STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051193	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY GARDENS NSG & REHAB	212 AIRPORT ROAD , NORTH AURORA, Illinois, 60542

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S0000	Initial Comments Facility Reported Incident of 11/24/2025/2683808	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		12/16/2025

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

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to safely transfer a resident. This failure resulted in R1 sustaining a right leg laceration requiring stitches when V4 (CNA/Certified Nursing Assistant) transferred R1 without a gait belt. This applies to 1 of 3 residents (R1) reviewed for resident injury in the sample of 3. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on October 4, 2023, with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, asthma, aphasia, and cellulitis of right lower limb. R1's MDS (Minimum Data Set) dated October 9, 2025, showed R1 was cognitively intact. The MDS continued to show R1 required substantial/maximal assistance from facility staff for toileting hygiene and toilet transfers. R1's ADL (Activity of Daily Living) care plan dated October 5, 2023, showed, "[R1] has a deficit in ADL self-care related to disease processes of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, epilepsy, history of TIA (Transient Ischemic Attack), osteoarthritis, and weakness." The care plan continued to show multiple interventions dated January 23, 2024, including, "Toilet transfer: Resident requires substantial/maximal assistance of one staff member with the use of a gait belt for all transfers."	S9999		

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S9999	Continued from page 2 On December 10, 2025, at 11:13 AM, R1 said a couple weeks ago she got a cut on her leg when a CNA was transferring her from the toilet to her wheelchair. R1 said the CNA did not use a gait belt and R1's leg got stuck on the wheelchair. R1 said she had to go to the hospital to get stitches on her leg. On December 10, 2025, at 11:49 AM, V4 said on November 24, 2025, V4 was transferring R1 from the toilet to her wheelchair. V4 said he was trying to move R1's wheelchair closer but he did not notice R1's foot was stuck where the leg rest goes on the wheelchair. V4 said he was not using a gait belt to transfer R1 and was holding onto R1's brief to transfer R1 from the toilet to the wheelchair. V4's statement dated November 25, 2025, showed, "Assigned to [unit] on this evening, [another CNA] asked me to take [R1] off the toilet. I went to her bathroom, and she did not have a brief on. I had applied a new brief, and I asked her to stand up so I could wipe her. Then I pulled up her brief and she said she did not want her pants pulled up because she wanted to lay down. When I pulled up her brief, I tried to make her turn so she could sit down in the wheelchair behind her. When I tried to pull the wheelchair closer both wheels were locked, and the right foot was caught under the little tire and when she tried to sit down her right leg swung out in front of her and made it hit the frame of the wheelchair. After she was seated, I was going to put her in bed and that is when I noticed her leg was bleeding and notified the nurse. She came into the room and grabbed ADON (Assistant Director of Nursing). We're mostly able to transfer her independently but her foot was stuck and that what caused her to bump her leg." On December 10, 2025, at 12:10 PM, V5 (Rehab Director) said R1 was discharged from therapy on August 2, 2025, and therapy's recommendation was for R1 to be an assist of one facility staff member for toilet transfers. V5 said facility staff should use a gait belt when transferring R1 for R1's safety. On December 10, 2025, at 1:00 PM, V6 (R1's Doctor) said R1's leg laceration was caused by the improper transfer. V6 said facility staff should be following proper procedure and use a gait belt when transferring a resident. On December 10, 2025, at 3:28 PM, V2 (DON/Director of Nursing) said facility staff should use a gait belt when transferring a resident. V2 said R1's care plan	S9999		

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S9999	Continued from page 3 and medical record showed facility staff were to use a gait belt when transferring R1. V2 said V4 should have used a gait belt when transferring R1 from the toilet to the wheelchair. The facility's final report dated November 28, 2025, completed by V3 (ADON) showed, "Complete Description of Occurrence: [R1] has BIMS (Brief Mental Score) of 13, has diagnosis of right sided hemiplegia, aphasia following cerebral infarction, osteoarthritis, and unspecified thrombocytosis. On Monday evening about [4:30 PM], resident was assisted by a CNA (Certified Nursing Assistant) from the toilet, and when attempting to sit back into the wheelchair her right foot was caught in the small tire of the right side of the wheelchair causing her right lower leg to swing forward once she was seated in the chair and bump into the frame of the wheelchair. The aide observed the injury and summoned the nurse to the bathroom. First aid was rendered, and pressure was applied to right lower leg laceration. Resident reported complaints of discomfort and [Physician] notified. Order received to transfer resident to emergency room for further evaluation and treatment. POA (Power of Attorney) made aware of incident and order to transfer to the emergency room, per POA request [local hospital] is first hospital of choice. EMS (Emergency Medical Services) notified of bypass request to [local hospital] and resident was transferred to [local hospital] ER (Emergency Room). Resident returned to the facility approximately [10:30 PM]. The resident was assessed and returned with 10 sutures to right lower leg with physician order to remove sutures in 10 days. Investigation being conducted. Final Investigation: On 11/25/2025 around [4:15 PM], [R1] was assisted to the bathroom. This aide reported entering the bathroom, asked if she was ready and she nodded. He placed a new brief around her legs, and as he stood on her right side, she used her left arm to pull herself up from the bathroom grab bar. While she stood, he cleaned her from behind, was in the process of pulling up her brief and pants, while pulling up her brief, she was turned to face the wall, to sit back in her wheelchair and while her chair was locked, the aide attempted to pull the wheelchair closer behind her legs. She sat back into the wheelchair and her right foot was against the front tire of the wheelchair causing her right leg (which is contracted) to swing forward and land back onto the frame of the wheelchair where the leg rest had been removed. When the aide had unlocked her chair to pull her out of the bathroom, there was blood on her right lower leg. The nurse was summoned to the room, and first aid was rendered. Pressure was applied and [Physician] notified, order was received to transfer	S9999		

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S9999	Continued from page 4 resident to emergency room for further evaluation and treatment. POA made aware. Resident was transferred to [local hospital] per the request of the POA, because it is her hospital of choice. Resident returned to facility at approximately [10:30 PM], while at the emergency room resident was administered an Tdap (Tetanus, Diphtheria, and Pertussis) vaccine, x-ray of the right tibia and fibula which showed no acute abnormalities and right lower leg laceration was closed with 10 sutures. An order was received to monitor site for signs/symptoms of infection and remove sutures in 10 days. Per staff interviews, resident participates with transfers despite right sided hemiplegia. Currently, [R1] has no changes in her ADLs from the laceration and propels self on unit. Upon completion of the investigation, it was determined transfers would now be two person assist to help guide the residual affected side post stroke. In addition, Restorative Nursing will assess transfer/safety needs. Plan of care has been updated; treatment and monitoring orders are in place for right leg laceration aftercare. Facility to remove sutures in 10 days as ordered." R1's Emergency Room medical records dated November 24, 2025, showed R1 went to the Emergency Room for a leg laceration which occurred while being transferred. The records continued to show R1's right leg laceration was 3 centimeters and required eight stitches. The facility's undated policy titled "Use of Gait Belt" showed "Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Policy Explanation and Compliance Guidelines: 1. Each nursing department employee will be given a gait belt during orientation. 2. All employees will receive education on the proper use of gait belt during orientation and annually. 3. It will be the responsibility of each employee to ensure they have it available for use at all times when at work…" (B)	S9999		