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	09/03/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to provide personal care to a resident with a pressure ulcer. This applies to 1 of 4 (R1) residents reviewed for pressure wounds in a sample of 6. Findings include:On 9/2/25 at 11:48 AM, R1stated she had recently admitted , but had developed a pressure wound on her buttocks and UTI (Urinary Tract Infection) since arriving to the facility. R1 stated the facility is short staffed. R1 stated on a few occasions she had called for incontinence care and left waiting for hours. R1 stated on one occasion she called V8 Family Member requesting he call the nursing station after waiting hours to be provided care. On 9/2/25 at 11:55 AM, V6 CNA (Certified Nursing Assistant) and V13 PT (Physical Therapist) came to R1's bedside for skin and brief observation. R1's undergarment was dry with large streak of dried feces. Dried caked feces were between the gluteal fold. R1's labia and gluteal fold was reddened. R1 had a small open area on her coccyx.On 9/2/25 at 12:32 PM, V6 CNA stated her shift started a 6AM, but she had not provided incontinence care or turned R1 prior to 11:55 AM. V6 stated the wound nurse provided incontinence care and repositioned the resident during the dressing change.On 9/2/25 at 12:42 PM, R1 stated V6 had not provided any incontinence care during her shift and repositioned her at 11:55 with the physical therapist.On 9/2/25 at 3:10 PM, V8 Family Member stated R1 had called him a couple of times with request for him to call nursing station for assistance. V8 stated on one of the calls R1 had complained of being left in soiled brief for over two hours.On 9/2/25 at 3:18 PM, V9 RN (Registered Nurse) stated R1 was on antibiotics for a UTI and had a pressure wound on her coccyx. On 9/2/25 at 4:50 PM, V3 Wound Nurse stated V3 stated R1 is obese and unable to reposition without the assistance of two staff members. R1 is incontinent of bowel and bladder moisture is a contributing factor to skin break down. V3 stated nursing staff is responsible for repositioning and providing incontinence care for R1.On 9/2/25 at 6:17 PM, V1 Administrator stated should not need to call their family members to obtain staff assistance.The facility policy Wound Care Prevention dated April 2025 states, all residents will receive appropriate care to decrease the risk of skin break down. The nursing department will review all new admissions / readmissions to put a plan in place for the prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. Clean skin at time of soiling and at routine intervals.The facility policy Incontinence Care dated April 2025 states, incontinence care is provided to keep residents as dry comfortable and odor free as possible. It also helps in preventing skin breakdown. On 9/2/25 at 11:48 AM, R1stated she had recently admitted , but had developed a pressure wound on her buttocks and UTI (Urinary Tract Infection) since arriving to the facility. R1 stated the facility is short staffed. R1 stated on a few occasions she had called for incontinence care and left waiting for hours. R1 stated on one occasion she called V8 Family Member requesting he call the nursing station after waiting hours to be cleaned up of urine and feces. On 9/2/25 at 11:55 AM, V6 CNA (Certified Nursing Assistant) and V13 PT (Physical Therapist) came to R1's bedside for skin and brief observation. R1's undergarment was dry with large streak of dried feces. Dried caked feces were between the gluteal fold. R1's labia and gluteal fold was reddened. R1 had a small open area on her coccyx.On 9/2/25 at 12:32 PM, V6 CNA stated her shift started a 6AM, but she had not provided incontinence care or turned R1 prior to 11:55 AM. V6 stated the wound nurse provided incontinence care and repositioned the resident during the dressing change.On 9/2/25 at 12:42 PM, R1 stated V6 had not provided any incontinence care during her shift and repositioned her at 11:55 with the physical therapist.On 9/2/25 at 3:10 PM, V8 Family Member stated R1 had called him a couple of times with request for him to call nursing station for assistance. V8 stated on one of the calls R1 had complained of being left in soiled brief for over two hours.On 9/2/25 at 3:18 PM, V9 RN (Registered Nurse) stated R1 was on antibiotics for a UTI and had a pressure wound on her coccyx. V9 did not see any documentation of a pressure wound or UTI prior to or on admission.On 9/2/25 at 4:50 PM, V3 Wound Nurse stated there was no documentation of a coccyx pressure wound on 8/27/25 when R1 was admitted to the facility. V3 stated there was no documentation of a coccyx pressure wound was in R1's hospital discharge records. V3 stated she discovered and documented R1's wounds on 8/29/25 during the skin assessment. V3 stated the coccyx wound measured 2.0 cm (centimeters)x 0.2 cm x 0.2cm. V3 stated R1 is obese and unable to reposition without the assistance of two staff members. R1 is incontinent of bowel and bladder moisture is a contributing factor to skin break down. V3 stated nursing staff is responsible for repositioning and providing incontinence care for R1.On 9/2/25 at 6:17 PM, V1 Administrator stated should not need to call their family members to obtain staff assistance.The facility policy Wound Care Prevention dated April 2025 states, all

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review the facility failed to provide adequate staffing to meet the care needs of residents. Staffing was insufficient to provide residents with assistance with incontinence care, preventing the development of pressure wounds, assisting with care needs, answering the call light and screams for help.This applies to 4 residents R1, R2, R3 and R6 in a sample of 6. Findings include:1.On 9/2/25 at 11:48 AM, R1stated she had recently admitted , and had a pressure wound on her buttocks and UTI (Urinary Tract Infection) since arriving to the facility. R1 stated the facility is short staffed. R1 stated on a few occasions she had called for incontinence care and left waiting for hours. R1 stated on one occasion she called V8 (Family Member) requesting he call the nursing station after waiting hours to be cleaned up of urine and feces. On 9/2/25 at 11:55 AM, V6 (CNA -Certified Nursing Assistant) and V13 (PT -Physical Therapist) came to R1's bedside for skin and brief observation. R1's undergarment was dry with a large streak of dried feces. Dried caked feces were between the gluteal fold. R1's labia and gluteal fold was reddened. R1 had a small open area on her coccyx.On 9/2/25 at 12:32 PM, V6 CNA stated her shift started a 6AM, but she had not provided incontinence care or turned R1 prior to 11:55 AM. V6 stated the wound nurse provided incontinence care and repositioned the resident during her dressing change.On 9/2/25 at 12:42 PM, R1 stated V6 had not provided any incontinence care during her shift and repositioned her at 11:55 with the physical therapist.On 9/2/25 at 3:10 PM, V8 Family Member stated R1 had called a few times with request for him to call nursing station for assistance. V8 stated on one of the calls R1 had complained of being left in soiled brief for over two hours.On 9/2/25 at 3:18 PM, V9 RN (Registered Nurse) stated R1 was on antibiotics for a UTI and had a pressure wound on her coccyx. On 9/2/25 at 6:17 PM, V1 Administrator stated should not need to call their family members to obtain staff assistance.2. On 9/2/25 at 10:50 AM, R2 was screaming for help. The call light was on and visible in the hall. Staff were observed walking past R2's room without addressing the calls for help. R2 stated she vomited earlier in the morning and had continued nausea. R2 also stated her bilateral knee braces were causing her discomfort because they were on too tight, and she wanted them loosened. R1 stated her room was too hot and wanted the temperature decreased. R2 stated she request V5 LPN (Licensed Practical Nurse) for assistance but did not receive it. R2 stated there isn't enough staff to complete the work needing to be done including providing her assistance. R2 stated she had been waiting since before 7AM for nausea and vomiting medication and hadn't gotten anything. During R2's interview staff were observed passing R2's room without addressing her call light.On 9/2/25 at 11:13 AM, V7 CNA (Certified Nursing Assistant) answered R2's call light stating she would let the nurse know a third time about R2's nausea.On 9/2/25 at 11:31 AM, V5 stated R2 complained of nausea not vomiting. V5 stated Ondansetron was ordered for R2's nausea but she had not given her any. On 9/2/25 at 3:26 PM, V10 Nursing Supervisor stated if the CNA reports resident concern to the nurse, the nurse should go to the resident right away or as soon as possible. R2's MDS (Minimum Data Set) dated 6/16/25 shows she is cognitively intact with a BIMS (Brief Interview for Mental Status) Score of 15. The facility policy Call Light Response dated April 2025, states answer the patient or resident's call as soon as possible. Listen to the patient / resident's request.3. On 9/2/25 at 2:58 PM, V12 (Family Member) stated staffing was insufficient and if she didn't visit the facility regularly nothing would get done for R3. V12 stated she arrived at approximately 11:55 AM. R3's undergarment was soaked through her clothing, and the staff didn't come and provide incontinence care until about 1:00 PM. V12 stated that the floor was dirty and R3's laundry hamper was overflowing with urine-soaked clothing.4. On 9/2/25 at 12:16 PM, R6 stated she didn't believe there was enough staff. R6 stated she has been told by staff they are working short of staff. R6 stated it can take ten minutes to three hours for the call light to be answered. R6 stated if staff are feeding other residents she must wait for incontinence care. R6 stated she put her call light on at about 8:30 AM to get dressed and out of bed but was not gotten up until 11AM.On 9/2/25 at 12:07 PM, V7 CNA (Certified Nursing Assistant) stated she sometimes has 17 to 20 residents to care for. V7 stated sometimes she is unable to complete like resident showers. Residents must sometimes wait a long time to have their call light answered. What we don't get done we inform the scheduler, and the task is passed on to the next shift or the next day. Some residents aren't happy when they're not showered when it's scheduled.On 9/2/25 at 3:50 PM, V11 CNA stated when there is a staffing shortage the residents may miss getting showered. If there is staffing shortage and no one picks up it's expected the CNAs working will make up the shortage.On 9/2/25 at 4:26 PM, V4 Scheduler stated if there is a staffing shortage the managers and restorative aids should fill in and assist but