STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146187	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Court Nursing & Rehab	1750 Elmhurst Road Des Plaines, IL 60018

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33783 Based on interview and record review, the facility failed to prevent a resident from physically abusing two other residents in the facility. This failure applied to three of three (R1, R2, R3) residents reviewed for abuse. Findings include: R1 is a [AGE] year-old male with medical diagnoses that include: Unspecified Dementia, Hemiplegia affecting left side, Unsteadiness on feet, Need for assistance with personal care, and Reduced mobility. MDS (minimum data set) assessment dated [DATE] documents that R1 has severe cognitive impairment. R2 is a [AGE] year-old female with medical diagnoses that include: Heart failure, COPD, Palliative Care, Osteoarthritis, Parkinson's Disease, and Gout. MDS, dated [DATE], documents that R2 has a BIMS (brief interview of mental status) score of 11 (moderately impaired). R3 is a [AGE] year-old female with medical diagnoses that include Chronic A-fib, Alzheimer's Disease, Bipolar Disorder, Dementia, and Unspecified anxiety disorder. MDS dated [DATE], documents that R3 has a BIMS (brief interview of mental status) score of 11 (moderately impaired). A review of facility reportable documents shows that on 8/17/24, R1 was transferred to a local hospital for evaluation of aggressive behavior. On 9/13/24 at 2:54PM, V4 (RN) stated that on the date of the incident (8/17/24), R1 was not his baseline starting around dinner time. V4 said that R2 told him that R1 hit her. Upon assessment, R2 had some redness on her neck. No bruising. R3 was trying to diffuse the situation with R1 and R1, then hit R3 on the forearm, and she got a skin tear. R1 was transferred to the hospital and diagnosed with a UTI. Now he's back to normal. They had their back to me so I couldn't see R3's arm (during the incident). Upon assessment, R3's skin tear looked fresh, it was pink. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/24 at 1:14PM, V1 (Administrator) stated that R1 was displaying physical aggression towards R2 in the dining room. He has dementia, and he hit R2 or attempted to, but staff separated them. We sent R1 out via a 911 call and had him assessed. He has dementia, but we sent him out, and he had a UTI. Upon return, we had him assessed by psychiatry. This is not his normal behavior at all. He had a UTI. He has dementia, but he doesn't normally hit residents. He's not aggressive and has no history of behaviors. There were a couple of staff in the dining room right after dinner. Staff witnessed this in the dining room. Review of R1's hospital records from 8/17 to 8/20 (admitted). admitted for aggressive behavior; found to have pyuria in urine; UTI dx; afebrile; Started on Cephalexin 500mg (1) capsule 4x/day. Witness statement provided and signed by V11 (CNA), regarding this incident, documents that R2 was heard screaming in the dining room and that R2 reported being hit in the back by R1. Nursing Progress Note written 8/17/2024 19:37 Behavior Note by V4 (RN) reads: Note Text: (R1) sent out to (local hospital) ER, transported using a stretcher, via an ambulance. Resident profile and order summary given, and an involuntary petition to the paramedic's team leader, as well as a brief behavioral history of the resident and medical condition. A Police officer came after a few minutes and investigated the incident. This writer informed the officer of what happened in the incident and also provided a brief summary of the patient's behavior and medical condition. POA made aware, NP informed through text message. DON informed. Nursing Progress Note written 8/17/2024 17:30 Behavior Note by V4 (RN) reads: Note Text: (R1) noted displaying physical aggression by repeatedly punching resident repeatedly and landed on the face that caused redness on the resident's face. Resident has ongoing physical aggression toward staff and other resident. PCP made aware, POA made aware regarding the behavior and was informed that an involuntary petition was filled out and will be sent to (local hospital) for further evaluation and treatment. DON informed. The resident is currently being monitored by staff until paramedics arrive. Nursing Progress Note written 8/18/2024 10:01 Nurses Note by V4 (RN) reads: Note Text: (R2) observed after the incident, calm and pleasant, denies pain or discomfort. Still has good appetite, able to take due medication and tolerated well. Plan of care ongoing. Nursing Progress Note written 8/18/2024 06:38 Nurses Note by V14 (RN) reads: Note Text: S/P incident: (R2) is alert and Ox1-2. Denied pain/discomfort to L cheek, no redness/swelling noted. Nursing Progress Note written 8/17/2024 17:30 Nurses Note by V4 (RN) reads: Note Text: (R2) was punched in the left side of her face while eating her dinner at the dining area. This writer immediately responded and de-escalated the situation. Resident stated that he punched her, but it was not serious and was not strong punch. Assessment was made, neuro check was made no swelling no bruising was present however a redness was noted on the left side of her mandible was observed. Resident denies pain. Immediately sent to her room and made comfortable. POA made aware and came to check the resident. Hospice made aware and stated they will send a nurse to evaluate the patient. MD made aware; DON made aware. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress Note written 8/17/2024 20:27 Nurses Note by V4 (RN) reads: Note Text: at around 5:40pm (R3) was hit by another resident on her right forearm. a skin tear was noted having a skin tear on her right forearm, measuring 1.5cm x 0.5cm. MD notified treatment orders in place. POA notified however wasn't able to get a hold of her, a voicemail was left stated what happened and a call back number was also given. Provided comfort and sent to her room, made comfortable, call light in easy reach. bed set to lowest setting. DON made aware. Nursing Progress Note written 8/17/2024 18:42 Nurses Note by V4 (RN) reads: Late Entry: Note Text: (R3) was reporting to this writer that a resident hit her in her arm, and she had a skin tear. Resident was calm not in distress and composed while reporting the incident. That guy hit me as verbalized. Immediately responded and assessment completed, a skin tear was noted measuring 1.5cm x .5cm on her right arm. Skin tear is not bleeding, pinkish in color. Patient was escorted to her room and provided therapeutic communication and calm approach throughout the conversation. Resident was not displaying signs of distress after the incident. Immediately notified PCP with treatment orders in place. Several attempt to contact POA however she was unavailable and just left a voicemail regarding the incident and also left with a good callback number for further questions or concerns. DON made aware. Facility abuse policy, last revised 10/2022, reads: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . I. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded, and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; C. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; E. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions; F. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed; G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. II. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse 2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body 3. Physical injury of a resident, of unknown source 4. Resident reports of theft of property, or missing property 5. Verbal abuse of a resident overheard 6. Physical abuse of a resident observed 7. Psychological abuse of a resident observed 8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning 9. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame . III. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33783 Based on the interview and record review, the facility failed to ensure that a resident was free of a significant medication error. This failure resulted in a resident receiving the incorrect dose of Hydromorphone and applied to one (R4) of four residents reviewed for medication administration. This past non-compliance occurred from 7/5/2024 to 7/21/2024. Findings include: R4 is an [AGE] year-old male admitted to the facility with medical diagnoses that include: Parkinson's Disease, Dementia, Repeated falls, and Other low back pain. R4 is currently on hospice. A review of medical records documents that on 7/5/24, R4 Physician Orders included an order for Hydromorphone 0.25ml. Current Physician Orders for R4 include: HYDROmorphone HCl Oral Liquid 1 MG/ML (Hydromorphone HCl) Give 1 mg/ml by mouth every 2 hours as needed for Breakthrough Pain, Active 08/31/2024. The facility provided a copy of the Employee Corrective Action Notice dated 7/16/24 for V5 (RN). Notice documents the following Corrective Action Issue: On 7/5/24, a dosage of 1ml of Hydromorphone was given to a resident. The correct dosage should have been 0.25ml. It is expected that the correct dosage will be checked before administering the medication. Also, the dressing was not changed for resident BM as scheduled. It is expected that treatments will be performed as scheduled. In an interview with V5 (RN) on 9/14/24 at 2:29PM, V5 was asked about the incorrect medication dose given to R4. V5 said, Usually, he would get 1mL. I gave him the correct dose but wrote the wrong amount on the file. I told the DON, but he gave me the correction. I have not had any issues with medication administration. I'm sure I gave him the right dosage, but I just wrote it down wrong. In an interview with V2 (Director of Nursing) on 9/13/24 at 4:12PM, V2 said There was one person, V5 (RN), who got written up because they gave the wrong medication. She gave too much of the medicine. We caught it by looking at the NARC sheet. I did write her up and sat down with her. The order was written wrong - it was 4g/mL, and we changed the order to get it corrected. It was hospice, so they gave us that particular dosage. The way the order was written, it should have been the 0.25mL. We are going over all the skills with new hires and, then every six months with existing staff. The co-DON (new position), we watch the staff and go through the checklist to make sure that they are doing all the right things. No other staff have had issues with medication administration. R4 did not have any side effects. We didn't even notice until we went back and looked at the NARC count after the fact. The facility provided Medication Administration policy last revised 02/2023, which reads: Policy: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: .Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 1. Review MAR to identify medication to be administered. 2. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. c. If other than PO route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.) . 6. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 7. If medication is a controlled substance, sign narcotic book. 8. Report and document any adverse side effects or refusals. 9. Correct any discrepancies and report to the nurse manager. Prior to the survey date, the facility took the following actions to correct the non-compliance. 1. The Director of Nursing (DON) conducted one-to-one education with staff involved V5 (RN) on 7/16/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Director of Nursing (DON) and/or designee completed in-service training with nursing staff starting on 7/16/2024 regarding facility policy and procedure regarding medication administration. The training of nursing staff was completed on 7/21/2024. At the time of this survey, there onsite observations and/or concerns were identified related to current non-compliance with F760.