STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510401	A. BUILDING: _____ B. WING _____	C 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBRIDGE ASSISTED LIVING	500 WYNDEMERE CIRCLE WHEATON, IL 60187

(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) COMPLETE DATE
A 000	Initial Comment Original investigation of Facility Reported Incident IL 200942 and Facility Reported Incident IL 202039. FRI IL 200942 - VIOLATION - 295.2050 a) b) FRI IL 202039 - VIOLATION - 295.6010 a) 1)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required. b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident. This requirement was NOT MET as evidenced by: Based on record review and interviews, the establishment failed to report an serious injury for	A2050		

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A2050	Continued From page 1 one of two sampled residents. (R1). This failure creates a substantial probability of harm to a resident or residents. Findings include: Establishment "Acknowledgement of Late Discovery" of an "Unwitnessed Fall" for R1 reads, "This correspondence is to report an unwitnessed fall with injury involving above-named resident (R1) that occurred on 1/23/26. On 1/30/26, facility leadership identified that the event met IDPH reportable criteria and had not been previously submitted. Upon discovery, the facility immediately initiated the required reporting process. On 5/30/26 at 11:05 A.M., E1 (Assisted Living Director) confirmed that R1 did have an unwitnessed fall on 1/23/26 that required R1 going to the hospital an receiving 11 sutures to her right upper arm. This incident was not reported in the required 24 hours after the occurrence.	A2050		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 2 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the	A6010		

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A6010	Continued From page 2 establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. This requirement was NOT MET as evidenced by: Based on record review and interview, the establishment failed to report an allegation of sexual abuse for one of two sampled residents. (R2). This failure creates a substantial probability of harm to a resident or residents. Findings include: Establishments, "Alleged Sexual Abuse" final report for R2 reads, "On 5/16/2026 at approximately 7:00 PM, the resident (R2) was observed in the hallway crying and calling for help by the Nurse on Duty (NOD). During assessment, the resident (R2) alleged that she had been 'raped two days ago by two men' in her apartment during the nighttime while seated in her recliner chair. The resident (R2) identified one of the alleged perpetrator as 'Robert' and stated she could not recall the second individual's name. The resident (R2 further stated she was afraid to provide additional information because 'he might get back at me.'..... On 5/30/26 at 11:05 A.M., E1 (Assisted Living Director) stated that R2 made this allegation on 5/16/26. E1 stated that he had another nurse go into talk with R2 an hour and a half later, and R2	A6010		

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A6010	Continued From page 3 denied any rape had occurred. E1 stated that R2's daughter stated that R2 was getting more confused and didn't believe this had happened. E1 stated that R2 then made the same claim on 5/23/26. E1 stated that they decided since R2 had made the same claim twice, they should report this to Illinois Department of Public Health. E1 confirmed that they did not report the allegation of rape after the first allegation. E1 stated through their complete investigation, they determined the allegations to be unfounded.	A6010		