

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055012		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER ASBURY COURT NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ELMHURST ROAD , DES PLAINES, Illinois, 60018			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			04/16/2026	
	Investigation of Facility Reported Incident of March 4, 2026/2960239						
S9999	Final Observations		S9999			04/21/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)4)5)						
	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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	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.						
	4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech,						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its safe resident handling and transfer policy by not having two people assist with the transfer of a resident using a mechanical lift. This applies to 1 of 3 residents (R1) reviewed for mechanical lift transfer and safety. These failures resulted in R1 falling during the transfer and had to be transferred to local emergency room for head laceration that required 5 staples. The findings include: R1 was admitted on 9/8/25 with moderate cognitive impairment as per the Minimum Data Set (MDS) dated 1/22/26. The MDS also documented that R1 is dependent on char/bed-to-chair transfer. R1's care plan (date initiated 10/19/23) documents R1 is dependent on the (mechanical) lift for all transfers. R1's care plan updated 3/4/26 documents "Neuro checks initiated, resident sent out to ER for further eval; Staff re-educated on steps and procedures involving proper mechanical lift transfers-return from hospital with staples in back of head." A review of the reportable documented an incident			S9999			04/21/2026

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S9999	Continued from page 2 of a fall during transfer using a mechanical lift transfer with a head injury, causing 5 staples to be reported to the state surveying agency on 3/4/26. On 4/7/26 at 9:15 AM, V5 (Registered Nurse/RN) stated, "I heard V4 (Certified Nursing Assistant/CNA) didn't use the proper sling and transferred R1 by herself. There should be at least two people with a mechanical lift transfer. On 4/7/25 at 10:45 AM, V3 (R1's Nurse on 3/4/26) stated, "V4 had been transferring R1 alone using a mechanical lift, despite knowing that at least 2 staff were required. After the incident, I was called by the CNA, and I assessed the resident, who had minor head bleeding and pain after hitting her head on the machine. The resident was sent to the hospital, received five staples, and returned within a few hours." On 4/7/26 at 12:45 PM, V4 (CNA) stated, "It was a busy morning. After the sponge bath, I placed a sling under R1 to help her up using the mechanical lift. The lift wasn't working, so I set the bed to the lowest position to make it work with R1. Both shoulder slings broke when I lifted her up, and she was only two feet above the ground as the bed was in its lowest position. I went to get a nurse, and she assessed her and found a little blood on R1's head. We called 911 and sent her out to the local hospital, and came back after 3 hours with 5 staples on her head." On 4/7/26 at 10:45 AM, V2 (Director of Nursing) stated that the V4 was alone while transferring R1 using a mechanical lift. She also didn't use the proper sling to transfer R1. V4 is not working for us anymore. The facility presented the Safe Resident Handling/Transfers policy (2025) statement document: It is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risk for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. 10. Two staff members must be utilized when transferring residents with a mechanical lift. "B"			S9999			04/21/2026