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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor - Naperville	720 Raymond Drive Naperville, IL 60563

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate and report an allegation of financial abuse by a family member. This applies to 1 out of 3 residents (R4) reviewed for financial abuse. The findings include: On 6/30/2025 at 1:10 PM, R4 was fatigued in bed. R4 at times during the interview became frustrated and showed signs of impaired memory. R4 said V8 (Family Member) had stolen his money from his bank account. R4 was unable to provide details of when it occurred and how much money he believed was stolen. R4 said after the alleged incident, he made sure V8 no longer had access to his bank account. R4 said he also removed V8 from his financial power of attorney (POA). On 6/30/2025 at 3 PM, V5 (Nurse Practitioner/NP) said R4 had recently started to decline physically and cognitively. V5 said R4's cognition was impaired and unable to make decisions on his own now. On 6/30/2025 at 10:45 AM, V2 (Director of Nursing/DON) said on 4/23/2025, V7 (R4's Family Member) called the facility, alleging R4 informed her V8 was stealing from his bank account. V2 said she informed V3 (Social Services/SS). On 6/30/2025 at 10:25 AM, V28 (Business of Manager) said V8 (Family Member) had contacted the facility on 6/30/2025, requesting assistance in obtaining a new financial POA because she was informed by R4's bank that it was invalid. On 6/30/2025 at 2:30 PM, V3 (SS) said residents were assessed for their risk for abuse and care plans are updated. V3 said she followed up with R4 on 4/25/2025, and he verbally revoked his financial POA from V8. On 6/30/2025 at 2 PM, V1 (Administrator) said he was the facility abuse coordinator. V1 said he was aware of V7's financial abuse allegation involving R4. V1 said he did not report or further investigate the allegation because he believed it was a misunderstanding on R4's behalf. R4's care plan initiated on 6/18/2024, said he was at risk for abuse. The care plan had multiple interventions, including Report issues pertaining to potential abuse/neglect situations per policy. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's progress note dated 4/23/2025 said Received a call from [V7] .indicated that her father has indicated that his current wife/POA along with his daughter [daughter] have been stealing his money from his bank account. The facility did not have any abuse allegation/investigation Illinois Department of Public Health eportable incident for R4's allegation of financial abuse by his family member from 4/23/2025. The facility's policy titled Abuse Prevention Program undated, said This facility desires to prevent abuse, neglect, exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Concern Identification and Follow-up: Resident and family concerns will be recorded, reviewed, addressed, and responded .Internal Reporting Requirements and Identification of Allegations .Protection of Residents .Internal Investigation 1. Incidents will be reviewed, investigated, and documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected .External Reporting .Public health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure the pressure ulcer intervention of a pressure-relieving mattress was working for a resident with known multiple pressure wounds. This applies to 1 out of 3 residents (R4) reviewed for pressure wounds. The findings include: On 6/29/2025 at 9:45 AM, R4 said he had pain all over his back. R4 was in bed on an air-loss mattress, with a beeping alarm. V20 (Certified Nurse Assistant) turned R4 in bed, and R4 was lying on two overlapping cloth pads and a sheet, which were bunched up together. V25 (Wound Care Nurse/WCN) said R4 was recently readmitted with multiple pressure wounds and required the use of an air-loss mattress. V25 changed R4's dressing to his left posterior lower leg vascular wound and pressure wounds to his bilateral mid buttock, coccyx, and right lateral buttock. At 10:15 AM, V20 and V25 finished providing care to R4's wounds. The beeping alarm on R4's mattress continued and the mattress was not inflated because the mattress was disconnected from the pump. V25 said she believed R4's mattress was working properly. On 6/30/2025 at 1:20 PM, V24 (WCN) said R4 had a facility-acquired deep tissue injury to his left buttock that was new. V24 said R4 had a history of non-compliance with skin management and required the use of an air-loss mattress to assist in relieving pressure. V24 said staff was expected to respond and troubleshoot medical equipment alarms, including air-loss mattresses to prevent bottoming out. R4's skin care plan initiated on 6/18/2025 said R4 was at risk for developing further skin breakdown. The care plan included multiple interventions, including Pressure reducing mattress provided for pressure relief and prevention. R4's Order Summary Report dated 6/30/2025 had an active order for Pressure Reducing Mattress to Bed: Ensure Placement and Functionality. Every shift for Prevention of developing/worsening pressure injury initiated on 6/19/2025. R4's Wound Assessment Details Reports dated 6/29/2025 said R4 had unstageable pressure injuries to bilateral buttocks and coccyx and a deep tissue injury to his right buttock. R4's Wound Assessment Details Report dated 6/30/2025 said R4 had a newly acquired deep tissue pressure injury to his left buttock on 6/30/2025. The wound measured 1.3 centimeters (cm) length x 1 cm width x unknown depth, with 100% deep maroon tissue. On 6/30/2025 at 4:30 PM, V2 (Director of Nursing/DON) said the facility did not have a specific policy regarding air-loss mattresses. The facility's policy titled Prevention of Pressure Injuries dated 04/2020, said The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors .Provide support devices and assistance as needed .

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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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a diabetic resident's feet were monitored to prevent complications. This failure resulted in the resident acquiring a necrotic diabetic ulcer on her left heel. This applies to 1 out of 3 residents (R5) reviewed for foot care. The findings include: R5's EMR (Electronic Medical Record) showed R5 was admitted to the facility on [DATE] with multiple diagnoses, including hemiplegia and hemiparesis following cerebral infarction, diabetes, stenosis, and vascular disease. R5's EMR said she was dependent on staff assistance with her mobility and hygiene care, and at risk for developing ulcers. On 6/30/2025 at 9 AM, V24 (Wound Care Nurse/WCN) changed R5's left heel wound dressing. R5's wound was open with serosanguinous drainage. V24 said R5's diabetic wound was acquired on 3/31/2025, and now required an outpatient vascular consultation for possible vascular surgical intervention because of her wound. V24 said nursing staff was expected to perform and document routine resident skin checks, including their feet. V24 said CNAs (Certified Nurse Assistants) were also expected to check residents' skin daily when providing care and report changes such as redness or discoloration. V24 said R5's heel wound was acquired with 100% hard eschar (necrotic) tissue measuring 4.5 centimeters (cm) x 4.5 cm x depth unknown. V24 said R5's wound should have been identified prior to becoming necrotic or at a smaller size. On 6/30/2025 at 3:25 PM, V10 (Nurse) said on 3/28/2025 she assessed R5's heel. V10 said R5's heel did not appear normal because it had a hard, black wound. V10 said R5 was new to the unit, and it was unclear when she acquired the wound. V10 said CNAs were expected to complete skin checks during routine care and report any changes to prevent skin complications. On 7/01/2025 at 12 PM, V6 (Podiatrist) said her team provided routine foot care services and facility foot care recommendations. V6 said residents with diabetes and vascular disease were at a higher risk for skin deterioration to pressure point areas because of their impaired circulation and sensation. V6 said facility staff was required to check skin routinely and report any changes to the providers because residents with these comorbidities were at a higher risk for accelerated skin deterioration and complications. R5's care plan initiated on 10/29/2024, said she was at risk for developing skin breakdown due to her immobility, diabetes, impaired circulation, and altered neurological status. R5's care plan included multiple skin monitoring preventions including Inspect foot/ankle/calf skin per facility protocol/as provider orders for changes; maceration (white, wrinkly, moist), redness, purple tinge, blue, rust coloring, weeping, edema, puffiness, tenderness, area with no sensation. R5's podiatry consult note dated 3/04/2025 said R5's skin on her feet was noted dry. The consultation included general foot hygiene recommendations, including daily look for swelling in the feet and ankles, use lotion daily, and reviewed the importance of getting regular foot care. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	R5's new skin condition note dated 3/28/2025 said R5's left heel was noted with hard, dry discoloration and swelling. R5's daily skin monitoring log from 3/01/2025-3/31/2025 showed no skin alterations were observed on her feet. R5's Skin Monitoring: Comprehensive CNA Shower Review sheets provided by the facility, dated 3/17/2025, 3/21/2025, and 3/24/2025, showed no skin alterations were observed. R5's Wound Assessment Details Report dated 3/31/2025 said R5 was at high risk for skin breakdown and had a newly acquired diabetic ulcer to her left heel. The report said the wound measured 4.5 cm length x 4.5 cm width x unknown depth, with 100% necrotic, hard, firm adherent tissue. R5's Wound Assessment Details Report dated 6/24/2025 said R5's left heel wound now measured 4.5 x 4 x 1.5 cm with 50% bright beefy red and 50% necrotic soft adherent tissue. The facility's policy titled Foot Care dated 03/2018, said Residents will receive appropriate care and treatment in order to maintain mobility and foot health. Policy Interpretation and Implementation 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care will include the care and treatment of medical conditions associated with foot complications (e.g., diabetes, peripheral vascular disease, etc.). The facility's policy titled Prevention of Pressure Injuries dated 04/2020, said Skin Assessment .2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels .). Monitoring 1. Evaluate, report and document potential changes in the skin.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to supervise a resident with high risk for falls. This failure resulted in the resident falling and requiring hospitalization for acute traumatic brain injury, seizures, and altered mental status. This applies to 1 out of 3 residents (R1) reviewed for accidents. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including history of falls, traumatic subdural hemorrhage, hydrocephalus with presence of cerebrospinal fluid drainage device, hallucinations, vascular dementia with moderate agitation, abnormalities of gait and mobility, unsteadiness on feet, difficulty in walking, cognitive deficit, and hearing loss. R1's EMR did not show a history of seizures. R1's MDS (Minimum Data Set) dated 8/22/2024 said R1 was severely cognitively impaired and required staff assistance with transfers. On 6/30/2025 at 3:15 PM, V9 (Nurse) said on 10/23/2024 at 12:30 PM, R1 was observed sitting on the floor in front of his wheelchair in his room. V9 said R1 was at a high risk for falls because he had a known history of falls, was confused, and impulsive. V9 said he assessed and initiated neurological checks for R1 after his unwitnessed fall. V9 said R1's neurological assessment was normal and did not appear to have any injury or change in condition. V9 said staff then assisted R1 into his wheelchair and transported him to the main dining area for lunch, where he was supervised. On 6/30/2025 at 1:50 PM, V2 (Director of Nursing/DON) said R1 was monitored after his fall per protocol, and at 3:15 PM, he was noted with a bump to his head. V2 said V5 (Nurse Practitioner/NP) was updated and gave orders to send R1 to the hospital for further evaluation. V2 said routine paramedics then transferred R1 into the ambulance when he started to have a massive seizure. V2 said the paramedics then contacted the emergency paramedics for additional support, and R1 was transferred to the hospital. V2 said R1 was admitted for altered mental status, seizure, and traumatic brain injury. V2 said the facility felt they could not determine if R1's acute change in medical condition was related to his fall incident because the facility elected to admit R1 into inpatient hospice care and not proceed with additional diagnostic testing. V2 said R1 had a known history of recurrent falls and head trauma with an intracranial bleed. V2 said fall incidents were investigated and fall prevention interventions were implemented in the residents' plan of care. On 6/30/2025 at 3:50 PM, V5 (NP) said she expected facility staff to complete a root cause analysis after a resident's fall to investigate the cause and then implement interventions to prevent reoccurrences. R1's fall care plan report initiated on 3/08/2024 said R1 was at risk for falls related to his confusion, deconditioning, gait and balance problems, poor comprehension, unaware of safety needs, dementia, hallucinations, and recurrent falls. R1's care plan included multiple fall interventions, including conduct rounds, toilet resident and place in dining room, hallways or nurses' station for more visual supervision, and increase supervision in the room. Monitor any attempt of self transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's fall incident reports showed he had 8 unwitnessed falls in his room prior to 10/23/2024. Falls had occurred on 3/12/2024, 4/13/2024, 5/28/2024, 7/17/2024, 8/11/2024, 8/23/2024, 8/23/2024, and 8/30/2024. The fall incident reports showed R1 falls occurred because he was trying to self-transfer in and out of his wheelchair. R1's fall incident report dated 10/23/2024 said R1 had another unwitnessed fall in his room after attempting to stand up from his wheelchair unassisted. The report said R1 was observed at 12:35 PM sitting on the floor facing his wheelchair with his legs flexed and holding on to his wheelchair. The report said after R1's fall assessment, he was then transported to the main dining room for his lunch. The report continued to say at 3:15 PM, a bump was noted to R1's right side of the head, and when being transported by medical paramedics to the hospital, he had a seizure. The report said emergency paramedics were then contacted for additional support, and R1 was transported to the hospital for further management. V17's (R1's assigned Certified Nurse Assistant/CNA) incident statement dated 10/23/2024 said, When the incident happened, I did not witness it happening. I was helping in the dining room with passing trays and feeding residents. V9's (R1's assigned Nurse) incident statement dated 10/23/2024 said, At the time of fall, I was at the nurse's station. Fall not witnessed. R1's hospital notes dated 10/24/2024 said R1 was admitted post-fall with a suspected significant head trauma likely subdural hematoma, acute encephalopathy, seizures, and dilated left pupil and flaccid left side. The note said R1 remained unresponsive and family elected for hospice care. The facility's policy titled Falls and Fall Risk, Managing undated, said Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors(s) of falls for each resident at risk or with a history of falls .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and record review, the facility failed to assist a resident with his social services needs. This applies to 1 out of 3 residents (R4) reviewed for social service needs. The findings include: On 6/30/2025 at 1:10 PM, R4 was fatigued in bed. R4 at times during the interview became frustrated and showed signs of impaired memory. R4 said V8 (Family Member) was no longer his Power of Attorney (POA) for health and finance. R4 said he believed V7 (Family Member) was now his assigned POA for health and finance. On 6/30/2025 at 10:45 AM, V2 (Director of Nursing/DON) said on 4/23/2025, V7 (R4's Family Member) called informing the facility that R4 was seeking legal aid to assist him in revoking his POA and divorce from V8. V2 said she informed V3 (Social Services/SS). On 6/30/2025 at 2:30 PM, V3 (SS) said residents were provided with social services, and if needed outside, referrals were made. V3 said R4 was a long-term care resident at the facility. V3 said she followed up with R4 on 4/25/2025, and he verbally revoked his financial and health POA from V8. V3 said R4 continued to say he wanted to proceed with his divorce and wanted V7 to be his POA. V3 said she believed V7 had POA documents indicating R4's directives. V3 said R4 was informed that it was expected he obtain his POA documents from V7 (who was out-of-state) to provide to the facility and proceed with his divorce on his own. V3 said she was unsure if V26 (Ombudsman) was assisting R4 with his legal aid request. On 6/30/2025 at 3 PM, V5 (Nurse Practitioner/NP) said R4 had recently started to decline physically and cognitively. V5 said R4's cognition was impaired and unable to make decisions on his own now. V5 said R4 was now physically impaired and dependent on staff for his care. On 6/30/2025 at 11:40 AM, V27 (Ombudsman) was called and said no referral was received for R4. R4's progress note dated 4/23/2025 said Received a call from [V7] .wanted to inform the facility that the resident was seeking legal aid to assist him with a divorce and with revoking his current POA for financial and healthcare . The facility's policy titled Social Services dated 10/2010, said Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .Making referrals to social service agencies as necessary or appropriate .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to follow insulin administration instructions for a diabetic resident. As a result of this failure, R4 had an acute episode of hypoglycemia, which required the administration of emergency reversal-medications by emergency paramedics. This applies to 1 out of 3 residents (R4) reviewed for diabetes management. The findings include: On 6/30/2025 at 11:45 AM, V11 (Nurse) said she administered R4's scheduled insulin on 6/17/2025. V11 said insulin was administered based on the order. V11 continued to say that if a resident refuses to eat, they should not receive their fast-acting insulin because their blood sugar would drop. V11 said she believed residents with diabetes required an active order for emergency glucagon for emergency episodes of hypoglycemia. On 6/30/2025 at 12 PM, V18 (Certified Nurse Assistant/CNA) said on 6/17/2025, R4 refused his breakfast and lunch meals. V18 said she was concerned R4's blood sugar would drop and informed the nurse on duty and V18 documented R4's meal refusals. On 6/30/2024 at 11:50 AM, V12 (Nurse) said on 6/17/2025 at approximately 4 PM, he noticed R4 was in a deep sleep, not responding to physical stimuli, and had abnormal breathing. V12 said emergency paramedics were called, and they checked R4's blood sugar. V12 said R4's blood sugar was 22, and they administered emergency intravenous fluids and glucagon. V12 said he was not aware of the facility's hypoglycemic protocol. V12 said if he had been informed of R4's insulin administration and meal refusals, he would have monitored his blood sugar closely. V12 said R4 was transferred to the hospital for further evaluation. On 6/30/2025 at 3 PM, V5 (Nurse Practitioner/NP) said she expected nurses to administer insulin as ordered and use clinical judgment when administering short-acting insulin for residents who refused their meals. V5 said she believed the facility's hypoglycemic protocol was standard of care for diabetic residents. R4's Medication Administration Record (MAR) for June 2025 said on 6/17/2025, R4 was administered Humalog insulin (fast-acting) 2 units at 9 AM and Fiasp insulin (fast-acting) 28 units at 8 AM and 12 PM. The MAR included specific instructions for the administration of Humalog, to administer with meals. R4's nutritional intake log for 6/17/2025 showed R4 refused his breakfast and lunch meals. R4's Order Summary Report dated 6/30/2025 did not have an active order for Glucagon emergency injection for hypoglycemia. R4's diabetic care plan initiated on 6/26/2024 said Monitor/document/report to MD PRN s/sx of hypoglycemia and Diabetes medication as ordered by doctor. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's hospital note dated 6/17/2025 said R4 received treatment for hypoglycemia. The note said, He received insulin this morning and this afternoon. Did not have lunch. Was found to be less responsive later this afternoon. EMS was called he was hypoglycemia with a sugar of 22. Was given glucagon and D10. The facility's document titled Hypoglycemia Protocol undated, said residents needed to be assessed for their level of consciousness, pulse, blood pressure, and respirations. The document provided instructions of nursing inteventions for the management of residents with acute episodes of hypoglycemia. The facility's policy titled Insulin Administration dated 09/2014, said Purpose To provide guidelines for the safe administration of insulin to residents with diabetes .3. The type of insulin, dosage, requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use .Rapid-acting Onset 10-15 min Peak 0.5-3 hrs .