STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146187	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that call lights were accessible for residents that require staff assistance for activities of daily living (ADL's). This failure affected four of (R2, R4, R5, R6,) six residents reviewed for call lights in a sample of seven. Findings include: 1. R2's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R2's Minimum Data Set ((MDS) dated [DATE] documents that R2 is Cognitively Intact and that she requires extensive assistance from two plus persons for physical transfer out of bed, chair and wheelchair. On 9/8/20 at 12:40pm, R2 was sitting up in her wheelchair at the foot of her bed and indicated that she had been sitting there for about two hours. R2's right leg was elevated and extended out in front of her. R2 indicated that she cannot maneuver herself in the wheelchair due to the extension of her right leg. It was noted that R2's call light was behind her attached to the wall at the head of her bed by a clip. When asked how long she waits for the call light to be answered, R2 stated, Sometimes, I wait 15 to 20 minutes. Sometimes, I don't have the call light at all, like today. R2's care plan documents that R2 is at risk for recurrent falls related to a history of falling. This care plan reads: Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/8/20 at 12:46pm, V3 (CNA-Certified Nurse Assistant) confirmed that R2's call light was behind R2 and not within reach and stated, She should have call light before I leave the room. Otherwise, she can't call for help. 2. R6's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R6's MDS dated [DATE] documents that R6 is moderately Cognitively Impaired and that she requires extensive assistance from two plus persons for physical transfer out of bed, chair and wheelchair. On 9/8/20 at 12:52pm, R6 was up in her wheelchair on the left side of the bed. The call light was wrapped around the right upper side rail. R6 stated, Call light? I can't find it. I guess it's all the way over there. I can't reach the call light. It's on the other side of the bed. They should know better. R6 continued, I have been sitting here for a few hours. I haven't had the call light since I've been sitting here. V5 (CNA) indicated that R6 had been in wheelchair since before lunch, for quite some time . R6's care plan documents that R6 is at risk for falls related to history of UTI (urinary tract infection), history of mechanical fall, mobility and ADL impairment, poor safety awareness, and pain. This care plan reads: Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/8/20 at 1:00pm, V5 stated, Call light should always be accessible and close to them. Otherwise, they can't call. I'm just helping. This is (V3's) patient. 3. R4's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R4's MDS dated [DATE] documents that R4 is Cognitively Intact and that she requires extensive assistance from two plus persons for physical transfer out of bed, chair and wheelchair. On 9/9/20 at 9:33am, R4 was reclined in a wheelchair which was situated by the window on the opposite side of the room from her bed. R4's left leg was elevated by the wheelchair. R4's call light was across the room from her and wrapped on her hand rail. A second call light was clipped to a string on the wall. R4 then pointed to her cellular phone that was on an over bed table that was close to the entrance of the room. R4 indicated that if she didn't have a call light than she could use her cellular phone to call the receptionist. R4 stated, Call light? They're an issue. Sometimes, I can be waiting for 20 minutes. I ring the bell because I can't get up independently. I call because I have to take care of my bowels or I'm wet. I've been up in the chair for about an hour. My call light is over there and it's too far for me to try and get. R4's care plan documents that R4 is at risk for falls related to a history of falling. This care plan reads: Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/9/20 at 9:40am, V1 (Interim Executive Director) confirmed that the call light was too far for R4 to reach and also confirmed placement of cellular phone on over bed table by the entrance to the room. V1 stated, Call light should be accessible to resident at all times. That call light is way too far. 4. R5's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R5's MDS dated [DATE] documents that R5 is Severely Cognitively Impaired and that she requires limited assistance from two plus persons for physical transfer out of bed, chair and wheelchair. This MDS also documents that R5 requires limited assistance from two plus persons for turning side to side in bed. On 9/9/20 at 9:56am, R5 was laying in bed on her right side. R5's call light was on the left side of the bed on the floor. This surveyor asked R5 where her call light was, R5 stated, I have no clue. I never had it. I need them to help me move around. If I'm in the spot, there's no way I can get out of it. I can't move myself. R5's care plan documents that R5 is at risk for recurrent falls related to a gait/balance problems, incontinence, poor communication/comprehension and unaware of safety needs. This care plan reads: Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/9/20 at 9:58am, V4 (CNA) confirmed that the call light was on the floor and stated, There's no clip on it so it doesn't stay on her. The clip helps to make sure that it stays on her. I'll wrap it on the chair. Residents should always have the call lights in case they need us. On 9/9/20 at 1:45pm, V2 (DON-Director of Nursing) stated, (R5) has a habit of throwing her call light on the floor. R5's fall care plan and behavioral care plans were reviewed without any notation that R5 has this habit. A facility policy titled, Call Light Policy documents: Policy: It is the policy of this facility to provide a communication call-light system that allows the Resident to communicate a need from their room, bathroom, and bathing areas. Staff responds to acknowledge and assist in a timely manner. Responsibility: All employees.

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

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.