Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021		
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomingdale, IL 60108			
For information on the nursing home's	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)		on)		
F 0690 Level of Harm - Actual harm Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES		ONFIDENTIALITY** 15845 ovide incontinence care in a timely re. This failure resulted in multiple to R1's bilateral thighs and and incontinence care. gnoses that included pulmonary ralking, morbid obesity due to history of COVID-19 infection, nultiple sites, muscle weakness and		

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 145333

If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 145333	A. Building B. Wing	10/07/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
West Suburban Nursing & Rehab Center		311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's p	olan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0690 Level of Harm - Actual harm Residents Affected - Few	ne's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES		dy and edge of the bed. The lack of a turn due to lack of space. R1 was in my own and have to depend on 5 6 staff if all females. The facility ly 3 times a day at 10:00 A.M., 4:30 oped more skin sores and the sistion in bed is the same and I am 10:00 A.M. I never got out of bed or urine. They don't apply my wound is a very aggravating situation. asked to check her skin and IA/Certified Nurse Assistant) were alidated that R1 was scheduled to turn R1, V3 (Licensed Practical 1; V5 (LPN); V6 (LPN); V7 f 6 staff with 1 male and 5 females. It to the opposite side. R1 was pect of her pubis area. R1 was A.M. There was no wound dressing und the groin area and labial folds if ailed to apply skin ointment observed with multiple patches of and right buttocks. V4 measured the ge). The following measurements the same group of clustered are group of wounds. When V4 was size wounds and measuring the eatment nurse and was not trained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIE	FR	STREET ADDRESS, CITY, STATE, ZI	P CODE
West Suburban Nursing & Rehab Center		311 Edgewater Drive Bloomingdale, IL 60108	FCODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0690	5) Left proximal posterior thigh= 1	cm. x 1 cm. x 0.5 cm.	
Level of Harm - Actual harm	6) Left distal/inner thigh= 0.5 cm. x	0.5 cm. x 0.2 cm.	
Residents Affected - Few	V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse) stated during the skin check observation that only the MASD (Moisture Associated Skin Damage) on the right proximal posterior thigh was observed on 10/3/2021 and that V3 applied foam dressing on it at that time. V3 also added that the rest of the MASD were new. V3 and V4 said R1 had history of MASD before but had healed and they were not as much as observed on 10/4/2021.		
	The care plan dated 5/19/2021 and 8/19/2021 showed that R1 has alteration in skin integrity and is at risk of deterioration and or additional skin issues related to limited mobility, incontinence with bladder and bowel, morbid obesity, lymphedema, refusing air mattress, refusing peri-care at times. The interventions to prevent deterioration and acquired additional skin alteration included but not limited to: good peri care; apply protective barrier; reposition frequently when in bed, chair, and or wheelchair; pressure redistributing mattress/air loss mattress; off load bilateral heel from pressure with pillow.		
	Review of the care plan showed that R1's incontinence care to prevent skin sores was not addressed. The limited size of the bariatric bed which had no air mattress and prevented R1 from turning to sides was also not addressed. R1's refusal of treatment on the care plan showed no revised intervention.		
	On 10/6/2021 at 3:00 P.M., V1 (Administrator) stated that the facility does not accept residents that weigh more than 350 pounds because it lacks staff to provide care.		
	On 10/6/2021 at 5:00 P.M., V2 (Director of Nursing) added that V4 was new to her position as a wound treatment nurse and was not trained yet. V2 also said that facility does not accept residents that weigh more than 350 pounds. V2 also added that they try their best to provide care to R1 but R1's situation needed additional support.		
	10/5/2021. V14 said R1 had multip posterior bilateral thighs and buttor rated for a 350-pound person. R1 valuring and repositioning. V14 also should be checked for incontinence pressure and an air loss mattress to V14 also said these preventions shadded that if these interventions we sores were unavoidable. V14 state avoidable or not. V14 said if R1 has should be applied to protect the da every 2 hours, causes urine and st	Jound Care Physician Specialist) said hale patches/clusters of MASD (Moisture ks area. V14 said R1 was on a bariatric by veighs ~600 pounds and her bariatric by validated R1 needed to be kept clean by care at least every 2 hours, should be be implemented to prevent pressure so would be implemented even if a resident ere implemented and pressure sores and all possible interventions should be pld complained of burning sensation due maged skin. V14 said Peri-care that is sool to saturate the skin and not cleansified the said even a non-medical person knows the	Associated Skin Damage) on the c bed but the bariatric bed was only bed cannot accommodate R1 for and dry from urine and stool and a turned every 2 hours to offload res, MASD or other skin alterations. It has multiple comorbidities. V14 and MASD still existed, then the provided to determine if sores were to urine, then a foam dressing not done timely, which is at leasting the perineum thoroughly will

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIE	:R	STREET ADDRESS, CITY, STATE, ZI	IP CODE
West Suburban Nursing & Rehab C	Center	311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG			ion)
F 0690 Level of Harm - Actual harm Residents Affected - Few	nab Center 311 Edgewater Drive		attocks after an incontinence every 2 hours. The policy also um toward the rectum. For a female pubic area to rectal area and to slitty's policy for incontinence care alteration. The POS showed to d 9:30 P.M. There was no intinence care. Ition. R2 has a stage 4 pressure dressing to R2. R2 was saturated ing the frontal/pubic area and R2's sacrum and the foam dressing en V4 cleansed the rectal area. R2 ef with the wound dressing edges as alteration in skin integrity and is at ity, incontinence of bladder and drying of skin, apply protective R3 has a stage 4 pressure ulcer provide R3 incontinence care. V4 R3 was clean and dry. V4 said I will roviding hygiene to R10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	145333	B. Wing	10/07/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
West Suburban Nursing & Rehab Center		311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0725 Level of Harm - Minimal harm or	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.		
potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 15845
Residents Affected - Some		nd record review, the facility failed to princontinence care and grooming/hygie	
	This applies to 4 of 4 residents (R1	, R2, R3, and R10) reviewed for staffin	g needs.
	The findings include:		
	1) The Face Sheet showed that R1 was a [AGE] year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.		
	Review of the weight record history showed R1's weights:		
	-06/18/2021= 629 pounds		
	-06/25/2021=632 pounds		
	-07/02/2021=633 pounds		
	-08/09/2021=633.4 pounds		
	-09/07/2021=608 pounds		
	that R1's had approximately 4-6 inc space meant that R1 could possibly alert and oriented times three. R1's to 6 staff to turn me. If there is a made does not have enough people to ha P.M. and 9:30 P.M. I am usually so sores do not heal because I am so never turned to sides. Last time I w sat on a chair. It really does sting n	vas lying in her bariatric bed. The width ches space between the side of her body end up on the floor if R1 attempted to said Don't worry, I cannot turn myself of ale staff, then 5 staff will do, otherwise andle me, so my diaper change was on taked with urine and stool. I have develoaked with urine most of the time. My pot as changed today was around 9:30 to my skin when my diaper is soaked with tarmy skin from the burning sensation. It	dy and edge of the bed. The lack of a turn due to lack of space. R1 was n my own and have to depend on 5 6 staff if all females. The facility sty 3 times a day at 10:00 A.M., 4:30 loped more skin sores and the osition in bed is the same and I am 10:00 A.M. I never got out of bed or urine. They don't apply my wound

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses and CNAs throughout the fa (Administrator). During this interview, R1 was calm incontinence care. V5 (LPN/ Licens present when R1 talked about her be changed 3 times a day. (10:00 // After the interview with R1 on 10/4/ Nurse /LPN/Wound Treatment Nur (CNA/Certified Nurse Assistant) an R1 had to be moved towards the e observed with 2 diapers under her saturated with urine. V7 said she ju on R1's perineum or thighs. V7 fails for thorough cleansing. V7 also fail barrier. R1 was noted with multiple On 10/4/21, R1 was compliant whe that this time 2 males were helping open skin sores surrounding her powounds that V4 categorized it as Were provided by V4: V4 started m wounds. V4 failed to measure the sasked if that was how she measure widest and longest part of wound), V4 then measured the cluster wound. Right distal posterior thigh= 4 cm. 2) Right proximal posterior thigh= 4 cm. 4) Right buttock= 1.5 cm. x 1.0 cm. x 1	in 21, the following staff were present to se); V4 (LPN/Wound Treatment Nurse); d V9 (Male Restorative Aide). A total of dge of the bed, to give room for turning buttocks and 1 diaper on the frontal as lest changed R1's diaper around 10:00 A led to open R1's multiple skin folds, around to open R1's multiple skin folds, around to wipe and clean R1's buttocks and skin folds that were not easily accessil on was asked if we could do a thorough V9 and V8 (Restorative Aide). R1 was esterior thighs (left and right) and left at IASD (Moisture Associated Skin Dama leasuring the biggest open skin area on surrounding open area with same clustered wounds (without measuring smaller V4 said she was new to the job as a finds from the longest and widest part of an x 4 cm and 1.0 cm. I cm x 1 cm. x 1 cm. Cm. x 1 cm. x 0.5 cm.	asked to check her skin and IA/Certified Nurse Assistant) were alidated that R1 was scheduled to turn R1, V3 (Licensed Practical; V5 (LPN); V6 (LPN); V7 f 6 staff with 1 male and 5 females. It to the opposite side. R1 was pect of her pubis area. R1 was A.M. There was no wound dressing und the groin area and labial folds a failed to apply skin ointment obe for visual skin inspection. skin check. Same staff, except observed with multiple patches of a right buttocks. V4 measured the ge). The following measurements of the same group of clustered er group of wounds. When V4 was size wounds and measuring the eatment nurse and was not trained. The wounds in a cluster group.

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	T OF DEFICIENCIES preceded by full regulatory or LSC identifying information)	
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more than 350 pounds because it I On 10/6/2021 at 5:00 P.M., V2 (Dir treatment nurse and was not traine than 350 pounds. V2 also added th additional support. On 10/6/2021 at 6:30 P.M., V14 (M 10/5/2021. V14 said R1 had multip posterior bilateral thighs and buttor rated for a 350-pound person. R1 w turning and repositioning. V14 also should be checked for incontinence pressure and an air loss mattress b V14 also said these preventions we sores were unavoidable. V14 state avoidable or not. V14 said if R1 har should be applied to protect the da every 2 hours, causes urine and str cause MASD and pressure sores a The undated facility's policy for incorreceive as much assistance as nee episode . Frequency depends on b 2) On 10/4/2021 at 3:15 P.M., toge a stage 4 pressure ulcer on the sac CNA around here on the 600 unit, if assistance. V4 together with V17 (if was assigned to the first floor and 6 R2 was saturated with urine and so The care plan dated 8/31/2021 sho maintain highest possible level of fic contributing diagnoses; impaired fu Alzheimer's disease, edema, weak After the V4 provided wound care a dining room with group of residents	rector of Nursing) added that V4 was not ad yet. V2 also said that facility does not at they try their best to provide care to all they try their best to provide care to be a set they try their best to provide care to be a set to be validated R1 needed to be kept clean a care at least every 2 hours, should be implemented to prevent pressure so would be implemented and pressure so read all possible interventions should be pd complained of burning sensation due maged skin. V14 said Peri-care that is sool to saturate the skin and not cleans and even a non-medical person knows and even a non-medical per	ew to her position as a wound at accept residents that weigh more R1 but R1's situation needed The saw and examined R1 on Associated Skin Damage) on the ic bed but the bariatric bed was only bed cannot accommodate R1 for and dry from urine and stool and a turned every 2 hours to offload res, MASD or other skin alterations. It has multiple comorbidities. V14 and MASD still existed, then the provided to determine if sores were to urine, then a foam dressing not done timely, which is at least and the perineum thoroughly will that. The facility to ensure that resident's attocks after an incontinence every 2 hours. The garding her skin alteration. R2 has all position. V4 stated there was not a around to look for a CNA for sist at 3:35 P.M. V17 stated she unfastened R2's incontinence brief. The guires assist with ADL's to glimitations and potential pordination, cognitive deficit, The state of the position of the said that she had no CNA on the

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, Z 311 Edgewater Drive	IP CODE
		Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informat	ion)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	station of the 400-wing unit, second and was soiled. R10 was noted with substance on top of the tongue. R1 substance on her face, shirt, pants,	was sitting in her wheelchair. R10 was d floor. R10 was wearing a thin shirt the her tongue exposed. There was a the 0 also was noted with large amount of and her wheelchair. V16 (Nurse) said boming to R10. V16 said R10 was dep	at was stained with brownish color ick accumulation of orange colored small crumbs of orange color it must be the cheese balls. V16
	teeth on the lower gum line. R3's locolor. R3's lips were dry. R3 was of sacrum. V4 provided wound dressi provide incontinence care to R3. V4	vas lying in bed. R3's was lacking teeth over teeth had heavy accumulation of observed regarding skin alteration. R3 hing to the sacrum. R3 was saturated wide proceeded to change R3's sacrum will let (V15, CNA) provide incontinence of the sacrum.	dental plaque, brownish/blackish in nas a stage 4 pressure ulcer on the th urine and liquid stool. V4 did not ound dressing without ensuring that

		1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
		D. WIIII	
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
West Suburban Nursing & Rehab Center		311 Edgewater Drive Bloomingdale, IL 60108	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0745	Provide medically-related social se	rvices to help each resident achieve the	e highest possible quality of life.
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 15845
Residents Affected - Few		ew, the facility failed to follow up in a ting a resident needing medical evaluation f	
	This applies to 1 of 3 residents (R1) requiring transportation services from	an outside entity.
	The findings include:		
	The Face Sheet showed that R1 was a [AGE] year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy, to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.		
	The weight record history showed R1's weights:		
	-06/18/2021= 629 pounds		
	-06/25/2021=632 pounds		
	-07/02/2021=633 pounds		
	-08/09/2021=633.4 pounds		
	-09/07/2021=608 pounds		
	-10/01/2021=600 pounds		
	that R1's had approximately 4-6 inc space meant that R1 could possible alert and oriented times three. R1 sto 6 staff to turn me. If there is a matherapy in bed, they stretch my leg an acute rehabilitation center. How twice because the ambulance refusivith transportation. I missed my Au October 14, 2021 but I don't know me yet what was going on with that	was lying in her bariatric bed. The width ches space between the side of her body end up on the floor if R1 attempted to said Don't worry, I cannot turn myself of ale staff, then 5 staff will do, otherwise is and my arms. This place is not for me ever, my appointments with the rehabilised to take me there because of my we agust and September (2021) appointments what will happen or if they will help me to.	dy and edge of the bed. The lack of a turn due to lack of space. R1 was n my own and have to depend on 5 6 staff if all females. R1 said, I have e. I want to have skilled therapy in itation hospital have been canceled eight. The facility did not help me ents. Now I have an appointment on
	(continued on next page)		

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, Z 311 Edgewater Drive Bloomingdale, IL 60108	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointment to the acute rehabilita appointment, V11 had called the property of the property o	Medical records/Scheduler for medical tion hospital on August 26, 2021. V11 rivate ambulance contracted by facility at she informed the private ambulance e. V11 said that the ambulance denied 2 (Director of Nursing) and V12 (Sociant. V11 said R1 had a second appointraid that she called again the private anabilitation hospital. V11 said the private at the third appointment to the rehabilitaround, the private ambulance will transfed the ambulance that facility uses do ne private ambulance' CEO (Chief Operapproved as of today (10/4/2021) that Social Service) stated the private ambulat the facility's plan was. V12 said that	said a week or two prior to the for residents' transport for outside that R1 was morbidly obese and the request for transport. V11 said I Service staff) that the private nent on 9/9/2021 since the first d said she needed bariatric service to ambulance again denied ation hospital on October 14, 2021. Insport R1. The service are not have enough manpower to rating Officer) and the facility's CEO R1 will be transported on ulance had not transported R1. V12