STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146065	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbington Vlge Nrsg & Rhb Ctr	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide timely Activities of Daily Living (ADL) assistance to residents who were dependent on staff for incontinence care. This applies to 3 of 3 residents (R1, R7 and R9) reviewed for incontinence care in a sample of 10. The findings include: 1. Face sheet, dated 9/25/25, showed R1's diagnoses included multiple sclerosis, obesity, congestive heart failure, and neuromuscular dysfunction of his bladder. MDS, dated [DATE], shows R1 was cognitively intact, was completely dependent on staff for toileting and personal hygiene, and was always incontinent of bowel and bladder. Review of R1's care plan showed R1 was totally dependent on staff for toileting and was able to tell staff when he needed to be changed after incontinence episodes. The care plan approaches included providing assistance for toileting after each incontinence episode. The care plan showed R1 was dependent on staff for transfers using a mechanical lift. On 9/24/25 1:10 PM, R1 stated the prior week he asked to be toileted at approximately 10:30-11:00 AM and waited until the next shift. R1 stated the last time his brief was changed was 8:00 AM when he got up from bed. On 9/24/25 at 2:25 PM, R1 asked V4 (Certified Nursing Assistant/CNA) to change his soiled incontinence brief. R1 sat in his room and waited for staff to arrive. On 9/24/25 at 2:55 PM, V4 was entering information into the computer system in the hallway. On 9/24/25 at 3:10 PM R1 was still waiting in his room for his incontinence brief to be changed. At 3:25 PM, R1 decided to leave his room and go downstairs. R1 had not had his soiled incontinence brief changed. R1 returned to his room soon after. On 9/24/25 at 3:28 PM, V6 (CNA) and V7 (CNA) both stated they were not aware R1 needed his incontinence brief changed and stated they got no report from V4 prior to V4 leaving her shift for the day. V2 (Director of Nursing) stated a staff member called in and the current facility staff needed to split the rooms to cover the floor. On 9/24/25 at 3:37 PM, V6 stated he was going to change R1's incontinence brief and then put R1 back in his wheelchair for dinner. V6 and V7 walked into R1's room and began to initiate changing R1's incontinence brief. At 4:00 PM, R1's incontinence brief was examined and appeared extremely full of urine and had a large amount of bowel movement in the brief. V6 and V7 both stated R1's incontinence brief was extremely full of urine and bowel movement. On 9/25/25 at 10:28 AM, V2 (Director of Nursing) stated nursing staff were expected to check incontinent residents' briefs every two hours even if residents were able to verbalize if they were wet or could change themselves. V2 stated on the morning of 9/24/25, V2 saw R1 and knew his incontinence brief needed changing by the smell of urine from R1. V2 stated she texted all the managers on duty on 9/24/25 to alert staff that R1 needed his incontinence brief change because he smelled of urine. On 9/25/25, V4 (CNA) stated she got R1 up out of bed and performed incontinence care for R1 at approximately 8:00 AM to 8:30 AM. V4 stated R1 becomes impatient when he needs to wait to have his soiled incontinence brief changed. V4 stated she overheard R1 tell V11 (Restorative) that he did not want a shower or incontinence care until the next shift. V4 stated R1 did not ask V4 for incontinence care during her shift. V4 stated she never asked R1 if he needed incontinence care because R1 usually asks himself for his incontinence brief to be changed. On 9/25/25 at 10:33 AM, V11 (Restorative) stated between 10:00 AM and 11:00 AM, she asked R1 if he wanted a shower and R1 told V1 that he was scheduled for a shower during the PM shift that day. V11 stated R1 never stated he did not want his incontinence brief to be changed until the PM shift. V11 stated the CNAs should offer residents to have their incontinence briefs changed every two to three hours even if a resident can verbalize that they need changed. On 9/25/25 at 11:28 AM, V1 (Administrator) stated the facility nursing staff should check incontinent residents' incontinence briefs every two to three hours regardless if a resident can verbalize their briefs are soiled. Facility Incontinence Care Policy, undated, shows, Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. Incontinent residents are changed every two hours and more frequently if needed. Facility Activities of Daily Living Policy, undated, shows, 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 2. Face sheet, dated 9/25/25, showed R7's diagnoses included hemiplegia and hemiparesis and dementia. MDS, dated [DATE], shows R7 was cognitively intact, and R7 was dependent on staff for toileting transfers and toileting hygiene. Review of R7's care plan showed R7 was dependent on two staff for transfers with a mechanical lift and was incontinent of bowel/bladder. R7 was care planned for being upset after five minutes if a CNA did not arrive to assist him and care planned to allege that he was waiting for hours. On 9/24/25 at 3:250 PM, R7 stated it took over an hour for staff to arrive to change his soiled incontinence brief. R7 stated

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide palatable food at warm temperatures. This applies to 4 of 5 residents (R1, R5, R7, and R9) reviewed for food palatability in a sample of 5. The findings include: 1. MDS (Minimum Data Set), dated 9/3/25, shows R1 was cognitively intact. On 9/24/25 at 1:10 AM, R1 stated his food was often served late and the hot food was cold. 2. MDS, dated [DATE], shows R7 was cognitively intact. On 9/24/25 at 3:50 PM, R7 stated his food is served cold and usually an hour late. 3. MDS, dated [DATE], shows R9 was cognitively intact. On 9/25/25 at 11:35 AM, R9 stated the food was often served late and cold. 4. MDS, dated [DATE], shows R5's cognition was severely impaired. On 9/24/25 at 11:55 AM, R5 stated her food is often served late and the hot food is cold. 5. Resident Council Meeting Minutes, dated 6/27/25, show the residents in the meeting complained that the breakfast meals were always cold when they received them. Resident Council Meeting Minutes, dated 7/25/25, show the residents stated the kitchen food continued to arrive cold, and the CNAs (Certified Nursing Assistants) were taking too long to pass meal trays to residents. Emergency Food Committee Meeting Minutes, dated 9/12/25, shows Residents will have lunch in the dining room to improve food temps. On 9/27/25 at 8:26 AM, V1 (Administrator) stated the facility did not have a policy on food palatability or food temperature expectations at the point of service to residents.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to serve resident meals at regular times per the facility meal schedule. This applies to all 60 residents residing in the facility receiving oral diets. The findings include: On 9/24/25 in the main dining room, meal times were posted stating that Breakfast would be served at 8:30 AM, Lunch would be served at 12:30 PM and Dinner would be served at 5:30 PM. On 9/24/25 in the main dining room lunch trays began to be delivered at 12:50 PM and were finished being served by 1:00 PM. On 9/24/25 during facility tour, R1, R2, R4, R5 and R7 all stated the meals at the facility were served late. R2 and R4 stated the meal trays arrived 30-45 minutes late, R6 stated sometimes the food came 20 minutes late, and R7 stated the food was usually served an hour late and sometimes received lunch at 1:15 PM. On 9/25/25 at 11:35 AM, R9 stated the food was usually served more than 30 minutes late. On 9/24/25 at 12:23 PM, V4 (Certified Nursing Assistant) stated the meal trays were usually served approximately 25 minutes late. On 9/24/25 at 11:03 AM, V5 (Cook) stated the food service was staffed with two aides in the morning but they were reduced to one aide which slowed down meal service. V5 stated the meal service may be later depending on how many items must be placed on the tray. V12 (Food Service Worker) stated the latest the staff have finished lunch was 1:15 PM. V12 stated in the past they were able to finish plating meals at 12:30 PM. On 9/25/25 at 8:40 AM, V8 (Food Service Manager) stated he was back from vacation and would serve as a second aide to ensure that meals were served on time. On 9/25/25 at 8:45 PM, V1 (Administrator) stated V8 returned from vacation and would serve as the second aide to make sure the meals were served on time. Facility Bed Roster, dated 9/23/25, shows the facility census was 61 residents. On 9/28/25, V1 (Administrator) stated there was one resident in the facility who did not receive oral diets. Resident Council Meeting Minutes, dated 7/25/25, shows the residents expressed concerns that the staff were taking too long to pass trays to residents. Resident Council Meeting Minutes, dated 8/29/25, show, Lunch keeps coming later and later. Facility Meal Schedule Policy, undated, shows, Three meals will be served daily at similar times as served in the community. The policy states mealtimes will be posted throughout the facility where they are accessible to residents and visitors.