STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for 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** 40067 Based on interview and record review, the facility failed to ensure that a resident (R1) remained free from physical abuse from another resident (R2) reviewed for physical abuse in the sample of 4. This failure affected R1 who was pushed down on the bed by R2. Findings include: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 8:50 am, V14 (Certified Nursing Assistant, CNA) stated that on 4/14/25 at approximately 7:30 am, I (V14) had worked night shift and was sitting at the computer, finishing my charting. I heard cursing, it was 2 (residents). I told the nurse (V3, Registered Nurse, RN) who was at nurse's station, do you hear that? We jump and run in (R1 and R2's) room. Both (R1 and R2) were cursing, and (R2) jumped up and run and pushed (R1) down on the bed. When asked for more details when V14 responded to R1/R2's room, V14 stated, They were both yelling at the same time. V14 stated, (R1) was standing up. And (R2) was sitting (on R2's bed). They were arguing. I tried to calm them down. I was trying to get (R2) to leave out of room with me. (R1) kept cursing and talking. (R2) jumped up from (R2's) bed and I (V14) tried to grab (R2's) shirt, saying 'Stop, stop. Come on, let's go.' I told the nurse (V3) to call the supervisor (V9, Nursing Supervisor, Licensed Practical Nurse, LPN). V14 stated that V14 was kind of tugging on (R2's) shirt. (R2) was getting at (R1). I told (R2) to sit down, which (R2) did, and (R2) jumped up again. When asked what V14 meant by R2 getting at R1, V14 stated, (R2) ran over to (R1) who was saying curse words, and (R2) slammed (R1) down on the bed. V14 stated that V14 was behind R2 pulling on R2's shirt to try to stop R2 from physically striking R1; however, R2 still pushed R1 down on the bed. V14 stated that V14 pulled more to get R2 to sit back on R2's bed to separate R2 from R1. V14 stated, But (R2) jumped up again. Got past me. I was pulling (R2's) back of shirt and (R2) pushed (R1) back on the bed again. When asked where V3 was when V14 was trying to prevent R2 from pushing R1 again, V14 stated, (V3) was right at the door, saying 'We need help in (R1/R2's room), and (V3) came back in. So, (V3) could hear on the phone call (with V9). They (R1/R2) were cursing so loudly. V14 stated that V6 (Housekeeper) entered into the room and went to R2 to try to calm R2 down, asking R2 to leave the room with V6. V14 stated that V3 is back in the room now still on the phone with V9, saying to stop, when V9 enters the room. V14 stated that R2 said that R2 liked V9 and would step out of the room to speak with V9. V14 reiterated that V14 witnessed R2 push R1 down on the bed two times. V14 stated that V14 left out of the room, and V3 remained with R1 in the room. When asked if V14 had witnessed R2 being physically or verbally aggressive before this incident, V14 stated that when R2 was first here in the facility, R2 was standing at the nurse's station and kept hitting his cane on nurse's station desk, swinging it at the nursing staff. R2 said that R2 was standing outside R2's room and was being ignored. V14 stated that V14 removed the nursing staff from the nurse's station from potential harm, and V9 (Nursing Supervisor, LPN) responded with separating R2 from the nurse's station and talking to calm R2 down. On 5/5/25 at 12:45 pm, V3 (RN) stated that on 4/14/25 at approximately 7:30 am, V14 (CNA) and V6 (Housekeeper) said that they hear some yelling. V3 stated that V3 was sitting at the nurse's station, and V3 and V14 ran into R1/R2's room. V3 stated, (R2) was yelling at (R1). Screaming and shouting. Mainly verbal. CNA (V14) stood in the middle to separate them. V3 stated that V3 asked R1 what the argument was about, and R1 said that R1 woke R2 up. V3 stated that V3 is at the front of the room and called V9 (Nursing Supervisor, LPN) on the phone to ask V9 (whose office is on the other side of the facility) to come to R1/R2's room for assistance. V3 stated that V6 (Housekeeper) walked into the room and was holding (R2) back. When asked did V3 witness R2 physically striking R1, V3 stated, No, the CNA (V14) did. I did not see anything. When asked is it acceptable for one resident to physically push another resident, V3 stated, absolutely not. You are not supposed to touch each other. Considered a sign of disrespect, of aggression and agitation. On 4/14/25 at 8:00 am, V3 (RN) documents, in part, in R1's progress notes, During nursing rounds, observed (R1) having a verbal conflict and exchanging words with roommate (R2) and (R1) was pushed (by) other resident (R2) into bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 7:30 am, V3 documents, in part, in R2's progress notes, During nursing rounds, observed (R2) having a verbal conflict and exchanging words with roommate (R1) and pushed other resident (R1) into bed. On 5/5/25 at 10:12 am, V6 (Housekeeper) stated that on 4/14/25, around 7:30 to 8:00 am, V6 was placing bags in the garbage outside of R4's room (room across hallway from R1/R2's room), and I (V6) heard commotion, real loud. V6 stated that V6 walked into the room and the CNA, V14, was telling V6 that R2 was choking R1. V6 stated that R2 was standing over R1 who was sitting up on the side of R1's bed. V6 stated, I walked in and said, 'What's up?' and (R2) wanted to get (R2's) hands on (R1) again. V6 stated that V6 said to R2, Come on, you know (R1's) a little bitty man, and R2 stepped back towards R2's bed. V6 stated, It (R2's physical assault to R1) happened already when V6 was in R1/R2's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 11:57 am, V9 (Nursing Supervisor, LPN) stated that V9 is the night shift supervisor in the facility and was working the night shift (4/13/25-4/14/25). V9 stated that V9 was first notified of R1/R2's incident by a phone call (4/14/25 in morning), and V9 can hear the commotion in background with V3 asking V9 to come to R1/R2's room. When asked what V9 was hearing on the phone, V9 stated that V9 heard R2 saying b****** and h****. When I was talking to (V3) on the phone at that time, I can hear (R2) in the background. When I got there, (V3) was still on the phone in room. V9 stated that when V9 arrived in R1/R2's room, V9 saw R2 standing up being aggressive towards (R1). V9 stated that V9 asked R2 'what's going on, let's calm down,' and (R2) sat down saying, 'I (R2) am glad to see you (V9). I can talk to you.' V9 stated, I was able to stop (R2). I put myself in front of (R2). (R2) would have pushed (R1) again. V9 stated that R2 walked out of the room with V9 to a separate area down the hallway, and V9 interviewed R2 asking R2 to tell V9 what happened. V9 stated that R2 said that R2 was annoyed that R1 had been asking housekeeping staff to pass R1 underwear out of R1's drawer, and R2 told R1 that it's not a housekeeper's job, but it's a CNA's job. V9 stated that R2 said that R1 and R2 went back and forth verbally, and R1 was challenging (R2), could beat (R1) up. V9 stated that V9 responded to R2, You (R2) cannot do that. Not be aggressive or physical to (R1). That's not safe for (R1) or for you. If you have a problem with your roommate, don't be physical. You let us know. And we can work on room change. Getting violent with your roommate is not that answer. V9 stated, I (V9) asked (R2) if (R2) physically put (R2's) hands on (R1), and (R2) said (R2) physically put (R2's) hands on (R1) and pushed (R1). V9 stated that R2 said, I (R2) didn't punch (R1). I (R2) just pushed (R1). V9 stated that V9 tried to reason with R2 by saying that R2 is much bigger (in size) than R1, and R2 responded saying, '(R1) puffed (R1's) chest out. I (R2) showed (R1).' V9 stated that V9 told R2 that R1 is physically disabled; that R1 cannot fight (R2); and that if R2 was annoyed by R1 with R1's words, then R2 should have not pushed R1 and asked staff for a room change. V9 stated that V9 was placed in a different room with supervision, and V9 went back right away to interview R1. V9 stated that R1 said, I (R1) know that he's (V6) a janitor and he can't change me. I was asking (V6) for a simple item. And (R2) got in my business and to butt in and tell me whose job it is. I told (R1) to mind (R2's) f****** business. No one was talking to (R2). When (R2) stood up, (R1) stood up and (R2) pushed (R1's) shoulder and (R1) fell back on the bed. (R1) was standing up in front of (R1's) bed. And each time, (R1) fell back down on the bed, to a sitting position. When asked how many times did R1 say that R2 pushed R1 back on the bed, V9 stated, Three times. First time by (R1's) shoulders. Second time, (R2) put hand on (R1's) face, and like face muffed (R1), and (R1) fell down. Last hit was when (R2) poked (R1) in the forehead and (R1) fell back on the bed. V9 stated, (R1's) fragile. Even a little blow and (R1) will fall down. (Residents) don't push no one. V9 stated that R2 is alert and oriented times 4 and (R2) knows what (R2) is saying. V9 stated that R1 is oriented times three to four, and R1's mobility is not there. (R1's) mentally there. V9 stated that V9 informed R1, I (V9) am sorry that this happen to you. (R1) said that you (V9) do not to apologize, it's not your fault. V9 stated that V9 responded to R1 saying, This did happen to you (R1) on our property. I am sorry that you were assaulted. It's not the right thing for your safety and dignity. It shouldn't have never happened. When asked about R2 having aggressive behavior prior to 4/14/25, V9 stated that R2 had another incident that occurred on the night that R2 was admitted to the facility. V9 stated that V9 responded to the incident with nursing staff who were behind the nurse's station desk, and R2 was standing in front of the desk, swinging R2's cane like R2 was going to hit the nursing staff, and cursing at staff. V9 stated that V9 removed R2 from the area, talking to R2 to calm R2 down. V9 stated, (R2) developed a form of trust with me from that night. Maybe that's why it was a little easier to defuse (R2) from angry level (R2) was at (on 4/14/25). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 2:13 pm, V2 (Director of Nursing, DON) stated that on 4/14/25, V2 was in the office when someone hollered that there was an altercation, so V2 went to R1/R2's room. V2 stated that R2 was already removed from the room, and V9 was talking to R2 sitting down the hallway. V2 checked in on R1 and R1 did not want R2 to come back to the room. V2 explained that R2 is being relocated to another room, and that R1 was satisfied with this. V2 stated that V2 assisted with picking up R2's personal items to move to R2's new room, and V9 returned to the room with R2 remaining under supervision. V2 stated that R2 wanted to go back to the room with R2 saying Honestly, that (R2) would beat (R1) up. (R2) wanted to beat (R1) up. Basically stating (R2) wanted beat (R1) up. R1's Admission Record documents, in part, diagnoses of liver cell carcinoma, secondary malignant neoplasm of bone, fusion of spine, pathological fracture in neoplastic disease (right shoulder), chronic pain, metabolic encephalopathy, toxic liver disease with chronic active hepatitis with ascites, severe protein-calorie malnutrition, gastrostomy status, dysphagia, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, peripheral vascular disease, acute renal failure, abdominal pain, and seizures. R1 and R2's Census Lists document, in part, that on 4/14/25, R1 and R2 were roommates in a 2-resident room. R1's Census List shows that R1's facility discharge date was 4/22/25, and R2's Census List shows that R2's facility discharge date was 4/14/25. On 5/5/25 and 5/6/25, this surveyor attempted several times to reach R1 and R2 via their phone numbers listed with no success. R1's Discharge Minimum Data Set (MDS), documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R1 is cognitively intact. R1's Functional Abilities show that R1's mobility is via manual wheelchair. R1's Nutritional status indicates that R1's height is 59 inches (4 feet, 11 inches) and weight of 107 pounds. R1's Care Plan dated 4/12/25 documents, in part, focuses of R1 has a diagnosis of cancer at risk for weight loss, pain, fatigue and other complications r/t (related to) cancer, neoplasm of the bone and a feeding tube r/t chronic dysphagia. R2's Admission Record documents, in part, diagnoses of human immunodeficiency virus (HIV) disease, cerebral infarction due to occlusion or stenosis of left cerebellar artery, acute kidney failure, type 2 diabetes mellitus, hyperkalermia, hypertension, hyperlipidemia, chronic kidney disease stage 4 (severe), and cerebral infarction due to thrombosis of right middle cerebral artery. R2's MDS, dated [DATE], documents, in part, that R2 has a BIMS score of 15 which indicates that R2 is cognitively intact. R2's Nutritional Status shows that R2 is 76 inches (6 feet, 4 inches) in height and is 206 pounds. R2's Care Plan dated 3/27/25 documents, in part, a focus of R2 can be verbally agitated at times with interventions of analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document and assess resident's coping skills and support system. R2's Care Plan dated 3/27/25 documents, in part, a focus of R2 at risk for abuse/neglect due to agitated behavior with intervention of observe resident when in company of peers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. Building B. Wing	05/06/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	R2's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, documents, in part, the date of notice is provided to the R2 on 4/14/25 due to the safety of individuals in this facility is endangered and is signed by V15 (Assistant Administrator) dated 4/14/25. On 5/5/25 at 10:46 am, R4 stated that R4 knows R1 and R2 who are in the room across from R4's room. R4 stated that R4 sees R2 walking around, and R1 moves around in a wheelchair. R4 stated that on 4/14/25 in the morning, I (R4) heard the commotion. They (staff) tried to stop the fight. R4 stated that R4 had heard them (R1 and R2) have verbal arguments before in their room. R4's Admission Record documents, in part, diagnoses of atherosclerotic heart disease of native coronary artery without angina pectoris, paroxysmal atrial fibrillation, aneurysm of ascending aorta without rupture, alcohol cirrhosis of liver with ascites, asthma, esophageal varices, systolic (congestive) heart failure, hypertension, chronic kidney disease, transient ischemic attach, hyperkalemia, fall, folate deficiency anemia, and hyperlipidemia. R4's MDS, dated [DATE], documents, in part, that R4 has a BIMS score of 12 which indicates that R4 has moderate cognitive impairment. On 5/6/25 at 7:53 am, V10 (LPN) stated that R1 was a newly admitted resident to the facility and was alert, oriented time three and has a gastrostomy tube (G-tube) which was leaking around the site. V10 stated that due to R1's stomach structure with cancer diagnosis, the G-tube site leaking was expected; but it caused R1 to be in pain frequently. V10 stated that R2 is alert, oriented times three and was independent with ADL (activities of daily living) care. V10 stated that R2 would walk using a cane, but sometimes, V10 would see R2 holding the cane while walking and not actually using it. Police report, dated 4/14/25, documents, in part, the incident of Domestic Battery with the victim named as R1. Facility policy dated 10/24/22 and titled Abuse Prevention and Reporting-Illinois documents, in part, Guidelines: 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 . This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Definitions. The following definitions are based on federal and state laws, regulations and interpretive guidelines . Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines).