

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Asbury Court Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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** 34516 Based on interview and record review the facility failed to have a system in place which prevents a cognitive impaired male resident (R1) from making an inappropriate sexual action towards a female resident (R2). This has the potential to affect 2 of 4 sampled residents (R1 and R2). Findings include: The facility submitted an incident report with an incident date of 8/19/24 and a time of 12:30pm involving R1 and R2. The description of occurrence was written as: The Certified Nurse's Aide (CNA) witnessed R2 with his had in the brief of R2. R2 did not appear or verbalize any distress. According to a face sheet, R1 is a [AGE] year-old male with diagnoses including but not limited to Atherosclerotic heart disease, [NAME] ataxia, anxiety disorder, major depressive disorder, mild dementia, and muscular dystrophy. According to R1's minimum data set assessment with the reference date of 7/12/2024, R1 has a BIMS of 11, mildly cognitively impaired. The section for indication for daily decision-making regarding tasks of daily life was not scored. On 10/12/24 at 11:15 AM, R1 was seated in his wheelchair attending an activity in the dayroom area with other residents and V5 (Activity aide) overseeing the residents and heading the activity session. R1 stated that he was fine, knew the year and where he resided. R1 indicated he could not recall the incident several months ago that occurred with R2. According to a face sheet, R2 is a [AGE] year-old female with diagnoses including but not limited to Parkinson's Disease, Hypertension, Vascular dementia, and Alzheimer's Disease. According to the incident report R2 had a BIMS of 06, indicating severe cognitive impairment. On 10/12/2024 during the onsite investigation, R2 was in the hospital but unrelated to the incident of 8/19/24. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 10:40 AM, V4 (CNA) was questioned about the incident of 8/19/2024 between R1 and R2. V4 stated, (R1) was at the table and I saw him put his hand in R1's incontinent brief in the dining room so I quickly told him to take his hands off R2 and I called the nurse. Once I told him to back off, R1 had some difficulty taking his hands out. I never seen him do this to anybody before. I pulled him away and I told the nurse, and she did the whole-body inspection, and he (R1) was taken to his room and cops were called. No other staff were around me in the dining room but me. I was charting in the I was in front of the nursing station that's when I saw R1 starting to creep up on her(R1). R2 was on tables on the edge and facing the windows and R1 was on the table next to hers. On 10/11/24 at 10:-30 AM V3 (Licensed Practical Nurse/LPN) said (R1) is alert and oriented times 2 to 3. About a month or 2 ago he touched resident in the dining room and the CNA saw him. It was around lunchtime on August 19, and I was passing my medications further down the hall. It was in the afternoon. Then CNA V4, came right away. I never saw anything. They already separated him when I got to the dining room. I checked the resident that was touched. I did my visual in the dining room and asked her if she's in any pain. And I pulled her right away to the bathroom close to the dining room and checked on her. I told her she was touched towards the bottom. I don't remember if I wrote any incident report. According to other nurses that R1 has behavior of touching R2 but no other people. I think he thinks she is his girlfriend or something. On 11/12/2024, V1 (Administrator) was asked provided any documentation of R2's behavior of flirting with or talking with other male residents. A social service note dated 8/20/2024 reference a conversation with R2's daughter /POA. According to the note the staff spoke to the daughter (V7) regarding R2 having relationships and the extent of the relationship with male residents. It was reported R2 like the attention from men and wants to have a boyfriend. The V7 (R2's Daughter/Power of Attorney) gave consent for R2 to have limited physical contact with male residents. On 11/13/2024 between 1:47pm-1:59 via phone, V7 (R2's Daughter/Power of Attorney) was interviewed regarding her knowledge of the reported 8/19/2024 incident involving R1, and statements made in the progress notes documented on 8/20/2024 in R1's medical record. V7 stated she was told about the incident and was not surprised nor upset about. She talked with facility staff who report to her staff witnessed a male resident touching R2 inappropriately. V7 also reported she discussed with staff her mother's behavior in the past. She reported while living on the assisted living side of the facility, her mother had a boyfriend/finance. During the interview the surveyor asked, would you interpret the action the male resident did to your mother as appropriate? V7 responded by saying, she didn't interpret it like that. Her mother is not capable of giving any consent. She did explain, she came in agreement with the facility that her mother could have a non-sexual relationship with a male (a companion agreement) under the supervision of staff.		