STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145333	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Suburban Nursing & Rehab Center	311 Edgewater Drive Bloomingdale, 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)
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 provide toileting assistance to a resident dependent on staff for toileting. This applies to 2 of 5 residents (R1 and R7) reviewed for toileting assistance in a sample of 12. The findings include:1. Review of R1's care plan shows R1's diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting her left non-dominant side, anoxic brain damage, neuralgia and neuritis, depression, anxiety disorder, low back pain, weakness, cognitive communication deficit, and muscle wasting and atrophy. The care plan shows R1 requires a mechanical lift with two staff to assist for transfers. The care plan shows R1 was incontinent of bladder and R1 should be given the opportunity to use the toilet before and after meals, activities, laying down for naps, and at bedtime. R1 was to be toileted at regular intervals. MDS (Minimum Data Set), dated 12/8/25, shows R1 was cognitively intact and was dependent on staff for toileting, bed mobility, and transfers. The MDS shows R1 was frequently incontinent of bladder and bowel. On 1/23/26 at 9:21 AM, R1 stated the facility staff only change her brief when they get R1 up in the morning at approximately 11:00 AM and not again until approximately 6:30 PM when R1 is transferred back in bed. R1 stated the staff tell R1 if R1 wishes to have her brief changed after 1:00 PM, the AM shift will transfer R1 to bed and change her brief but R1 will have to remain in bed until after the 3:00 PM staff begin their shift to be transferred back to R1's wheelchair. R1 stated R1 did not want to remain in bed if her brief was changed after lunch so she chose not to be changed until the staff put her in bed after dinner. On 1/23/26 at 1:21 PM R1 was sitting in the activity room coloring and stated she needed her brief changed. At 1:25 PM, V22 (CNA - Certified Nursing Assistant) arrived to change R1 and told R1 she would transfer R1 to bed and change her brief, but that R1 would have to remain in bed until after 3:00 PM when the next shift arrives. V22 stated she had not yet had a break and needed to begin her resident rounds before her shift ended at 3:00 PM. On 1/23/26 at 1:57 PM, V2 (Director of Nursing) stated it is expected that if R1's brief needed to be changed after lunch that R1 would be transferred to bed, have her brief changed, and be transferred back to her wheelchair in a timely manner by the AM shift. V2 stated R1's AM shift CNA was not to make R1 wait until after 3:00 PM shift begins to be transferred back to her wheelchair if she is changed after lunch. V2 stated during one instance at approximately 2:50 PM R1 requested to have her brief changed. V2 stated R1's AM CNA was finishing her tasks and almost ready to leave her shift and V2 stated R1's PM CNA would transfer R1 back to her wheelchair. V2 stated R1 accused V2 of not prioritizing resident care. V2 stated she never told staff R1 should remain in bed from after lunch until after 3:00 PM shift change if R1 wanted her brief changed after lunch. On 1/23/26 at 1:54 PM, V1 (Administrator) stated it was his expectation that R1 have her incontinence brief changed and that R1 was transferred back to her wheelchair without waiting. Facility document Guidelines for Incontinence Care, dated 9/1/23, shows, It is the policy of the facility to ensure that residents receive as much assistance as needed for (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleansing the perineum and buttocks after an incontinent episode or with routine daily care. Frequency depends on bladder diary results and/or routine minimal q (every) 2 hour checks as well as care planning. 2. Review of R7's care plan shows R7's diagnoses included cerebral infarction, cirrhosis of liver, depression, anxiety, seizures, encephalopathy, schizoaffective disorder, history of falls, dementia, hemiplegia and hemiparesis following cerebral infarction, abnormal gait/mobility, weakness, and transient cerebral ischemic attack. The care plan shows R7 was incontinent of bowel and bladder and R7 was to be checked every two hours, toileted at regular intervals, and assisted with toileting as needed. The care plan shows R7's ADL care needs, including transfers and toileting, may fluctuate due to the presence of potential acute changes with exacerbations of chronic health conditions. MDS, dated [DATE], shows R7's cognition was intact, R7 required substantial/maximal assistance for toileting, and required supervision/touching assistance for transfers. On 1/23/26 at 10:33 AM, R7 stated on 1/22/26 at approximately 10:30 PM R7 put her call light on because she needed to go to the bathroom. R7 stated she was not assisted until 1:30 AM and R7 wet her bed.