

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  12/11/2025
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)
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)

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 0684</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 observation, interview and record review the facility failed to ensure ordered scheduled medications were administered for one resident (R2). This failure affected one resident out of three residents reviewed for medication administration. Findings include: R2's medical diagnoses include but are not limited to type 2 diabetes mellitus with diabetic autonomic (Poly) neuropathy, heart failure, major depressive disorder, anxiety disorder, presence of cardiac pacemaker. R2's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 15, indicating R2's cognition is intact. R2's care plan dated 11/15/25 documents in part, I have Diabetes Mellitus diet manage, Insulin dependent. Diabetes medication as ordered by doctor. R2's care plan dated 11/15/25 documents in part, I am at risk for decreased cardiac output R/T (related to): atrial fib, congestive heart failure, hyperlipidemia, hypertension, pacemaker malfunction. Administer medications as orders and observe for side effects and effectiveness. On 12/08/25 at 12:20pm surveyor observed R2 being fed lunch by CNA (Certified Nursing Assistant). On 12/08/25 at 12:42pm R2 stated that she has not received any medication yet. R2 stated that she is a diabetic and has orders to have her blood glucose checked three times a day and is to be given insulin with each meal. R2 stated that she has not had her blood glucose checked all day, nor has she been given any insulin. On 12/08/25 at 12:58pm V3 (Registered Nurse/RN) stated that she had not given R2 any of her morning medications. V3 stated that R2 is a diabetic and R2 should have a blood sugar check twice on her shift. V3 stated that R2 should have had her blood sugar checked at 8am and 11:30am. V3 stated that she had not checked R2's blood sugar or given R2 any insulin. V3 stated that it is important for R2 to have her blood sugar checked because R2 is a diabetic and takes long and short acting insulin. R2's progress note dated 12/08/25 at 3:30pm documents in part, Accucheck (blood glucose) not tested. Notified V16 NP (Nurse Practitioner). Medication not given. Notified V16 NP. R2's medication administration audit record shows that V3 (Registered Nurse/RN) gave R2 insulin injection on 12/08/25 at 3:30pm. R2 physician order dated 11/10/2025 documents in part, Humalog Mix 75/25 KwikPen. Inject 16 units subcutaneously one time a day related to Type 2 diabetes mellitus with diabetic autonomic (Poly) neuropathy 9am. R2's physician order dated 01/08/2025 documents in part, Accu check before insulin, Breakfast, Lunch and Bed time before meals. R2's physician order dated 10/12/2025 documents in part, Lyumjev KwikPen. inject 7 units subcutaneously one time a day related to Type 2 diabetes mellitus with diabetic autonomic (Poly) neuropathy. One time a day with lunch if blood glucose &gt; (greater than) 150. R2's physician order dated 12/05/2025 documents in part, Metoprolol Succinate ER (extended release) oral tablet extended release 24-hour 25 MG (milligram) give 2 tablet by mouth one time a day related to unspecified atrial fibrillation. R2's physician order dated 10/17/2025 documents in part, Furosemide tablet 40 MG give 1 tablet by mouth two times a day related to heart failure. R2's physician order dated 02/04/2025 documents in part, Eliquis oral tablet 5 MG. Give 1 tablet by mouth two times a day for blood thinner. On 12/10/25 at 1:39pm V2 (Director of Nursing) stated that medication should be given an hour before or an hour after the scheduled medication time. V2 stated that 9am medications can be given up until 10am. V2 stated that she has educated the nursing staff about time sensitive medications. V2 stated that blood pressure medication should be given every twelve hours because it is a time sensitive medication. V2 stated that it is expected that nurses follow doctor's orders. V2 stated that it is not okay for the nurse to not check a resident's blood glucose if the resident has an order for the blood glucose to be checked. V2 stated that R2's insulin should have been administered at the time of R2's meal. V2 stated that if medications are not administered on time, the physician should be notified so that a medication time adjustment could be made. V2 stated that if medications are missed and the times are not adjusted, the resident could become overmedicated. On 12/10/25 at 12:24pm V16 (Nurse Practitioner) stated that she was informed that V3 (RN) did not administer insulin as ordered. V16 stated that V3 did not inform her that R2's morning medications were not given to her. V16 stated that it is expected that all medications are given when they are due. V16 stated that if a medication is not given, it can cause a reverse action. V16 stated that if insulin doses are skipped, it can harm the resident if they are eating 100% of their meals. Facility's undated policy titled Medication Administration General Guidelines documents in part, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). Administration:</p>		