

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000968		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/04/2026	
NAME OF PROVIDER OR SUPPLIER West Chicago Living and Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 928 JOLIET ROAD , WEST CHICAGO, Illinois, 60185			
(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			S0000			
	First Probationary Licensure Survey						
S9999	Final Observations			S9999			
	Statement of Licensure Violations:						
	1 of 5						
	300.627c)						
	Section 300.627 Transfer of an Identified Offender						
	c) When a resident who is an identified offender is transferred to another facility regulated by the Department, the Department of Healthcare and Family Services, or the Department of Human Services, the transferring facility shall notify the Department and the receiving facility that the individual is an identified offender before making the transfer.						
	This requirement is not met as evidenced by:						
	Based on interview and record review, the facility failed to notify the Department when a resident was transferred out of the facility.						
	This applies to 9 of 14 residents (R14-R22) reviewed for resident background checks in the sample of 22.						
	The findings include:						
	IDPH (Illinois Department of Public Health) generated facility report showed that there were 25 residents that were in the facility that were identified offenders (IO) with low to moderate risk. Facility generated Report had only 11 residents listed as identifying offenders.						
	On February 2, 2026, at 3:25 PM, V4 PRSD (Psychiatric Rehabilitation Services Director) stated that 14 of the 25 residents listed on IDPH list were discharged from the facility. V4 stated that she knows that she is supposed to notify IDPH via their website of these discharges but did not do so.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 On February 3, 2026, at 10:30 AM, V4 provided information that 4 of the 14 residents left the facility AMA (against medical leave) and 1 (one) resident was discharged home. V4 stated that the rest were either discharged to the hospital or to another facility. V4 provided information as follows for the rest of the 9 discharged residents: R14 was admitted to the facility on August 28, 2025, and discharged on November 17, 2025, to another facility. R19 was admitted to the facility on September 3, 2024, and discharged on June 15, 2025, and did not return. V4 stated that she does not know where R19 went from the hospital. R19 was at moderate risk. Face sheet showed that R19 went to another "home" but not theirs. R20 was admitted to the facility on February 2, 2023, and discharged on July 17, 2024, to hospital and V4 stated that she does not know where R20 went from the hospital. R20 was at low risk. R20's risk factor is not identified. R15 was admitted to the facility on August 23, 2023, and discharged on November 29, 2024, to another facility. R15 was at moderate risk. R16 was admitted to the facility on August 23, 2023, and discharged on December 13, 2024, to another facility. R16 was at low risk. R17 was admitted to the facility on March 2, 2023, and discharged on June 6, 2025, to a supporting living facility. R17 was at moderate risk. R21 was admitted to the facility on August 26, 2023, and discharged to the hospital on June 6, 2024. V4 stated that R21 did not return to the facility, and she did not know where R21 went from the hospital. R21 was at moderate risk. R18 was admitted to the facility on August 4, 2021, and discharged on February 23, 2023, to a transitional living center. R18 was at low risk. R22 was admitted to the facility on June 22, 2018, and discharged on March 26, 2024, to the hospital and did not return. V4 stated that she did not know where R21 went from the hospital. R22 was at low risk. Facility policy titled "Resident Discharge" (revised August 2025) included: Policy: The purpose of the discharge summary and post-discharge plan of care is to assist [the resident] in adjusting to his/her new living environment by providing continuity of care information. Procedure: 8. If a resident that is of an IO status is discharged from the facility, PRSD or designee will discharge from the IO portal system. If the resident is on probation/parole, PRSD or designee to notify probation/parole officer. (C) 2 of 5			S9999			

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S9999	Continued from page 2 300.670a) 300.670c)1)2)3) 300.670d) 300.670e) 300.670f) 300.670g) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift. e) The facility shall provide for the evacuation of physically handicapped persons, including those who are hearing or sight impaired. f) If the welfare of the residents precludes an actual evacuation of an entire building, the facility shall conduct drills involving the evacuation of successive portions of the building under conditions that assure the capability of evacuating the entire building with the personnel usually available, should the need arise.	S9999					

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S9999	Continued from page 3 g) A written evaluation of each drill shall be submitted to the facility administrator and shall be maintained for one year. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the facility conducted the fire drills and disaster drills per policy and procedure. This applies to all 86 residents who reside in the facility. The findings include: The facility's census detail report dated February 2, 2026, showed that there were 86 residents residing in the facility. Review of the facility's binder for fire drills showed that the last fire drill was held on June 13, 2025. On February 3, 2026, at 10:47 AM, V14 (Maintenance Consultant) stated that the facility was acquired by the current owner on November 17, 2025. V13 (Maintenance Director) stated that he started working at the facility in his current position on October 2025. V13 and V14 both stated that based on the available fire drills documentation, the last fire drill was held on June 13, 2025. V14 stated that based on the facility's policy, the fire drills should be performed quarterly for each shift. According to V14, because the facility has three shifts (morning, evening and night) and the fire drills need to have a month gap in between each drill, the facility is required to do fire drills monthly to ensure that each shift is covered. During the same interview, V14 stated that based on the facility's policy regarding disaster drills to include tornadoes, floods, extreme hot or cold weather, bomb threat and missing person the facility should perform the drills twice a year for each shift, therefore six disaster drills need to be completed each year to ensure that each shift is covered. V13 and V14 stated that they cannot show any evidence that disaster drills were completed from January 2025 to the present. Review of the facility's policy dated November 2025 showed, "To define the frequency of and procedure for conducting fire and disaster drill to ensure that all personnel have a working knowledge of the fire safety and preparedness plans." The same policy under specifications showed in-part, "1. The following drills will be conducted by the facility to assist personnel		S9999				

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S9999	Continued from page 4 in preparing for emergency or disaster situations that could occur or affect routine operations: a. Fire drills (one per quarter per shift), b. Disaster drills (biannually on each shift). 2. Drills will be conducted to familiarize all personnel with emergency procedures allowing them to practice their drill responsibilities. ... 8. Appropriate documentation will be maintained for each drill conducted by the Maintenance Director." (C) 3 of 6 300.2040 c)2) Section 300.2040 Diet Orders c) Medical providers shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. A medical provider may delegate writing a diet order to the dietitian. 2) The diet shall be served as ordered. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve Regular diet and double portions for a resident as ordered by the Physician. This applies to 1 of 3 residents (R8) reviewed for therapeutic diets in the sample of 22. The findings include: R8's face sheet showed multiple diagnoses including Parkinson's disease with dyskinesia with fluctuations, Paranoid Schizophrenia, Gastro-Esophageal Reflux disease, Vascular Dementia unspecified severity without behavior/mood/anxiety. R8's diet order on POS (Physician Order Summary) showed Regular diet, thin liquids, low potassium, and double portions at all meals (order date October 2, 2025). R8's nutrition care plan dated initiated September 24, 2025, showed that R8 had physician orders for a Regular diet that remains well tolerated and received with excellent intakes at most meals. On February 2, 2026, at 9:14 AM, during initial tour of the facility kitchen, V6 (Morning Cook) stated that facility manager is not in. Staff present in the kitchen spoke mainly Spanish. No diet order listing was seen available in the kitchen.		S9999				

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S9999	Continued from page 5 On February 2, 2026, at 9:24 AM, V1(Administrator) stated that the Dietary Manager is on vacation, and she will figure out how to provide a diet order listing of the residents. This same list was provided within another two hours of the request and showed that R8 is on Regular diet with thin liquids, low potassium, and double portions. On February 2, 2026, at 12:10 PM, during lunch meal service in the dining room, R8 meal ticket showed mechanical soft, low potassium diet and R8 received one serving portion each of mechanical soft consistency ham sandwich, pasta salad, green peas and peaches respectively. On February 2, 2026, at 12:13 PM, V7 (Afternoon Cook) was notified that R8 only received one portion of the meal and V7 stated that R8 received the same because his card does not show double portions. V7 stated that she only has the diet card and does not have the diet order listing of the residents in the kitchen. Daily Spreadsheet for Week 2, Monday for regular diets showed to serve ham sandwich 3-ounce portion on 2 slices of bread, pasta salad #6 scoop, vegetable of the day #8 scoop, fruit cup #8 scoop=1/2 cup. The same spreadsheet showed that for double portions to serve 6 oz of ham on 4 slices of bread, 2 #6 scoops of pasta salad, 2 #8 scoops of vegetable of the day, 2 #8 scoops of fruit cup. On February 3, 2026, at 10:15 AM, V16 (Dietitian) stated that the dietary manager makes changes on the diet cards. V16 stated that facility should serve diet as ordered for the residents and if the residents have a diet order for double portions, they should receive the same. Facility "Scoop and Ladle equivalents" showed that #6=6 ounces and that #8=4 ounces. (B) 4 of 5 300.2210 b)1)5) 300.2900 b)1) Section 300.2210 Maintenance b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings;			S9999			

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S9999	Continued from page 6 peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. Section 300.2900 General Building Requirements b) Handrails and Grab Bars 1) Handrails shall be provided on both sides of all corridors and ramps used by residents. This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that handrails were equipped on both sides of the corridors, failed to ensure that handrails were secured and in good repair, failed to ensure that ceiling tiles were not stained, and failed to ensure that resident closets and bedside drawers were in good repair. This applies to all 86 residents who reside in the facility. This also applies to 5 of 5 residents (R5, R9, R10, R11 and R12) reviewed for room furnishings in the sample of 7. The findings include: 1. On February 2, 2026, at 10:36 AM, R12's closet had one missing drawer and R12's bedside table drawer was broken and off track, and R9's closet had one missing drawer. 2. On February 2, 2026, at 10:42 AM, R10's closet had one missing drawer. R10 stated that his closet drawer had been missing since he moved to his current room, more than a year ago. 3. On February 2, 2026, at 10:55 AM, R11's chest drawer had one missing drawer. R11 stated that the drawer had been missing for a "long time." Inside R11's room was another closet that had one missing drawer. 4. On February 2, 2026, at 10:24 AM, R5 had three chest drawers inside his room. R5's chest drawer number one had a broken drawer on the bottom. R5's chest drawer number two and number three, both had missing top drawers. 5. On February 2, 2026, at 10:42 AM, during the tour of		S9999				

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S9999	Continued from page 7 the C unit, wobbly and loose corridor handrails were observed between rooms C1 and C3, C4 and C6, C7 and C9, C8 and C10, C10 and C12, and C11 and the unit exit door. No corridor handrails were provided between the medical office leading to the C unit fire door and between the shower room and mechanical room, leading to the C unit fire door. 6. On February 2, 2026, at 11:58 AM, inside the main dining room, seven ceiling tiles stained with brown circle spots were observed. V13 (Maintenance Director) and V14 (Maintenance Consultant) were present during the observation. 7. On February 2, 2026, at 12:15 PM, during the tour of unit D with V13 and V14, wobbly and loose corridor handrails were observed between rooms D1 and D3, D2 and D4, D3 and D5, and D6 and D8. No corridor handrails were provided between the Director of Nursing's office leading to the D unit fire door and the corridor outside the mechanical room. 8. On February 2, 2026, at 12:21 PM, during the tour of unit E with V13 and V14, wobbly and loose corridor handrails were observed between rooms E2 and E4, E10 and E12, and E12 and the unit exit door. No corridor handrails were provided between the mechanical room and the nursing station and between the soiled utility room and the storage room. 9. On February 2, 2026, at 12:32 PM, during the tour of unit B with V13 and V14, wobbly and loose corridor handrails were observed between rooms B1 and B3, B2 and B4, B7 and B9, B8 and B10, B10 and B12, unit exit door and B11, and B12 and the unit exit door. No corridor handrails were provided between the mechanical room towards the dining area and the corridor between the environmental service/activity office towards the B unit fire door. 10. On February 2, 2026, at 12:42 PM, during the tour of unit A with V13 and V14, wobbly and loose corridor handrails were observed between rooms A2 and A4, A4 and A6, A5 and A7, A6 and A8, A7 and A9, A8 and A10, A9 and A11, and A11 and the unit exit door. No corridor handrails were provided between the mechanical room and kitchen and the corridor outside the staff room towards the A unit fire door. On February 2, 2026, at 1:00 PM, V14 (Maintenance Consultant) acknowledged that most of the facility's corridor handrails in all the units were wobbly, loose and in need of repair. V14 confirmed that there are portions of the unit corridors that do not have			S9999			

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S9999	Continued from page 8 handrails for ambulatory residents to hold on to for support when needed. V14 also stated that there are several drawers inside the residents' room that were missing and/or in need of repair. On February 3, 2026, at 10:12 AM, V14 stated that the stained ceiling tiles inside the main dining room were from the old leaks and were not changed. V14 added that he checked the heating and cooling ducts that were at the ceiling, and they were not wet. On February 4, 2026, at 11:42 AM, V2 (Director of Nursing) stated that all 86 residents eat their meals inside the main dining room. The facility's census detail report dated February 2, 2026, showed that there were 86 residents residing in the facility. Out of the 86 residents, 84 residents were identified by the facility as ambulatory. (B) 5 of 5 300.2900 d)1)7) Section 300.2900 General Building Requirements d) Doors and Windows 1) Main entrance and all exit doors shall swing outward and be provided with door closers and panic hardware. 7) Doors and windows shall fit snugly and be weather tight, yet open and close easily. This requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that emergency exit doors are easily open outward. This applies to all 86 residents who reside in the facility. The findings include: The facility's census detail report dated February 2, 2026, showed that there were 86 residents residing in the facility. On February 2, 2026, during the environmental tour of the facility which started at 12:15 PM, the emergency exit doors at the D unit (exit door number 7), E unit (exit door number 9) and B unit (exit door number 5) were not opening outward easily. The emergency exit			S9999			

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S9999	Continued from page 9 doors on the B, D and E units when pushed outwards by V14 (Maintenance Consultant) and can only be opened slightly. V14 stated that the door plates on the emergency exit doors on the B, D and E units were dragging on the exterior concrete, which causes the said doors to slightly open and not swing freely. Review of V14's signed statement dated February 2, 2026, showed in-part, "It was observed that emergency exits in halls B, D and E were not swinging freely and the kick plate of the door was dragging on the exterior concrete," (C)		S9999				