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	06/16/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to address a resident's grievances in a timely manner. This applies to 1 of 3 residents (R1) reviewed for grievances in a sample of 3.The findings include: R1's face sheet showed he was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus, atrial fibrillation, hypertension, osteoarthritis, chronic kidney disease, cardiac pacemaker, abnormalities of gait & mobility, bipolar disorder, affective mood disorder, and peripheral vascular disease. R1's MDS (Minimum Data Set) dated 04/13/26 showed R1 was cognitively intact. On 06/16/26 at 10:32 AM, R1 said he was waiting to hear about several things that he had filled out the grievance form. R1 said he had brought up concerns regarding his state ID (Identification), his community pass, and missing items since February 2026. R1 said when he would ask V3 (SSD/Social Services Director) about it, V3 would say it was being taken care of, but nothing was resolved. R1 said no one had explained to him why he was not permitted a community pass and had asked the nursing staff, V3, and V1 (Administrator) about it, and was not given a clear answer regarding why he was not allowed to have access to the community. R1 said he had books misplaced during a room change, and they had not been replaced by the facility. R1 said he needed assistance with getting his state ID, but there had not been any attempts for follow up. R1 said he filled out grievance forms because of the delay in response. R1 said he was trying to give the facility a chance to address his concerns but had not heard any updates since February 2026. The facility's Concern Form for R1 dated 04/06/26 (over two months earlier) showed the following: 1. I have had no follow up about my green pass.2. I would like to meet with my doctor about pass.3. I need help replacing my Chime card.4. I need help getting a replacement ID.5. I gave a list of missing items to [V3] ~3 weeks ago. He keeps saying he ordered it, but nothing ever comes. List I gave him is attached.Follow-up action taken: Resident educated on green pass restriction and the policy regarding appropriate green pass. Resident educated that he will be put on list for next trip to DMV for replacement ID. Missing items: missing books ordered through preferred website. Sardines, hot sauce replaced with a date of response of 06/10/26 by V1 (Administrator).The facility's Concern Form for R1 dated 06/09/26 showed the following:While speaking to DON and Admin, [R1] expressed frustration with not having an independent community pass. [R1] believes others that do have independent community access are bringing in contraband.Follow-up action taken: Guardian Angel program is now focusing on contraband. Rooms have been searched. Community access has been evaluated for residents. Per DON, [R1] is not a candidate for an independent pass at this time with a date of response of 06/12/26 by V1.On 06/16/26 at 8:30 AM, V7 (Ombudsman) said she had been working with R1 since 02/26 and mentioned to the facility R1's concerns. V7 said she filed a written grievance with the facility on 04/06/26 and they had not heard anything regarding the grievances. V7 said they were trying to give the facility a chance to correct the issues but had not heard any resolution since 04/06/26.On 06/16/26 at 10:32 AM, R1 said he was waiting to hear about several things that he had filled out the grievance form. R1 said he had brought up concerns regarding his state ID (Identification), his community pass, and missing items since February 2026. R1 said when he would ask V3 (SSD/Social Services Director) about it, V3 said it was being taken care of, but (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nothing was resolved. On 06/16/26 at 1:33 PM, V3 (SSD) said they had struggled with R1's grievance form and the ombudsman had gotten involved and assisted them. V3 said he ordered the books. V3 provided an undated order with the books and when asked, showed documentation that the books were ordered on 06/16/26 (during the survey). V3 said he had not taken R1 to the DMV (Department of Motor Vehicles) to get the temporary ID and was unable to show documentation of a scheduled visit to the DMV. On 06/16/26 at 2:45 PM, V1 (Administrator) said there was no policy on the timeline of when grievances needed to be addressed. On 06/16/26 at 2:45 PM, V1 (Administrator) said he did not have an answer as to why R1's grievances were not addressed, and they may have missed it. V1 said the Ombudsman emailed V1 about the concerns and that was the first time he had been notified of R1's concerns. V1 said there were a ?million things' occurring at the facility and they try to handle the concerns as quickly as possible. On 06/16/26 at 1:33 PM, V3 said he had purchased R1's books but was unable to provide a dated receipt of when the books were purchased. At 2:50 PM, V3 provided bank statements which showed R1's books were purchased on 06/16/26 (during the survey). At 4:12 PM, V3 said when a resident wanted community privileges, they needed to trigger the Community Survival Skills Assessment and notify the doctor for an order. V3 said R1 had initially requested community privileges around the end of February or early March, and he notified R1 he needed to check with the doctor first. V3 said by the time he looked through R1's chart, he saw R1 did not qualify for community access. V3 said he completed R1's Community Survival Skills Assessment in October 2025, when R1 was originally admitted (eight months earlier), but had not completed a new assessment when R1 requested community access. V3 said the October 2025 Assessment showed R1 was appropriate for community access. V3 said he did not notify the doctor of R1's request and was unable to provide a progress note showing he had spoken to R1 about why he was not allowed community access. V3 said he was not sure why he had not taken R1 to the DMV (Department of Motor Vehicles) during the facility's last trip to the DMV, which was on 05/08/26. V3 said R1's situation was a rare case. The facility's undated Grievances/Complaints/Missing Property policy showed There will be a clearly visible posting of the reasonable expected time for completing a complaint or grievance review as well as the fact that the person (resident/resident's advocate) who presented the complaint/grievance has the right upon request to receive in writing the decision or outcome related to the complaint or grievance. If necessary, taking any required immediate action to prevent further potential violations of any resident right while the violation is being investigated to include any notifications to the Administrator or any state agency or law enforcement agency. The facility's undated Outside Community Pass Privileges Policy showed During the 14-day observation period, residents will be assessed by their physician, psychiatrist, and Interdisciplinary Team (IDT) for: Cognitive status, Degree and severity of mental illness, Addiction history and present addictive behaviors, Community safety skills, Psychiatric status, Ability to follow the rules and procedures, Maintenance of appropriate grooming and hygiene. Once the resident is assessed, he/she will be placed on a pass status.A resident pass level will not automatically change once requested by the resident or family. If a resident would like to request a more independent pass level, that resident/Guardian must place that request with a member of social services. Social services will evaluate and approve appropriate requests and inform the resident if the request has been denied or approved. Doctor's orders will have to be obtained the day of upgrade.