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No. 0938-0391

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 04/27/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to comprehensively assess a resident for post-fall complications, including failing to identify worsening acute pain and failing to obtain timely diagnostics. This failure resulted in a resident receiving delayed care for his left hip fracture.This applies to 1 of 3 residents (R1) reviewed for quality of care in a sample of 5. The findings include:R1's 2/17/26 progress note from 5:30 AM showed R1 .was noted on the floor in front of his wheelchair in an upright sitting position, sustaining a skin tear to the left elbow. When asked what happened, (R1) said that he was reaching for papers on the chair and slid out of the wheelchair. Left elbow cleansed and dressing applied. Wife made aware and also NP [Nurse Practitioner] aware of fall.On 4/23/26 at 10:12 AM, V3 ADON (Assistant Director of Nursing) stated that R1 had a fall on 2/17/26 at 5:30 AM. V3 stated R1 got up from his wheelchair and ambulated with his rolling walker to the bed without assistance. V3 stated R1 got up from his bed, tripped over his leg rest and fell to the floor. R1 was observed to be sitting in front of his wheelchair on the floor. At that time, he had a skin tear to his elbow. V3 stated that V6 (Nurse Practitioner) came and saw R1 and he refused to be assessed by her because of the pain so she ordered a STAT X-ray. V3 stated she remembered R1's daughter calling her and asking about the fall and she told her what happened. V3 stated she had asked her about the X-ray and asked why it took until the next morning to do it. V3 stated she told her they were looking into it. They said there was a delay in the technician arriving at our facility. V3 stated she did not see a note that R1's nurse (V8-RN/Registered Nurse) called the Nurse Practitioner, and she should have documented that. V3 stated it's the Nurse Practitioner's call whether to send him to the hospital or not. R1's 2/17/26 Post-Fall Monitoring form from 8:50 AM showed R1 had pain of 7 out of 10 and as needed pain medication was given. R1's 2/17/26 Medication Administration Note from 9:35 AM showed his as needed administration of 650 mg (milligrams) of Tylenol was ineffective. The note further showed R1 asked physical/occupational therapy assistant to put him back to bed [related to] complaint of left hip pain. Ice pack applied on left hip, as resident requested, NP notified. Resident refused therapy due to complaint of pain. On 4/23/26 at 10:39 AM, V6 (Nurse Practitioner/NP) stated on 2/17/26 a staff member notified her that R1 had a fall early in the morning and she went and saw R1. V6 stated R1 refused to let her do range of motion on him because he had pain in his left hip. V6 stated she told the nurse to put in an order for a STAT X-ray. V6 stated and it is nursing who calls the X-ray company. V6 stated a STAT X-ray means that it should be done within four hours. V6 stated if they don't come within four hours, we request the nurse to call the company. V6 stated the nurse should have called the X-ray company and followed up because she ordered R1's X-ray as STAT. V6 stated if the X-ray company doesn't come within four hours, they need to notify me so we can reassess the situation. V6 stated R1 would need to go to the hospital if he was complaining of excruciating pain or if he was unable to move.On 4/24/26 at 11:37 AM, V8 (RN) stated she worked on 2/17/26 from 6:30 AM to 11 PM and she was R1's nurse. V8 stated R1 had fallen during the night shift at 5:30 AM and at 8:45 AM, he was complaining of pain 7/10 and she gave him Tylenol 650 mg (milligrams). V8 stated after V6 (Nurse Practitioner) saw R1, V6 told her to put in the order for the X-ray. V8 stated she put it in as regular X-ray order. V8 stated after their stand-up meeting, V6 came to her and told her to make it a STAT X-ray order. V8 stated she called the X-ray company and told (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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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	them it was STAT and they said they would be here as soon as they can. V8 stated if they don't come in within four hours, we have to call the X-ray company and notify the doctor. V8 stated that at 3:55 PM, R1 complained of pain 10/10 and she gave him another Tylenol 650 mg. V8 stated the X-ray company never came that day. V8 stated R1 had his X-ray done on 2/18 and he had a fracture on the hip area.No documentation was present from 2/17 that showed R1's MD was notified of his increased pain and of the X-ray not being completed. On 4/23/26 at 12:00 PM, V4 (R1's wife) stated that R1 had a fall in the facility on 2/17. V4 stated she received a call from someone at 6:38 AM that day (as she was looking at her phone log). She stated she got to the facility at 8:30 AM and R1 was sitting in his wheelchair. V4 stated R1 had an open wound on his elbow which was not dressed, an ice pack on his leg, and a bruise on his forehead. V4 stated R1 was in a lot of pain. V4 stated a Physical Therapist (PT) or Physical Therapy Assistant (PTA) came to the room and asked R1 if he was going to therapy. V4 stated we told her that R1 had a fall during the night shift and he was in a lot of pain. V4 stated she thought the PT or PTA went and told a nurse that R1 needed a pain pill. V4 stated If my husband was in so much pain and he couldn't get up from his wheelchair using his walker and the PTA or the PT had to transfer him using a mechanical lift and X-ray people weren't here yet, then why was (R1) not just transferred to the hospital? V4 stated R1 ended up waiting more than 24 hours and he stayed in bed and experienced a lot of pain. V4 stated the X-ray company did not come until the next day (2/18). V4 stated when they found out it was a fracture, only then did they send him out to the hospital. V4 stated I just don't understand why they couldn't send him to the hospital in the first place instead of him suffering with all that pain. It's ridiculous.On 4/23/26 at 12:45 PM, V2 DON (Director of Nursing) stated R1's X-ray report showed R1's X-ray was not done until 2/18/26 (the following day). V2 stated a STAT X-ray should be done within four hours. V2 stated if they don't come within that time, the nurse is to follow up with the doctor and ask what to do and possibly get new orders whether to go to hospital or order more tests. V2 stated she reviewed the progress notes and there was no documentation on 2/17/26 from V8 (RN) that she contacted the X-ray company. V2 stated V13 (RN) followed up the next day on 2/18/26 with the X-ray company and told them R1's X-ray was not completed yet.R1's 2/17/26 Nurse Practitioner Note (V6) from 1:57 PM showed The patient had a fall on 2/17/26. The staff reported that [R1] was noted on the floor in front of the wheelchair in an upright sitting position, sustaining a skin tear to the left elbow. The examiner assessed the resident. [R1] stated that he was sitting on the edge of the bed and used his walker to reach papers on a chair and fell. [R1] indicates pain in the left hip. [R1] is unable to participate in range of motion. STAT hip X-ray ordered. This note was electronically signed on 2/18/26 at 1:58 PM.R1's 2/17/26 Post-Fall Monitoring form from 9:09 PM showed his pain had gotten worse to a score of 10 out of 10 and as needed pain medication was given. This form also showed R1 experienced Increased difficulty with bed mobility [related to] left hip pain. On 4/24/26 at 2:24 PM, V13 (RN) stated she worked on 2/18/26. V13 stated she noticed that R1's X-ray had not been completed and so she called the X-ray company and told them R1 was supposed to have a STAT X-ray the day before (2/17/26). V13 stated they did not provide her with a reason as to why it was not completed, but the X-ray technician was already in the building seeing another resident, so they came within 20 to 30 minutes to complete R1's X-ray. V13 stated a STAT X-ray should be done within four hours and if the X-ray company hasn't come, she would call the X-ray company and inform the Doctor or NP and let them know what's going on.R1's 2/18/26 left hip Radiology Results Report showed a reported date of 2/18/26 at 9:45 AM with Impression: Acute comminuted left femoral intertrochanteric fracture.R1's 2/18/26 progress note from 3:19 PM showed At 10:30 AM, X-ray result relayed to attending nurse practitioner with new orders received to send (R1) to hospital for evaluation and treatment. 10:50 AM, Ambulance left with (R1) via stretcher en route to hospital. Hospital records showed [R1] admitted to (hospital) for management of left intertrochanteric femur fracture after [Ground Level Fall].patient complaining of pain, was medicated with Oxycodone.he had a left hip open reduction internal fixation of peri trochanteric fracture on 2/20/26 after stress test was completed .Facility's policy titled Physician (continued on next page)

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	145614	A. Building B. Wing	04/27/2026

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Orders (8/1/21) shows: III. Execution of Order and Notifications- General: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The safety of residents. is of primary importance. a.) The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse. i. Contact.radiology services.as required to execute the medical order. iii. Notify internal staff of changes/updates as appropriate. iv. Notify resident/resident's representative of changes or new orders as appropriate. v. Notify attending or other providers as appropriate.Facility's policy titled Pain- Clinical Protocol dated (8/2008) shows: 3. The physician will perform or order appropriate tests as needed to help clarify aspects of pain (location, cause, etc.). For example, an x-ray may help to identify the cause of joint pain. Resident's physician and resident' s family/responsible party should be notified of significant changes pertaining to resident's pain level.Facility's policy titled Falls- Clinical Protocol (August 2008) shows: Monitoring and Follow-Up- 1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have ruled out or resolved. a. Frail elderly individuals are often at a greater risk for serious adverse consequences of falls.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and record review, the facility failed to ensure a timely hip X-ray was obtained for a resident after a fall. This applies to 1 of 3 residents (R1) reviewed for diagnostic services in a sample of 5.The findings include:R1's 2/17/26 progress note from 5:30 AM showed .noted on the floor in front of his wheelchair in an upright sitting position, sustaining a skin tear to the left elbow. When asked what happened, (R1) said that he was reaching for papers on the chair and slid out of the wheelchair. Left elbow cleansed and dressing applied. Wife made aware and also NP (Nurse Practitioner) aware of fall .R1's 2/17/26 progress note from 1:57 PM (written by V6-Nurse Practitioner/NP) showed The patient had a fall on 2/17/26. The staff reported that (R1) was noted on the floor in front of the wheelchair in an upright sitting position, sustaining a skin tear to the left elbow. The examiner assessed the resident. (R1) stated that he was sitting on the edge of the bed and used his walker to reach papers on a chair and fell. (R1) indicates pain in the left hip. (R1) is unable to participate in range of motion. STAT hip x-ray ordered .On 4/23/26 at 10:12 AM, V3 (ADON) stated that R1 had a fall on 2/17/26 at 5:30 AM. R1 got up from his wheelchair and ambulated and tripped over his leg rest and fell to the floor. R1 was observed to be sitting in front of his wheelchair on the floor. At that time, he had a skin tear to his elbow. Later V6 (NP) came and saw him and he refused to be assessed because of the pain and she ordered a STAT X-ray. V3 stated I remember R1's daughter calling me and asking me about the fall and she asked me why it took until the next morning to do the X-ray. V3 stated they eventually came on 2/18/26 to do the x-ray. On 4/23/26 at 10:39 AM, V6 (Nurse Practitioner) stated she was notified of R1's early morning fall on 2/17/26 and she went and saw R1. V6 stated R1 refused to let her do range of motion on him because he had pain in his left hip so she told the nurse to put in an order for a STAT X-ray. V6 stated it is nursing who calls the X-ray company. V6 stated a STAT X-ray means that it should be done within four hours. On 4/23/26 at 12:45 PM, V2 DON (Director of Nursing) stated according to the X-ray report, the X-ray was not done until 2/18/26. She said a STAT X-ray should be within 4 hours. On 4/24/26 at 11:37 AM, V8 (RN-Registered Nurse) stated she worked a double shift on 2/17/26 from 6:30 AM to 11 PM and she was R1's assigned nurse. V8 stated R1 had fallen earlier during the night shift at 5:30 AM and at 8:45 AM, he was complaining of pain 7/10 and she gave Tylenol. V8 stated after V6 (NP) saw R1, she told V8 to put in the order for the X-ray and she put it in as regular X-ray order. V8 stated after our stand-up meeting, V6 came to me and told me to make it a STAT order. V8 stated she called the X-ray company and told them it was a STAT X-ray order. R1's 2/18/26 progress note from 8:52 AM (the next day) showed Writer contacted x-ray company regarding estimated time of arrival for X-ray of hip. Per company, a technician has been assigned and will be out this morning to complete X-ray. Exact ETA not available.R1's Physician Orders showed two X-ray orders for his left hip, unilateral with pelvis when performed, 2-3 views one time only on 2/17/26. It does not show it as stat orders. It was ordered by V6 (Nurse Practitioner) and put in by V8 (RN). The first order was put in at 10:47 AM and the second order was put in at 1:05 PM. Both orders show one time only.R1's Radiology Results Report showed results were reported on 2/18/26 at 9:45 AM, and R1 had an acute comminuted left femoral intertrochanteric fracture.Facility's policy titled Physician Orders (8/1/21) shows: III. Execution of Order and Notifications a) The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse. i. Contact.radiology services.as required to execute the medical order. iii. Notify internal staff of changes/updates as appropriate. iv. Notify resident/resident's representative of changes or new orders as appropriate. v. Notify attending or other providers as appropriate.