STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145614	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Nrsg & Rehab Center	7050 Madison Street Willowbrook, IL 60521

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46409 Based on observation, interview, and record review, the facility failed to prevent a resident from falling off the bed during care resulting in R1 sustaining a femur fracture. This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 3. The findings include: On March 11, 2025, at 10:39 AM, V3 (CNA/Certified Nurse Assistant) said on February 24, 2025, she had gone to R1's room to change R1's incontinence brief. V3 said R1 was a one-assist from staff and could help her with some things. V3 said when she walked into R1's room to the left side of the bed, she observed R1's body was closer to the right side of the bed, versus being centered. V3 said she flattened R1's bed out and picked up her draw sheet from underneath her left side and told her to turn towards the right, and as V3 turned R1 away from her, R1's legs started falling off the bed out of the right side. V3 said she tried to catch them, but it was too late, and R1 had fallen out of the bed onto the ground. V3 said she ran and notified the nurse. V3 said R1 was on an air mattress, which should have had bolsters on them to prevent the fall. R1's face sheet showed she was admitted to the facility with diagnoses including lack of coordination, lymphedema, morbid obesity, muscle wasting and atrophy in the right and left shoulder, dysarthria and anarthria, pain in right and left knees, dysphagia, major depressive disorder, rheumatoid arthritis, anxiety disorder, abnormalities of gait and mobility, altered mental status, and abnormal posture. R1's MDS (Minimum Data Set) dated February 24, 2025, showed R1 had severe cognitive impairment and showed R1 required moderate assistance to roll to the left and right. On March 11, 2025, at 11:59 AM, V5 (RN/Registered Nurse) said she was called to the room by V3 and when she entered the room, saw R1 was holding onto the bed rails and her knees were on the floor on the side next to the window. V5 said she assisted in lowering R1 to the floor and onto her back, when R1 complained about having pain. V5 said she called 911. V5 said if she had to reposition a resident to provide bed mobility and incontinence care, she would pull the resident closer to her before turning the resident away from her. V5 said she would pull her closer because at times, putting the resident in the center of the bed still may not give enough space for the resident's body to remain on the bed when they are turned away from the staff. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Chateau Nrsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7050 Madison Street Willowbrook, IL 60521	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On March 11, 2025, at 12:09 PM, V6 (RN) said she was called by V3 (CNA) and when she went to R1's room, saw her kneeling next to the bed with her hands on the halo side rail. V6 said the staff need to help R1 by giving her a push on the buttocks to turn her. V6 said she would have to put one of R1's legs over the other leg for R1, because R1 was only occasionally able to lift her legs, and when she did, it was only a little bit. V6 said R1 had better upper body strength than lower and was unable to walk. V6 said R1 had always been in a wide mattress as R1 was heavier set. V6 said if she provided care for R1, she would pull R1 towards her so there was more space on the other side when she was turned away from her. On March 12, 2025, at 11:15 AM, V17 (NP/Nurse Practitioner) said R1's right femur fracture was a result of her fall. V17 said it was her expectation if one staff was providing R1 with incontinence care, she would roll the resident towards her, not away from her, to prevent the resident from falling out of the bed. V17 said the staff should roll the residents towards them because in the case something occurred, there would be a place for them to roll them back safely, and the staff's placement would create a boundary to aide in them not falling out of the bed. V17 said due to R1's weight and deconditioned muscles, if her legs were close to the edge of the bed, she would not be able to prevent herself from falling off the edge of the bed. On March 12, 2025, at 9:22 AM, V18 (PTA/Physical Therapy Aide) said when the CNA provided incontinence care, the resident should be turned towards the side they are on, not away from them. V18 said this was done because of safety, and turning the resident away could cause a fall. On March 12, 2025, at 9:24 AM, V19 (Director of Rehab) said the resident should be pulled closer to the staff, and then turned away. V19 said the resident should always be in the middle of the bed to turn to the left or the right side. V19 said the staff should also press the button on the air mattress that would make the mattress firm, and not doing so could cause the resident to fall. On March 12, 2025, at 9:32 AM, V20 (Director of Restorative) said R1 was an extensive one-assist prior to her fall, which meant the staff completed majority of the task performed. V20 said R1 would be able to help but would get tired and needed a boost to get her arms to reach the side rail, and a boost given around the hip/glute area to move her leg over. V20 said R1 needed help with the initial turning motion. V20 said she was not notified by any of the CNAs that R1 had any issues with bed mobility. On March 11, 2025, at 1:40 PM, V8 (CNA) said she had previously cared for R1 prior to her fall, and R1 required two staff for bed mobility. V8 said there were days R1 was unable to assist in turning, and once she observed that, she always brought another staff member to assist in providing care for R1. V8 said she wanted to make sure R1 was covered on both sides and would pull R1 towards her before turning her towards the opposite side. V8 said R1 could fall if she was not positioned in either the center of the bed or closer to the staff member. On March 11, 2025, at 2 PM, V11 (CNA) said she had cared for R1 prior to R1's fall and she always had two staff in the room to take care of her. V11 said R1 was on an air mattress and used a mechanical lift for transfers, so they would have two staff. V11 said because R1 was also heavier and on the air mattress, two people was a safety measure. V11 said prior to the fall, R1 was not able to lift her legs to turn during bed mobility. V11 said R1 needed to be pushed towards the halo side rail to grab hold of it. V11 said she would never change R1 by herself and would always pull R1 towards her prior to turning her. V11 said R1 was heavy and did not have balance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On March 11, 2025, at 3:30 PM, V12 (CNA) said she floated all over the facility and had cared for R1 prior to her fall. V12 said R1 was able to turn but she needed help to lift her legs. V12 said R1 had upper body strength but would need her leg lifted to turn her. V12 said if the staff were providing bed mobility, R1 should be centered in the bed before she was turned away from the staff. V12 said R1 would need enough moving room before turning as she was heavier, and it could lead to her falling out of bed. On March 11, 2025, at 3:50 PM, V16 (CNA) said she had taken care of R1 prior to her fall and R1 only needed one person assisting with bed mobility prior to her fall. V16 said R1 needed help crossing her legs, then a boost on her back to get her over so that R1 could grab the side rail. V16 said she would pull R1 closer to her or in the middle prior to turning her because R1 could slide due to the air mattress. V16 said the air mattress would cause R1 to slide more to the side she was lying on. On March 12, 2025, at 3:21 PM, V2 (DON/Director of Nursing) said the residents receiving incontinence care and bed mobility should be placed in the middle of the bed. V2 said the facility did not have a policy regarding which way the resident should be turned. V2 said if the resident was not placed in the center of the bed, rolled away from the staff, and there was no other staff on the other side, it could cause the resident to roll out onto the other side. R1's progress notes showed the following: On February 24, 2025, at 8:10 PM, V5 (RN) wrote, Writer was down the hall passing medication when writer was called to resident room, writer enter resident room noted resident holding on to bed rail with both hands while bilateral knees touching the floor next to the bed by the window. Writer lower resident to the floor on to her stomach, then staff help writer to reposition resident on to her back, resident complained of pain writer administer PRN [As Needed] tramadol 50 mg [Milligrams] PER MD [Medical Doctor] orders. vs [Vital Signs] taken, 911 was called. 153/78, 80, 97.8 20, 93% N/C [Nasal Cannula]. NP [Nurse Practitioner-name] made aware/ ADON [Assistant Director of Nursing]. Resident POA [Power of Attorney- name] made aware of resident fall/Transfer to [Hospital] ER (emergency room). On February 24, 2025, at 8:34 PM, V5 wrote, 911 in facility, 911 and staff used [Mechanical] Lift to get resident off and placed on stretcher to be transferred to [Hospital] ER for Eval. On February 25, 2025, at 4:13 AM, the documentation showed, @4A.M Writer called [Hospital] ER and spoke with ER nurse regarding resident's status and received report that resident was transferred to [Hospital]. Writer spoke with nurse at [Hospital] and received report that resident is admitted with diagnosis of right femur fracture . On February 27, 2025, at 11:09 AM, V17 (NP) wrote, [History of Present Illness]: .The patient was sent to [Hospital] on 2/24/2025 due to a fall. The patient had the following imaging at the hospital: CT [Computed Tomography] Femur Right WO IV [Without Intravenous] Contrast (2/24/25) Impression: Acute distal right femoral metaphyseal fracture. R1's EMR (Electronic Medical Record) showed the following documentation by the CNAs caring for R1 regarding R1's ability to Roll Left and Right: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On February 11, 2025, at 2:07 AM, R1 required moderate assistance. At 1:31 PM, R1 was dependent on staff for bed mobility, and at 4:23 PM, R1 required maximal assistance for bed mobility. On February 12, 2025, at 1:55 PM and 6:07 PM, R1 required maximal assistance for bed mobility. At 11:37 PM, R1 was dependent on staff for bed mobility. On February 13, 2025, at 9:59 PM, R1 was dependent on staff for bed mobility. On February 14, 2025, at 12:04 AM, 1:59 PM, and 9:34 PM, R1 was dependent on staff for bed mobility. On February 15, 2025, at 2:50 AM, 1:59 PM, and 9:30 PM, R1 was dependent on staff for bed mobility. On February 16, 2025, at 4:35 AM, 1:59 PM, and 7:44 PM, R1 was dependent on staff for bed mobility. On February 17, 2025, at 4:32 AM, 1:59 PM, and 11:05 PM, R1 was dependent on staff for bed mobility. On February 19, 2025, at 1:59 PM, R1 was dependent on staff for bed mobility. On February 20, 2025, at 9:22 AM and 9:59 PM, R1 was dependent on staff for bed mobility. On February 21, 2025, at 1:59 PM, R1 was dependent on staff for bed mobility. At 5:37 PM, R1 required moderate assistance from staff for bed mobility. On February 22, 2025, at 4:20 PM, R1 was dependent on staff for bed mobility. At 8:52 PM, R1 required maximal assistance from staff for bed mobility. On February 23, 2025, at 12:58 AM and 9:16 AM, R1 was dependent on staff for bed mobility. At 6:44 PM, R1 required maximal assistance from staff for bed mobility. On February 24, 2025, at 1:07 AM, R1 was dependent on staff for bed mobility. At 1:59 PM, R1 required maximal assistance from staff for bed mobility. The facility's Positioning policy reviewed on October 2021 showed to promote resident comfort, safety, and dignity. To prevent complications of improper positioning such as skin breakdown, contracture development and decreased circulation. The facility was unable to provide a policy regarding bed mobility.