

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Manor - Naperville		STREET ADDRESS, CITY, STATE, ZIP CODE 720 Raymond Drive Naperville, IL 60563	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on observation, interview, and record review, the facility failed to assess and obtain treatment orders for a resident with a known surgical wound.</p> <p>This applies to 1 of 3 residents (R1) reviewed for quality of care.</p> <p>The findings include:</p> <p>R1's EMR (Electronic Medical Record) showed a readmitted [DATE]. R1's EMR showed R1 had multiple diagnoses including left gluteal abscess, urinary tract infection, right arm deep vein thrombosis, metabolic encephalopathy, vascular dementia, morbid obesity, and malnutrition. R1's MDS (Minimum Data Set) dated 7/03/2024 showed R1 was incontinent of bowel and bladder and required substantial to maximal staff assistance with toileting hygiene.</p> <p>On 8/09/2024 at 12:30 PM, V10 (Certified Nurse Assistant/CNA) and V11 (Restorative Aide) were providing care to R1 and were asked to check R1's skin. V10 said R1 was readmitted with a wound to her left inner groin area that was not covered. R1 had an exposed open tunneling wound to her left inner gluteal fold area. R1's wound bed had 100% granular tissue with serosanguineous drainage. Then V9 (Wound Care Nurse/WCN) came to assist with R1's skin check. V9 said she was notified on 8/06/2024 that R1 was readmitted on [DATE] with an abscess wound to her left inner groin area that was surgically drained at the hospital. V9 said R1 had a dressing covering the wound during her readmission which was not removed. V9 continued to say R1's wound had not yet been assessed and R1 did not have treatment orders in place. V9 proceeded to clean R1's wound with wound cleanser then packed the wound with an iodoform packing strip dressing and covered it with a dry dressing.</p> <p>On 8/09/2024 at 2:47 PM, V7 (Nursing Unit Manager) said the facility was informed by the hospital of R1's left groin abscess wound during her readmission. V7 said she performed a skin check on R1 on 8/05/2024 and noticed a dressing in R1's left groin area. V7 said she did not assess nor contact R1's physician to obtain treatment orders for R1's wound. V7 said she notified V9 (WCN) of R1's surgical wound dressing on 8/06/2024.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's hospital document titled Report of Inpatient Wound Care Consultation dated 8/05/2024 showed R1 had a left gluteal fold abscess wound that was surgically drained on 8/01/2024. The report showed R1's wound was assessed and measured 1 cm (centimeter) in length, 0.5 cm in width, 1 cm in depth, and had tunneling at 12 o'clock which measured 2.2 cm. The report said R1's wound was a full-thickness wound with pink and red granular tissue that had moderate serosanguineous drainage. The report continued to show R1 had discharge wound care orders to cleanse the wound with saline and pack with iodoform packing strip then cover with a foam dressing daily and as needed.</p> <p>R1's Order Summary Report reviewed on 8/09/2024 did not show treatment orders for R1's left gluteal fold wound prior to 8/09/2024.</p> <p>The facility does not have documentation to show R1's left gluteal fold wound was assessed when she was readmitted on [DATE] through 8/09/2024.</p> <p>R1's Wound Assessment Details Report dated 8/12/2024 showed R1's left gluteal fold surgical wound was assessed on 8/12/2024 (during the survey). The report said R1's wound measured 1 cm in length x 0.3 cm in width x 0.5 in depth with undermining between 12 o'clock to 6 o'clock measuring 1 cm. The report said R1's wound had 100% bright pink or red tissue with moderate serosanguineous exudate.</p> <p>R1's care plan reviewed on 8/09/2024 showed R1 was at risk for developing skin breakdown. The care plan showed multiple interventions including Observe skin routinely .and report any possible signs of skin breakdown and/or changes immediately.</p> <p>On 8/05/2024 at 4:00 PM, V2 (Director of Nursing/DON) said nurses are responsible for performing skin assessments, and if an alteration is noted they are expected to contact the physician to obtain treatment orders and refer to the wound care nurse. V2 said she reviewed R1's facility EMR and R1's wound was not assessed nor had treatment orders when she readmitted to the facility.</p> <p>The facility's policy titled Prevention of Pressure Injuries with a revised date of 04/2020 showed Skin Assessment 1. Conduct a comprehensive skin assessment upon (or soon after) admission .3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLS .Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. The facility's policy titled Pressure Injury Risk Assessment with a revision date of 03/2020 showed Steps in the Procedure .4. Conduct a comprehensive skin assessment with every risk assessment . b. Once inspection of the skin is completed document the findings on a facility-approved skin assessment tool. c. If a new alteration is noted, initiated a (pressure or non-pressure) form related to the type of alteration in skin. 5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessment, the condition of the skin, the resident's overall clinical condition .Documentation The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted. 2. The date and time and type of skin care provided, if appropriate .4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified .11. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted. 12. Documentation in medical record addressing MD notification if new skin alteration in skin noted with change of plan of care, if indicated .</p>		