

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

Printed: 06/25/2026
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 04/15/2026
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident from theft. This affected one resident (R1) of three residents reviewed for misappropriation of property. On 4/14/26 at 12:30pm, R1 stated that \$1800 was taken from her bank account without her consent but has been refunded by her bank and that she manages her own finances. On 4/14/26 at 10:00am, V1 (Administrator) stated she was informed by one of her staff that R1 made a concern about a missing check. V1 stated that she interviewed R1 who accepted, and she called the police who took over the investigation. V1 stated that this was the second time V5 (Agency Certified Nursing Assistant/CNA) had worked in the facility. V1 stated that during an investigation, it was discovered that V5 worked on Thursday (3/26/26) the day the \$1800 check was cashed out, and on 3/28/26 when the second check was missing. V1 stated that R1 has a BIMS (Brief Interview for Mental Status) of 15 and handles all her banking issues. V1 stated the facility offered R1 a safe but R1 decided to keep her check books in her room. V1 stated that during investigation from the police, V5 stated that she did not have any belongings but after a search of the empty rooms, V5's belongings were found in an empty room because she refused to put her belongings in the staff break area. V1 stated that a search was conducted and V5's belongings contained resident financial items from other states. V5 was escorted out of the building by the police, and the case was handed to the police. V1 stated that the facility received a cleared background from the agency prior to V5 working. V1 stated that a follow up was conducted by V4 (social Service Director) on residents who carry out their financial transactions and the facility has not had any issues with any residents' finance, and a notification was sent to all residents and POA (Power of [NAME]) notifying them of the incident and to reach out to the facility with any concerns. V1 stated the facility was safe but R1 decided to keep her check books. V1 stated that facility offered R1 transportation if she wanted to go to the bank, and recommendation to freeze her accounts, but R1 stated that her family is handling the situation. On 4/14/26 at 11:06am, V3 (R1's Nursing Assistant) stated that she was informed by R1 after returning from Physical Therapy (PT) and pulling up her bank statement that a check was cashed for \$1800 which she did not approve, and she also noticed that another check was missing which she had before going for PT. V3 stated that she informed the nurse, and then googled the business name on the check and also searched on social media and saw V5's profile attached to the account, and who was presently working on the unit. V3 stated that she immediately reported the incident to V1 who started an investigation. V3 stated that she worked with V5 on 3/28/26 (The day of the missing check). Facility policy titled: Abuse, Neglect and Exploitation revised 7/2025 reads, Policy: It is the policy of this facility to provide protection 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. Definition: Misappropriation of Resident Property Means the deliberate misplacement, exploitation, or wrongful, temporarily or permanent, use of a resident's belongings or money without the residence consent. 111. 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 chiefs. B. Identifying, correcting and intervening in situations (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146187
		If continuation sheet Page 1 of 2

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in which abuse, neglect, exploitation, and/ or misappropriation of resident property is more likely to occur with the deployment of training and qualifying, registered, license, and certify staff on each shift in sufficient numbers to meet the needs of the residents and assured that these staff assign have knowledge of the individual residents care needs and behavioral symptoms		