STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E392	A. Building B. Wing	06/04/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pain medication to a resident in pain per physician orders. This applies to 1 of 3 residents (R4) reviewed for pain in a sample of 8.The findings include: R4's Hospital Physical Medicine Physician progress note, dated 5/11/26, shows R4's diagnoses included chronic low back pain, right sciatica, and myofascial pain. R4 was referred for a nerve test of her legs and a trigger point injection of her low back. MAR (Medication Administration Record), dated May 2026, shows R4 received a physician order for tramadol as needed for pain on 5/18/26 at 7:48 PM . The MAR shows tramadol was first administered 5/19/26 at 4:37 PM for back pain described by R4 as 9 on a scale of 10 with 10 being the worst pain.On 6/2/26 at 11:05 AM, R4 stated once her Tramadol was ordered by V5 (Nurse Practitioner) it .took forever for them to give it to me once it was ordered. R4 stated her pain was a 9 on a scale of 0 to 10 with 10 being the most pain she had experienced. R4 stated she could get out of bed and could get herself dressed, but her legs hurt badly when she was putting on her pants and she felt like she could barely walk. R4 stated she had a high threshold for pain and was not crying, but she was in severe pain.On 6/2/26 at 10:00 AM, V7 (Registered Nurse) stated R4 complained of chronic pain in her back and received a physician order for Tramadol in the evening of 5/18/26. V7 stated he faxed the prescription to the pharmacy at the time he received it. V7 stated the prescription was received late for the next day delivery and it took two days for the pharmacy to deliver the Tramadol. On 6/3/26 at 11:32 PM, V6 (Registered Nurse) stated on 5/18/26 R4 was asking to receive her Tramadol but it was not yet delivered to the facility. V6 stated they called the pharmacy and requested a code for the emergency medication storage to be able to retrieve Tramadol for R4 until her medication delivery arrived. V6 stated the code was not opening the emergency medication storage and they were unable to retrieve the Tramadol until a staff noticed the electrical plug was not securely inserted into the machine on 5/19/26. Progress note, dated 5/18/26 at 7:52 PM, shows R4 complained of chronic back pain and V5 (Nurse Practitioner) ordered R4 Tramadol for her pain. The note shows the prescription was faxed to the pharmacy. Progress note, dated 5/18/26 at 10:48 PM written by V6 (Registered Nurse), shows the prior nurse received a physician order for Tramadol for R4 and faxed the prescription to pharmacy. At 9:09 PM V4 called the pharmacy to request the access code for the resident's medication. V4 received a reference number and was informed the after hours pharmacy would call back in 30 minutes. V4 received a call back from the pharmacist and was told the pharmacy did not receive a written prescription for R4's medication. V4 re-faxed R4's prescription and received a confirmation. V4 attempted to call the pharmacy back multiple times all the while R4 was requesting her medication. R4 became upset with V4 and stated, this is [NAME]---, you don't want to do it, I'm calling the state on this place. The note shows after multiple re-attempts with pharmacy V4 was able to reach a representative who would reach out to the overnight pharmacist and ask them to call the facility. The note shows V4 attempted to explain the status of the prescription to R4 but R4 continued to voice loudly that she was calling the state. The note shows at 11:11 PM V4 received a call back from the after-hours pharmacist who gave V4 an access code to the emergency medicine storage. V4 (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted to retrieve the medication twice with the after-hours pharmacist on the phone but the drawer containing the Tramadol would not unlock and open. V4 was instructed by the pharmacy to call the emergency medication storage company in the morning to service the machine. The note shows R4's Tramadol was not dispensed. Progress note, dated 5/19/26 at 6:40 AM shows V6 called the pharmacy and attempted to retrieve R4's medication from the emergency medication storage. The note shows V6 was told a pharmacy representative would call V6 back with a code to the emergency medication storage unit.On 6/3/26 at 3:41 PM, V8 (Corporate Nurse Consultant) stated the nursing staff could have re-ordered R4's Tramadol stat from the pharmacy when they could not retrieve it from the emergency medicine storage. Resident Pain Management policy/procedure, dated 1/2026, shows, Policy 1. To ensure residents are pain free as possible by using a variety of approaches in pain management of their pain. 2. To ensure residents are medicated for pain as per physician orders.Medication Administration Policy, dated January 2023, shows, Drugs will be administrated in accordance with orders of licensed medical practitioners of the State in which the facility operates. 11. In the event the drug is unavailable, the charge nurse shall be responsible for notifying the pharmacy for delivery. Medication convenience box may be utilized depending on type of medication.