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	04/15/2025

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 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** 33330 Based on observation, interview, and record review, the facility failed to ensure residents receive showers as shown on the facility's shower schedule, and failed to ensure residents receive assistance with shaving and fingernail care. This applies to 4 of 4 residents (R1, R2, R3, and R4) reviewed for ADL (Activities of Daily Living) assistance in the sample of 4. The findings include: 1. On April 10, 2025 at 9:17 AM, R1 was lying in bed in his room. No sign was present to show R1 was in isolation. R1 had beard growth approximately 1/4 inch to 1/2 inch long, and long fingernails. R1's scalp hair had copious amounts of white flakes present. R1's hands were severely contracted and R1 said he is unable to perform personal care due to his contracted hands and paralysis. R1 said he does not like having long facial hair or fingernails. R1 also said he does not like receiving bed baths and he prefers to receive showers. R1 continued to say that since the facility moved him to a different room in March 2025, the level of care he has been receiving has been different and he has not been receiving showers, which he prefers. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 left the facility against medical advice on August 28, 2023. R1 was readmitted to the facility on [DATE] with multiple diagnoses including, displaced fracture of the first cervical vertebrae, functional quadriplegia, hallucinations, paresthesia of skin, major depressive disorder, UTI (Urinary Tract Infection), abnormal posture, need for assistance with personal care, hypertension, migraines, Covid-19, history of falling, nicotine dependence, morbid obesity, seborrheic dermatitis, COPD (Chronic Obstructive Pulmonary Disease), encephalopathy, and spinal cord injury. R1's MDS (Minimum Data Set) dated February 28, 2025 shows R1 is cognitively intact, dependent on facility staff for all ADLs including showering, has an indwelling urinary catheter, and is always incontinent of stool. R1's care plan for ADL self-care performance deficit, initiated on December 4, 2024 shows multiple interventions initiated on December 4, 2024 including, Bathing: Requires 2 staff participation with bathing. Dependent of 2+ staff for shower transfers using full body mechanical lift machine. Check nail length and trim and clean on bath day and as necessary. (continued on next page)

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	R1's care plan for actual impairment to skin integrity, initiated on December 4, 2024 shows multiple interventions initiated on December 4, 2024 including, Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. The EMR shows the following order for R1 dated March 26, 2025: Strict contact/droplet isolation due to Covid-19 x 10 days. All services to be provided in room. The EMR shows the following order for R1 dated April 7, 2025: Covid isolation discontinued. The facility's shower schedule shows R1 should receive a shower on Tuesdays during the afternoon (PM) shift (2:00 PM to 10:00 PM), and on Fridays during the day shift (6:00 AM to 2:00 PM). Based on the shower schedules provided by the facility, R1 should have received showers on March 4, 7, 11, 14, 18, 21, 25, and 28, 2025, and April 1, 4, and 8, 2025. R1's shower sheets show R1 received a bed bath on March 4, and 27, 2025. On March 11, and 18, 2025, V15 (CNA-Certified Nursing Assistant) documented R1 received a shower bath. R1's shower sheet dated March 28, 2025 shows R1 received a bed bath due to being in isolation. The facility does not have documentation to show R1 received his scheduled showers on March 21, 2025, April 1, 4, and 8, 2025, or that R1 refused to receive a bed bath/shower on those days. The facility does not have documentation in POC (Point of Care) to show R1 received a shower/ bed bath during the previous 30 days. On April 10, 2025 at approximately 3:10 PM, V15 (CNA) said when she writes shower bath on a resident's shower sheet, it means she gave a bed bath, not a shower. On April 14, 2025 at 9:47 AM, V2 (DON-Director of Nursing) said residents can still receive a shower if they are in isolation for Covid-19. 2. On April 10, 2025 at 9:15 AM, R2 was lying in bed in the room he shared with R1. No sign was present on R2's door to show R2 was in isolation. R2's breakfast tray was on the bedside table near his bed. The breakfast on the tray was not eaten. R2 said he could not reach his breakfast tray and was waiting for facility staff to set up the breakfast tray near him. R2 said he has not received a bed bath or shower for quite a few days. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, generalized osteoarthritis, unspecified head injury, diabetes, obstructive and reflux uropathy, gastritis, congenital stenosis and stricture of the esophagus, OSA (Obstructive Sleep Apnea), difficulty walking, cognitive communication deficit, repeated falls, weakness, presence of cardiac pacemaker, and heart failure. R2's MDS dated [DATE] shows R2 is cognitively intact, requires supervision with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with toilet hygiene, showering, lower body dressing, bed mobility, and transfers between surfaces. R2 has an indwelling urinary catheter and is always continent of stool. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's care plan for ADL self-care performance deficit, initiated March 24, 2025 shows multiple interventions initiated on March 24, 2025 including, Bathing: [R2] requires substantial/maximal assistance from staff participation with bathing. Provide a sponge bath when a full bath or shower cannot be tolerated. [R2] requires substantial/maximal assistance from staff. The EMR shows the following order for R2 dated March 26, 2025: Strict contact/droplet isolation due to Covid-19 x 10 days. All services to be provided in room. The facility's undated shower schedule shows R2 should receive a shower on Tuesdays during the afternoon shift (2:00 PM to 10:00 PM), and on Fridays during the day shift (6:00 AM to 2:00 PM). Based on the shower schedules provided by the facility, R2 should have received showers on March 25, and 28, 2025 and April 1, 4, and 8, 2025. R2's shower sheets show R2 refused a shower on March 25, and had a bed bath on March 28 and April 1 due to being in isolation. The facility does not have documentation to show R2 received a shower or bed bath on April 4, or 8, 2025, or that R2 refused to receive a bed bath/shower on those days. The facility does not have documentation in POC to show R2 received a shower/bed bath since he was admitted to the facility on [DATE]. 3. On April 14, 2025 at 10:18 AM, R3 was lying in bed in his room. R3 had long fingernails. R3 had a dark substance underneath his fingernails. R3 said, They don't give you a shower twice a week. The EMR shows R3 was admitted to the facility on [DATE]. The EMR continues to show R3 was transferred to the local hospital on February 9, 2025 and returned to the facility on [DATE]. R3 has multiple diagnoses including left femur fracture, COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation, PVD (Peripheral Vascular Disease), anxiety disorder, diabetes, acute kidney failure, heart failure, chronic pain, depression, unsteadiness on feet, altered mental status, metabolic encephalopathy, and DVT (Deep Vein Thrombosis) of the left lower extremity. R3's MDS dated [DATE] shows R3 has moderate cognitive impairment, requires setup assistance with eating, partial/moderate assistance with oral and personal hygiene, substantial/maximal assistance with lower body dressing, and is dependent on facility staff for toilet hygiene, showering, bed mobility, and transfers between surfaces. R3 is occasionally incontinent of bowel and bladder. R3's care plan for ADL self-care performance deficit, initiated on November 3, 2024 shows multiple interventions initiated on November 3, 2024, including, Bathing: Requires 2 staff participation with bathing. Dependent of 2+ staff for shower transfers using full body lift machine. Bathing: Provide with a sponge bath when a full bath or shower cannot be tolerated. R3's care plan for actual impairment to skin integrity, revised on February 17, 2025 shows multiple interventions initiated on November 2, 2024 including, Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated shower schedule shows R3 should receive a shower on Wednesdays during the day shift (6:00 AM to 2:00 PM), and on Saturdays during the afternoon shift (2:00 PM to 10:00 PM). Based on the shower schedules provided by the facility, R3 should have received showers on March 19, 22, 26, and 29, 2025 and April 2, 5, and 9, 2025. R3's shower sheets show R3 refused to be showered on March 26, 2025. The facility does not have documentation to show R3 received a shower or bed bath on March 22, and 29, 2025 and April 2, and 9, 2025 or that R3 refused a shower/bed bath on those days. The facility does not have documentation in POC to show R3 received a shower/bed bath during the previous 30 days. 4. On April 10, 2025 at 3:25 PM, R4 was sitting up in a high-back wheelchair. R4 was unable to answer questions due to his cognitive status and medical condition. The EMR shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, encephalopathy, UTI (Urinary Tract Infection), diabetes, pleural effusion, chronic Hepatitis C, Alzheimer's disease, gastrostomy tube, dementia, glaucoma, dysphagia, heart disease, history of kidney and prostate cancer, delirium, absence of kidney, and weakness. R4's MDS dated [DATE] shows R4 has moderate cognitive impairment and is dependent on facility staff for all ADLs. R4 has an indwelling urinary catheter and is always incontinent of stool. R4's care plans were reviewed. R4's care plan for ADL Self-care performance deficit, initiated on March 7, 2025 shows multiple interventions dated March 7, 2025 including, [R4] is totally dependent on 2 staff to provide a bath and as necessary, and provide with a sponge bath when a full bath or shower cannot be tolerated. [R4] is dependent from staff. The facility's undated shower schedule shows R4 should receive a shower on Mondays during the day shift (6:00 AM to 2:00 PM), and Thursdays during the afternoon shift (2:00 PM to 10:00 PM). Based on the shower schedules provided by the facility, R4 should have received showers on March 10, 13, 17, 20, 24, 27, and 31, 2025 and April 3, and 7, 2025. The shower sheets show R4 received bed baths on March 17, 20, 24, and April 3, 2025. The facility does not have documentation to show R4 received showers/bed baths on March 10, 13, 27, and 31, 2025 and April 7, 2025 or that R4 refused to receive a shower/bed bath on any of those days. The facility does not have documentation in POC to show R4 received a shower/bed bath during the previous 30 days. On April 10, 2025 at 10:57 AM, V5 (RN/WCN-Registered Nurse/Wound Care Nurse) said, When the CNA gives a shower, they fill out the shower sheet. If the resident has an open wound, then the nurse goes to the room and assesses the resident right away and will let me know. Either they bring me the shower sheets, or I pick them up every day. V5 continued to say the shower sheets she provided were the most up-to-date shower sheets she had and there were no outstanding shower sheets. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated shower schedules for residents residing on the floor where R1, R2, R3, and R4 reside show daily shower assignments based on the resident's room number. The shower schedule shows each resident has a day of the week and a shift when the resident should be showered. Each resident room shows two different days of the week when showers should take place. The shower schedules show: 1. Shave your residents including females when appropriate. 2. Remember to fill out the shower sheet and report any findings to nurse for the nurse to assess. 3. Please report any refusal in the beginning of the shift to your supervisor as showers need to be done 2 times a week. Please remember to also chart in POC. The facility's undated policy entitled, Shower Policy and Procedure shows, Policy: It is the policy of this facility that all residents be bathed and groomed appropriately on a regular basis. Purpose: To establish a mechanism for ensuring that residents receive baths/showers on a routine basis. To ensure that nursing is notified of residents who refuse showers, and to establish a mechanism for ensuring that residents who refuse showers are offered a shower the next shift/following day. Procedure: 1. A schedule of showers for each room/resident has been established to ensure that each resident receives at least one shower on the day shift and one on the PM shift per week.3. When showers are given, the staff giving the resident the shower/bed bath will document on the Point of Care that shower was given; refusals will also be documented on the Point of Care by the staff who attempted to provide the shower. 4. If a resident refuses a shower, the nurse on the unit will be notified and the following shift will attempt to give the resident his/her shower. 5. Should the resident continue to refuse showers; the Director of Nursing/Designee will visit the resident and attempt to intervene to determine reason for refusal and to provide resident education about importance of person hygiene. 6. In the event the resident continues to refuse showers/bed baths, the POA (Power of Attorney) will be notified, and his/her assistance will be requested to encourage the resident to take his/her shower/bed bath. 7. Continued refusal of showers will be documented on Point of Care and a care plan will be developed to address resident refusal.