STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Meadowbrook Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35267 Based on observation, interview and record review, the facility failed to provide assistance to residents who required staff assistance for ADL (Activities of Daily Living) care. This applies to 4 of 6 residents (R2, R11, R12 and R13) reviewed for ADL care in a sample of 13. The findings include: 1. Face sheet, dated 1/7/25, shows R11's diagnoses included ideopathic progressive neuropathy, weakness, low back pain, reduced mobility, lack of coordination, open wounds of the toes, and chronic kidney disease. MDS (Minimum Data Set), dated 10/4/24, shows R11 was cognitively intact, R11 was always incontinent of bowel/bladder, and R11 was dependent on staff for toileting hygiene, bathing/showering, dressing, hygiene, tub/shower transfers, and chair/bed transfers. Care plan, dated 2/27/23, shows R11 had decreased balance, mobility, and strength, and R11 was dependent on two staff for using a full body mechanical lift machine for transfers. On 1/7/25 at 10:19 AM, R11 was lying in his bed and expressed frustration that the staff were not assisting him to get him out of bed. R11 stated he requested to be gotten out of bed at approximately 9:00 AM earlier that morning. R11stated when he puts his call light on, staff respond, turn off the light and tell him they will return, but do not. R11 stated he lived at the facility for 2 years and prefers to get up out of bed after breakfast. On 1/7/25, R11 remained in bed until 10:50 AM. 2. Face sheet, dated 1/7/25, shows R12's diagnoses included fracture of left pubis and anterior wall of left acetabulum, head contusion, depression and anxiety, colostomy, and history of falls. MDS, dated [DATE], shows R12's cognition was intact and R12 required substantial/maximal assistance from staff for toileting hygiene. Care plan, dated 10/28/24, shows R12 had a colostomy and staff were to check and change R12 approximately every two hours. (continued on next page)

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.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 10:25 AM, R12's call light was on above the door of her room. R12 stated, I can't get a CNA (Certified Nurses Assistant) to change my colostomy and it's full! The colostomy bag was inflated and bulging from beneath her night gown. R12 stated My daughter is coming and I don't want her to see me like this! It's full! R12 stated she had already waited an hour since her initial request to staff to care for the colostomy. At 10:28 AM, V12 (CNA) came into R12's room and stated she was coming and that she needed to care for one more resident prior to assisting R12 with her colostomy bag. R12 stated, I will be back! Just under an hour later at 11:20 AM, R12's colostomy bag was changed. 3. Face sheet, dated 1/7/25, shows R2's diagnoses included fracture of upper and lower right fibula dorsalgia, chronic kidney disease, difficulty walking, cognitive communication deficit, and wedge compression fracture thoracic vertebra. MDS, dated [DATE], shows R2 was cognitively intact, was frequently incontinent of urine/bowel, was dependent on staff to move from lying to sitting on the side of the bed, and was dependent on staff for toileting. Care plan, dated 1/6/25, shows R2 was to be checked and changed approximately every two hours or as needed and staff were to assist with toilet hygiene and urinal use. On 1/6/25, R2 stated he waited hours at night and no staff would come to his room when he needed assistance with using his urinal. R2 stated there were not enough staff in the facility to answer call lights at night and R2 was happy to see the AM shift staff because they were very helpful. 4. Face sheet, dated 1/7/25, shows R13's diagnoses included fracture of right patella, chronic obstructive pulmonary disease, asthma, shortness of breath, chronic kidney disease, history of falls, spondylosis, spinal stenosis, and pain in left leg. MDS, dated [DATE], shows R13 was cognitively intact, required substantial/maximal assistance from staff for dressing and bathing, and required partial/moderate assistance for oral /toileting/personal hygiene. R13's care plan, dated 12/26/24, shows R13 had impaired balance, limited mobility, weakness, and functional limitations requiring partial/moderate assistance from staff to use the toilet. The care plan shows staff were to assist with toileting needs upon getting up in the AM, after meals, and before bedtime and as needed. The care plan also shows staff were to set up all needed hygiene items and ensure they are within reach. On 1/7/25 at 10:27 AM, R13 stated she was waiting for staff to assist her because she needed pain pills and warm water and grooming supplies so that she can wash up for the day. R13 stated she sometimes waits an hour for staff to respond to her call light and bring her washing/grooming items or medications for pain. Facility Policy Activities of Daily Living (ADLs), Supporting, dated 2001, shows, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Resident who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming and personal and oral hygiene 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently . including appropriate support and assistance with a: Hygiene .c. Elimination

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35267 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to meet the care needs of facility residents. This applies to 4 of 6 residents (R2, R11, R12 and R13) reviewed for staffing in a sample of 13. The findings include: 1. MDS (Minimum Data Set), dated 10/4/24, shows R11 was cognitively intact, R11 was always incontinent of bowel/bladder, and R11 was dependent on staff for toileting hygiene, bathing/showering, dressing, hygiene, tub/shower transfers, and chair/bed transfers. On 1/7/25 at 10:19 AM, R11 was lying in his bed and expressed frustration that the staff were not assisting him to get him out of bed. R11 stated he requested to be gotten out of bed at approximately 9:00 AM earlier that morning. R11 stated when he puts his call light on, staff respond, turn off the light and tell him they will return but do not. R11 stated he lived at the facility for 2 years and prefers to get up out of bed after breakfast. On 1/7/25, R11 remained in bed until 10:50 AM. On 1/7/25 at 10:28 AM, V12 (CNA - Certified Nursing Assistant) stated they were short of staff at the facility more than frequently. V12 stated that morning there were only three CNAs for the 45 residents on the unit. V12 stated she had many residents requiring two staff to transfer/reposition and there were only three CNAs assigned to the 45 residents on the unit. V12 stated she was a strong CNA and she was trying to get to all the residents as fast as she could but some of the residents were having to wait for care. Facility document, dated 1/7/25, shows of the 46 residents on the Pavillion Unit, 26 residents required the assistance of two staff for transfers. On 1/7/25 at 1:18 PM, V14 (Staffing Coordinator) reviewed the schedules dated 12/23/24 to 1/6/24. The schedules showed the facility was short staffed during approximately one third of the shifts worked at the facility (14 of 44 shifts were short). Facility assessment, dated 11/2024, shows the facility nursing and CNA staffing was to be based per unit and acuity. 2. MDS, dated [DATE], shows R12's cognition was intact and R12 required substantial/maximal assistance from staff for toileting hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 10:25 AM, R12's call light was on above the door of her room. R12 stated, I can't get a CNA to change my colostomy and it's full! The colostomy bag was inflated and bulging from beneath her night gown. R12 stated My daughter is coming and I don't want her to see me like this! It's full! R12 stated she had already waited an hour since her initial request to staff to care for the colostomy. At 10:28 AM, V12 (CNA) came into R12's room and stated she was coming and that she needed to care for one more resident prior to assisting R12 with her colostomy bag. R12 stated, I will be back! Almost an hour later at 11:20 AM, R12's colostomy bag was changed by staff. 3. MDS, dated [DATE], shows R2 was cognitively intact, was frequently incontinent of urine/bowel, was dependent on staff to move from lying to sitting on the side of the bed, and was dependent on staff for toileting. On 1/6/25, R2 stated he waited hours at night and no staff would come to his room when he needed assistance with using his urinal. R2 stated there were not enough staff in the facility to answer call lights at night and R2 was happy to see the AM shift staff because they were very helpful. R2 stated the facility did not have enough staff to answer resident call lights. Grievance, dated 1/3/25, shows V13 (R2's Family) expressed concern regarding R2's care needs not being met. 4. MDS, dated [DATE], shows R13 was cognitively intact, required substantial/maximal assistance from staff for dressing and bathing, and required partial/moderate assistance for oral /toileting/personal hygiene. On 1/7/25 at 10:27 AM, R13 stated she was waiting for staff to assist her because she needed pain pills and warm water and grooming supplies so that she can wash up for the day. R13 stated she sometimes waits an hour for staff to respond to her call light and bring her washing/grooming items or medications for pain. On 1/7/25 at 10:30 AM, V16 (CNA) stated the unit was short staffed and she was assigned 16 residents - of which 4 or 5 residents required two staff for transfers/repositioning. V16 stated it was difficult to perform care for all of her assigned residents. On 1/7/25, V11 (RN - Registered Nurse) stated the facility was short staffed that day and often. V11 stated the CNAs are assigned approximately 15 residents but many of the residents require two people each to care for them. V11 stated on 1/7/25 the unit had 45 residents and only 3 CNAs working. On 1/6/25 at 11:07 AM, V3 (CNA) and V4 (CNA) both stated two staff called off on their unit which caused both of the CNAs to have 15 residents each which was more than usual.