

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/28/2025
NAME OF PROVIDER OR SUPPLIER  West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  311 Edgewater Drive Bloomington, IL 60108	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview and record review the facility failed to assist a resident in discharge planning. This applies to 1 of 3 residents (R1) reviewed for discharge planning in the sample of 9.</p> <p>The findings include:</p> <p>On April 28, 2025 at 11:28 AM, R1 was sitting up in his wheelchair in his room. R1 stated he wants to move to a different facility to be closer to his family. R1 has talked with V11 Ombudsman and V4 Social Services (SS) about it, and nothing has been done.</p> <p>On April 28, 2025 at 8:51 AM, V11 Ombudsman stated, R1 wants to go to a different facility to be closer to his family. R1 has provided a list to the facility of facilities that are closer, and they still haven't done anything. R1 has asked about the progress and V4 SS told R1 that V4 has sent the referral packet but V4's not actually reaching out to the facilities.</p> <p>On April 28, 2025 at 10:06 AM, V4 SS stated, he did not have anyone actively discharging at the moment. V4 had sent a referral to another local skilled nursing facility (SNF) for R1 a couple of weeks ago but that was it. At 12:56 PM, V4 SS stated, he was aware that R1 wanted to go to another SNF to be closer to his family. V4 said he has sent a lot over a year to get R1 moved but no one would accept R1. At 1:28 PM, V4 SS brought the referrals he had sent for R1. V4 had one referral dated January 31, 2025 that he sent to a local SNF. There was no fax transmittal that showed it was sent and/or received. V4 stated, he never heard anything back about it. V4 stated, he has called to follow up but they never tell him anything. There is nothing documented in R1's chart from December 2024- current about any referrals being sent or followed up on.</p> <p>On April 28, 2025 at 2:23 PM, V12 local facility Administrator stated, they have never received a referral for R1.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's email thread between V4 SS and V11 Ombudsman shows: an email dated January 31, 2025 from V11 Ombudsman to V4 SS showing, Good morning! So, I looked on Medicare.gov for SNFs that accept Medicaid near the location R1 wants to go to. Attached is a PDF of that list. I looked up a few (#1, #3, #5) since those were the closest to the location R1 wants to go to. Out of those 3, from the website I could only tell #1 for sure has onsite dialysis R1 actually mentioned by location. They have onsite dialysis. Could you apply him there? .As a start, though, could you guys apply R1 to the location he wants to go to and let him, and I know if he is or is not accepted once you hear back? Thank you! V4 SS replied on January 31, 2025 showing, Hey, no problem, I'll send to that location. It sounds familiar I believe I've sent in one there before, but enough time has passed to send another. Thanks for your help and research! V11 Ombudsman sent another email to V4 SS and CC'd V1 Administrator on March 14, 2025 (over a month later) showing, Hi! .I wanted to follow-up about how things went referring R1 to SNFs that have onsite dialysis. I know R1 himself mentioned the local facility he wanted to go to. Do you know if he was applied there since February? What was said about his referral? If he was applied there and denied, can you share with me (and R1) what places he was applied to and when? She continues to add more facilities they could referred R1 too that may take him. She ends the email with, Thanks for helping R1 out with this. He just wants to be back up north closer to his family so they could potentially visit him (or visit him more frequently). There is no reply to that email. V11 Ombudsman sends another email to V4 SS and V1 Administrator on March 19, 2025 showing, Hello! I was following back up from my email on Friday about R1 and his desire to transfer to another SNF further north by the location he wants to go too. Please see the original email below If anyone could shed some light on any progress in applying R1 to other SNFs since the beginning of February, I'd greatly appreciate it! There is no reply after that. On April 28, 2025 at 8:51 AM, V11 Ombudsman stated she last talked with the facility about R1's transfer/referrals on April 11, 2025 that started with emails back in January 2025 and still had not gotten anywhere in the process.</p> <p>R1's Minimum Data Set, dated dated dated [DATE] shows, he is cognitively intact.</p> <p>R1's care plan dated March 25, 2022 shows, Focus: Discharge potential-long term, R1 been evaluated for discharge potential and, at present, placement for him is identified as long-term secondary to medical, cognitive, mental health and behavioral challenges. Interventions: Assessment of d/c (discharge) potential quarterly. Document in the plan of care accordingly. Available options will continue to be identified. Referrals will be made to appropriate resources and services, as indicated. Goals will continue to be discussed with the resident/representative, clarified .</p> <p>The facility's discharge planning policy, protocol and procedure dated March 2025 shows, Purpose: To identify appropriate candidates for inclusion in active discharge planning facilitating the transition to a less structured environment and to coordinate adequate supportive community care services. This nursing facility strongly emphasizes preparation and preparedness.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40085</p> <p>Based on interview and record review the facility failed to ensure residents were supervised in the dining area to prevent a resident to resident incident resulting in a fall for 2 of 4 residents (R3, R4) reviewed for supervision in the sample of 9.</p> <p>The findings include:</p> <p>The facility provided roster shows R3 and R4 reside in the memory care unit of the facility.</p> <p>R3's Care Plan shows she has a diagnosis of dementia and has a cognitive deficit with periods of disorientation.</p> <p>R3's 4/17/25 Minimum Data Set (MDS) assessment shows she has a cognitive impairment and has periods of confusion and forgetfulness.</p> <p>R4's Care Plan shows she has a diagnosis of dementia and has a cognitive deficit with periods of disorientation.</p> <p>R4's 2/6/25 MDS assessment shows she has a cognitive impairment and has periods of confusion and forgetfulness.</p> <p>A facility Resident to Resident Altercation reported completed by V7 (Registered Nurse/ RN) on 4/19/25, shows during the noon meal on 4/19/25, R3 was found lying on the floor of the dining room. The report shows when V7 spoke with R3, R3 indicated that another resident (R4) had been trying to move R3 out of her way and it caused R3 to fall to the floor. R3 said that she had been trying to move in by R4 to get a spot at the table.</p> <p>A facility reportable incident completed by V1 (Administrator) on 4/19/25 shows R3 and R4 were in the common area of the facilities dementia unit when R3 was found on the floor and claimed R4 and made contact with her to move her. The report also shows that there were no staff witnesses to the incident.</p> <p>On 4/28/25 at 10:05 AM, R7 said she was sitting at the table when R3 and R4 had the incident. R7 said R3 was trying to move in by R4 because she wanted the same chair. R3 was sort of nudging R4 and R4 raised her arm up and this caused R3 to lose her balance and fall to the floor. R7 could not recall where staff were at the time of this incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/28/25 at 11:24 AM, V7 said on the day of the incident between R3 and R4 she was the only staff watching the dining room. V7 said the other activity staff had gone on lunch break and the CNA's (Certified Nursing Assistants) were passing meal trays. V7 said she was called away from the dining room to answer a telephone call and no one replaced her to monitor the dining room. V7 said she had been paged twice about the call, so she decided she had to go answer it. V7 said while on the phone she heard what sounded like a resident falling so she went to the dining room and found R3 lying on her side on the floor. V7 said when she asked what happened R3 reported that R4 had caused her to fall. V7 said R7 explained to her how R3 ended up on the floor, that it was due to R3 nudging and trying to move R4 out of her way for her to get a certain chair at the table. V7 said there should always be 2 staff present to monitor the dining room but that day there was not due to a staff on break and her leaving to answer a phone call.</p> <p>On 4/8/25 at 2:01 PM, V2 (Director of Nursing) said generally there is 3-4 CNA's, 1 nurse and 1-2 activity staff to monitor the resident dining area but that day the CNA's were passing trays and V7 had left to take a phone call. V2 said R3 was sent to the hospital emergency room due to complaints of hip pain and per facility protocol since no staff witnessed the incident. V2 said R3 did develop some bruising to her buttocks.</p> <p>R3's nursing progress notes show on 4/27/25 there is a purplish discoloration to her left buttock relative to the fall.</p> <p>The facility provided Standard Supervision and Monitoring policy dated 5/17/23 shows the facility will provide adequate supervision and guidance to meet the needs of the residents including meal times.</p>		