

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Asbury Gardens Nsg & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Airport Road North Aurora, IL 60542	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to safely transfer a resident. This failure resulted in R1 sustaining a right leg laceration requiring stitches when V4 (CNA/Certified Nursing Assistant) transferred R1 without a gait belt. This applies to 1 of 3 residents (R1) reviewed for resident injury in the sample of 3. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, asthma, aphasia, and cellulitis of right lower limb. R1's MDS (Minimum Data Set) dated October 9, 2025, showed R1 was cognitively intact. The MDS continued to show R1 required substantial/maximal assistance from facility staff for toileting hygiene and toilet transfers. R1's ADL (Activity of Daily Living) care plan dated October 5, 2023, showed, [R1] has a deficit in ADL self-care related to disease processes of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, epilepsy, history of TIA (Transient Ischemic Attack), osteoarthritis, and weakness. The care plan continued to show multiple interventions dated January 23, 2024, including, Toilet transfer: Resident requires substantial/maximal assistance of one staff member with the use of a gait belt for all transfers. On December 10, 2025, at 11:13 AM, R1 said a couple weeks ago she got a cut on her leg when a CNA was transferring her from the toilet to her wheelchair. R1 said the CNA did not use a gait belt and R1's leg got stuck on the wheelchair. R1 said she had to go to the hospital to get stitches on her leg. On December 10, 2025, at 11:49 AM, V4 said on November 24, 2025, V4 was transferring R1 from the toilet to her wheelchair. V4 said he was trying to move R1's wheelchair closer but he did not notice R1's foot was stuck where the leg rest goes on the wheelchair. V4 said he was not using a gait belt to transfer R1 and was holding onto R1's brief to transfer R1 from the toilet to the wheelchair. V4's statement dated November 25, 2025, showed, Assigned to [unit] on this evening, [another CNA] asked me to take [R1] off the toilet. I went to her bathroom, and she did not have a brief on. I had applied a new brief, and I asked her to stand up so I could wipe her. Then I pulled up her brief and she said she did not want her pants pulled up because she wanted to lay down. When I pulled up her brief, I tried to make her turn so she could sit down in the wheelchair behind her. When I tried to pull the wheelchair closer both wheels were locked, and the right foot was caught under the little tire and when she tried to sit down her right leg swung out in front of her and made it hit the frame of the wheelchair. After she was seated, I was going to put her in bed and that is when I noticed her leg was bleeding and notified the nurse. She came into the room and grabbed ADON (Assistant Director of Nursing). We're mostly able to transfer her independently but her foot was stuck and that what caused her to bump her leg. On December 10, 2025, at 12:10 PM, V5 (Rehab Director) said R1 was discharged from therapy on August 2, 2025, and therapy's recommendation was for R1 to be an assist of one facility staff member for toilet transfers. V5 said facility staff should use a gait belt when transferring R1 for R1's safety. On December 10, 2025, at 1:00 PM, V6 (R1's Doctor) said R1's leg laceration was caused by the improper transfer. V6 said facility staff should be following proper procedure and use a gait belt when transferring a resident. On December 10, 2025, at 3:28 PM, V2 (DON/Director of Nursing) said facility staff should use a gait belt when transferring a resident. V2 said R1's care plan and medical record showed facility staff were to use a gait belt when transferring R1. V2 said V4 should have used a gait belt when transferring R1 from the toilet to the wheelchair. The facility's final report dated November 28, 2025, completed by V3 (ADON) showed, Complete Description of Occurrence: [R1] has BIMS (Brief Mental Score) of 13, has diagnosis of right sided hemiplegia, aphasia following cerebral infarction, osteoarthritis, and unspecified thrombocytosis. On Monday evening about [4:30 PM], resident was assisted by a CNA (Certified Nursing Assistant) from the toilet, and when attempting to sit back into the wheelchair her right foot was caught in the small tire of the right side of the wheelchair causing her right lower leg to swing forward once she was seated in the chair and bump into the frame of the wheelchair. The aide observed the injury and summoned the nurse to the bathroom. First aid was rendered, and pressure was applied to right lower leg laceration. Resident reported complaints of discomfort and [Physician] notified. Order received to transfer resident to emergency room for further evaluation and treatment. POA (Power of Attorney) made aware of incident and order to transfer to the emergency room, per POA request [local hospital] is first hospital of choice. EMS (Emergency Medical Services) notified of bypass request to [local hospital] and resident was transferred to [local hospital] ER (Emergency Room). Resident returned to the facility approximately [10:30 PM]. The resident was assessed and returned with 10 sutures to right lower leg</p>		