STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046177	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU NRSG & REHAB CENTER	7050 MADISON STREET , WILLOWBROOK, Illinois, 60521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		08/11/2025
S9999	Final Observations Statement of Licensure Violations: 1 of 4 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		08/11/2025

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

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident had a leg rest while using a wheelchair, this failure resulted in R24 falling out of her wheelchair face forward sustaining a laceration requiring sutures. The facility also failed to ensure a resident was safely repositioned and transferred in a manner to prevent injury. This applies to 3 of 25 residents (R24, R110, R5) reviewed for safety in the sample of 25. The findings include: 1. R24's electronic face sheet accessed on 7/28/25 shows R47 has diagnoses of progressive supranuclear ophthalmoplegia (Steele-Richardson Olszewski) R24's facility assessment dated 6/18/25 shows R24 has no cognitive impairment with BIMS of 14. The same assessment shows R24 has no behaviors of rejection of care. On 7/28/25 at 9AM, R24 was sitting in her wheelchair alert and pleasant. R24 was noted to have stooped posture (hunch over posture) her head and neck were bent forwards. R24 had a dressing noted on the right side of her forehead. On 7/29/25 at 9:04 AM, R24 said she was being pushed in her wheelchair by a CNA to the shower room. R24 said the shower room was away from her room. R24 said as she was being turned around the corner towards the shower room, she fell out of her wheelchair face forward hitting her head on the floor. On 7/29/25 at 9:30 AM V11 said she was R24's Certified Nursing Assistant-(CNA) when R24 fell last 7/18/25. V11	S9999		

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S9999	Continued from page 2 (CNA) said it was close to 8PM, R24 wanted to wheel herself to the shower room. so V11 stayed a few feet away from R24. V11 said she noticed that while R24 was wheeling herself in her wheelchair, R24 was leaning forward. V11 said she did not think any of it. Then R24 was noted to be leaning more towards her side then forward. V11 said she also noticed both of R24's feet were now caught underneath her wheelchair, R24 was unable to hold her feet up while wheeling herself, then R24 fell out of her wheelchair forward. V11 said she then realized R24 did not have her leg rest on. V11 said she should have applied R24's leg rest for safety. V11 said she should have made sure she was nearer R24 so that "when she was leaning, I should have just got there sooner to pull her backwards." R24's hospital records dated 7/18/25 documents, diagnosis, head injury, fell out of wheelchair face forward hitting right side of forehead. Laceration repair (to right forehead.) With discharge order to remove sutures in 7-10 days. The Facility Reported Incident (FRI) dated 7/23/25 with date of incident of 7/18/25 show, "(res) propelling to shower room, accompanied by CNA when she lost balance and fell forward out of the wheelchair onto the floor. R24 was assessed, noted laceration to her forehead. Pressure dressing was applied and denied pain, 911 called and sent to the local hospital. Returned to facility with 6 sutures to remove within 7-10 days. On 7/29/25 at 1 PM, V10 (Registered Nurse-RN) said R24 leans forward due to her disease, "it is like Parkinson but not quite." R24 needs her leg rest when she is in her wheelchair for long distance. R24 was unable to lift her feet up for long periods of time. R24's room was in the middle of the hallway. The shower room was in front of the Nurses station at the end of the hall. On 7/29/25 at 9:45 AM both V12 and V13 (CNAs) said R24 moves very slow. R24 needed to be wheeled for long distances and needs her leg rests for safety. On 7/30/25 at 9AM, V13 (Nurse Practitioner) said R24 has a rare neurological condition that affects her physical function- it affects her movement and balance. This makes R24 high risk for falls. R24's posture is hunch over, (leans forward). R24 moves slow and tires easily. R24 is very alert and knows what is going on, when she relates something, that is really what happened. R24's safety come first. If R24 prefers to use her leg inside the room while in her wheelchair, that was fine. But for R24's safety, which is again the priority, when R24 was outside her room, in her	S9999		

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S9999	Continued from page 3 wheelchair going to point A to point B, (room to shower room) R24 should have a leg rest to help her balance and prevent her from falling forward. The facility policy on Falls dated 1/24 shows, Fall Guidelines, to consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization wide ownership for fall prevention… to prevent or reduce injuries related to fall, to enhance residents' dignity and self-worth, to rehabilitate residents to their fullest potential of function. 2. R110's face sheet shows she has diagnoses including weakness, pain to leg and shoulder, abnormal posture, and a history of colon and breast cancer. On 7/28/25 at 10:16 AM, R110 was in bed, on her left mid forearm there was a fading bluish green bruise with several dark purple spots in the middle of it. The bruise wrapped around her inner and outer forearm. Above her bed was a sign indicating that no blood draws or blood pressures should be taken with her left arm. R110 said she got the bruise a week ago Thursday (7/17/25) when an agency CNA (Certified Nursing Assistant) went to turn her to do care and get her out of bed. R110 said instead of the agency CNA assisting her to turn by using her shoulder or back to roll her she grabbed her left arm and pulled on it to turn her. R110 said she had a mastectomy for breast cancer in her left breast and that arm is very sensitive and bruises so there is a sign letting staff know to not use her left arm. R110 said the CNA should not have used her arm at all to turn her. R110 went on to say that while this same agency CNA was then getting her up via a mechanical lift the CNA used a wrong size sling, and she was leaning forward and experienced some pain to her buttocks and kept telling her something is wrong this should not hurt. R110 said the CNA was the only one in the room using the lift to get her up and luckily another CNA ended up coming into the room and helped get her finished up. R110 she was afraid something would happen to her since it was the wrong size sling. R110 said she did tell another staff person the next day about her arm because it was hurting her. R110's Electronic Medical Record (EMR) shows she was seen by V13 (Nurse Practitioner/NP) on 7/18/25. V13 documented in a provider follow up note that R110 had a bruise on her left arm that was caused by a staff person who assisted her with mobility and used her left arm.	S9999		

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S9999	Continued from page 4 The investigation for the incident for R110 on 7/18/25 shows photos of her left arm discoloration that was beginning to bruise that had been taken by V15 (Wound Care Nurse). V15 also documented that an aide had gripped her arm during peri care. A witness statement completed on 7/18/25 by V20 (Restorative Aide) shows she entered R110's room and saw R110 being inappropriately positioned in the mechanical lift sling during a transfer. On 7/28/25 at 1:10 PM- V13 (NP) said she was asked to see R110 because she had pain and discoloration (bruising) to her left forearm. V13 said R110 is fully alert and oriented, and what I was told is she was grabbed by a CNA who was "heavy handed" while assisting her with care. V13 said they would describe the bruise as cuffing, and it would be consistent with someone being grabbed by the arm. V13 said R110 denied that she felt the CNA purposely intended to hurt her, but she should not have used her left arm because R110 does have left sided weakness and swelling from a past mastectomy. On 7/29/25 at 1:47 PM, V17 (Assistant Director of Nursing/ADON) said it was reported to her on 7/18/25 about the incident with the agency CNA and R110. She identified the agency CNA as V19. V17 said V19 was put on a do not return list and was not allowed to work at the facility anymore. V17 said V19 should not have used R110's left arm and she was also made aware from V20 that V19 also used the mechanical lift alone and had R110 in the wrong size sling during the transfer. On 7/29/25 at 1:53 PM, V20 (CNA) said she did walk into R110's room to see if she was ready for her bath and found another CNA transferring her with the mechanical lift alone. V20 said you could see it in R110's face she was uncomfortable, and she was "crammed" into the sling. V20 said the CNA (V19) should not have transferred R110 alone and she also used a sling that was too small. The facility provided Lifting Machine, using a Portable policy revised August 2008 shows that residents should be properly positioned and comfortable during a mechanical lift transfer. R110's active care plan shows 2 staff should be present during R110's transfer via a mechanical lift. 3. R5's Fall's Report dated 7/16/25 states, "CNA on duty called out for help, writer immediately went to room. CNA on duty stated that resident rolled off her air mattress during care, resident noted on the floor	S9999		

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S9999	Continued from page 5 to the left side of the bed, lying on her right side. When asked what happened resident stated, “I just rolled.” On 7/29/25 at 2:10PM, V5 (Registered Nurse) stated, “The CNA was (V6). She rolled (R5) over and she was supposed to have 2 people when caring for her. (R5) didn't have any injury, she did not hit her head. We used a mechanical lift to get her off the floor.” On 7/29/25 at 2:45PM V6 (Certified Nursing Assistant) stated, “I was giving her a bed bath, and I was washing her back and her legs just slipped off the bed. She grabbed onto the halo (side rail) then slid to the floor. We usually have 2 staff to care for her, but the agency girl was pregnant, so I did it by myself.” On 7/30/25 at 11:15AM (R5) stated, “It was an accident. They usually use 2 people. They have been very careful since the fall. I didn't get hurt- it was just the fear that is caused.” R5’s Physician’s Order Sheet dated July 30, 2025, shows that R5 has diagnoses including Paraplegia, Sacral Pressure Ulcer and Muscle Wasting and Atrophy. R5’s Current Care Plan states, “Resident has impaired mobility due to paraplegia” and “The resident is at risk for falls related to decreased mobility, weakness and paraplegia.” R5’s care plan does not address her need to have 2 staff members to assist with turning and repositioning. (B) 2 of 4 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a	S9999		

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S9999	Continued from page 6 background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure background checks and Illinois Sex Offender registry checks were done within 24 hours of admission to the facility. This applies to 10 of 10 residents (R133, R135, R136, R32, R31, R27, R66, R98, R91 & R63) reviewed for background checks in the sample of 25. The findings include: R133's electronic medical record (EMR) shows, she was admitted on 7/25/25. R135's EMR shows, he was admitted on 7/21/25. R136's EMR shows, she was admitted on 6/8/25. R32's EMR shows, she was admitted on 7/10/25. R31's EMR shows, he was admitted on 7/10/25. R27's EMR shows, he was admitted on 7/8/25. R27's background check is still pending with the Illinois State Police (ISP). R66's EMR shows, she was admitted on 7/8/25. R98's EMR shows, she was admitted on 6/5/25. R98's background check shows, she had a hit. R91's EMR shows, she was admitted on 6/25/25. R63's EMR shows, he was admitted on 6/24/25. R133, R135, R136, R32, R31, R27, R66, R98, R91 and R63's new admission files show, their Criminal History Information Response Process (CHIRP) (background check) were done on 7/28/25 (first day of the annual survey). None of the resident's background checks were done	S9999		

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S9999	Continued from page 7 within 24 hours of admission as stated in the regulation. The files also show, they were not checked on the Illinois sex offender registry. On 7/29/25 at 1:25PM, V3 Admissions Director stated, she is the only one who checks the background checks on the residents. She was aware they were late. She was on vacation, and she got locked out of her account. She has not been able to log in to check the resident's background checks. She also stated, she only checks the national sex offender registry and not the Illinois sex offender registry. She did not know she was supposed to check the Illinois sex offender registry. The facility's IOP (identified offender program) program policy (no date) shows, "Step 1: A check of the national sex offender database can be obtained online from the United States Department of Justice National Sex Offender Registry... Step 2: A Criminal History Information Response Process (CHIRP) should be ran within 24 hours of admission to the facility..." Their policy does not show, they should be checking the Illinois sex offender registry as stated in the regulation. (C) 3 of 4 300.625c)1) Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure the Illinois State Police were notified of identified offenders. This applies to 3 of 6 residents (R30, R108, R120) reviewed for identified offenders in the sample of 25. The findings include: The facility provided on 7/30/25 an Identified Offender list that shows, R30, R108 & R120 are currently in the facility and known identified offenders.	S9999		

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S9999	Continued from page 8 R30's EMR shows he was admitted on 12/26/22. His CHIRP was done on 12/26/22 and shows he had a HIT. The Illinois State Police (ISP) was not contacted. The facility is unaware of the resident's "risk level." R108's EMR shows, he was admitted on 5/31/22. His CHIRP was done on 6/6/22 and shows he had a HIT. The ISP was not contacted. The facility is unaware of the resident's "risk level." R120's EMR shows, he was admitted on 5/15/25. His CHIRP was done on 6/13/25 and shows he had a HIT. The ISP was not contacted. The facility is unaware of the resident's "risk level." On 7/30/25 at 2:15 PM, V1 Administrator stated, they didn't know what R30, R108 or R120's risk level was because they never notified IDPH or ISP that they were in the facility. The facility's IOP (identified offender program) program policy (no date) shows, "Step 4: If resident CHIRP says, "no record" please place in a binder for safe keeping. If resident CHIRP states it's a "HIT" or "Multi-Hit" fingerprints are required for the following: all classes 1, 2, 3 and 4 require finger printing... Step 5: Once fingerprinting is complete, submit all documentation to Illinois Department of Public Health, Identified Offender Program... Step 6: Wait for investigator from department of human services to contact you regarding an interview with resident...." (to identify risk level). (C) 4 of 4 300.2930c)5) Section 300.2930 Plumbing Systems c) Water Supply Systems 5) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hot water in resident bathroom sinks was maintained at a safe temperature. This applies to 4 of 4 residents (R9, R21, R81, R108)	S9999		

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S9999	Continued from page 9 reviewed for safe water temperatures in the sample of 25. The findings include: On 7/29/25 starting at 2:15PM Surveyor and V7 (Maintenance Director) did water temperature checks on random rooms throughout the building. The temperature of the water in the bathroom of R9's room read 114.4 degrees Fahrenheit. The temperature of the water in the bathroom of R81's room read 114.2 degrees Fahrenheit. The temperature of the water in the bathroom of R21 and R108's room read 113.7 degrees Fahrenheit. During this time V7 stated, "We like to keep the water temperatures about 110-111 degrees (Fahrenheit)." The facility's Water Management Daily Log for July 2025 shows that water temperature of Domestic Tank #1 ranging from 109 to 115 degrees Fahrenheit. The undated facility policy entitled Monitoring of Water Temperatures states, "Water temperatures in resident bathrooms, showers and common areas cannot exceed 110 degrees. " (C)	S9999		