STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145710	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor	431 West Remington Boulevard Bolingbrook, IL 60440

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to follow their policy to fully investigate a grievance/concern and ensure grievances by family members are resolved. This applies to 1 of 3 residents (R7) reviewed for grievances in the sample of 7. The findings include: On October 7, 2024 at 10:22 AM, V14 (Family of R7) said, Someone from our family goes to the facility every single day to be with (R7). Of course, we love him and want to be with him, but our main concern is that we frequently find him soiled with urine or stool, and our main concern is we want to make sure he is dry. He has wounds on his scrotum from being wet all the time. When they heal, they come back. I frequently spoke to V7 (Former Administrator) about our concerns regarding timely incontinence care, but he no longer works there. He was very aware of everything and would always say he would get back to me. The other day I came in and (R7's) pants and sleeve were wet with urine. How would you feel going to visit your father and finding him soiled like that? How many times do we need to ask for this and nothing changes? On October 8, 2024, continuous observations of R7 were done from 8:47 AM to 11:15 AM. R7 was not able to answer questions due to his cognitive status. R7 was asleep for most of the observation period. During the continuous observation period, R7 remained sitting in a high back wheelchair in the dining room. No staff approached R7 to check his incontinence brief or take him from the room to provide incontinence care during the continuous observation period. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 8, 2024, at 11:15 AM, V10 (Nursing Assistant Supervisor) said incontinent residents should be checked for incontinence and changed at least every two hours. V11 (CNA/Certified Nursing Assistant) said she was assigned to care for R7. V11 said R7 had been in the dining room since at least 7:00 AM this morning. V11 continued to say she had not brought R7 back to his room to change his incontinence brief between 7:00 AM and 11:15 AM. V11 continued to say she was too busy with other residents and was unable to transfer R7 back to bed until 1:30 PM to change his incontinence brief. At 11:29 AM, V10 (Nursing Assistant Supervisor) and V12 (CNA) transferred R7 back to bed to do a skin check and perform incontinence care. V13 (Family of R7) was also present. V10 removed R7's incontinence brief and said the brief was slightly damp with urine. V10 used disposable wipes to clean R7's bilateral groin areas. As V10 wiped R7's right groin area, the wipe became covered with a brown substance and a strong odor was present. V10 disposed of the soiled wipe and used a new disposable wipe to clean R7's left groin area. As V10 used the disposable wipe to clean, the wipe again became covered with a brown substance and a strong odor was present. Multiple disposable wipes were necessary to clean R7's bilateral groin areas. V10 and V12 turned R7 to his left side in the bed. A six-inch round protective dressing was covering R7's sacral area. The dressing was transparent, and no wound was visible through the dressing. Two open areas were noted on R7's scrotum. V10 (Nursing Assistant Supervisor) used a disposable wipe to clean R7's rectal area. A scant brown substance was visible on the disposable wipe, and V10 said, I think maybe he just had a wet fart. V13 (Family of R7) said, This is a concern we have voiced over and over again since his admission in April 2024. We just want him to be kept clean. He has a wound on his scrotum, and we do not want it to get worse. He needs to be kept clean and dry. We have made a request to make sure (R7) is put back to bed every day after lunch with the hope that if he is put back to bed, they will at least check and change him once a day. That is the only reason we requested for him to be put back to bed just so he receives incontinence care, and as you can see, that still is not happening. The EMR (Electronic Medical Record) shows R7 was admitted to the facility on [DATE]. R7 has multiple diagnoses including, cerebral atherosclerosis, palliative care, hypertension, COPD (Chronic Obstructive Pulmonary Disease), PTSD (Post-Traumatic Stress Disorder), depression, vascular dementia, restlessness and agitation, history of falling, history of UTI (Urinary Tract Infection), non-pressure chronic ulcer of the right lower leg, and aggressive behaviors. R7's MDS (Minimum Data Set) dated July 12, 2024 shows R7 has moderate cognitive impairment and is dependent on facility staff for all ADLs. R7 is always incontinent of bowel and bladder. On June 2, 2024 at 8:55 AM, V15 (Social Services) documented, [V14] (Daughter of R7) requested to speak with MOD (Manager on Duty-writer). Writer introduced self. [V14] stated she came to see her dad and when she got here, resident and his blankets was soiled. CNA was already in room helping resident. Writer informed nursing staff of situation and completed concern form. Writer told [V14] where to contact self, if she needs anything. [V14] thanked writer. On October 5, 2024 at 12:54 PM, V8 (Supervisor) documented: Resident daughter c/o (complained of) resident in bed soiled. Changed resident's brief and shirt. Daughter wants to file complaint. Complaint form provided to resident. Resident resting comfortable in bed, call light within reach. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Grievance/Concern Form dated October 5, 2024 shows the following statement by V14 (Daughter of R7): When I arrived at 11:47 AM, two CNAs were putting my father in the bed. When I walked in, I checked my father, and he was soiled with urine and feces. His shirt was wet, and his pants were just pulled down to his feet. The grievance form continues to show R7 was immediately provided pericare, a bed bath, and clean linen. The facility does not have documentation to show an investigation was completed, including names of any witnesses and their account of the alleged incident, the resident's account of the alleged incident, the employee's account of the alleged incident, accounts of any other individuals involved, or recommendations for corrective action. On October 8, 2024 at 1:08 PM, V2 (DON-Director of Nursing) said he thought the family's grievance from October 5, 2024 was resolved. They provided care immediately and provided cream and new linen. V2 could not provide documentation to show an investigation had been completed to determine why care had not been provided to R7, if staff or the resident had been interviewed, and what corrective action had been put in place to ensure the incontinence care concern would not be repeated. The facility's undated policy entitled, Grievance/Concern Policy and Procedure shows: Policy: It is the policy of [the facility] to make every effort to promptly and satisfactorily resolve any complaint, grievance, or concern brought to the attention of the facility. This includes grievances filed for missing property and allegations of improper resident treatment. (Allegations of abuse are addressed in facility Abuse Policy and Procedure.) Procedure: 1. Residents and visitors may voice grievances without threat of discrimination or reprisal. Such grievances may include those with respect to treatment that has been provide as well as that which has not been provided, staff or resident behaviors, and any other concerns about the resident's stay in the facility. 2. Individuals may file grievances/concerns orally, in writing, or anonymously. 3. Grievance/Concern forms are located at the front desk in the lobby and can be completed and returned to the receptionist. Receptionist will notify Administrator immediately of grievance/concern. 4. The facility has designated Administrator as the designated point of contact for grievances/concerns.8. Grievance/Concern Investigations will include (as appropriate) the following information: a. Date/time of alleged incident, b. Circumstances surrounding the alleged incident, c. Location of alleged incident, d. Names of any witnesses and their account of alleged incident, e. Resident's account of alleged incident, f. Employee's account of alleged incident, g. Accounts of any other individuals involved, h. Recommendations for corrective action .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse. This applies to 2 of 3 residents (R4, R5) reviewed for abuse in the sample of 7. The findings include: The facility's initial report to IDPH (Illinois Department of Public Health) dated September 23, 2024 shows: [R5] involved in physical altercation with [R4]. Staff responded and immediately separated residents. Placed on 1:1 supervision. Both residents assessed. [R5] has discoloration to back of right hand with superficial skin tear to right wrist. [R4] observed with minimal bump to top of left forehead and skin tear to lip. Provided with first aide . The facility's final report to IDPH dated September 27, 2024 shows, Original allegation: [R5] resident involved in physical altercation with [R4]. Both residents assessed and family and MD notified. Facts determined: .3. Both residents have severe impairment. Summary and analysis of the evidence: [R5] and [R4] have a BIMS (Brief Interview for Mental Status) indicating severe impairment. [R4] walked into the room of [R5] looking for her own personal items and as a result a physical altercation took place. Residents were immediately redirected, assessed, and a room change initiated. Follow up will continue with psychiatric services and monitoring in place. There have no further incidents between these two residents. Conclusion and action taken: Based on the interview of the staff involved, and the residents being severely cognitively impaired, abuse could not be substantiated. Psychiatric support to be provided as well as well-being checks. Family and MD is aware and satisfied with the investigation. On October 7, 2024 at 9:46 AM, R4 was sitting in a chair in the dining room. R4 was not able to be interviewed due to her cognitive status. The EMR (Electronic Medical Record) shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, dementia with behaviors, hypertension, major depressive disorder, anxiety disorder, psychosis, auditory hallucinations, spinal stenosis, delusional disorder, chronic kidney disease, Alzheimer's disease, wandering, repeated falls, and insomnia. R4's MDS (Minimum Data Set) dated July 10, 2024 shows R4 has moderate cognitive impairment, requires partial/moderate assistance with showering and lower body dressing, and supervision with all other ADLs (Activities of Daily Living). R4 is occasionally incontinent of urine and always continent of stool. On September 23, 2024 at 1:32 PM, V17 (Physician) documented, I performed the examination of the patient. Formulated plan of care and medical decision making. I reviewed the note by [V19] (NP-Nurse Practitioner) and agree with the documented findings and plan of care.Assessment/Plan: Altercation with another resident. Patient has some bruising to her forehead. Will monitor. Neuro checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 7, 2024 at 9:40 AM, R5 was sitting in a chair in the dining room. R5 could not be interviewed due to her cognitive status. V16 (Nurse) said, [R5] wanders, but is doing better since she got to the dementia unit. She did get in an altercation with another resident but has not had any further altercations since she came to the dementia unit. She cannot answer questions due to her dementia. The EMR shows R5 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease, dementia, left knee pain, skin rash, anxiety disorder, chronic kidney disease, major depressive disorder, traumatic brain injury, repeated falls, psychosis, low back pain, wandering. R5's MDS dated [DATE] shows R5 has severe cognitive impairment, requires supervision with eating, oral hygiene, bed mobility, and transfers between surfaces, partial/moderate assistance with lower body dressing and personal hygiene, and substantial/maximal assistance with toilet hygiene and showering. R5 is occasionally incontinent of urine, and always continent of stool. On September 23, 2024 at 3:37 PM, V16 (Nurse) documented, Redness to right hand, scratches noted. Cleaned with normal saline, covered for protection. On October 7, 2024 at 11:15 AM, V2 (DON-Director of Nursing) said his final report to IDPH on September 27, 2024 was inaccurate. V2 said R5 entered R4's room and started going through R4's belongings in R4's dresser. V2 continued to say, [R4] told [R5] to get out of here. [R4] attempted to push [R5] away. [R5] responded by hitting [R4] with a hairbrush. [R4] had slight swelling and a bruise on her forehead and a cut on her lip, and [R5] had scratches on the top of her hand from [R4] grabbing her wrists and scratching her. It was unsubstantiated because they both have dementia. The facility's policy entitled Abuse Policy and Procedure, reviewed 11/15/2022 shows: Policy Statement: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose: The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation.Definitions: Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to follow their policy to conduct a thorough abuse investigation following a resident-to-resident physical altercation. This applies to 2 of 3 residents (R4, R5) reviewed for abuse in the sample of 7. The findings include: On October 7, 2024 at 9:40 AM, R5 was sitting in a chair in the dining room. R5 could not be interviewed due to her cognitive status. V16 (Nurse) said, [R5] wanders, but is doing better since she got to the dementia unit. She did get in an altercation with another resident but has not had any further altercations since she came to the dementia unit. She cannot answer questions due to her dementia. On October 7, 2024 at 9:46 AM, R4 was sitting in a chair in the dining room. R4 was not able to be interviewed due to her cognitive status. The EMR (Electronic Medical Record) shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, dementia with behaviors, hypertension, major depressive disorder, anxiety disorder, psychosis, auditory hallucinations, spinal stenosis, delusional disorder, chronic kidney disease, Alzheimer's disease, wandering, repeated falls, and insomnia. R4's MDS (Minimum Data Set) dated July 10, 2024 shows R4 has moderate cognitive impairment, requires partial/moderate assistance with showering and lower body dressing, and supervision with all other ADLs (Activities of Daily Living). R4 is occasionally incontinent of urine and always continent of stool. The EMR shows R5 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease, dementia, left knee pain, skin rash, anxiety disorder, chronic kidney disease, major depressive disorder, traumatic brain injury, repeated falls, psychosis, low back pain, wandering. R5's MDS dated [DATE] shows R5 has severe cognitive impairment, requires supervision with eating, oral hygiene, bed mobility, and transfers between surfaces, partial/moderate assistance with lower body dressing and personal hygiene, and substantial/maximal assistance with toilet hygiene and showering. R5 is occasionally incontinent of urine, and always continent of stool. The facility's initial report to IDPH (Illinois Department of Public Health) dated September 23, 2024 shows: [R5] involved in physical altercation with [R4]. Staff responded and immediately separated residents. Placed on 1:1 supervision. Both residents assessed. [R5] has discoloration to back of right hand with superficial skin tear to right wrist. [R4] observed with minimal bump to top of left forehead and skin tear to lip. Provided with first aide . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's final report to IDPH (Illinois Department of Public Health) dated September 27, 2024 shows, Original allegation: [R5] resident involved in physical altercation with [R4]. Both residents assessed and family and MD notified. Facts determined: .3. Both residents have severe impairment. Summary and analysis of the evidence: [R5] and [R4] have a BIMS (Brief Interview for Mental Status) indicating severe impairment. [R4] walked into the room of [R5] looking for her own personal items and as a result a physical altercation took place. Residents were immediately redirected, assessed, and a room change initiated. Follow up will continue with psychiatric services and monitoring in place. There have no further incidents between these two residents. Conclusion and action taken: Based on the interview of the staff involved, and the residents being severely cognitively impaired, abuse could not be substantiated. Psychiatric support to be provided as well as well-being checks. Family and MD is aware and satisfied with the investigation. On October 7, 2024 at 11:15 AM, V2 (DON-Director of Nursing) said his final report to IDPH on September 27, 2024 was inaccurate. V2 said R5 entered R4's room and started going through R4's belongings in R4's dresser. V2 continued to say, [R4] told [R5] to get out of here. [R4] attempted to push [R5] away. [R5] responded by hitting [R4] with a hairbrush. [R4] had slight swelling and a bruise on her forehead and a cut on her lip, and [R5] had scratches on the top of her hand from [R4] grabbing her wrists and scratching her. It was unsubstantiated because they both have dementia. On October 8, 2024 at 12:32 PM, V2 (DON) showed the interviews he conducted during the investigation of resident-to-resident abuse between R4 and R5 on September 23, 2024. V2 provided statements from R4 and R5. V2 did not have documentation to show possible witnesses, including residents or staff members were interviewed to determine if physical abuse could be substantiated. On October 9, 2024 at 9:41 AM, V18 (Corporate Consultant) said, We are struggling with substantiating something if we didn't see it. V18 said the policy for conducting a thorough investigation should have been followed and statements from staff and residents should have been obtained during the investigation. The facility's policy entitled Abuse Policy and Procedure, reviewed 11/15/2022 shows: Purpose: The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation.IV. Investigation: As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the administrator or designee will initiate an investigation into the allegation which may include the following elements: interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: all persons who reported the suspicion, allegation or incident, the alleged victim (if the victim is unable to be interviewed, this shall be documented), the alleged perpetrator (if the alleged perpetrator is a resident who cannot be interviewed, this shall be documented), any witnesses or potential witnesses to the alleged occurrence or incident, any staff having contact with the resident during the period of the alleged incident, roommates, other residents, family or visitors. A review of the medical record, including care plan, a review of all circumstances surrounding the incident, and physicians will be notified of any incident and any medical treatment will be done as ordered. The investigation shall conclude whether the allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation can likely be sustained. Records of the investigation shall be maintained.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to provide timely incontinence care to a resident who is dependent on facility staff for all ADLs (Activities of Daily Living), including toilet hygiene. This applies to 1 of 3 residents (R7) reviewed for timely incontinence care in the sample of 7. The findings include: On October 8, 2024, continuous observations of R7 were done from 8:47 AM to 11:15 AM. R7 was not able to answer questions due to his cognitive status. R7 was asleep for most of the observation period. During the continuous observation period, R7 remained sitting in a high back wheelchair in the dining room. No staff approached R7 to check his incontinence brief or take him from the room to provide incontinence care during the continuous observation period. On October 8, 2024, at 11:15 AM, V10 (Nursing Assistant Supervisor) and V11 (CNA-Certified Nursing Assistant) were approached by this surveyor to request a skin and incontinence check for R7. V10 said incontinent residents should be checked for incontinence and changed at least every two hours. V11 (CNA) said she was assigned to care for R7. V11 said R7 had been in the dining room since at least 7:00 AM this morning. V11 continued to say she had not brought R7 back to his room to change his incontinence brief between 7:00 AM and 11:15 AM. V11 continued to say she was too busy with other residents and was unable to transfer R7 back to bed to do a skin check at that moment and since R7's family wanted R7 transferred back to bed after lunch, she would like to wait until 1:30 PM to put R7 in bed and change his incontinence brief. At 11:29 AM, V10 (Nursing Assistant Supervisor) returned with a different CNA (V12) to transfer R7 back to bed to do a skin check and perform incontinence care. V13 (Family of R7) was also present. V10 pushed R7's high back wheelchair from the dining room to his room and used a total body mechanical lift to transfer R7 back to bed with V12's assistance. V10 removed R7's incontinence brief and said the brief was slightly damp with urine. V10 used disposable wipes to clean R7's bilateral groin areas. As V10 wiped R7's right groin area, the wipe became covered with a brown substance and a strong odor was present. V10 disposed of the soiled wipe and used a new disposable wipe to clean R7's left groin area. As V10 used the disposable wipe to clean, the wipe again became covered with a brown substance and a strong odor was present. Multiple disposable wipes were necessary to clean R7's bilateral groin areas. V13 (Family of R7) said, This is a concern we have voiced over and over again since his admission in April 2024. We just want him to be kept clean. He has a wound on his scrotum, and we do not want it to get worse. He needs to be kept clean and dry. I do not think the person who cleaned him the last time did a good job and left him with stool between his legs. V10 and V12 turned R7 to his left side in the bed. A six-inch round protective dressing was covering R7's sacral area. The dressing was transparent, and no wound was visible through the dressing. Two open areas were noted on R7's scrotum. V10 (Nursing Assistant Supervisor) used a disposable wipe to clean R7's rectal area. A scant brown substance was visible on the disposable wipe, and V10 said, I think maybe he just had a wet fart. V10 and V12 continued incontinence care on R7 and used a mechanical lift to transfer R7 back to his high back wheelchair so he could eat lunch in the dining room with his family present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 8, 2024 at 1:08 PM, V2 (DON-Director of Nursing) said incontinence care should be performed every two hours or sooner if needed. The EMR (Electronic Medical Record) shows R7 was admitted to the facility on [DATE]. R7 has multiple diagnoses including, cerebral atherosclerosis, palliative care, hypertension, COPD (Chronic Obstructive Pulmonary Disease), PTSD (Post-Traumatic Stress Disorder), depression, vascular dementia, restlessness and agitation, history of falling, history of UTI (Urinary Tract Infection), non-pressure chronic ulcer of the right lower leg, and aggressive behaviors. R7's MDS (Minimum Data Set) dated July 12, 2024 shows R7 has moderate cognitive impairment and is dependent on facility staff for all ADLs. R7 is always incontinent of bowel and bladder. On October 5, 2024 at 12:54 PM, V8 (Supervisor) documented: Resident daughter c/o (complained of) resident in bed soiled. Changed resident's brief and shirt. Daughter wants to file complaint. Complaint form provided to resident. Resident resting comfortable in bed, call light within reach. R7's wound care assessment dated [DATE] shows R7 has MASD (Moisture-Associated Skin Damage) on his scrotum. The wound care assessment shows R7's MASD of the scrotum measures 1.5 cm. (centimeters) by 1.0 cm. by 0.1 cm., was facility-acquired, and was identified on September 17, 2024. R7's care plan, initiated April 10, 2024 shows R7 has actual impairment to skin integrity r/t (related to) several risk factors. At risk for moisture AEB (As Evidenced By) incontinent of bowel and bladder. Multiple interventions, initiated April 10, 2024 include, Peri care after each incontinent episode and [R7] will be turned and repositioned at least every two hours while in bed and every hour while up in wheelchair and Offer bedpan/urinal and glass of water in conjunction with turning schedule.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33330 Based on observation, interview, and record review, the facility failed to follow their policy to assess a resident for elopement risk within the first 24 hours and implement interventions to prevent elopement and exit seeking. This applies to 1 of 5 residents (R1) reviewed for supervision and elopement in the sample of 7. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. R1 has multiple diagnoses including, Parkinson's disease, chronic kidney disease, heart failure, atrial fibrillation, aortic aneurysm, thrombocytopenia, adult failure to thrive, dementia, anxiety, and bilateral hearing loss. R1's MDS (Minimum Data Set) dated September 30, 2024 shows R1 has moderate cognitive impairment, requires supervision with eating, substantial/maximal assistance with showering, and partial/moderate assistance with all other ADLs (Activities of Daily Living). R1 is always continent of bowel and bladder. The facility does not have documentation to show an elopement risk assessment was completed for R1 within 24 hours of admission to the facility. R1's Elopement Risk assessment dated ,d+[DATE] shows an elopement risk score of 10. The form shows 7 or higher - high risk. Document approaches and interventions to minimize elopement risk in the care plan. The facility does not have documentation to show approaches and interventions to minimize elopement were put in place for R1 after completing the elopement risk assessment and obtaining a score of high risk for elopement. On October 7, 2024 at 9:25 AM, R1 was lying in bed in his room. R1 was unable to answer questions due to his cognitive status. V20 (Nurse) was standing outside of R1's room preparing medications. V20 said, [R1] normally stays on this floor, but he can walk around by himself. Yesterday he tried to get on the elevator, but luckily, we saw him, so we stopped him. He does not wear any type of alarm device. We don't have those here. On October 6, 2024 at 3:27 PM, V20 (Nurse) documented the following behavior observation: Exit seeking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145710	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor	431 West Remington Boulevard Bolingbrook, IL 60440

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 - Minimal harm or potential for actual harm Residents Affected - Few	On October 7, 2024 at 11:15 AM, V2 (DON-Director of Nursing) said, [R1] wanders within the unit and needs to be redirected. He is fairly new to the facility. I was not aware that he tried to leave the floor. Nothing was reported to me. There was a breakdown in communication of his exit seeking. I don't know if there is a process for doing elopement risk assessments on residents. If someone tries to get out or is exit seeking, we put their pictures at the front desk to identify them as an elopement risk. On October 7, 2024 at 12:00 PM, two pieces of paper were taped to the back of the reception desk. The papers were labeled 10/4/24 and pictures of 13 residents and their names were shown on the papers. The papers were not labeled elopement risk. R1's picture and name were not on the papers. On October 8, 2024 at approximately 8:40 AM, two pieces of paper were taped to the back of the reception desk. The papers were labeled, At risk and 10/4/24 and pictures of 13 residents and their names were shown on the papers. The papers were not labeled elopement risk. R1's picture and name were not on the papers. On October 8, 2024 at approximately 2:20 PM, V2 (DON) said, [R1's] elopement risk assessment should have been done within 24 hours of his admission. The staff need to be made aware of a resident who can possibly elope. After we determine someone is an elopement risk, we notify the staff and figure out what interventions should be put in place. We put a yellow bracelet on the resident to notify the staff the resident is an elopement risk. I believe [R1] was given a yellow bracelet. On October 8, 2024 at 2:32 PM, R1 was lying in bed in his room. R1 was asked to show his wrists. R1 was not wearing a yellow bracelet. The facility's policy entitled, Wandering and Elopements revised March 2019 shows: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation: 1. A resident with a memory care diagnosis will be assessed for elopement risk within the first 24 hours or first business day after resident admission. However, if upon admission, the resident is displaying or verbalizing the desire to leave then the admitting nurse can immediately alert staff that the resident could be a high risk for elopement and should be monitored closely. The risk assessment is completed by Social Service Department. 2. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 3. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner, b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident is attempting to leave or has left the premises.