

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/17/2024
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to ensure one resident (R1) was kept safe from falls and failed to implement effective fall prevention interventions. This failure resulted in R1 falling seven times in one month (11/13/24, 11/15/24, 11/20/24, 11/27/24, 12/1/24, 12/2/24, and 12/6/24) which resulted in R1 sustaining a subdural hematoma and a head laceration that required sutures. Findings include: R1 is a [AGE] year-old female who originally admitted to the facility on [DATE] and continues to remain in the facility. R1 has multiple diagnoses including but not limited to the following: dementia, type II DM, head injury, repeated falls, psychosis, and traumatic subdural hemorrhage. Per facility fall incident log show R1 experienced a fall on 11/13/24, 11/15/24, 11/20/24, 11/27/24, 12/1/24, 12/2/24, and 12/6/24. Facility reported incident dated 11/27/24 shows R1 was observed on floormat next to R1's bed. R1 sent to hospital. Hospital records indicate R1 sustained a traumatic subdural hematoma after an unwitnessed fall and received sutures to a head laceration. Facility reported incident dated 12/2/24 shows R1 was observed on the floor in front of the toilet in the bathroom. R1 was sent to the hospital due to R1 stating she hit her head. Hospital records indicate a diagnosis of a subdural hematoma. Following investigation, R1 had been assisted to the toilet by V5 (Certified Nursing Assistant/CNA) who then stepped out of the bathroom to obtain assistance for R1. Upon returning, R1 had fallen. On 12/16/24 at 11:20AM, V4 (CNA) was interviewed regarding R1 and fall on 12/2/24. V4 said I was R1's assigned CNA that day. It was during lunch service, and I was in the dining room passing trays. V5 came up to me in the dining room and told me she had assisted R1 to the toilet and wanted me to assist her when R1 had finished. V4 said I immediately ran to the bathroom in her room. When I walked in, I saw R1 on the floor in front of the toilet and she was saying my head, my head. V4 said R1 is a high fall risk, and she should never be left alone in the bathroom. V5 should have known this. R1 has had many falls and sometimes she needs more than one person assistance depending on her behaviors. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/16/24 at 11:56AM, V3 (Co-Director of Nursing) was interviewed regarding R1 and falls. V3 said R1 is a resident that is very at risk for falls. R1 has had many falls, and we are constantly putting interventions to prevent her from falling. V3 said V5 assisted R1 to the bathroom during lunch. V5 left R1 in the bathroom and grabbed V4 for assistance. When they returned, R1 had fallen. The staff should be aware of the importance to not leave R1 in the bathroom unattended. V3 said on 11/27/24, R1 sustained a subdural hematoma from the fall. The hospital records from 12/2/24 indicated that the hematoma had grown and there was new blood present. R1's Minimum Data Set (MDS) dated [DATE] shows R1 requires maximum assistance when using the toilet. On 12/16/24 at 1:05PM, V8 (CNA) and V9 (CNA) told this surveyor that if a resident is a high fall risk and requires maximum assistance with toileting that they should never be left unattended in the bathroom. Facility Fall Prevention Policy with last revision date of 2/2023 states in part but not limited to the following: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Provide interventions that address unique risk factors. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness.		