

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Abbington Vlge Nrsg & Rhb Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Central Roselle, IL 60172	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure residents had functioning call lights within their reach. This failure applies to 6 of 9 residents (R1, R2, R6, R7, R8, and R9) reviewed for accommodation of needs. Findings include: 1. On September 09, 2025 at 10:45 AM, R1 stated his roommates have no call light. R1 stated R2 (roommate) complains about his call light constantly, and R1 had to pull his call light closer to his bed because it is out of reach. R1's room had only one call light positioned closer to R2's bed and pulled over to R1's bed. R1's Face Sheet showed he is a [AGE] year-old male with diagnoses of multiple sclerosis, chronic congestive heart failure, and recurrent major depressive disorder, and he was admitted to the facility 08/27/2025. On September 09, 2025 at 10:58 AM, R2 stated he doesn't have a call light and he has to yell out or come out of his room for assistance. R2's Face Sheet showed he is an [AGE] year-old male with diagnoses of schizoaffective disorder, stage 2 chronic kidney disease, peripheral vascular disease, lymphedema and prostate cancer, and he was admitted to the facility 09/23/2024. On September 10, 2025 at 8:51 AM, V2 (Director of Nursing) acknowledged that R2 did not have a call light. V2 stated residents should have call lights and she isn't sure why there is only one call light in R1 and R2's room. R2 responded to V2's statements with talk to maintenance. 2. On September 09, 2025 at 9:24 AM, R6 was asleep in her wheelchair a few feet away from and next to her bed, and her call light was behind her bed on the floor, several feet away from her and out of her reach. V3 (Assistant Director of Nursing) stated R6's call light should be clipped to her wheelchair as R6 could not access it. R6's face Sheet showed R6 is an [AGE] year-old female with diagnoses of partial paralysis due to stroke, vascular dementia, and contractures, and she was admitted to the facility 09/25/2024. 3. On September 09 at 9:30 AM, R7 was lying in her bed in her room. R7 stated her call light doesn't work and she is checked on infrequently by staff. R7 pressed her call light and it did not work. R7 stated her call light hasn't worked since her admission to the facility and she has told everyone that has come into her room about it but there has been no follow up. R7's Face Sheet showed she is a [AGE] year-old female who was admitted on [DATE] with diagnoses of multiple sclerosis, chronic embolism and thrombosis, generalized osteoarthritis, and contracture of right knee. Additionally, there was only one call light in R7's room that she shared with R8. V2 (Director of Nursing) then tested R7's call light and it did not work. 4. On September 09, 2025 at 9:38 AM, R8 sat on her bed with a walker in front of her and stated she doesn't have a call light and would like one. V2 stated R8 is able to use the call light and could not explain why R8 did not have her own call light. R8's Face Sheet showed she is a [AGE] year-old female with diagnoses of cerebral ischemia (insufficient brain blood flow), stage 1 chronic kidney disease, muscle disorders, difficulty in walking, and abnormalities of gait and mobility, and she was admitted to the facility 09/19/2024. 5. On September 09, 2025 at 9:40 AM, R9 was in her wheelchair with a bedside table in front of her near the foot of her bed. R9's call light was several feet away at the head of her bed and out of her reach. V2 stated R9's call light should be next to her, and although R9 could ambulate to access it, it was not advisable because R9's gait is unsteady. R9's Face Sheet showed she is a [AGE] year-old female with diagnoses of Alzheimer's disease, vertigo, difficulty in walking, and lack of coordination, and she was admitted to the facility 11/27/2023. The facility's Answering Call Light Policy Received 09/10/2025 showed: The purpose of this procedure is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Report all defective call lights to the Maintenance Department promptly. Call lights must be accessible to residents from their bed or other sleeping accommodation. The call light system should be accessible to a resident lying on the floor.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure resident's clothing items were labeled and safeguarded from loss. This failure applies to 3 residents (R1, R2, and R3) reviewed for laundry services. Findings include:Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for personal effects by not ensuring resident's clothing items were properly labeled and safeguarded from loss. This failure applies to 3 residents (R1, R2, R3) reviewed for laundry concerns. Findings include: 1.On September 09, 2025 at a10:45 AM, R1 stated he has at least 5-6 pairs of gray pants that are missing, the facility's washing machines are down, his laundry was picked up to be taken out to be cleaned this morning, and he would like to know where his clothes are that were since the first time they were sent out. 2.On September 09, 2025 t 10:58 AM, R2 stated his clothes don't come back from the laundry. 3.On September 09, 2025 at 3:05 PM R3 stated he had some clothing items go missing when he was first admitted to the facility. R3's face Sheet showed he was admitted [DATE]. On September 09, 2025 at 9:57 AM V1 (Administrator) stated a couple of months ago, they switched from in-house laundering of personal clothes to outside laundry services because the washers in the building were broken. V1 stated there have been some complaints about missing clothes. V1 stated there were approximately four grievances of residents reporting missing clothing, along with email communication and documentation between she and the laundry vendor regarding this issue. On September 09, 2025 at 11:40 AM, V13 (Housekeeper) transported a laundry cart with several laundry bags, delivered them to residents room, removed the clothing from the bags, and hung up the clothes in the resident's closets. V8 (Dietary Aide) helped translate with V13. V13 stated she collects clean laundry from the large blue bins on Tuesdays and Fridays and delivers the clothing to the residents. V13 stated she has received complaints from residents about missing clothing. On September 09, 2025 at 11:52 AM, multiple laundry bags in the cart had no clear labeling on them to identify who the clothing items belonged to. V11 (Activity Director) helped translate with V13 (Housekeeper). V13 stated if there is no clear label on the bag, she will open them and look for labels on the clothing to identify who they belong to. On September 09, 2025 at 12:27 PM, a large, tall, blue storage container contained several clear bags of clean laundry with no labeling on the bags. V13 (Housekeeper) opened the bags to identify who the clothes belonged to, and the clothes were also not labeled. V13 she could not determine who the bags of clothing belonged to. On September 10, 2025 at 8:51 AM, V2 (Director of Nursing) stated last week on Tuesday or Wednesday, R1 reported to her that his clothes were missing and she explained to him that clothes are sent out on Tuesday will be returned on Friday. V2 could not explain why R1's clothes that were collected last Tuesday were still missing. V2 stated the CNAs (Certified Nursing Assistants) and nurses inventory resident's items upon admission, and then sometimes family members and activities aides will label residents clothes within 24 hours of admission. V12 (Housekeeping Supervisor) stated either he or the laundry aide label laundry bags with the room and bed numbers, and the CNAs collect laundry bags from the rooms. V12 stated if a resident doesn't have a laundry bag, clear bags are used and labeled, and the bags and clothes should be labeled. Resident Council Concern Form regarding housekeeping dated 05/30/2025 showed a concern regarding residents not getting their laundry back. Resident Council Meeting reports from June to August 2025 showed concerns regarding residents clothes missing from laundry, and a resident reporting his clothes were placed in a clear bag that was not labeled and was missing. Multiple Grievance forms from September 2025 document multiple residents reported missing clothing, including R1. A 09/05/2025 email communication from administrator to the laundry vendor showed the administrator reported residents' clothes had been missing for weeks, laundry bags have been provided to the laundry vendor and not returned, and over 30-40 items are missing. The facility's Personal Effect's Policy received 09/10/2025 showed: .It is the policy of this facility to promptly investigate all reports of missing resident personal property and appropriately resolve the issue.Policy Specifications. To promote resident satisfaction and comfort regarding handling and security of personal property.The facility, at the discretion of the Administrator, may replace any items for which it cannot account .</p>		