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	07/11/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement safety interventions and provide supervision to prevent two residents from injury. These failures resulted in R2 sustaining a laceration and a displaced bilateral nasal bone fracture and acute fracture of the bony nasal septum and R3 sustaining a head laceration requiring 5 staples and being admitted to the hospital. This applies to 2 of 6 residents (R2 and R3) reviewed for falls in a sample of 12. The findings include:1.R2's records showed that she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses including dementia, psychosis, restlessness and agitation. R2's record showed that on 5/29/25, R2 fell from her bed. R2's 5/29/25 FRI (Facility Reported Incident) to the Illinois Department of Public Health showed that V5 CNA (Certified Nurse's Assistant) reported that she removed the floor mats and began providing ADL (activities of daily living) care to R2. During care, V5 realized she did not have all the necessary supplies. V5 turned towards the dresser to retrieve the remaining items, the resident fell from the bed and struck her face on the floor. R2 was taken to the local community hospital. R2's 5/29/25 hospital records showed that R2 sustained a laceration to her forehead and acute mild displaced bilateral nasal bone fracture and acute fracture of the bony nasal septum with leftward bowing. R2's 5/29/25 progress notes showed that R2 returned to the facility with sutures (number of sutures not indicated) in place to be removed in 7 days. R2's 10/18/24 care plan showed a focus on high risk for falls/injury/trauma with interventions including provided with high/low bed with floor mattress to further meet resident's safety needs.On 6/25/25 at 2:57 pm V5 said that she was providing care for R2, and she had removed the mat from the side of R2's bed, had R2's bed in a high position and then took 1 or 2 steps away from R2's bed to get wipes and a brief off the dresser. V5 said that she had her back turned away from R2 when R2 fell off the bed and hit the floor. V5 said that she saw blood and went and got the nurse. V5 said that R2 was awake at the time and that R2 has a tendency of trying to get out of the bed and falling.On 6/25/25 at 1:58 pm V9 NP (Nurse Practitioner) said that R2's laceration and nasal fracture was caused by the staff not putting the mat back next to the bed and putting bed rails up before walking away from the resident. V9 said by V5 not having the safety measures in place it caused R2 to fall causing a laceration and fractured nose.On 6/27/25 at 4:15 pm V1 (Administrator) said that V5 should have gotten the wipes and briefs before attempting to provide incontinence care for R2. V1 said that V5 should have lowered the bed and put the mats back in place and made sure the bed rails were up before she stepped away to get the needed items. V1 said that when R2 fell out of the bed it caused a fracture to her nose and a laceration. V1 said that R2 has a history of falling and attempting to get out of the bed causing falls. V1 said that staff should have been monitoring her even closer knowing she had the behaviors of attempting to get out of bed. V1 said that if V5 had put all those interventions in place, it could have prevented R2 from falling.On 6/27/25 at 1:34 pm V2 (Assistant Director of Nursing) said that when R2 fell on 5/29/25 the fall caused a nasal fracture to R2. V2 said that V5 should have brought the items to provide care before starting. V2 said that V5 should not have walked away, leaving the bed in a high position, the bed rails not up, and not putting the mats back. V2 said if those safety precautions were in place, V5 would have been proactive and that would have kept R2 safe and kept her from falling.2. R3's electronic health records showed that he is a [AGE] year-old male admitted to the facility with diagnoses including Parkinson's disease, dementia, restlessness, agitation, and history of falls. R3's 6/14/25 FRI Final report that was sent to the Illinois Department of Public Health showed that on 6/14/25 around 7:30 PM R3 was being pushed in his wheelchair when he fell forward out of his wheelchair hitting his head on the floor and sustained a laceration to his forehead. R3 was sent to the hospital and admitted to the hospital. R3 received five staples to his forehead from the laceration. R3's 6/14/25 hospital report shows that on 6/14/25 R3 was being pushed in a wheelchair by staff when R3 caught his foot on the floor and fell forward out of the wheelchair, hitting the front of his head on the ground. R3 sustained a large laceration to the frontal scalp and was admitted to the hospital. R3's 6/15/25 5:43 pm progress note showed that R3 returned to the facility with five staples to his forehead. R3's 6/14/25 care plan showed R3 had a risk for falls related to Parkinson's disease, dementia with agitation, anxiety, confusion and a history of falls. R3's intervention's included anticipate resident's needs, resident needs a safe environment with even floors, and staff to recline high back chair when moving resident and ensure proper positioning in chair.On 6/25/25 at 2:46 PM V7 CNA (Certified Nurse's Assistant) said that she was the CNA for R3 on 6/14/25 and she had asked V3 CNA to help her transfer R3 to bed. V7 said that V3 was pushing R3 in his