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	12/18/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46409 Based on interview and record review, the facility failed to change a resident's rectal tube collection bag according to manufacturer guidelines. This failure effects 1 of 1 residents (R1) reviewed for quality of care in a sample of 3. The findings include: On December 17, 2024 at 8:07 AM, V3 (Family Member) said R1 had a tube inserted into his rectum and the waste was collected into a bag. V3 said the facility staff had not changed the bag and it had been on for three days. V3 said the bag was leaking and so the staff wrapped a plastic bag around the collection bag and hung it on the bed. V3 said the staff would remove the bag, empty out the waste into the toilet, and reattach the bag to the tubing. V3 said she believed they were supposed to put a new bag on every day. V3 said V4 (ADON/Assistant Director Of Nursing) met up with her on December 13, 2024 and was told they would order new bags. V3 said she asked V4 how often the bags were supposed to be changed, to which V4 said the bags should be changed daily. V3 said on December 14, 2024, V8 (RN/Registered Nurse) came to look at the collection bag because it was leaking and cleaned the top of the bag and said she believed it was leaking because the CNAs (Certified Nurse Assistants) were not tightening the bag when reattaching it. On December 17, 2024 at 2:05 PM, V5 (RN/Registered Nurse) said she did not have to change the bag on her shift, but they empty the stool from the bag and reattach it to the tube. V5 said she did this with the CNA (Certified Nurse Assistant). V5 said she empties the bag at the end of the shift when the bag is full and as needed. On December 17, 2024 at 2:56 PM, V6 (CNA) said when R1 initially came to the facility, he only had one replacement collection bag. V6 said she takes the bag off, takes it to the bathroom, cleans it out, and clips the bag back to the tubing. On December 17, 2024 at 4:13 PM, V8 (RN) said she was the supervisor over the unit for the weekend and spoke with V3 (Family Member). V8 said V3 thought the bag was leaking and V8 shook the bag in front of V3 to show it was not leaking. V8 said the CNAs undo the seal and empty the stool. V8 said if the CNAs do not snap the bag back into the tube properly, it could cause leaking. V8 said she was not aware the bag needed to be changed every day. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 17, 2024 at 2:48 PM, V9 (RN) said she took care of R1 last week. V9 said they are not supposed to empty the bag, they are supposed to change it. V9 said there was no hole to squeeze and empty the stool. On December 18, 2024 at 9:20 AM, V4 (ADON) said if she was the floor nurse, she would grab a basin and empty the stool at bedside and reattach the bag to the tubing. On December 17, 2024 at 12 PM, V7 (Clinical Nurse Specialist) said she was the nurse specialist for the company with the rectal tubes. V7 said it was not the practice to empty the bag and replace it. V7 said there was a filter and rinsing out the bag would not maintain the filter. V7 said the bag was not made to be emptied. V7 said when she trained people on the use of the bag, she would tell them to change the bag every time it was full. V7 said the risk of dumping the stool was if the resident had Clostridium Difficile, pouring it out could cause the spores to become airborne and would increase the risk of spreading. At 3:26 PM, V7 said she reviewed the manufacturer guidelines, which showed not to reuse the device, and although it did not specify the collection bag, she said it was all inclusive of all the equipment in the kit. V7 said every part of the device was not designed to be reused. On December 17, 2024 at 3:51 PM, V2 (DON/Director of Nurses) said the rectal collection bag can be emptied into a basin and reattached back into place. V2 said it was a task for the nurse. V2 said the facility did not have a policy for rectal tubes so they would be following the manufacturer guidelines. The Manufacturer Guidelines for Flexi-Seal Signal Fecal Management System showed 13. This device is for single use only and should not be re-used. Re-use may lead to increased risk of infection or cross contamination. Physical properties of the device may no longer be optimal for intended use.