STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510021	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY COURT	1750 ELMHURST ROAD DES PLAINES, IL 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) COMPLETE DATE
A 000	Initial Comment Annual Licensure Survey Violations: 295.4010 d) 5) h) Service Plan 295.5000 b) Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. These requirements are not met as evidenced by:	A4010		

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A4010	Continued From page 1 Based on observation, interview and record review, the establishment failed to follow service plan for medication administration for one (R5) resident and failed to incorporate hospice intervention for one (R1) resident. These deficient practices affected two of five residents reviewed for service plan. Findings include: According to R5's Medication Review Report, R5 is 87 years old. R5's diagnoses include but not limited to Essential Hypertension, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease. R5's Service plan dated 1/7/25 indicated for Medication: Administer LN (Licensed Nurse). On 8/20/25 at 11:06pm, medication pass observation was conducted. E7 (Certified Nursing Assistant), opened the lock red box located in R5 apartment. E7 removed a medication packet out of the box, handed the medication packet to R5. R5 opened the medication packet with a pair of scissors then took the pill with water. R5 was asked for the name of medication she took, R5 said, "To be honest, I do not know the name, it was a blood pressure medication. I figured; they know what they were doing." The empty medication packet indicated the name of the medication-Hydralazine 50 mg. On 8/20/25 at 4:12pm, E5 was asked why R5's service plan indicated R5's medication was to be administered for the nurse, but the CNA was observed giving the medication packet to R5. E5 said R5 does not come down to the Wellness office in the morning, the afternoon meds are	A4010		

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A4010	Continued From page 2 passed by the nurse. Per R1's face sheet, R1 is 91 years old. R1 moved to the establishment on 3/17/25. R1's Hospice admission document indicated on 2/20/25, R1 was admitted to hospice care with a diagnosis of Malignant Neoplasm of Unspecified Bronchus or Lung. R1's Service plan signed 3/17/25 did not include hospice care. On 8/20/25 at 8:50am, R1 said he administer his own medications that was prepared by the Hospice nurse during one of nurse visitation. If Morphine is needed, the nurse on the first floor administers the Morphine, if Morphine is needed during the night, R1 was instructed to use the call button to be assisted. R1 appeared alert, oriented x4, independent with mobility with the use of a scooter. On 8/20/25 1:38pm, E2 (Director of Nursing) said, he tries to update interventions on service plan within 24 hours to include, hospice, wound...	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: General Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage b) Medication reminders include: 1) Reminding residents to take	A5000		

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A5000	Continued From page 3 pre-dispensed, self-administered medication; 2) Observing the resident; and 3) Documenting whether or not the resident took the medication. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to sufficiently assess medication administration service requirements affecting one (R2) of three residents reviewed for medication administration. Findings include: According to R2's face sheet, R2 is 85 years old. R2's diagnoses include but not limited to Unspecified Dementia and Essential Hypertension. R2's Brief Interview for Mental Status (BIMS) score dated 4/7/25 was 8, indicating moderate impairment. R2's Self Medication Assessment of the same date indicated R2 does not meet criteria to self-administer medication. "Resident has medication that will be given in the form of med reminder." On 8/20/25 at 8:44am, R2 was observed in the communal area clutching a brown stuff dog. R2 appeared alert, oriented x2. On 8/20/25 at 4:01pm, medication reminder process was observed involving R2. E6 (Certified Nursing Assistant) opened lock red box containing medications located inside R2's apartment. E6 removed white pill from weekly pill container labeled Wednesday with moon picture. There was no label indicating medication name	A5000		

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A5000	Continued From page 4 and dosage. E6 placed pill on white tissue paper in front of R2. R2 took white pill with water. R2 said she didn't know the name of the pill she took. E6 said, she didn't know the name of the medication she gave to R2. E6 was asked if R2 is coherent enough to know her medications, E6 said, R2 knows routine activities such as going back and forth from the apartment to the dining area, however, R2 wouldn't know the name of medications. E6 said, the pillbox is prepared by the nurse. R2's Service plan updated 6/1/25 indicated for Medication: Remind (CNA). E6 did not remind R2 to take medication according to the process indicated on this requirement, rather E6 administered the medication to R2 by removing from the container then placing the pill in front of R2. R2 did not have any input in the process, R2 did not give any instructions to E6 which medication to pull out. R2 was not aware what medication she took.	A5000		