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No. 0938-0391

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	04/21/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide bed hold information to residents who were transferred from the facility to hospitals.This applies to 2 of 3 residents (R1 and R3) reviewed for transfers in a sample of 7.The findings include: 1. Petition for Involuntary / Judicial Admission, dated 2/26/26, shows R1 was involuntarily transferred to the hospital after displaying aggressive behavior toward a peer. Review of R1's clinical record failed to show a facility bed hold notification was provided to R1.On 4/21/26 at 3:39 PM, V13 (Registered Nurse) stated on 2/26/26 she transferred R1 to the hospital after he displayed aggressive behaviors. V13 stated she did not provide a bed hold notification to R1 due to attending to multiple emergencies at the time of transfer. 2. Progress notes, dated 3/30/26, shows R3 complained of not feeling well and called 911 to be transferred to the hospital. On 4/21/26 at 3:39 PM, V2 (Director of Nursing) stated R3 did not receive a written copy of the facility bed hold policy but she verbally told R3 she could return to the facility when visiting R3 at the hospital. Review of R3's clinical record shows no evidence the facility provided a written copy of their bed hold policy at the time of transfer to the hospital. Facility Guidelines for Resident Bed Holds and Readmissions to the Facility, dated 2/20/25, shows, a) The second presentation of the State's (and therefore the facility's) bed-hold policy will be presented and discussed with the resident and/or their Responsible Party/POA at the time of transfer, or---in the case of an emergency transfer-within 24 hours and in writing. If this is not possible, it is expected of the facility to document multiple attempts to reach the resident's Responsible Party/POA, to include sending this information via certified mail with a signed return of acknowledgement of receipt requested-and when this was done. A copy will be maintained in the resident's medical record.

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to safely transfer residents to prevent injury.This failure resulted in R2 falling and hitting her head, being admitted to the Intensive Care Unit for days to monitor a possible subarachnoid hemorrhage, and experiencing ongoing dizziness, headache, low back pain, and left hip pain with left leg spasms. This applies to 3 of 6 residents (R2, R6 and R7) reviewed for resident safety in a sample of 7.The findings include:1. Face sheet, dated 4/20/26, shows R2's diagnoses included atrial fibrillation, dementia, chronic kidney disease, obesity, sequelae of cerebral infarction, Diabetes Mellitus type 2, hypertension, kidney disease, dependence on renal dialysis, anxiety, and osteoarthritis. MDS (Minimum Data Set), dated 1/22/26, shows R2's cognition was intact and R2 required partial / moderate assistance from staff for tub/shower transfers as well as sit to stand transfers.Care plan, dated 2/9/26, shows R2 was at risk for falls related to atrial fibrillation, chronic kidney disease, sequelae of cerebral infarction, diabetes, morbid obesity, anxiety, and hypertension. On 4/17/26 at 11:13 AM, R2 stated V6 (CNA- Certified Nursing Assistant) provided R2 a shower, transported R2 to her room in the shower chair, and R2 began to transfer from the shower chair to the wheelchair. R2 stated she asked V6 if both the shower chair and the wheelchair were locked and V6 affirmed both sets of wheels were locked. R2 stated she placed her hands on the arms of the shower chair, began to stand, and the shower chair moved backwards. R2 stated she was unable to sit back down on the chair and fell to the floor. R2 stated she could not remember if her buttocks hit the edge of the shower chair, but she was sure her head hit the floor because she heard a loud thump. R2 stated V6 was in front of her near her wheelchair when she began to stand and not behind the shower chair securing the chair. R2 stated if V6 was trained properly, he would have known he needed to hold the back of the shower chair during transfers. R2 stated she normally transferred independently in the past with staff holding on to the back of the shower chair. R2 reiterated when she fell the shower chair slipped backward. R2 stated nurses assessed R2 and sent R2 via 911 to the hospital. R2 stated she later heard that staff alleged she held the wheelchair and not the shower chair when she began to transfer. R2 stated she became upset when she heard the allegation because if that was the case she would have fallen forward and not backward. R2 stated she was experiencing ongoing dizziness and vision difficulties, headaches, lower back pain, hip pain and spasms down her left leg.Hospital physician note, dated 4/7/26, shows R2 experienced head, neck and back pain radiating to her legs following a mechanical fall at the facility. The note shows R2 was getting out of the shower chair when the shower chair slipped and R2 struck her head. The note shows R2 had a possible 2-3 millimeter subarachnoid hemorrhage, trace hyper-density along the posterior interhemispheric falx / adjacent sulci measuring 2 to 3 millimeters not previously seen which may represent trace subarachnoid blood products given the history of the fall. The note shows R2 was admitted to ICU for close monitoring and was experiencing lumbar/sacral pain acute on chronic due to the fall.Hospital physician note, dated 4/8/26, shows R2 experienced a minimal left parieto-occipital region hematoma and mildly tender. Head CT result 4/8/26 unchanged 2 mm hyper-density along the posterior right parietal lobe, possibly representing a trace subarachnoid hemorrhage.On 4/17/26 at 11:30 AM, V7 (LPN - Licensed Practical Nurse) stated when she arrived at R2's room after she fell, she saw R2's shower chair between the doorway and the bed, R2 was on the other side of the shower chair on the floor, and V6 was standing on the far side of R2. V7 stated V6 told her that he was trying to fix the wheelchair in front of R2 when R2 fell. V7 stated the wheel of the shower chair did not fall off the chair last night. V7 stated R2 was normally able to transfer herself independently. On 4/17/26 at 10:41 AM, V6 (CNA) stated he showered R2 and brought her back to her room in the shower chair. V6 stated he locked the shower chair and the wheelchair and R2 began to stand up. V6 stated he offered to help but R2 stated she could transfer independently. V6 stated he (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stood behind the shower chair and R2 stood up and held on to the wheelchair with her hands when she stood up. V6 stated R2 appeared to become weak when she began to turn, sat back on the edge of the seat of the shower chair, and the back of the shower chair raised up and tipped forward because of the weight of R2's body on the front of the shower chair seat. V6 stated the shower chair had only two brakes - one on a front wheel and one on a back wheel.Facility incident note, dated 4/7/26, shows V6's statement included, After shower resident was transferring herself from shower chair to her wheelchair in her room. I was holding her wheelchair while she was transferring from shower chair to wheelchair and one of the wheels from the shower chair came out and she lost her balance, and she fall on floor.On 4/17/26 at 1:00 PM, V3 (Assistant Director of Nursing) stated she interviewed R2 in the hospital who told her that before she fell, R2 stood up and the shower chair moved. V3 stated R2 reported V6 was moving her wheelchair and R2 was trying to stand from the shower chair while holding the armrests of the shower chair. V3 stated she was clear R2 stated she was holding the armrests of the shower chair when trying to get up and not grabbing for the wheelchair when the shower chair flipped up. V3 stated she was told the back wheel came off the shower chair. V3 stated V2 (Director of Nursing) asked V8 (Maintenance) to check all of the facility shower chairs after R2 fell.On 4/17/26 at 9:33 AM in the conference room, V2 (Director of Nursing) stated R2 was normally able to transfer independently. V2 stated V3 was with her in the hospital when she interviewed R2 and R2 stated she grabbed the wheelchair armrests to stand from the shower chair and then fell. R2 reported she pulled up on the wheelchair, the shower chair popped out despite the wheels being locked, R2 lost her balance and fell to the floor. V2 stated her investigation showed V6 was beside the wheelchair when R2 attempted to transfer and fell. V2 stated the wheelchair and shower chair wheels were all locked and a wheel came off the shower chair when the chair went backward. The actual shower chair was in the conference room and examination of the shower chair showed it had plastic casters on all four legs. The casters were attached to the chair legs by bolts that inserted far into the plastic legs. The right front caster and back left caster had locks on the wheels. The left front and right back casters had no locks. When sitting in the chair with both casters locked, the chair was able to be propelled by using feet to push backward. The two locked wheels slid easily on the floor and then the wheels rolled backward despite being locked. On 4/20/26 at 10:21 AM, V8 (Maintenance Director) stated he inspected the facility shower chairs after R2 fell and had no concerns that the shower chair brakes were not functioning properly. V8 stated the facility CNAs knew they had to hold shower chairs because they slide on tile floors, and it did not matter if the wheels were locked. V8 stated he inspected the chair from which R2 fell and the wheels seemed brand new. V8 stated he could not make the wheels roll when the brakes were locked. V8 stated on 4/17/26 he removed all the shower chairs with plastic casters from the facility because he was told they were unsafe. On 4/20/26 at 10:45 PM, V8 stated he reexamined the shower chair from which R2 fell and despite the break mechanism being applied, the wheels did turn.On 4/17/26 at 12:17 PM in the second floor shower room, V10 (LPN) and V11 (CNA) locked all four wheels on two of the shower chairs with plastic casters. The staff demonstrated they could easily roll both the shower chair wheels despite all the wheels being locked. When the shower chair was pushed, all the wheels rolled despite the locks being applied on the wheels. On 4/17/26 at 12:15 PM, V10 (LPN) stated some of the shower chairs in the facility had plastic wheels and slide/roll on the tile even if all four of the wheels are locked. V10 stated that even if a resident can independently stand from a chair, a staff must hold the shower chair to stop it from moving when residents transfer. Review of R2's clinical record showed R2 was admitted to the hospital Intensive Care Unit with a subarachnoid bleed on 4/7/26 and returned to the facility on 4/9/26.Physician assistant note, dated 4/13/26, shows R2 reported experiencing headache (particularly in the frontal region) as well as dizziness, mild vision blurring, and improving lower back pain since her hospitalization due to her fall. The note shows R2 was seen by ophthalmology regarding her blurring vision and may need to see an outpatient ophthalmologist for further evaluation.Facility Transfers Policy, undated, shows, Stabilize or lock all surfaces including (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	wheelchairs and beds. Have the resident lean forward and push up from the wheelchair armrests with both extremities if able. Instruct the resident to stand up as straight as possible to assist with maintaining balance. If the resident uses an assistive device, have him/her reach for the assistive device once standing erect. DO NOT allow the resident to pull up from the assistive device once standing erect. DO NOT allow the resident to pull up from the assistive device to achieve standing.As of 4/21/26, the facility was unable to provide a manufacturer's instruction manual for the chairs utilized by the facility.2. Face sheet, dated 4/20/26, shows R6's diagnoses included dementia, unsteadiness on feet, abnormal gait and mobility, lack of coordination, and weakness.MDS, dated [DATE], shows R6's cognition was severely compromised and R6 required supervision / touching assistance for all transfers.On 4/18/26 at 11:48 AM in the second floor shower room during transfer from his shower chair, V9 (CNA) asked R6 to hold the wall grab bars and asked R6 to stand from his shower chair. As R6 stood, the shower chair rolled slightly back as V9 was holding R6's incontinence brief and did not secure the shower chair. V9 then used one arm to easily move the shower chair away from the back of R6 while holding R6's incontinence brief. V9 stated the brakes were engaged on all the shower chair wheels when she moved it. V9 then rolled the wheelchair to the back of R6, placed her foot between the spokes of the wheelchair and stepped down on the wheel, and without locking the brakes of the wheelchair told R6 to sit in the wheelchair. V9 then locked the wheels of the wheelchair to reposition R6 in the chair. V9 stated the brakes on the shower chairs were not solid and even with the brakes engaged V9 could move the shower chair. V9 stated, Most of them are like that. I don't use the brakes to hold it. I use my muscles to hold it. I don't put my faith in the brakes. V9 then demonstrated that even with the brakes locked on the shower chair the wheels were able to roll when the chair was pushed on the tile floor.3. Face sheet dated 4/20/26 shows R7's diagnoses included Parkinson's disease with dyskinesia, bipolar disorder, depressive episodes, anxiety, congestive heart failure, cardiomegaly, osteoarthritis, transient ischemic attack and cerebral infarction. MDS, dated [DATE], shows R7 was cognitively intact and required only set up or clean up assistance for all transfers.R7's care plan shows R7 required partial/moderate assistance during transfers and R7 was at risk for falls. On 4/17/26 at 12:20 PM, V11 (CNA) brought a plastic-wheeled shower chair into R7's room and placed the shower chair near R7 who was sitting on the edge of his bed. V11 locked the wheels of the shower chair and began to transfer R7 to the shower chair using a gait belt. R7 began to stand up from the bed, grabbed the arm rests of the shower chair and easily pulled it closer and in front of him with the brakes still locked while V11 was holding R7's gait belt. R7 began to turn holding one armrest of the chair and R7 easily pulled the chair toward R7. As R7 sat in the shower chair, the chair slid backward. V11 then wheeled R7 out of his room and down the hall to the shower room with the brakes still locked. V10 (LPN) examined the brakes on the shower chair which were locked and rolling while the resident was transported down the hallway in the shower chair.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to maintain safe shower chair equipment at the facility to prevent resident injuries.This applies to 3 of 6 residents (R2, R6, R7) reviewed for resident injuries in a sample of 7. The findings include: Facility Daily roster dated 4/20/26 was highlighted with residents who receive bed baths. The roster shows 164 of the 220 residents in the facility received showers at the facility including R2-R7. 1. MDS (Minimum Data Set), dated 1/22/26, shows R2's cognition was intact and R2 required partial / moderate assistance from staff for tub/shower transfers as well as sit to stand transfers.Care plan, dated 2/9/26, shows R2 was at risk for falls.On 4/17/26 at 11:13 AM, R2 stated during transfer from a shower chair to her wheelchair with V6 (CNA - Certified Nursing Assistant), the shower chair moved backwards as she stood causing R2 to fall. R2 stated she asked V6 if both the shower chair and the wheelchairs were locked and V6 affirmed the locks were on both chairs. Facility incident note, dated 4/7/26, shows V6's statement included, After shower resident was transferring herself to from shower chair to her wheelchair in her room. I was holding her wheelchair while she was transferring from shower chair to wheelchair and one of the wheels from the shower chair came out and she lost her balance, and she fell on floor.On 4/17/26 at 9:33 AM in the conference room, V2 (Director of Nursing) stated R2 reported she pulled up on her wheelchair during transfer from the shower chair to her wheelchair and the shower chair popped out despite the wheels being locked. R2 lost her balance and fell to the floor. V2 stated the wheelchair and shower chair wheels were all locked and a wheel came off the shower chair when the chair went backward. The actual shower chair was in the conference room and on examination, the shower chair had a white plastic frame and plastic casters on all four legs. The casters were attached to the chair legs by bolts that inserted into the plastic legs. The right front caster and back left caster had locks on the wheels. The left front and right back casters had no locks. When sitting in the chair with both casters locked, the chair was able to be propelled by using feet to push backward. The two locked wheels slid easily on the floor and then the wheels rolled backward despite being locked. V2 stated she asked V8 (Maintenance Director) to inspect all the facility shower chairs for safety after R2 fell.On 4/20/26 at 10:21 AM, V8 (Maintenance Director) stated he inspected the facility shower chairs after R2 fell and had no concerns the shower chair brakes were not functioning properly. V8 stated the facility CNAs knew they had to hold shower chairs because they slid on tile floors, and it did not matter if the wheels were locked. V8 stated he inspected the chair from which R2 fell and the wheels seemed brand new. V8 stated he could not make the wheels roll when the brakes were locked. V8 stated on 4/17/26 he removed all the shower chairs with plastic casters from the facility because he was told they were unsafe. On 4/20/26 at 10:45 PM, V8 stated he reexamined the shower chair from which R2 fell and despite the break mechanism being applied, the wheels did turn.On 4/17/26 at 12:15 PM, V10 (LPN) stated some of the shower chairs in the facility move and slide on the tile even if all four of the wheels are locked. V10 stated even if a resident can independently stand from a chair, a staff is needed to hold the shower chair. V10 stated the wheels were plastic on most of the shower chairs and shower chairs were able to slide and roll even if the brakes were locked.On 4/17/26 at 12:17 PM in the second floor shower room, V10 (LPN) and V11 (CNA) locked all four wheels on two of the shower chairs. The staff demonstrated they could easily roll both the shower chairs on the tile floor despite all the wheels being locked. When pushed, all the wheels rolled despite the locks being applied on the wheels. As of 4/21/26, the facility was unable to provide a manufacturer's instruction manual for the chairs utilized by the facility.2. On 4/18/26 at 11:48 AM in the second floor shower room, V9 (CNA) used one arm to easily move the shower chair away from the back of R6 while holding R6's incontinence brief. V9 stated the brakes were engaged on all the shower chair wheels when she moved it. V9 stated the brakes on the shower chairs were not solid and even with the brakes engaged V9 could move the shower chair. V9 stated, Most of them are like that. I don't use the brakes to hold it. I use my muscles (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to hold it. I don't put my faith in the brakes. V9 then demonstrated that even with the brakes locked on the shower chair the wheels were able to roll when the chair was pushed.On 4/18/26 at 11:55 AM, V2 (Director of Nursing) observed the shower chair slide on the floor with ease and the wheels roll despite all of the wheels being fully locked.3. On 4/17/26 at 12:20 PM, V11 (CNA) brought a plastic-wheeled shower chair into R7's room and placed the shower chair near R7 who was sitting on the edge of his bed. V11 locked the wheels of the shower chair and began to transfer R7 to the shower chair. R7 was able to easily slide the shower chair back and forth while holding the armrest during the transfer. When R7 sat down, the shower chair slid backward despite the brakes being locked. V11 then wheeled R7 out of his room and down the hall to the shower room with the brakes still locked. V10 (LPN) examined the brakes on the shower chair which were locked while the resident was transported down the hallway in the shower chair.On 4/17/26 at 12:12 PM in a first floor shower room, V2 (Director of Nursing) and V12 (Corporate Consultant) examined 2 plastic shower chairs with the brakes locked. All four of the wheels on both shower chairs rolled when the brakes were fully locked and the shower chair was able to be rolled on the floor.On 4/17/26 at 12:43 PM in a second first floor shower room, V2 and V12 inspected a plastic shower chair and locked all four wheels of the chair. The chair wheels moved and rolled on the floor despite the brakes being locked. A bariatric shower chair had only two locks (one each on the back two wheels) and no locks on the front two wheels. When pushed, the front of the shower chair swung from side to side and the back two wheels remained fairly in place.