STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Chicago Living and Rehab Center	928 Joliet Road West Chicago, IL 60185

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were able to exercise their rights to retain personal items and failed to provide justification as to why those personal items were confiscated.This applies to 2 of 3 residents (R4 and R5) reviewed for resident rights in the sample of 15.The findings include: Face sheet, dated 2/25/26, shows R4's diagnoses included major depressive disorder.MDS (Minimum Data Sheet), dated 1/1/26, shows R4's cognition was intact.On 2/24/26 at 2:40 PM, R4 stated in October of 2025 R5 was having pain in his stomach which caused him trouble bending forward. R4 stated he ordered an object grabber for R5 and attempted to provide the grabber to R5 however V3 (Psychiatric Rehabilitation Services Director) and V5 (Former Administrator) both stated they were concerned the grabber could be used as a weapon, confiscated the object, and told R4 that R5 required a physician order to utilize an object grabber. R4 stated he and R5 obtained a physician order for the object grabber and V3 and V5 once again denied the use of the grabber R4 provided and the facility ordered a different grabber for R5. R4 stated the facility did not return his grabber to R4 and only offered to assist R4 to return the object for a refund. R4 stated he objected to the confiscation of the object and requested a policy which justified the confiscation of the object, the need for a physician order, and a policy stating the reason the original object grabber was of concern. R4 stated he felt disrespected and dismissed by the facility staff response to his requests for justifications of the confiscation and the denial of R5's use of the grabber R4 ordered. R4 stated he wrote two memos to the facility requesting a policy to justify the facility's actions and outlining his concerns his rights were being violated and he was being treated unfairly/disrespectfully, and R4 never received any written documentation in response. R4 stated he never received the grabber he purchased.On 2/24/26 at 3:00 PM, V2 (Assistant Administrator) stated she was aware R4 bought a object grabber for R5 and V5 would not allow R4 to keep the grabber or give the grabber to R5 because she was concerned it could be used as a weapon at the facility. V2 stated R5 later obtained a physician order for a object grabber and a different object grabber was ordered and provided to R5. V2 stated since V5 no longer worked at the facility, she could not locate the object grabber. V2 stated V5 was suspended pending an investigation regarding R4's accusation he was not treated fairly or respectfully. V2 stated the facility former corporate staff met with R4 to investigate his concerns of being treated disrespectfully and that his rights were violated and determined no abuse occurred. V2 stated she had no knowledge of R4's object grabber being returned to R4 or R4 being provided justification as to why his object grabber could not be utilized in the facility.On 2/25/26 at 11:49 AM, V3 (PRSD) stated she did not know what happened to the object grabber R4 purchased and stated V5 told R4 not to give the object grabber he purchased to R5. Social Services progress note, dated 10/8/25 at 1:00 PM, shows during a wellness check visit, R4 stated he was very angry and R4 was offered suggestions for coping including playing videos, writing and journaling, and talking to his therapist.Social services note, dated 10/8/25 at 5:46 PM by V3 (PRSD), shows R4 stated he purchased a grabbing device and wanted to give it to another resident. The note shows the staff explained to R4 that the shape of the object grabber could potentially render it usable as a weapon by (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another individual, and therefore not safe to have in the facility. R4 then stated he understood and wanted to give it to housekeeping staff but staff declined and suggested he return the object grabber. The note shows V3 offered to assist in returning the object and retrieving R4's money. The note shows R4 agreed and told V3 he would get the receipt. The note shows later R4 stated he wanted to give the object grabber to his peer and V3 told him if it was medically needed for a resident there would be a physician order. Resident memo, dated 10/8/25, shows R4 expressed his displeasure with the lack of professionalism, arbitrary denial of resident's rights and general discourtesy shown to R4 and R5. The memo shows R4 bought R5 an object grabber for picking up items. The memo shows when the item arrived at the facility, the receptionist instructed R4 to take the item to Psych Social and then to the facility administrator. The memo stated R4 remained silent, discounted and being rather offended and stunned by his treatment. The memo shows the administrator identified the object grabber as a weapon and parties agreed that if R5 obtained a physician order for the item, the item would be allowed to be given to R5. The memo shows V3 took the object grabber and offered to help R4 return the item but R4 offered to donate it to housekeeping which was rejected by facility staff. The document shows R4 felt he followed procedures and his request to give the item to R5 was denied and his item was confiscated. The document shows R4 was told V5 (Former Administrator) was not going to allow the object in the facility. The document shows R4 requested a policy showing his item was not allowed in the facility but a policy was not provided. The document shows R4 felt V5 denied his right to formal documentation as to why his object was not allowed.Social Services progress note, dated 10/10/25 at 3:35 PM, shows social services met with R4 regarding his concerns regarding the object grabber he purchased and R4 expressed he felt ambushed by staff interviewing him and felt his rights to possess or provide the object grabber to R5 were violated without justification. The note shows R4's concerns did not rise to the level of abuse, R4 was allowed to vent his frustrations, and R4 continued to assert he was not being listened to. The note shows R4 remained dissatisfied and R4 was referred to his therapist. An addendum, dated 10/10/25 at 6:16 PM shows social services attempted to follow up with R4 and R4 requested to involve peers in the meeting who were not available and social services told R4 the intent was to meet with R4 and R4's peers would be contacted as needed. The progress notes fail to show R4's request to meet with the staff and his peers was accepted.Resident memo, dated 10/10/25, shows R4 met with a facility corporate representative, V2, R5, and R6 (Former Resident Council President) shows corporate informed R4, R5 and R6 that the original concerns R4 raised was an error in communication and poor communications between V5, V3 and R4. R4's memo shows R4 disagreed with the assertion and stated he experienced an arbitrary violation in his and R5's rights. The memo shows R4 felt the facility staff was not listening to his concerns and stated R4 was attempting to help R5 within facility rules but was experiencing arbitrary decision making by the facility. The memo shows R4 felt discounted, ignored, and invalidated and experienced anger and anxiety regarding the facility's failure to address his concerns fairly - which was escalated by the subsequent meeting with corporate insisting there was poor communication.During the investigation, V2 (Assistant Administrator) and V7 (Director of Nursing) both stated V5 (Former Administrator) and V3 (PRSD) made the decision to confiscate R4's object grabber and neither have seen it since the concerns were first brought up and the object was confiscated. V7 stated R5 did receive a physician order for the grabber and received a different grabber ordered by the facility.Face sheet, dated 2/25/26, shows R5's diagnoses include major depression, anxiety, suicidal ideations, alcohol dependence, and insomniaMDS, dated [DATE], shows R5's cognition was intact. Physician order sheet, dated 2/25/26, shows R5 had a physician order (dated 10/10/25) for use of a grabber tool for personal assistance as needed.Social Services note, dated 10/625, shows R5 approached psych social and expressed he wanted to use a grabber that another resident bought for him. The note shows per the facility administrator, R5 was not allowed to have the grabber due to facility regulations and R5 was made aware of the information.Progress note, dated 10/10/25, shows R5 received a physician order for a grabber and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided a grabber by the facility.Facility Resident Rights Policy, reviewed 1/2026, shows residents at the facility have the right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. The residents also have the right to retain and use or wear personal property in Resident's immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. Facility Dignity document, undated, shows the facility staff will not speak in a manner that could be interpreted as even minimally condescending/critical or argumentative.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the abuse of a facility resident.This applies to 1 of 4 residents (R7) reviewed for abuse in a sample of 15.The findings include: Facility Abuse Prevention Policy, dated 10/24/24, shows, The facility affirms the right of our residents to be free from abuse. The facility has attempted to establish a resident sensitive and resident secure environment. The policy shows, Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Verbal abuse is the use of oral. language that willfully includes disparaging and derogatory terms to residents or families. regardless of an individuals' age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Face sheet dated 1/21/26 shows R3's diagnoses included schizoaffective disorder and dizziness and giddiness. MDS (Minimum Data Sheet), dated 2/17/26, shows R3's cognition was intact. Care plan, effective 11/16/25, shows R3 had a history of physical aggression such as throwing consumable liquid at a peer. Identified offender care plan, dated 2/2/26, shows R3's background check revealed R3 had a felony conviction for aggravated battery and R3 was to be monitored and supervised. R3's verbal abuse care plan, dated 1/4/26, shows R3 had a history of being verbally abusive toward staff and R3 was verbally abusive toward his roommate by calling him an ?idiot. R3's schizoaffective disorder care plan, dated 11/16/25, shows R3 had ineffective coping modalities, disorganized thought processes and mood patterns, delusions, hallucinations, and reduced insight and judgement. Illinois State Police Criminal History Record, dated 9/11/25, shows R3 had convictions of battery with bodily harm and disorderly conduct.On 2/24/26 at 3:20 PM, R3 stated he threw coffee on R7 because she would not stop talking and R7 was annoying R3. On 2/24/26 at 3:28 PM, R7 stated R3 threw hot coffee on her because R3 was arguing with R7. On 2/24/26 at 2:00 PM, V4 (Activity Aide) stated on 1/27/25 at approximately 12:15 PM he saw R3 and R7 speaking, R7 then got up and R3 threw coffee at her. V4 stated R3 most likely obtained the coffee during lunch service which can be obtained before and during lunch beginning at 11:45 PM. Final Incident Investigation Report, dated 1/27/26, shows R3 was observed throwing his beverage at R7. R3 was placed on 1:1 monitoring and R7 was assessed for injuries, and no abnormal findings were observed. R3 was sent to the hospital for evaluation. The report falsely claims R3 had no history of verbal aggression with his peers, and the investigation shows the allegation of abuse was unfounded. Progress notes, dated 1/21/26, show at 11:58 AM an activity aide reported that R3 threw coffee on R7 because R7 kept saying she was pregnant, and showed her belly, then stated she was annoying and wouldn't shut up so I threw coffee on her. The note shows R3 was referred to psychology and social services, was placed on 1:1 monitoring, and received orders to be transferred to the psychiatric hospital for evaluation and treatment. R3's progress notes show R3 was admitted to the psychiatric hospital with a diagnosis of schizoaffective disorder and was discharged back to the facility on 1/27/26. Involuntary petition, dated 1/21/26, shows R3 presented with extreme agitation and aggression, R3 threw his cup of coffee at another resident, was agitating other residents, was disrupting the environment, and was not redirectable. R7's diagnosis report, dated 1/21/26, shows R7's diagnoses included malignant neoplasm of the colon, liver, and intrahepatic bile duct, schizophrenia, epilepsy, and low back pain. MDS, dated [DATE], shows R7's cognition was intact. Review of R7's progress notes, dated 1/21/26, show R7 was involved in an altercation that resulted in a peer throwing a beverage on her. The progress notes show R7 stated she was ok and would change her shirt.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report resident allegations of abuse.This applies to 1 of 4 residents (R1) reviewed for abuse in the sample of 15.The findings include:On 2/24/26 at 1:36 PM, V6 (Psychiatric Rehabilitation Services Counselor) stated R1 reported that R2 threatened to hit R1 with a walker and he immediately told V2 (Assistant Administrator). On 2/24/26 at 10:01 AM, V2 (Assistant Administrator) stated she spoke to R1 who told V2 that a resident was shaking her walker at her so V2 reported the allegation to V5 (Former Administrator) who initiated an investigation. V2 stated R1 told V2 that R1 was scared and the facility sent R2 out to the psychiatric hospital. Investigation Assessment (Resident to Resident Aggression), dated 1/26/26 and completed by V5 (Former Administrator), shows an investigation was conducted regarding resident aggression between R1 and R2. Investigation document, dated 1/27/26, shows on 1/26/26 an incident occurred between R1 and R2 and R2 was placed on 1:1 monitoring. The document shows R1 was sitting in the dining room and R2 approached R1, grabbed R1's walker, began stating she would shove it up [R1's] ass and that R2 threatened to kill R1. The report shows R1 stated she was scared because she was unsure what R2 would do. The report shows video footage was reviewed and R2 walked to R1 and began talking to R1. The video showed R2 was speaking toward R1 and then placed both hands on R1's walker, lifted it slightly off the ground and pushed it toward R1. The document shows R2 was petitioned to the psychiatric hospital for evaluation and treatment of the exacerbation of her serious mental illness. The investigation document fails to show the allegation was reported to IDPH (Illinois Department of Public Health).Witness statement, dated 1/27/26, shows R1 was interviewed and R1 stated R2 walked to R1, grabbed R1's walker, threated to shove R1's walker up her ass, and threatened to kill R1. The document shows R1 was scared and did not know what R2 was going to do. Witness statement, dated 1/27/26, shows V2 (Assistant Administrator) stated R1 told her that R2 approached R1, grabbed R1's walker, and R2 stated she was going to hit R1 over the head with the walker as well as stated she was going to kill R1. The witness statement shows R1 expressed she was scared of R2. The statement shows V2 immediately reported the allegation to V5 and assigned a staff 1:1 supervision over R2. On 2/23/26 at 1:31 PM, V1 (Administrator) read the investigation report and stated, based on the threats made toward R1, the incident should have been reported to IDPH based on the verbal threats in spite of the walker not being thrown at R1. V1 stated she had no evidence the allegation was reported to IDPH by the facility.Facility Abuse Prevention Policy, dated 10/24/24, shows, Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator or designee, shall notify Department of Public Health's regional office immediately by telephone or fax.