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	09/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and records review, the facility failed to protect privacy for one (R101) resident of six residents reviewed in a sample of 29. R101's current face sheet documents R101's diagnosis to include but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, alcoholic cirrhosis of liver without ascites, adult failure to thrive, dysphagia, oropharyngeal phase. R101's Brief Interview for Mental Status (BIMS) dated 08/22/2025 documents R101 has BIMS score of 6/15, indicating R1 has severe cognitive disability. On 09/09/205 at 12:00PM, R101 was observed wearing a wrist band from a nearby hospital on his left wrist that documented his name, age, gender, date of birth .On 09/09/2025 at 12:02PM, V14 (Registered Nurse-RN) observed R101's wrist band and stated R101 came back with it from a recent hospital visit. V14 stated the wrist band should have been removed when R101got back to the facility because the wrist exposed R1's personal information; full name, age, date of birth , and gender, and anyone can see the information on the wrist band. V14 stated this was a HIPAA (Health Insurance Portability and Accountability Act) violation. On 09/11/2025 at 10:50AM, V2 (Director of Nursing-DON) V2 stated R101 when come back from the hospital, the wrist band from the hospital should have been removed to protect R101's privacy because the wrist band showed R101's identifying private information such as date of birth , age, name and gender and was exposed where anyone could see R101's personal information which is a HIPAA concern. Policy titled Dignity dated 4-23-18 documents: -Place labels on each resident in a way that is conspicuous and respects his or her dignity.

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to obtain a physician order, develop plan of care and determine if self-administration of medication was appropriate for one (R52) of one resident observed with medication at bed side table in a sample of 29. The findings include:R52's admission record showed initial admit date on 7/26/2024 with diagnoses not limited to End stage renal disease, Dependence on renal dialysis, Benign prostatic hyperplasia, Essential (primary) hypertension, Multiple subsegmental thrombotic pulmonary emboli, Unspecified atrial fibrillation, Obstructive and reflux uropathy, Wedge compression fracture of fourth lumbar vertebra, Wedge compression fracture of second lumbar vertebra. MDS (Minimum Data Set) dated 8/6/2025 showed R52's cognition was intact. On 9/9/25 at 12:36 PM Observed R52 resting in bed, alert and verbally responsive. Appears comfortable and well groomed. Observed 2 brown with green capsules in the medication cup at bedside. R52 said it was brought by the nurse, not sure when. On 9/9/25 At 12:39PM Surveyor requested V28 (Licensed Practical Nurse / LPN) to R52's room and stated those 2 capsules are Tamsulosin / Flomax and it is scheduled at nighttime. Stated maybe the night nurse left it at bedside. On 9/11/25 At 9:18AM V2 (Director of Nursing / DON) stated nurses are not supposed to keep or leave medications at bedside. She said self-medication administration should be determined or assessed to determine if the resident is able /can safely self-administer medication and if they are cognitively appropriate to keep medication at bedside. V2 said self-administration should have a physician order and should be care planned. V2 stated if medications were left at bedside, the nurse would not know the exact time the resident took the medications, and not following medication timing of physician order and resident could possibly result in not receiving the therapeutic effect of the medication. R52's electronic health record reviewed with V2 and did not find assessment and care plan for self-administration and no physician order for medication to leave at bedside. R52's POS (Physician order sheet) dated 9/9/25 and MAR (Medication Administration Record) showed active order not limited to Tamsulosin HCl Oral Capsule 0.4 MG Give 2 capsule by mouth at bedtime at 9PM related to Benign Prostatic Hyperplasia. Facility's Self-administration of medications policy dated 8/2020 showed in part: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team (or equivalent) has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self- administer. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical and visual ability to carry out this responsibility during the care planning process.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to complete the Quarterly Minimum Data Set (MDS) assessment using the Centers for Medicare Medicaid (CMS) specified Resident Assessment Instrument (RAI) process within the regulatory timeframe for 1 (R80) of 1 resident reviewed for quarterly resident assessment in a sample of 29.On 09/11/2025 at 12:56PM, V22 (Minimum Data Set (MDS)/Care Plan Coordinator) stated the purpose of the MDS is to describe the resident and give a picture of the care a resident will receive. V22 stated the MDS is submitted to CMS (Centers of Medicare Medicaid) every quarter (every 92 days) or more frequently if the resident has experienced significant change.V22 stated R80's ARD (Assessment Reference Date) was completed late and further stated assessment should be completed within 14 days from the ARD. V22 stated that timing completion of the MDS assessments are based on the RAI manual.The facility's RAI Version 3.0 Manual dated October 2019 page 2-17 titled RAI OBRA-required Assessment Summary indicates that Quarterly (Non-Comprehensive) MDS assessment should be completed no later than 14 days from the ARD.Assessment final validation report dated 7/24/2025 showed Message: Assessment completed late. Assessment completion date is more than 14 days.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to initiate a person-centered care plan with appropriate interventions for one resident (R94) of 29.Findings include:9/9/25 at 12:11 PM, Writer observed R94 lying in bed eating lunch. R94s head of the bed was not upright, it was approximately 30 degrees high. R94 was almost lying flat. R94 was bending at the neck to put food in R94s mouth. Writer observed R94 coughing as R94 ate and drank. Writer observed signage on the wall above R94s bed that read in part: remember safe swallowing: sit upright when eating and drinking. R94 said R94 eats like this every meal. R94 said staff pull R94 up but R94 keeps sliding back down.9/10/25 at 12:22 PM, R94 said when the head of the bed is up, R94 slides down so there is no point in putting it up. 9/10/25 at 12:28 PM, V39 (Certified Nursing Assistant) stated R94 always refuses to have the head of bed up while eating. V39 stated V39 has warned R94 of the choking hazard. V39 stated V39 has not told the Director of Nursing or anyone of R94s preference.9/10/25 at 12:51 PM, V42 (Licensed Practical Nurse) stated V42 is familiar with R94. V42 stated R94 always wants to lay flat even when eating and for medication administration. V42 stated V42 has educated R94 on the choking, aspiration hazard. V42 stated V42 believes the Director of Nursing is aware of R94s preference but V42 has not notified the Director of Nursing or management.9/11/25 at 9:54 AM, V2 (Director of Nursing) stated staff have not made V2 aware that R94 eats lying down. V2 stated R94 is a picky eater as far as food preferences. V2 stated we will make a plan for R94 to help R94 stay in position, particularly when eating. V2 stated R94s preference should be care planned. V2 stated whoever is aware of the situation could care plan it. Nurses can care plan it. V2 checked R94s care plan and stated R94s lying down while eating is not care planned. R94s face sheet provided by facility indicates R94 has diagnoses that include but not limited to gastro-esophageal reflux disease; dyspepsia.Facility was not able to provide a care plan that addresses R94s preference to not be positioned upright while eating.Facility policy Comprehensive Care Plan, 11/17/17, reads in part: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review, the facility failed to properly position one resident (R24) of 29 reviewed for activities of daily living. Findings include:9/9/25 at 12:23 PM, writer observed R24 lying in bed with the head of the bed not in an upright position, approximately 30 degrees. R24 was not pulled up in the bed. R24s lunch tray was on the bedside table across the bed. Writer observed the tray had been eaten from. Writer observed R24 take spoonsful from the tray and eat them. 9/9/25 at 12:27 PM, V24 (Licensed Practical Nurse) stated R24s head of bed was almost flat. V24 stated R24 feeds self. V24 stated R24 could have choked, aspirated with the head of bed low and R24 not positioned upright.9/9/25 at 2:04 PM, V41 (Certified Nursing Assistant) stated residents should not be flat to eat because they could aspirate. V41 stated V41 placed R24s meal tray down and R24 reached for the food to eat. V41 stated next time V41 will reposition R24 first before giving the meal tray.9/11/25 at 9:54 AM, V2 (Director of Nursing) stated when setting up a resident to eat, the CNA will set them up. They sit them up in the bed. Elevate the head of the bed to at least 45 degrees. They put the bedside table in front of the resident with the food tray and drinks and position everything in their reach. They assess for any other needs before leaving the resident. R24 needs assistance to prop-up in bed. R24 should not be lying in bed to eat.R24s face sheet provided by facility indicates R24 has diagnoses that include but not limited to dementia; dysphagia, oropharyngeal phase; fall; presence of artificial hip joint, bilateral.R24s MDS (Minimum Data Set) 8/11/2025, indicates a BIMS (Brief Interview for Mental Status) score was not able to be obtained due to R24 was unable to complete the interview. R24 requires setup or clean-up assistance for eating. R24 requires partial/moderate assistance to go from lying to sitting on the side of the bed.R24 has care plan that reads in part: I have a swallowing problem related to swallowing assessment results; with intervention including: Instruct resident to eat in a upright position, to eat slowly, and to chew each bite.Writer requested policies for choking, aspiration precautions. V1 (Administrator) stated there are no policies of this subject.V2 (Director of Nursing) stated we do not have a policy for feeding setup in bed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure feeding assistance was provided to a resident on aspiration precaution. This failure affected one (R83) resident reviewed for activities of daily living (ADL) care out of 29 residents in the final sample.Findings Include: On 9/9/25 at 12:18 PM, R83's in bed eating lunch independently with head of bed up to 90 degrees. R83's meal ticket reads in part: 1200 fluid restriction with 1:1 [one-to-one] feeding. Surveyor observed a signage posted on R83's closet documents in part: Feeding-Aspiration precautions. Patient requires 1:1 feeding. Small teaspoon presentation at a time. Do not provide secondary bites until patient swallows and clears mouth. Do not leave patient alone with tray.On 9/9/25 at 12:28 PM, R83 was observed still eating lunch unassisted in her room. Surveyor called the attention of V5 (Certified Nursing Assistance). On 9/9/25 at 2:28 PM, V12 (Speech Pathologist) stated that R83 was discharged from skilled speech therapy services on 7/16/25 and the recommendation was solid mechanical soft, thin liquids and one-to-one feeding assistance. V12 stated that R83 needs full staff assistance with feeding and general swallow precaution: upright posture, slow rate, slow bites and sips. V12 stated R83 is at risk for choking or aspirating if she's not assisted with meals.R83's clinical records show an admission date of 10/16/24 with included diagnoses but not limited to type 2 diabetes mellitus, Alzheimer's disease, dysphagia oropharyngeal phase, and chronic obstructive pulmonary disease. R83's order summary report with active orders as of 9/9/25 reads in part: ST [Speech Therapy] diet clarification: Diet effective 7/8/2025: mechanical soft solids/thin liquids- STRICT ASPIRATION PRECATIONS- 1:1 FEEDER. R83's ST Discharge summary dated [DATE] documents in part: one to one feeding with mechanical soft diet. R83's comprehensive care plan documents in part: Eating: My usual performance is: partial/moderate assist x 1, 1:1 feeder.Surveyor requested for the facility's policies and procedures for aspiration precaution and ADL care. V1 (Administrator) stated that the facility has no such policies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy and procedure to (a) measure upper circumference and exterior catheter length, (b) change midline dressing timely, (c) provide maintenance flush, and (d) develop comprehensive care plan of midline use for 1 (R12) resident. The facility also failed to ensure physician's order was followed for a resident (R1) with aspiration precaution. These failures affected two (R1, R12) residents out of 29 residents in the final sample reviewed for quality of care. Findings Include: R12's admission record showed admit date on 5/9/25 with diagnoses not limited to Malignant neoplasm of central portion of left male breast, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes, Secondary malignant neoplasm of retroperitoneum and peritoneum, Secondary malignant neoplasm of pleura, Malignant neoplasm of abdomen, Malignant pleural effusion, Secondary malignant neoplasm of unspecified lung, Essential (primary) hypertension, Other ascites, Spontaneous bacterial peritonitis. MDS (Minimum Data Set) dated 8/13/2025 showed R12's cognition was intact. On 9/10/25 At 11:02AM Observed R12 resting in bed, alert and oriented x 3, verbally responsive. R12 showed single lumen midline on left upper arm, dressing was dated 8/29/25. He said midline was placed in the hospital and dressing was never replaced in the facility. R2's midline was never accessed, and no flushing was done. He said his left arm circumference and midline external catheter was never measured. On 9/10/25 at 1:32PM V31 (Licensed Practical Nurse / LPN) stated she is working with R12 today. She said R12 has a midline and dressing was dated 8/29/25. On 9/11/25 At 9:18AM V2 (Director of Nursing / DON) stated midline dressing should be changed every 7 days to prevent potential infection. She said arm circumference and exterior catheter length of midline should be measured and documented to monitor complications such as swelling / edema / infiltration or catheter migration. V2 said midline use should be care planned to establish plan of care and so staff would know how to care for the resident that would include interventions. R12's Nurses Note dated 9/8/2025 showed in part: Has IV Midline on the Left forearm. Care plan reviewed; no plan of care found for R12's midline. R12's health record reviewed with no documentation found that left arm circumference and external catheter of midline was measured. Facility's policy for IV (intravenous) access line maintenance protocol dated 2/7/20 showed in part: Midline: Maintenance flush for each lumen = 10ml NS (Normal Saline) every week. Transparent dressing changed = On admission then weekly and as needed. Measure upper arm circumference and exterior catheter length with each dressing change and prn (as needed). Facility's comprehensive care plan policy dated 11/17/17 showed in part: to develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences and services that are to be furnished to attain or maintain the resident's highest practicable well-being. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/25 at 10:43 AM, R1 was lying in bed alert and awake noted with bouts of confusion noted. Surveyor observed a cup of water with a straw on top of R1's bedside table within easy reach of R1. Surveyor observed a signage posted on top of R1's head of bed. On 9/9/25 at 10:59 AM, V5 (Certified Nursing Assistant) entered R1's room and stated that the signage means R1 should not be given a straw with her fluids. V5 stated the cup of water with a straw had been on top of R1's bedside table since V5 came in the morning. V5 stated, I will take it away from her. On 9/9/25 at 11:10 AM, V6 (Agency Licensed Practical Nurse) stated that it's her first time working in the facility. Surveyor showed V6 the signage that was posted on top of R1's bed. V6 stated that the signage means no straw. V6 confirmed in R1's electronic health records that R1 has an order for NO STRAW because R1 at risk for aspiration or choking. On 9/9/25 at 2:28 PM, V12 (Speech Pathologist) stated that R1 was discharged on 8/4/25 from skilled speech therapy services. V12 stated R1's discharge instruction/recommendation from speech is pureed diet and thin liquid with no straws. V12 stated staff should be giving R1 a straw because she can aspirate if they allow R1 to use a straw. R1's clinical records show an admission date of 3/25/23 with included diagnoses but not limited to hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, dysphagia oropharyngeal phase, acute pulmonary edema, and acute bronchitis. R1's Minimum Data Set (MDS) dated [DATE] shows R1 has impaired cognition and requires supervision assistance for eating. R1's order summary report with active orders as of 9/9/25 reads in part: GENERAL * diet Pureed * texture, Thin consistency, NO STRAWS (ordered 7/8/25) and ST (Speech Therapy) diet clarification: puree/nectar to puree/THIN- NO STRAWS. Administer medications crushed in puree. STRICT NO STRAWS RESTRICTION- ASPIRATION W/STRAWS. Diet effective: 7/7/2025: Puree solids/Thin liquids- Set up assist, no straws. R1's comprehensive care plan shows R1 is at risk for aspiration date initiated on 2/21/24. Surveyor requested for the facility's policy and procedure for aspiration precaution and/or general care. V1 (Administrator) stated that the facility has no such policies.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to implement fall interventions for two residents (R24, R151) of 29 reviewed for falls.Findings include:9/9/25 at 12:05 PM, writer observed R151 lying in bed watching television. A fall mat was observed on the floor next to R151's bed. R151's bed was observed not in the lowest position. R151's bed was approximately knee height. R151 said the bed has been like this all day. R151 said R151 needs assistance to get out of bed.9/9/25 at 12:23 PM, writer observed R24 lying in bed and the bed was not at the lowest position. 9/9/25 at 12:27 PM, V24 (Licensed Practical Nurse) stated R24s bed was raised to about knee level. The bed was not at the lowest position. V24 stated R24 tries to get up from bed. V24 stated R24 could have fallen out of bed and been injured with the bed not at lowest position. V24 stated R151's bed should be lower to prevent a fall with injury.9/9/25 at 2:04 PM, V41 (Certified Nursing Assistant) stated R151 is a fall risk because there is a fall mat on the floor by the bed. The bed should be low for fall precaution because R151 could fall out of bed. 9/11/25 at 9:54 AM, V2 (Director of Nursing) stated R24 is a fall risk. R24's bed should be in the lowest position. V2 stated R151 is a fall risk. R151's bed should be in the lowest position. The bed should be in the lowest position because it decreases the risk of significant injury. R151's face sheet provided by facility indicates R151 has diagnoses that include but not limited to dementia; repeated falls.R151's MDS (Minimum Data Set) 6/23/2025, indicates R151 has a BIMS (Brief Interview for Mental Status) score of 12 indicating moderately impaired cognition.R151 has care plan that reads in part: Potential for falls related to: confusion, history of falls, unfamiliar environment, weakness.Fall Risk Assessment, 4/28/2025, categorizes R151 as at risk for falls.R24's face sheet provided by facility indicates R24 has diagnoses that include but not limited to dementia; dysphagia, oropharyngeal phase; fall; presence of artificial hip joint, bilateral.R24's MDS (Minimum Data Set) 8/11/2025, indicates a BIMS (Brief Interview for Mental Status) score was not able to be obtained due to R24 was unable to complete the interview. R24 requires partial/moderate assistance to go from sitting to standing.R24 has care plan that reads in part: Potential for falls related to: confusion, history of falls, unfamiliar environment, weakness.Fall Risk Assessment, 8/11/2025, categorizes R24 as at risk for falls.Facility policy Fall Prevention Program, 11/21/17, reads in part: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the water ordered for flushes is administered per doctor orders for one (R99) out of five residents reviewed in a total sample of 29. This failure places residents at risk to be provided with inappropriate care and services to meet the resident's physical, mental and/or psychosocial needs. Findings include:On 09/09/2025 at 11:21 AM, R99 was observed laying down on his bed, head of the bed elevated, gastrostomy tube feeding rate set at 65 ml (milliliter) per hour, water flush set at 160ml every 6 hours. Noted with 599 ml fed and 160 ml flushed. R99's water flush bag dated 09/08/25 and feeding formula labeled with R99's name, room number, rate, and date 09/08/25. On 09/10/2025 at 11:12 AM, with V25 (Registered Nurse), R99 is not in his room but R99's g-tube feeding pump noted in R99's room. V25 stated that R99's g-tube is disconnected and turned off when R99 goes to dialysis. V25 stated I am the one that disconnected it this morning, it was connected when I came in to work at 7:00 AM. V25 turned on R99's g-tube pump to inform this surveyor the settings that R99's g-tube pump is set at. V25 stated that R99's g-tube feeding is set at 65ml (milliliter) per hour, and the water flush is set at 160ml every 6 hours. V25 stated that R99 is being followed by the dietician and V25 does not work regularly with R99. On 09/11/2025 at 10:39 AM, with V2 (Director of Nursing), observed R99's g-tube feeding pump on and attached to R99. V2 stated I see the water flush is set at 160ml every 6 hours, and the feeding formula is set at 65ml/hour. V2 stated that the feeding and water flush settings should be cross referenced with the resident's orders. On 09/11/2025 at 9:59 AM, V35 (Registered Dietician) stated that she is the dietician that follows the residents who are on dialysis. V35 stated that she recommended for R99 to have a decrease in water flushes because V35 increased R99's gastrostomy (g-tube) feeding rate. V35 stated that she increased his feeding because R99 was underweight. V35 stated she decreased water flushes because of heart concerns and total amount of fluid that a dialysis patient can remove. V35 stated that the feeding tube is already providing fluid. V35 stated that if R99 were to continue to receive 160ml (milliliters) every six hours of water flushes and 65ml/hour of g-tube feeding, it would be exceeding the amount of fluids and the blood sodium level will be lower than 135 milliequivalents per liter (mEq/L).On 09/11/2025 at 9:45 AM, V2 (Director of Nursing) stated that it is important to follow the enteral orders including flushing orders because it is the residents' nutritional status and it will impact their weights and overall health. R99's face sheet documents that R99 is a [AGE] year-old individual with diagnoses not limited to: unspecified protein-calorie malnutrition, gastrostomy status, end stage renal disease, dependence on renal dialysis, chronic systolic (congestive) heart failure. R99's MDS/Minimum Data Set Section C dated 07/15/2025 documents that R99 is severely cognitively impaired. R99's active care plan documents in part R99 requires tube feeding. Interventions document in part I am dependent with tube feeding and water flushes. See MD (Doctor of Medicine) orders for current feeding orders.R99's nurses note dated 09/05/2025 12:13 PM documents in part dialysis dietician recommended to decrease water flush from 160ml every 6 hours to 100 ml every 8 hours. NP (Nurse Practitioner) approved recommendation noted and carried out. R99's active physician order set documents in part state date 09/05/2025, enteral feed order every 8 hours 100 ml water flush q 6hrs. Facility document dated 8-3-20 documents in part gastrostomy tube- feeding and care. To provide nutrients, fluids and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach. Licensed nurse will review physician's order for type of formula, concentration, rate of flow, and method of administration.

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	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Rehab at Fairmont	5061 North Pulaski Road Chicago, IL 60630

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident (R83) received the correct oxygen flow rate as ordered by the physician and to ensure nasal cannula tubing was applied to a resident receiving oxygen for 1 (R1) of 2 residents reviewed for respiratory care in a final sample of 29.Findings Include:On 9/9/25 at 10:43 AM, R1 was lying in bed alert and awake noted with bouts of confusion. R1's oxygen (O2) concentrator was turned on and flow rate set to 2 liters per minute (lpm). R1's nasal cannula (nc) tubing was wrapped around her left side rail; the nasal prong was on the floor and was not applied in her nose. R1 was not in distress. On 9/9/25 at 10:59 AM, V5 (Certified Nursing Assistant) entered R1's room and applied the nasal cannula tubing for R1. V5 stated that it should have been in her nose. On 9/9/25 at 10:57 AM, R83's sleeping in bed noted receiving oxygen (O2) via nasal cannula that was set to 3 liters per minute (lpm).On 9/9/25 at 11:10 AM, V6 (Agency Licensed Practical Nurse) stated that it's her first time working in the facility. V6 confirmed R83's electronic health record shows an order for continuous oxygen at 2lpm. On 9/10/25 at 11:42 AM, R83 was sleeping in bed and noted her O2 concentrator flow rate was still set to 3lpm. On 9/10/2025 at 11:52 AM, surveyor asked V14 (Registered Nurse) to check R83's oxygen and confirmed R83's O2 concentrator flow rate was set to 3lpm. V14 stated the order is 2lpm.9/11/25 at 9:43 AM, V2 (Director of Nursing) stated, When administering oxygen, the nurse is to check the doctor's order. They must administer and monitor the resident's oxygen based on the doctor's order because it is considered a medication and if the resident does not need it, it should be removed or if they need it, then it should be adjusted accordingly. It is important to follow the doctor's order because oxygen falls on medication safety practice.R1's clinical records show an admission date of 3/25/23 with included diagnoses but not limited to hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, acute pulmonary edema, and acute bronchitis. R1's Minimum Data Set (MDS) dated [DATE] shows R1 has impaired cognition and requires staff assistance with bed mobility and transfers. R1's order summary report with active orders as of 9/9/25 shows Oxygen 2 lpm/nc every shift (ordered 6/15/25).R83's clinical records show an admission date of 10/16/24 with included diagnoses but not limited to chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. R83's MDS dated [DATE] shows R83 has moderately impaired cognition and is total dependent on staff's assistance for transfers and bed mobility. R83's order summary report with active orders as of 9/9/25 reads in part: Oxygen via nasal cannula on 2LPM (ordered 10/17/24).The facility's Oxygen Concentrator policy (2013) documents in part: To provide Oxygen for therapeutic use by utilizing a concentrator that converts ambient air to a higher concentration level of oxygen. Verify and understand the physician's order. Know the flow rate and duration of use. Adjust the flow meter control knob to the flow setting prescribed by the physician.

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	145867	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess the risk versus benefits of using side rails and review them with the resident prior to use and failed to implement person-centered comprehensive care plan addressing the use of the side rails. These failures affected two (R4, R52) out of three residents reviewed for side rails in a final sample of 29. Findings Include: On 9/9/25 at 11:47 AM, R4 was sitting on the side of the bed and noted with two upper half side rails up. R4 stated she gets out of bed by herself and uses a wheelchair to get around. On 9/10/2025 at 11:37 AM, R4 was sleeping in bed and noted with two half upper side rails up. On 9/10/25 at 10:43 AM, V22 (MDS Coordinator) stated that the purpose of the care plan is to notify the staff how to provide care for the residents. V22 stated if the resident has a change in condition the care plan should be updated as soon as possible. V22 stated that comprehensive care plan should be initiated on admission MDS (Minimum Data Set), annually, significant change, and with any change in condition. V22 stated that the needs of the resident should be addressed in the care plan and how to provide the care for the residents. V22 stated the use of side rails should be addressed in the care plan. V22 confirmed in R4's electronic health records that R4 had no side rails care plan. V22 also confirmed that there was no side rail assessment completed for R4, and that the last one was done on 6/28/24 from R4's previous admission. On 9/10/25 at 3:11 PM, V32 (Restorative Nurse) stated that side rail risk assessment should be completed before using the side rails for the residents. V32 stated that the purpose of the assessment is to determine for risk of injury when they are using the side rails, to determine if the resident can use the side rails safely and the benefits of the side rails. V32 stated that a consent obtained from the resident or responsible party prior using the side rails is incorporated in the side rail risk assessment. V32 stated that side rail risk assessment is completed upon admission and reviewed on a quarterly basis or if there is a significant change or as needed. V32 stated that the use of side rails needs to be incorporated in the ADL (Activity of Daily Living) care plan as part the bed mobility performance. V32 stated that the side rail assessment needs to be re-evaluated for continued use or for any changes. R4's clinical records show an admission date of 6/25/25 with included diagnoses but not limited to dementia, essential hypertension, and chronic kidney disease. R4's Minimum Data Set, dated [DATE] shows R4 is cognitively impaired and requires substantial maximal assistance from staff for bed mobility and transferring from bed. R4's physician orders do not have an order for use of side rails. R4's electronic health records revealed no side rail/s assessment since the admission date of 6/25/25. R4's comprehensive care plan does not address the use of side rails. (continued on next page)

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	145867	A. Building B. Wing	09/12/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's admission record showed initial admit date on 7/26/2024 with diagnoses not limited to End stage renal disease, Dependence on renal dialysis, Benign prostatic hyperplasia, Essential (primary) hypertension, Multiple subsegmental thrombotic pulmonary emboli, Unspecified atrial fibrillation, Obstructive and reflux uropathy, Wedge compression fracture of fourth lumbar vertebra, Wedge compression fracture of second lumbar vertebra. MDS (Minimum Data Set) dated 8/6/2025 showed R52's cognition was intact. He needed total assistance with toileting hygiene, shower / bathe self, lower body dressing; Partial / moderate assistance with upper body dressing and personal hygiene, roll from lying on back to left and right side, sitting on side of bed to lying flat on the bed; Dependent with chair / bed transfer. On 9/09/2025 at12:36PM Observed R52 in bed, alert and verbally responsive, with 2 upper side rails up. R52 said rails are always up. On 9/10/25 At 3:22PM V32 (Restorative nurse) stated side rails should have a care plan. Surveyor reviewed R52's EHR (Electronic Health Record) with V32 and stated there is side rail assessment indicated for bed mobility. Stated no care plan found for Side rail use. On 9/11/25 At 9:18AM V2 (Director of Nursing / DON) said use of bedrails should have an assessment and usually it is being used to enhance bed mobility. Stated bedrail use should be planned for safety of the resident and so staff would be able to know the use of bed rails for positioning. The facility's Side Rails/Bed Rails policy dated 10/24/22 documents in part: The facility shall ensure that prior to the installation of bed rails, the facility has attempted to use alternatives. After alternatives to bed rails have been attempted and determined that these alternatives do not meet the resident's needs, the facility shall assess the resident for the risks of entrapment and possible benefits of bed rails. In addition, the resident assessment should include an evaluation of the alternatives to the use of a bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. The facility shall also assess the resident's risk from using bed rails. The following includes potential risks regarding the use of bed rails: Accident hazards, barrier to residents from safely getting out of bed independently, physical restraint, other potential negative physical outcomes, and other potential negative psychosocial outcomes. After alternatives have been attempted and prior to installation, the facility shall obtain informed consent from the resident or if applicable, the resident representative for the use of bed rails. The care plan shall be developed on an individual basis, and may include but is not limited to the following related to use of bed rails: Which medical need would be met through the use of bed rails; How often the bed rail is applied, duration of use, and the circumstances for when it is to be used; How monitoring is provided, and when and how often the bed rail is to be released and assistance provided for use of the bathroom, walking and range of motion; What the resident's functional ability is, such as bed mobility and ability to transfer between positions, to and from bed or chair, and to stand and toilet and staff required for each function that requires assistance; Identification of interventions to address any potential complications such as physical and/or psychosocial changes related to the use of the bed rails, such as increased incontinence, decline in ADLs or ROM, increased confusion, agitation, and depression; Identification of interventions to minimize or eliminate the use of the bed rails; and Who monitors for the implementation of the use of the bed rails, and who evaluates and assesses the resident to determine the ongoing need for bed rails, whether the bed rail use should be gradually decreased, and how the modifications.

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	145867	A. Building B. Wing	09/12/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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	145867	A. Building B. Wing	09/12/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and record reviews, the facility failed to ensure a medication error rate of less than 5% for three (R55, R58 and R147) of five residents with 12 errors for 35 medication administration opportunities. This resulted in a medication error rate of 34.29%. The findings include:On 9/9/2025 at 9:44AM Medication administration observation conducted with V6 (Agency Licensed Practical Nurse / LPN). Observed V6 prepare and administer the following medications to R58: Guaifenesin 400 MG (milligrams) 1 TabletJanuvia 50 MG 1 TabletClopidogrel 75 MG 1 TableNifedipine 60 MG Extended Release 1 TabletIron ferrous gluconate 27mg 1 TabletEliquis 5 MG 1 Tablet Observed R58 take prepared medications by mouth. R58's POS (Physician Order Sheet and MAR (Medication Administration Record) showed medication orders not limited to: Mucinex cough and chest congestion oral capsule 10-200mg give 1 capsule by mouth two times a day at 9AM and 9PM. Ferrous sulfate 325 MG (65 Fe) give 1 tablet by mouth two times a day at 8AM and 8PM.Observed medication errors due to wrong dose for Mucinex and Ferrous sulfate. On 9/9/25 at 10:04 AM Observed V6 (Agency LPN) prepared and administered the following medications to R147: Ferrous fumarate 325 MG 1 Tablet. Senna 1 tablet Aspirin 81 MG chewable 1 Tablet Losartan potassium 100 MG 1 Tablet. Nifedipine 90 MG Extended Release 1 Tablet. Insulin lispro 200 UNT/ML Pen Injector 5 UnitsObserved V6 injected insulin to R147's right side of the abdomen and R147 took prepared medications by mouth. R147 POS and MAR showed medication orders not limited to: Senna plus twice a day give 1 tablet by mouth two times a day at 8AM and 8PM. Nifedipine 90 MG Extended Release give 1 tablet by mouth two times a day at 9AM and 9PM. HUMALOG Kwik pen inject 5 units subcutaneously with meals at 8AM, 12PM and 5PM.Observed medication errors due to wrong time for the following medications: Senna, Nifedipine, Insulin Humalog.On 9/9/25 At 10:31am Medication administration observation conducted with V28 (LPN). Observed V28 prepared and administered the following medications to R55: Sertraline 50mg 1 tabletLinzess 72mcg 1 tabletPolyethylene glycol 1 capful mixed with waterAllopurinol 100mg 1 tabletAspirin EC 81mg 1 tabletDocusate Sodium 100mg 1 tabletMagnesium oxide 400mg 1 tabletProtonix 40mg 1 tabletRena Vite R1x 1mg 1 tabletSenna plus 1 tabletHydralazine 50mg 1 tabletSpironalactone 50mg 1 tabletCarvedilol 25mg 1 tabletNifedipine ER 60MG 1 TabletMetolazone 2.5mg 1 tabletLosartan 100mg 1 tabletObserved R55 took prepared medications by mouth.R55's POS (Physician Order Sheet and MAR (Medication Administration Record) showed order not limited: Docusate sodium 100 MG Oral Capsule [Colace] two times a day at 9AM and 5PM. Pantoprazole 40 MG Delayed Release Oral Tablet give 40mg by mouth two times a day at 9AM and 5PM. Senna oral 8.6mg give 1 capsule by mouth two times a day at 9AM and 5PM. Hydralazine hydrochloride 50 MG Oral Tablet give 1 tablet by mouth three times a day for hypertension at 8AM, 12PM and 8PM Carvedilol 25 MG Oral Tablet give 1 tablet by mouth two times a day at 9AM and 5PM. Nifedipine 60 MG Extended Release Oral Tablet give 1 tablet by mouth two times a day at 9AM and 5PM. Furosemide 80 MG Oral Tablet give 1 tablet by mouth two times a day at 9AM and 5PM. Observed medication errors due to wrong time for the following medications Docusate sodium, Pantoprazole, Senna, Hydralazine, Carvedilol, Nifedipine. Furosemide 80 MG was omitted or was not given during medication administration. On 9/11/25 At 9:18AM V2 (Director of Nursing / DON) stated nurses are expected to follow Medication administration policy by giving medications in a timely manner. She said nurses have 2-hour window one hour before and one after the ordered time. V2 said nurses should follow 5 R's (Right resident, route, dose, time, medication) in medication administration. She said if a nurse is not following doctor's order for the right time and dose in giving medication it could have a negative impact to the resident. V2 said for example Blood pressure medication was not given at the ordered time, could potentially lead to hypertensive crisis and trip to the hospital. She said If insulin was not given in a timely fashion, hyperglycemic incident could occur and potentially lead to a trip to the hospital. V2 said if medication dosage was not followed, potentially the resident could not receive therapeutic effect of the medication.Facility's administration procedure for all medications dated 8/2020 showed in part: Medications will be administered in a safe and effective manner. At a minimum, review the 5 rights at each of the following steps of medication administration. Check the MAR for the order

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	145867	A. Building B. Wing	09/12/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to (a) properly date opened multi-dose insulin for three (R7, R126 and R137) residents, and (b) ensure multi-dose eye drops were properly stored at appropriate temperature for two (R35 and R67) from 4 of 8 medication carts and 1 of 2 medication rooms inspected for medication storage and labeling. The findings include: On n [DATE] at 11:26AM Team 4 Medication cart inspected with V25 (Registered Nurse / RN) and observed the following: R137's multi dose LANTUS insulin was opened with no open date. Pharmacy label showed once opened refrigerate or not discard after 28 days. R35's unopened multi dose Latanoprost eyedrop was kept inside the medication cart. Pharmacy label showed: Refrigerate unopened, store opened at room temperature discard after 6 weeks. R67's unopened multi dose Latanoprost eyedrop was kept inside the medication cart. Pharmacy label showed: Refrigerate unopened, store opened at room temperature discard after 6 weeks. V25 said once insulin was opened it should be dated to know when to discard. She said Unopened Latanoprost eyedrop should be refrigerated as it is indicated in the pharmacy label. On n [DATE] at 11:43AM Team 1 medication cart inspected with V27 (Licensed Practical Nurse / LPN) and observed the following: R7's multi-dose dose Lantus insulin pen was open with no date. Pharmacy label showed: Once opened store at room temperature for 28 days. R126's multi-dose dose Lantus insulin pen was open with no date. Pharmacy label showed: Once opened store at room temperature for 28 days.V27 said insulin once opened should be dated and discarded after 28 days.On [DATE] At 9:18AM V2 (Director of Nursing / DON) stated nurses should follow recommendation from the pharmacy for proper storage of medication. She said if the medication needed to be refrigerated then it should be kept in the right temperature. V2 said if medication is not properly stored at right temperature potentially the effect of the medication could be altered, or the potency of the medication could be affected. V2 said nurses should date insulin once opened because insulin is only good for certain days. She said if insulin is not properly dated could potentially give expired medication to the resident. V2 said Lantus insulin once opened is good for 28 days and should be discarded. R7's POS (Physician Order Sheet) dated [DATE] showed active order not limited to: Lantus solution pen injector 100unit/ml inject 32 units subcutaneously at bedtime. R35's POS dated [DATE] showed active order not limited to: Latanoprost ophthalmic solution instill 1 drop in right eye in the evening. R67's POS dated [DATE] showed active order not limited to: Latanoprost solution instill 1 drop in both eyes at bedtime. R137's POS (Physician Order Sheet) dated [DATE] showed active order not limited to: Lantus solution 100unit/ml inject 36 units subcutaneously two times a day. Facility's storage of medications policy (undated) showed in part: Medications are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. Medications requiring refrigeration are kept in a refrigerator at temperature between 36F - 46F. Certain medications or package types such as multiple dose injectables vials, ophthalmic, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. Facility's reference guide - medications with shortened expiration dates dated [DATE] showed in part: Lantus vial - once opened store below 30. Product expires 28 days after the first use or removal from refrigerator whichever comes first. Lantus pen: once opened, do not refrigerate. Store at room temperature. Product expires 28 days after the first use or removal from refrigerator whichever comes first. Latanoprost: store unopened bottles under refrigeration (36F - 46F). Once opened, product may be stored at room temperature for 42 days.

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	145867	A. Building B. Wing	09/12/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow food item labeling practices to ensure there are no outdated food items in the kitchen for resident consumption. This failure has the potential to effect 141 residents that receive food from the kitchen.Findings include:9/9/25 at 9:23 AM, conducted initial tour of kitchen with V40 (Dietary Manager)Observed in milk cooler #1:-one carton of Thickened Lemon Flavored Water, not sealed, with no Opened date-one carton of Thickened Lemon Flavored Water, not sealed, with Opened date 8/29/25. V40 stated the flavored water is kept one week after unsealing.Observed in reach-in refrigerator:-three salad bowls labeled with prep date 9/7/25 and use by date 9/14/25-two salad bowls labeled with prep date 9/6/25 and no use by date-one salad plate with prep date 9/6/25 and no use by date-three salad plates with prep date 9/7/25 and use by date 9/14/259/10/25 at 1:07 PM, V43 (Cook) stated we have to put the open and use by date on kitchen items for resident safety. Salads should be used within three days. Other items seven days. After three days salad can get slimy, brown and no good. Residents should never get expired foods because of possible food poisoning, sickness.9/10/25 at 1:14 PM, V40 (Dietary Manager) stated V40 prefers the salads to be made daily and kept no longer than three days. It is important to label correctly so old food is not given to the residents and to describe the food. Dating the items tell when the item is to be trashed. If residents are given old food, there is potential for the resident to get food born illness. The facility has one resident that takes honey thick water.Facility policy Storage Periods, Use-By Guidelines, no date, reads in part: Food should be stored properly and used within the appropriate time period to ensure safe and high-quality food is served. The Use-By Guidelines-Posted should be used to determine a use-by date when labeling opened or unopened food that must be used within a certain time frame (i.e. not manufacturer use by dates). Foods with a manufacturer's use-by date should still require an opened-on date once the item is opened. Expired food items should be disposed of.

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	145867	A. Building B. Wing	09/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to a) perform hand hygiene before and after having direct contact with residents and ensure necessary equipment are maintained to carry out an effective infection control program for five (R14, R55, R58, R140 and R147) of five residents reviewed for infection control b) ensure that its staff follow proper personal protective equipment (PPE) protocols for one (R99) out of five residents reviewed in a sample of 29. The findings include: On 9/9/25 at 9:44 AM During medication administration observed V6 (Agency LPN / Licensed Practical Nurse) checked R58's BP (Blood Pressure) = 120/59, PR (Pulse Rate) =77/minute and administered medications to R58. V6 did not perform hand hygiene before entering / exiting R58's room, and after direct contact with R58. Standing BP device was not cleaned /disinfected / sanitized after R58's use. On 9/9/25 at 9:54 AM Observed V6 donned gloves and checked R140's BP = 133/46; PR =71/minute using the same Standing BP device used with R58. V6 did not perform hand hygiene before entering, exiting R140's room, donning and doffing of gloves, and after direct contact with R140. Standing BP device was not cleaned /disinfected / sanitized after R140's use. On 9/9/25 at 10:05 AM Observed V6 donned gloves and checked R147's BP =104/67; PR = 83 using the same standing BP device that was not sanitized or disinfected after R58 and R140's used. Observed V6 checked R147's Blood Sugar = 212. V6 removed gloves and did not perform hand hygiene and wore gloves again. V6 did not perform hand hygiene before entering / exiting R147's room, donning and doffing of gloves, and after direct contact with R147. Standing BP device was not cleaned /disinfected / sanitized after R147's use. On 9/9/25 10:20 AM During medication administration, R14's room with door signage indicated EBP (Enhanced Barrier Precaution). V28 donned PPEs (Personal Protective Equipment) gloves and gown without performing hand hygiene. V28 entered R14's room and administered medications to R14. V28 removed PPEs without performing hand hygiene. V28 did not perform hand hygiene before entering / exiting R14's room, donning and doffing PPEs, and after direct contact with R14. On 9/9/25 At 10:31 AM Observed EBP door signage on R55's room. V28 donned gloves and gown without performing hand hygiene. V28 checked R55's BP = 183/65, PR = 57/MIN Temperature = 98.1F and Oxygen saturation = 98% at room air. V28 did not sanitize / disinfect / clean standing BP device used for R55. V28 was not observed perform hand hygiene before and entering R55's room and direct contact with R55. On 9/11/25 At 9:18 AM V2 (Director of Nursing / DON) stated staff is expected to perform hand hygiene when entering and exiting resident's rooms and direct contact with resident to prevent nosocomial infection / spread of infection. V2 said reusable medical equipment such as BP, and Pulse oximeter and oxygen saturation should be sanitized, cleaned or disinfected every after use or in between in resident's use to prevent cross contamination or spread of infection. Surveyor attempted to request policy for reusable medical equipment such as BP, Thermometer, Pulse oximeter to facility but was not able to provide. V1 (Interim Administrator) and V2 (Director of Nursing / DON) said no policy for such. (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	09/12/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Hand hygiene policy dated 7/30/24 showed in part: Examples of when to perform hand hygiene: At room entry. Before exiting room. Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure. Facility's Infection prevention and control program dated 11/28/17 showed in part: All facility personnel are required to routinely wash hands. The facility shall assure that necessary equipment are maintained to carry out an effective Infection Control Program. On 09/09/2025 at 11:21 AM, CDC (Centers for Disease Control and Prevention) enhanced barrier sign outside of R99's bedroom door and PPE (personal protective equipment) supplies in a bin outside of R99's room. On 09/09/2025 at 11:31 AM, V9 (Certified Nursing Assistant) noted applying gloves, removing R99's blanket, not wearing gown. Despite this surveyor informing V9 that the surveyor will step out since the surveyor knows that V9 will need to gown up and gather supplies. Observed R99 with a disposable chuck, a flat sheet, and a brief that was not placed properly on R99. This surveyor stepped outside of R99's room and did not observe V9 don on proper PPE as V9 closed the bedroom door. V10 (Certified Nursing Assistant) opened door to throw soiled linen in a bin a few steps away from R99's room only wearing gloves, both V9 and V10 were not observed wearing a gown. As V10 opened and closed R99's door, V9 is not wearing a gown while changing R99's linen. V10 stated that she is new and is an orientee. V10 stated I was just picking up the dirty briefs and dirty linen. I threw the gloves inside dirty cart and now heading back inside the room. V10 stated I didn't provide care to R99, I just asked V9 if she needed anything else. V10 stated that she will be washing her hands after she finishes helping V9. V9 opened R99's room door and asked V10 if she can provide V9 with a clean hospital gown for R99. V9 observed not wearing a gown, only gloves. On 09/09/2025 at 11:44AM, V9 (CNA) stated that she has completed providing ADL (activities of daily living) care to R99. V9 said that she provided the following care to R99, I cleaned him, changed his sheets, washed his face again, hands. V9 stated that she didn't wear a gown because V9 was already in there. V9 stated I didn't wear it; I should have been wearing one. V9 stated that the importance of wearing proper PPE (personal protective equipment is for infection control. On 09/09/2025 at 3:01 PM, V2 (Director of Nursing) stated that enhanced barrier is the biggest one or most often used one in the facility. V2 stated because anyone that has foley catheters, intravenous (IV), urostomy tubes, gastrostomy tubes, anything that we are worried the residents getting them infected, requires to wear a gown and glove when engaging with the patient such as touching the patient. CDC (Centers for Disease Control and Prevention) enhanced barrier precaution sign reads in part providers and staff must also: wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. R99's active physician order set documents in part enhanced barrier precautions for chronic wound. R99's active physician order set documents in part enhanced barrier precautions for dialysis catheter, Gtube (gastrostomy tube). (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	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility document dated 5/7/24 documents in part Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities, especially when care is being bundled: providing hygiene, changing linens, changing briefs or assisting with toileting.