum Data Set (MDS), dated [DATE], documents, in part, a brief interview of mental status (BIMS) score of 14 which indicates R1 is cognitively intact.

R1's progress note per V4 (Registered Nurse/RN), dated 12/20/2024 at 10:43pm, documents, in part, 9:20pm the patient (R1) had a physical altercation with her roommate (R2). The patient stated that she (R1) has a broken left thumb but refused to go with the ambulance to be checked in the hospital. NP (nurse practitioner) . made aware of the situation. The administrator was made aware of the situation .

R1's progress note per V4 (Registered Nurse/RN), dated 12/20/2024 at 10:45pm, documents, in part, The patient (R1) refused to go to the hospital to get her thumb checked. the patient is showing her thumb but refused to be touched for examination.

R1's progress note per V5 (Social Worker) dated 12/21/24 at 12:10pm, documents, in part, Well-being Note: Writer checked in on pt (patient) today. Pt was tearful and became upset when discussing an altercation between her and her former roommate (R2). Pt reports to be in pain and that she is awaiting to have an x-ray done of her hand. Writer sat with pt until she (R1) became calm. Pt began to ask if she'd be able to get her belongings from her old room with writer. Writer informed her that it would be best to allow staff to retrieve her (R1) belongings to keep things cordial. She (R1) verbalized understanding. Writer retrieved all pt's belongings and assisted pt with putting them away in her new room.

R1's progress note per V6 (Medical Records), dated 12/26/2024 2:54pm, documents, in part, Appointment for Orthopedic consult ASAP. I (V6) made an appointment for (R1) it was for the 30th of December at 1:45. She (R1) canceled the appointment. She (R1) made another appointment, and she (R1) also made her own transportation arrangements. This is what the resident stated when I (V6) went to ask her for the new information about her appointment to facilitate transportation.

R1's progress note per V7 (Licensed Practical Nurse/LPN), dated 12/26/2024 6:35pm, documents, in part, (R1) cancelled her Ortho appt and said, no one schedules my appt! I'll (R1) do it myself! I (R1) have my own doctor! I (R1) don't want any doctors that's associated from here!!

R1's Care plan, revision date 10/21/24, documents, in part, At Risk For Abuse/Neglect: Pt (patient/R1) scored low (2) on Abuse/Neglect Screening Assessment; however, there was an allegation of abuse while she (R1) was in the hospital. According to the patient (R1), a police report was done but claimed she (R1) did not file a complaint, with goal that documents, in part, Pt (patient/R1) will be cared for in a safe manner and verbalize to staff any incidences of abuse or neglect through review date, and with interventions that document, in part, Ensure safety if feeling unsafe.R1's Care Plan, revision date 12/26/24, documents, in part, Pt (patient/R1) is non-compliant with application of ace wrap to left hand due to fracture. Patient educated on importance of application however still reluctant. R1's Care Plan, revision date 10/22/24, documents, in part, I (R1) use psychotropic medication, with interventions that document, in part, Monitor/record occurrence of for target behavior symptoms (inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's Abuse/Neglect Screening, dated 10/21/24 (most recent assessment done prior to the physical altercation between R1 and R2 on 12/20/24), documents, in part, Score:2. R1's Abuse/Neglect Screening, dated 10/21/24, documents, in part, B. Risk measure. Risk measure for likelihood for a history of previous/ . mistreatment and/ or potential future problems/ symptoms related to mistreatment. 0. Low= 0-2, Moderate = 3-4, High = 5 +. On R1's Abuse/Neglect Screening, dated 10/21/24, the following was answered NO 4. Psychiatric history and /or present mental health diagnosis: including psychotic symptoms (e.g. delusional thinking, hallucinations) and possible misinterpretations of events and the intentions of others. R1's face sheet documents, in part, diagnosis that include but are not limited to bipolar disorder and major depressive disorder, which are both mental health diagnosis. Answering NO put R1 at low risk for potential further abuse, however if the question was answered correctly as Yes, R1 would have a score of 3 which would put R1 at Moderate risk for potential further abuse. R1's Order Summary Report, dated 1/24/25, documents, in part, order date 1/3/25: ORTHO CONSULT - DIAG; LEFT THUMB FRACTURE. R1's Order Summary Report, dated 1/24/25, documents, in part, order date 12/21/24: STAT X-Ray of left thumb due to pain/swelling. R1's x-ray of left thumb, dated 12/21/24, documents, in part, acute versus old ununited cortical fracture at the ulnar margin of the base of the 1st metacarpal. On 1/24/25 at 11:47am. R2 said, (R1) was saying something to me while I (R2) was in the bathroom. I (R2) couldn't hear her (R1), so I (R2) told her (R1) to hold on. When I (R2) came out of the bathroom, I (R2) went up to her (R1) and asked (R1) what she (R1) was saying. (R1) then yelled What do you think? I'm (R1) stupid. She (R1) then grabbed my shirt. I (R2) gave (R1) to count of 3 to let go of my shirt. I (R2) counted to 3 and (R1) said what are you going to do now, so I (R2) grabbed her (R1) hand to stop her (R1) from grabbing my shirt and I (R2) must have hurt her (R1) thumb. I (R2) didn't mean to break it (left thumb), but I (R2) did intentionally grab her (R1) hand in self-defense. I (R2) grew up in a not so good neighborhood. I (R2) think she (R1) thought I (R2) was just going to stand there and let her (R1) hurt me, and then (R1) told the nurses I (R2) bit her (R1). Why would I (R2) bite someone with HIV (Human Immunodeficiency Virus)? I'm (R2) not stupid. She's (R1) a liar. She (R1) gave me scratches all over my chest. Those scratches hurt. It looked like I (R2) was attacked by a rabid cat. R2's face sheet documents, in part, diagnosis that include but are not limited to anxiety disorder, depression and bipolar disorder. R2's Minimum Data Set (MDS), dated [DATE], documents, in part, a brief interview of mental status (BIMS) score of 15 which indicates R2 is cognitively intact. R2's progress note per V4 (Registered Nurse/RN), dated 12/20/2024 at 10:48pm, documents, in part, At 9:20pm, the patient (R2) had a physical altercation with her roommate (R1). She (R2) was grabbed by her roommate (R1) in the chest that caused some scratches. She (R2) then grabs her roommates (R1) hand so that she (R1) will let go . causes pain to the roommate. Both patients were separated and put in different rooms. NP (nurse practitioner) . and Administrator made aware of the situation. R2's progress note per V10(Licensed Practical Nurse/LPN), dated 12/21/24 at 7:20pm, documents, in part, . Scratch marks still noted on resident chest area . R2's Abuse/Neglect Screening, dated 10/16/24 (most recent assessment done prior to the physical altercation between R1 and R2 on 12/20/24), documents, in part, Score:3, which puts R2 at MODERATE risk for potential further abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's Care plan, revision date 10/16/24, documents, in part, I (R2) am at risk for abuse/neglect ., with interventions that document, in part, Assess resident for risk for abuse . Observe resident when in company of peers. R2's Care plan, revision date 7/22/24, documents, in part, I (R2) use antidepressant medication, with interventions that document, in part, Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition . On 1/24/25 at 2:05pm, V8 (Social Service Director) affirmed that she (V8) is familiar with R1 and R2. V8 affirmed that she (V8) is aware of the altercation that occurred between R1 and R2 on 12/20/24 and that R1 and R2 rooms were changed. V8 said, It was a he said she said type of thing since the minute it happened. On 1/24/25 at 2:11pm, V5 (Social Worker) affirmed that both R1 and R2 were separated immediately, and their rooms were changed the same day due to a physical altercation. V5 said, I (V5) couldn't tell what actually happened. They (R1 and R2) had different stories . On 1/24/24 at 2:21pm, V3 (Assistant Administrator) said, . The incident with (R1) and (R2) was not substantiated because both residents were telling different stories. The stories were not coinciding. We (staff) ensured both were safe. I (V3) followed up with both (R2) and (R1). I (V3) followed up with them (R1 and R2) and I (V3) asked them if they (R1 and R2) feel safe and they (R1 and R2) both said yes. On 1/24/25 at 2:44pm, V2 (Director of Nursing/DON) said, I'm (V2) aware of the incident with (R1) and (R2). The thing I (V2) know is that (R1) was lying in bed and (R2) was coming out of bathroom. (R2) was upset and angry and kept talking and talking. (R1) said to stop talking. (R2) suddenly jumped on her (R1) and then (R1) had to defend herself. They (R1 and R2) were separated right away, and the administrator was called. They (R1 and R2) both had injuries. I (V2) feel most injuries can cause pain, some worse than others. On 1/24/24, surveyor called V4 (Registered Nurse/RN) for an interview, but V4 did not pick up call. On 1/24/25 at 3:15pm, V9 (Medical Director) said, I'm (V9) familiar with them (R1 and R2), but I (V9) don't follow them. When asked if grabbing someone's hand or scratching someone can cause pain, V9 replied, Possibly. When asked if a fractured thumb can cause pain or harm to resident, V9 replied, Well, yes. On 1/25/24, surveyor called V4 (Registered Nurse/RN) for an interview, but V4 did not pick up call. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Facility's policy titled, Abuse Prevention and Reporting- Illinois, revised date 10/24/22, documents, in part, This facility affirms the right of our residents to be free from abuse, neglect, exploitation misappropriation of property deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse neglect exploitation, misappropriation of property and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse neglect exploitation misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: . Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment . Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5) . Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines) . Resident-to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations . Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict . Facility's policy titled, Quality Assurance Performance Improvement Program (QAPI), revised date 10/24/22, documents, in part, Quality of care will be monitored and evaluated in areas of resident care and services at each QAA meeting, including but not limited to: Abuse/Resident Rights .