STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145874	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor - Naperville	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to follow their policy to immediately notify a resident's representative when a resident had a change in condition requiring transfer to the local hospital. This applies to 1 of 3 residents (R1) reviewed for change in condition notification in the sample of 6. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on January 2, 2025, and returned to the facility on [DATE]. R1 has multiple diagnoses including, acute encephalopathy due to sepsis, acute respiratory failure with hypoxia, diabetes, multiple sclerosis, paraplegia, major depressive disorder, PVD (Peripheral Vascular Disease), heart disease, idiopathic neuropathy, cognitive communication deficit, dysphagia, severe sepsis with septic shock, pneumonitis due to inhalation of food and vomit, hydronephrosis, Stage 4 pressure ulcer of the sacral region, weakness, dementia, hearing loss, history of falling, and acquired absence of right leg above the knee. R1's MDS (Minimum Data Set) dated November 4, 2024 shows R1 is cognitively intact, is dependent on facility staff for transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder. On January 2, 2025 at 8:37 PM, V3 (LPN-Licensed Practical Nurse) documented R1 had three episodes of vomiting and was clammy, with an elevated heart rate. V3 documented, she notified R1's doctor and family and he was sent to the local hospital at 8:30 PM. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 27, 2025 at 12:05 PM, R1 was lying in bed in his room. V5 (Spouse of R1) was sitting at R1's bedside. V5 said, R1 was sent to the local hospital on January 2, 2025. V5 said, No one called me to tell me my husband (R1) was sent to the hospital. I had no idea. The next morning the hospital calls me and tells me [R1] was being rushed to surgery. I didn't even know he was at the hospital, and I didn't get to see him before he went to surgery. This was very upsetting to both of us. We have been married over [AGE] years, and I would have wanted to be there for him. He ended up with a kidney stone and other problems, and he ended up in intensive care. I was told by [V2] (DON-Director of Nursing) that the nurse called the wrong number when she tried to call me. She used the wrong area code. My number is in the chart. There is no reason for this. They also have his sister's phone number, and our daughter's phone number. Why didn't they try to call someone else if they weren't able to reach me? Instead, they left a message on a total stranger's telephone about my husband. On January 27, 2025 at 11:23 AM, V3 (LPN) said, [R1] was clammy, and his heart rate was elevated. I called the NP (Nurse Practitioner) and she said to send him out to the hospital. I thought I called the family, but I called the wrong area code, so I never spoke to the wife. I did not try to call the wife again. I did not try to call his other emergency contacts. On January 28, 2025 at 12:10 PM, V2 (DON) said, The nurse called the wrong number when [R1] went to the hospital, and never spoke to a family member. She should have kept trying to call the spouse, and if she wasn't able to reach her, then reach out to one of the other two contact numbers we have for his other family members. The wife did call me and tell me she was very upset about not being notified by us. No one wants to hear from the hospital that their family member has been there overnight and is going to surgery when they thought they were here sleeping in their bed. The facility's policy entitled Notification of Change in Condition, Discharge, and Transfer, created October 9, 2021 shows: Policy Statement: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Procedure: 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive): .b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication.d. A decision to transfer or discharge the resident from the facility.

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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 follow their policy to ensure residents received timely incontinence care, showers, oral care, and assistance with shaving. This failure applies to 5 of 6 residents (R1, R2, R3, R5, and R6) reviewed for assistance with ADLs (Activities of Daily Living) in the sample of 6. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on January 2, 2025 and returned to the facility on [DATE]. R1 has multiple diagnoses including, acute encephalopathy due to sepsis, acute respiratory failure with hypoxia, diabetes, multiple sclerosis, paraplegia, major depressive disorder, PVD (Peripheral Vascular Disease), heart disease, idiopathic neuropathy, cognitive communication deficit, dysphagia, severe sepsis with septic shock, pneumonitis due to inhalation of food and vomit, hydronephrosis, Stage 4 pressure ulcer of the sacral region, weakness, dementia, hearing loss, history of falling, and acquired absence of right leg above the knee. R1's MDS (Minimum Data Set) dated November 4, 2024 shows R1 is cognitively intact, is dependent on facility staff for transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder. R1's care plan initiated on February 5, 2020 shows R1 has an ADL Self-care performance deficit due to decreased strength and decreased functional mobility. Care plan interventions, initiated on February 5, 2020 include, Bathing: Resident requires total assistance of 2 people using full lift machine with bathing transfer. Resident requires substantial assistance of 1 person with bathing. Resident requires substantial people to turn and reposition. Resident requires substantial assistance of 1 person with personal hygiene/oral care. Resident requires dependent assistance of 2 people using full lift machine with transfers. On January 27, 2025 at 9:36 AM, R1 was lying in bed. R1 had facial hair stubble, and his teeth had visible debris. On January 27, 2025 at 10:44 AM, R1 was lying in the same position in his bed. V5 (Spouse of R1) was sitting at R1's bedside. V5 said, I came in this morning and shaved him and brushed his teeth. If I don't come in and do it every day, it doesn't get done. He never receives showers anymore, just bed baths. He really enjoys getting showers, and never refuses. R1 appeared clean-shaven. R1 said no facility staff had helped him brush his teeth or shaved him. R1 continued to say he wants to get a shower and does not understand why the facility only gives him bed baths when he prefers showers. On January 27, 2025 at 12:05 PM, R1 was lying in his bed, covered by a top sheet. A large bulge was visible on R1's lower abdomen, through the top sheet of the bed. V5 (Spouse of R1) pulled back the top sheet and showed R1 was wearing an incontinence brief. V5 opened R1's incontinence brief. Inside R1's incontinence brief was a folded bath towel and a second incontinence brief. Loose stool was present between R1's legs and covering his scrotum. The folded bath towel was wet, and a urine odor was present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On January 27, 2025 at 12:31 PM, V7 (CNA-Certified Nursing Assistant) said, I changed [R1's] incontinence brief at 8:00 AM. I have not had time to do it again. There are still people I haven't been able to get to. I have 20 patients to take care of today. No one is getting showers today! We usually shave people during their showers. I did not have time to brush teeth or shave anyone. On January 27, 2025 at 2:21 PM, V5 (Spouse of R1) said, I gave him a bed bath because the CNA said he will not be getting a shower today. If I don't do it, no one else will. The facility's undated Assignment Sheet shows R1 should receive showers on Mondays between 6:00 AM and 2:00 PM, and Fridays between 2:00 PM and 10:00 PM. The facility's Skin Monitoring: Comprehensive CNA Shower Review sheets for R1 show R1 received a bed bath on January 13, 2025, January 15, 2025, and January 24, 2025. The facility does not have documentation to show R1 received his scheduled shower or a bed bath on January 10, 2025, January 17, 2025, or January 20, 2025. The facility does not have documentation to show R1 receives daily oral care. 2. On January 27, 2025 at 11:57 AM, R2 was lying in bed. R2's teeth appeared caked with a black debris. R2 said he had not received oral care by facility staff, nor had facility staff brought him a toothbrush with toothpaste to do his own oral care. R2 said, I can't get out of the bed, so how am I supposed to get toothpaste onto my toothbrush to brush my teeth. The facility does not have documentation to show R2 received oral care by facility staff. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, multiple sclerosis, hypertension, dysphagia, open left leg wound, PVD, weakness, cognitive communication deficit, hydronephrosis, history of falling, right buttock pressure ulcer, and anemia. R2's MDS dated [DATE] shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, substantial/maximal assistance with toilet hygiene, showering, dressing, personal hygiene, and bed mobility, and is dependent on facility staff for transfers between surfaces. R2 has an indwelling urinary catheter and is frequently incontinent of stool. 3. On January 27, 2025 at 12:02 PM, R3 was lying in bed. R3 had long facial hair. R3 said, I need a shave. On January 28, 2025 at 9:31 AM, R3 was lying in bed, fully dressed. R3 continued to have long facial hair and debris in his teeth. The EMR shows R3 was admitted to the facility on [DATE]. The EMR continues to show R3 was transferred to the local hospital on January 2, 2025 with altered mental status and returned to the facility on [DATE]. R3 has multiple diagnoses including metabolic encephalopathy, hemiplegia affecting the left non-dominant side, multiple sclerosis, heart disease, spinal stenosis, anxiety disorder, delirium, major depressive disorder, weakness, muscle disorder, hematuria, restlessness and agitation, epilepsy, and urinary tract infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's MDS dated [DATE] shows R3 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, substantial/maximal assistance with dressing and bed mobility, and is dependent on facility staff for toilet hygiene, showering, and transfers between surfaces. R3 has an indwelling urinary catheter and is frequently incontinent of stool. R3's care plan for ADL self-care performance deficit due to decreased strength, created on February 28, 2020 shows multiple interventions created on February 28, 2020, including, Resident requires dependent of 1 person with bathing. Personal hygiene/oral care: Resident requires substantial of 1 person with personal hygiene. The facility's Assignment Sheet shows R3 should receive showers on Tuesdays between 6:00 AM and 2:00 PM, and Saturdays between 2:00 PM and 10:00 PM. The facility's Skin Monitoring: Comprehensive CNA Shower Review sheets show R3 refused a shower on January 14, 2025 and January 17, 2025. The shower sheets show R3 received a shower on January 24, 2025. The facility does not have documentation to show R3 received his scheduled showers on January 18, 2025 or January 21, 2025. The facility does not have documentation to show R3 received oral care or assistance with shaving. 4. On January 27, 2025 at 9:15 AM, during initial tour of the facility, R5 and R6 were observed with long facial hair. R5 and R6 are male residents. R5 and R6 said they do not like having long facial hair and would like facility staff to assist them with shaving. R5's MDS dated [DATE] shows R5 requires setup assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with bed mobility and transfers between surfaces, and is dependent on facility staff for toilet hygiene, showering, and dressing. R6's MDS dated [DATE] shows R6 is dependent on facility staff for transfers between surfaces and requires substantial/maximal assistance with all other ADLs. On January 28, 2025 at 12:10 PM, V2 (DON-Director of Nursing) said, Showers should be given twice a week. Unless their preference is a bed bath, then the resident should get a shower. [V5] (Spouse of R1) told me in early January that she was upset [R1] wasn't receiving showers. I don't know why he still isn't getting showers. There is no reason for any resident not to get their showers. V2 continued to say no residents should be wearing double briefs or have a bath towel folded inside their incontinence brief and residents should receive incontinence care every two hours. V2 also said there was plenty of staff in the facility on January 27, 2025 to assist V7 (CNA) if she was falling behind with her residents. The facility's policy entitled, Supporting Activities of Daily Living revised March 2018 shows: Policy Statement: 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). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation: .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems). .4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers were repositioned at regular intervals as ordered by the physician, received timely incontinence care, and received wound care treatments to ensure wounds are clean, as ordered by the physician. This failure resulted in delayed healing of R1's facility-acquired pressure ulcer. This failure applies to 2 of 3 residents (R1 and R2) reviewed for pressure ulcers in the sample of 6. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on January 2, 2025 and returned to the facility on [DATE]. R1 has multiple diagnoses including, acute encephalopathy due to sepsis, acute respiratory failure with hypoxia, diabetes, multiple sclerosis, paraplegia, major depressive disorder, PVD (Peripheral Vascular Disease), heart disease, idiopathic neuropathy, cognitive communication deficit, dysphagia, severe sepsis with septic shock, pneumonitis due to inhalation of food and vomit, hydronephrosis, Stage 4 pressure ulcer of the sacral region, weakness, dementia, hearing loss, history of falling, and acquired absence of right leg above the knee. R1's MDS (Minimum Data Set) dated November 4, 2024 shows R1 is cognitively intact, is dependent on facility staff for transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder. R1's pressure ulcer care plan, created on July 11, 2024 shows, Reopened Stage 3 pressure injury on the coccyx with treatment in place and rendered. September 2, 2024: Wound on coccyx is now Stage 4 pressure injury. R1 has multiple care plan interventions, including, Get up in the wheelchair during lunchtime and be back in bed after 2 hours or when requested to go back to bed initiated on September 27, 2024. Turn/reposition resident at regular intervals and as needed initiated on September 28, 2024. On January 27, 2025 at 9:36 AM, R1 was lying in bed. R1 was lying on his back with one pillow behind his head. No other pillows or positioning wedges were visible in R1's room. On January 27, 2025 at 10:44 AM, R1 was lying in the same position in his bed, with one pillow behind his head and no other pillows or positioning wedges in the room. V5 (Spouse of R1) was sitting at R1's bedside. V5 said, she came to the facility around 9:45 AM. V5 said R1 was lying on his back when she arrived, and no facility staff had been in the room to change his position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On January 27, 2025 at 12:05 PM, R1 was lying in his bed, covered by a top sheet. A large bulge was visible on R1's lower abdomen, through the top sheet of the bed. V5 (Spouse of R1) pulled back the top sheet and showed R1 was wearing an incontinence brief. V5 opened R1's incontinence brief. Inside R1's incontinence brief was a folded bath towel and a second incontinence brief. Loose stool was present between R1's legs and covering his scrotum. The folded bath towel was wet, and a urine odor was present. R1 continued to be lying on his back, with one pillow behind his head, and no other pillows or positioning wedges visible in the room. V5 said no facility staff had been in the room to reposition R1 since she arrived at 9:45 AM. On January 27, 2025 at 12:31 PM, R1 remained lying on his back, with one pillow behind his head. V7 (CNA-Certified Nursing Assistant) said, I changed [R1's] incontinence brief at 8:00 AM. I have not had time to do it again. V7 continued to say she had not repositioned R1 since 8:00 AM. V7 was asked if there were additional pillows or positioning wedges for R1 and V7 said, What would I need those for? R1 was turned to his left side by V7 (CNA) while V4 (WCN/LPN-Wound Care Nurse/Licensed Practical Nurse) cleaned stool from the area of R1's pressure ulcer and provided wound care to R1's sacral pressure ulcer. A four-inch by 5-inch dressing was covering R1's sacral pressure ulcer. An area approximately 1.5 inches in diameter of dark red drainage was visible on the dressing before the dressing was removed from R1's sacrum. V4 (WCN/LPN) removed the dressing and cleaned the wound with normal saline. The wound appeared to be approximately two inches in diameter. V4 was able to insert her gloved fingers approximately 1.5 inches into the wound and demonstrated the area of the wound where tunneling was present. V4 packed the wound with two calcium alginate/silver foam dressings, and then covered the wound with a four-inch by 5-inch dressing. V4 said R1 should be getting up to the chair every day and should be turned at regular intervals. V4 continued to say if R1 was in the same position since 8:00 AM, he was not being repositioned often enough. V4 said the pressure ulcer was identified on July 11, 2024 as an unstageable pressure ulcer and is now a Stage 4 pressure ulcer. V4 also said R1's pressure ulcer was assessed by V6 (Wound Care NP-Nurse Practitioner) at approximately 8:00 AM that same day and the wound measurements were 5.1 cm. (centimeters) long by 3.1 cm. wide by 3.6 cm. deep, with tunneling from 11 o'clock to 5 o'clock at a depth of 6. 3 cm. On January 28, 2025 at 10:48 AM, V10 (Physician) documented, Sacrum and Coccyx: Stage 4 pressure injury to coccyx. Wound measures as 5.1 cm. by 3.1 cm. by 3.6 cm. with 6.3 cm. undermining from 12 o'clock to 5 o'clock. Wound with 100 percent granulation tissue. Moderate serosanguineous exudate. Deteriorated surface area. Due to patient's multiple comorbidities, patient is at high risk for developing new and worsening wounds. To reduce risk for developing new and/or worsening wounds, recommend turning repositioning to relieve pressure on areas at risk and to maintain general skin integrity. Recommend to offload bilateral heels at all times. Case discussed with the members of wound care team. We will re-evaluate patient during the next visit. Patient seen and examined during wound rounds today. Case discussed with [V6] (Wound Care NP). Agree with documentation and plan as outlined. The EMR shows the following order for R1 dated November 4, 2024 and discontinued on December 16, 2024: Dakin's (1/4 strength) External solution (antiseptic solution). Apply to coccyx topically two times a day for wound care. Cleanse with normal saline, pat dry. Loosely pack soaked roll gauze to 1/4 strength of Dakin's solution and cover with dry dressing. R1's TAR (Treatment Administration Record) shows R1's wound care was scheduled at 5:00 AM and 5:00 PM daily. The facility does not have documentation to show R1 received the wound care treatment as ordered by the physician on the following dates and times: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	November 7, 2024 5:00 PM November 8, 2024 5:00 AM, 5:00 PM November 9, 2024 5:00 AM November 11, 2024 5:00 AM, 5:00 PM November 15, 2024 5:00 PM November 16, 2024 5:00 AM, 5:00 PM November 17, 2024 5:00 PM November 18, 2024 5:00 AM November 21, 2024 5:00 PM November 22, 2024 5:00 AM November 23, 2024 5:00 PM November 24, 2024 5:00 AM, 5:00 PM November 25, 2024 5:00 PM November 26, 2024 5:00 PM November 27, 2024 5:00 PM November 28, 2024 5:00 PM November 29, 2024 5:00 AM November 30, 2024 5:00 AM, 5:00 PM December 4, 2024 5:00 PM December 5, 2024 5:00 PM December 6, 2024 5:00 AM, 5:00 PM December 8, 2024 5:00 AM, 5:00 PM December 9, 2024 5:00 PM December 11, 2024 5:00 PM (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	December 13, 2024 5:00 PM December 14, 2024 5:00 AM The EMR shows the following order for R1 dated December 17, 2024 and discontinued on January 3, 2025: Dakin's (1/4 strength) External Solution. Apply to coccyx topically every day shift for wound care. Cleanse with 1/4 strength Dakin's solution, pat dry and apply alginate Ag and cover with dry dressing. The facility does not have documentation to show R1 received the wound care treatment as ordered by the physician on December 21, 28, and 31, 2024. The EMR shows the following order for R1 dated January 11, 2025: Coccyx cleanse with normal saline, pat dry. Loosely pack silver alginate to wound and cover with dry dressing every day shift for wound care. The facility does not have documentation to show R1 received the wound care treatment as ordered by the physician on January 18, 19, and 26, 2025. 2. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, multiple sclerosis, hypertension, dysphagia, open left leg wound, PVD (Peripheral Vascular Disease), weakness, cognitive communication deficit, hydronephrosis, history of falling, right buttock pressure ulcer, and anemia. R2's MDS dated [DATE] shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, substantial/maximal assistance with toilet hygiene, showering, dressing, personal hygiene, and bed mobility, and is dependent on facility staff for transfers between surfaces. R2 has an indwelling urinary catheter and is frequently incontinent of stool. R2's care plan created on September 23, 2022 shows, Resident developed unstageable pressure injury on the sacrum. R2's care plan was revised on October 14, 2024 to show, 10/14/2024 sacrum extending to right buttock Stage 4 pressure injury. R2's care plan shows multiple interventions created on September 23, 2022 including, Treatment done per M.D. orders. On January 27, 2025 at 11:57 AM, R2 was lying in bed in his room. R2 did not wish to be interviewed regarding his wound care treatments. On January 27, 2025, V10 (Wound Care Physician) documented, Sacrum and coccyx: Wounds to coccyx and right buttock are now coalesced into one contiguous wound. Stage 4 pressure injury to coccyx extending to right buttock. Reopened. Wound measures as 1 x 0.6 x 0.1 cm. with 100 percent granulation tissue. Scant serous exudate. Deteriorated surface area. The EMR shows the following order for R2 dated November 12, 2024, and discontinued on December 9, 2024: Sacrum, extending to right buttock. Cleanse with normal saline, pat dry. Apply alginate then cover with foam dressing. Apply triad to periwound every day shift for wound care. The facility does not have documentation to show R2 received the wound care treatment as ordered by the physician on December 7 or 8, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145874	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor - Naperville	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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The EMR shows the following order for R2 dated December 10, 2024 and discontinued on January 6, 2025: Sacrum extending to right buttock. Cleanse with normal saline, pat dry. Apply silver alginate then cover with foam dressing. Apply triad to periwound every day shift for wound care. The facility does not have documentation to show R2 received the wound care treatment as ordered by the physician on December 21, 22, 28, 29, 30, and 31, 2024, and January 4 and 5, 2025. The EMR shows the following order for R2 dated January 14, 2025: Sacrum extending to right buttock. Cleanse with normal saline, pat dry. Apply alginate and cover with foam dressing every day shift for wound care. The facility does not have documentation to show R2 received the wound care treatment as ordered by the physician on January 18, 19, and 26, 2025. On January 27, 2025 at 1:42 PM, V6 (Wound Care NP) said she assesses the residents with pressure ulcers every Monday and provides her notes to V10 (Wound Care Physician). V10 then provides written notes to the facility of V6's examination. V6 (Wound Care NP) said, I expect the facility staff to provide the wound care treatments as ordered, and as needed with incontinence episodes. The wounds need to be kept clean. [R1] needs to be turned at regular intervals, based on his tolerance. Four or five hours in the same position is too long for him. I was not aware he was missing wound treatments, not receiving timely incontinence care, and not being repositioned. All those failures are contributing factors as to why his pressure ulcer isn't healing. On January 28, 2025 at 12:10 PM, V2 (DON-Director of Nursing) said, The standard of care is to reposition residents every two hours. No resident should be lying in the same position for hours at a time. No resident should be wearing two briefs or not receiving timely incontinence care. Residents should get their wound care treatments as ordered by the physician. I was not aware we were having a problem with that. [V6] (Wound Care NP) sees the residents every week and submits a report to me. [V10] (Wound Care Physician) submits his progress notes to us for downloading into the medical record, but [V6] is the one who actually sees the residents. The wound care IDT (Interdisciplinary Team) has fallen by the wayside. We have not been meeting about pressure ulcers. The facility's policy entitled Prevention of Pressure Injuries, revised April 2020 shows: Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Mobility/Repositioning: 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident's risk factors and current clinical guidelines. The facility's policy entitled Wound Care, revised October 2010 shows: Purpose: the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure . Documentation: The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition.8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the wound care .