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	06/18/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on the interview and record review, the facility failed to provide adequate supervision and failed to have effective and individualized, resident-specific interventions to prevent a resident from having a fall with injury. This failure affected one (R1) of three residents reviewed for accidents and supervision. These failures resulted in R1 having a witnessed fall requiring emergency transfer to a local hospital and being diagnosed with a hematoma of the scalp. Findings Include: R1 was admitted to the facility on [DATE] with diagnoses including but not limited to dementia, osteoarthritis of the knee, gait and mobility abnormality, depressive disorder, and anxiety. On the (MDS) Minimal Data Set assessment on 4/7/2026, section C, the BIMS (Brief Interviewed Mental Status) score was 1/15, indicating severe cognitive impairment. Minimum Data Set assessment (MDS) of 4/7/2026, Section GG documents that R1 requires substantial/maximal assistance for toileting hygiene, personal hygiene, chair/bed to chair transfer, and toileting transfer. Helpers do more than half of the effort. Helper lifts, holds, or supports the trunk or limbs. But R1 provides less than half effort. R1's care plan, 4/2/26 initiated date, includes in part to encourage the resident to participate in activities that promote exercise; keep bed in lowest position; be sure the resident's call light is within reach; anticipate and meet the resident's needs. The facility's fall incident report dated 5/14/2026 documented, R1 had a witness fall and slid from the wheelchair and hit her head on the floor with a visible head contusion. R1 was transferred to a local hospital and returned with documented discharge diagnoses of head injury and scalp hematoma, hospital records dated 5/14/2026. The Computed Tomography results of the brain dated 5/14/2026 showed focal swelling in the left frontal scalp. On 6/16/26 at 2:00 PM, V7 (Licensed Practical Nurse/LPN) said, I witnessed R1's fall on 5/14/2026. I was sitting at the nursing station on my computer, and R1 was sitting at the middle table in the dining room. R1 was sitting in a wheelchair, and I saw her midway going down. Her wheelchair turned on its side, and R1 fell on her left side and bumped her head on the floor. I don't recall any bleeding. We all ran over there. The on-duty nurse started to assess the R1, and I helped with ice and vital signs. R1 eats breakfast in the dining room from 7:30 AM until 8:30AM. The R1 was sleeping on and off in the dining room. The active person was at the other table and not close to her. I don't know why the staff did not put her back to bed. On 6/16/26 at 2:20PM, V4 (Activity Aide) stated, I was running an activity for the residents, and I was not physically looking at R1 when she fell. It was a small group with 13 residents, and I was helping a visually impaired resident to find a number on her card when I heard a thump, and someone said R1 fell. I had my back way from the R1, and I was about 15 feet away. V4 said, I cannot monitor everyone at one time. On 6/16/26 at 2:29PM, V5 (Certified Nursing Assistant/CNA) said, I was not taking care of R1 when she fell, but I am familiar with R1 and provide care to R1 when I am here. Every day when I get here, R1 is already up in the dining room. I am not sure how early R1 gets up, but I assist her back to bed around 1:00PM-1:30PM. R1 usually is up and stays up for breakfast and lunch in the dining room, and R1 sleeps on and off in her wheelchair, and sometimes R1 tries to push herself away from the table. On 6/16/26 at 2:38 PM, V2(Director of Nursing) said, R1 is a new resident to the long-term unit. My expectation is for the staff to lay down the residents to rest when they are tired and sleeping (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 Note: The nursing home is disputing this citation.	in the dining room. I think that one activity aide to monitor residents and do activities for 13 residents is not sufficient to watch the residents and run the activity at the same time. On 6/16/2026 at 3:15PM, observed R1 sleeping in her wheelchair, sitting at the middle table with her shoulder relaxed, and a bluish discoloration noted on the left forehead. R1 was alert to herself and only answered yes when questioned if she was sleeping, and R1 said yes to if she was tired. V8 (Activity Aide) was doing an activity with a group closer to the kitchen serving area. V8 had to get something for the game and left the dining area, and no nursing staff were seen at the nursing station for about 2 minutes. The surveyor asked V8 if she needed to let anyone know if she needed to go out of the unit, and V8 said no because there is always someone around. When questioned about no one being at the nursing station when she left, V8 did not answer. The surveyor counted approximately 19 residents in the dining room, and only one table was participating in the activity. V8 had her back toward the middle table and focused on the activity with the residents participating. On 6/18/2026 at 12:15PM V9 (CNA) said, R1 is on the night shift resident get-up list. V9 stated V9 gets here at 6:30AM. V9 said, When R1 fell on 5/14/26, R1 was already up in the dining room that day. Breakfast was served at 7:30AM, and I usually assist with her meals. R1 finished eating at 8:45AM. If R1 is active, I will not put her back to bed until around 4:30PM, because she is a fall risk. If she is doing a lot of movements sometimes, she stays up, and sometimes I put her down. The facility policy titled, Accidents and Supervision dated 10/2025, which reads in part but not limited to:Policy:The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:1.Identifying hazard(s) and risk(s).2. Evaluating and analyzing hazard(s) and risk(s).3.Implementing interventions to reduce hazard(s) and risk(s).4.Monitoring for effectiveness and modifying interventions when necessaryFall Prevention programPolicy: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.b. Implement routine rounding schedule.c. Monitor for changes in residents' cognition, gait, ability to rise/sit, and balance.