STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146093	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor - Lagrange	339 9th Avenue LA Grange, IL 60525

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on interview and record review the facility failed to ensure resident medications were available for administration for 2 of 3 residents (R3, R4) reviewed for medications in the sample of 4. The findings include: 1. R3's face sheet printed on 6/27/24 showed an admitted [DATE]. The same face sheet showed diagnoses including but not limited to surgical after care following respiratory system surgery, larynx and glottis cancer, tracheostomy, major depression, and anxiety disorder. R3's admission assessment showed no cognitive impairment. On 6/27/24 at 9:44 AM, R3 communicated via handwritten notes, she did not receive her anti-anxiety medication when she arrived at the facility. R3 said she has severe anxiety and missed several doses before anyone finally gave her the medication. R3's progress notes showed a facility arrival day of 6/18/24 at 5:00 PM. R3's June 2024 MAR (Medication Administration Record) showed an order start dated 6/18/24 at 5 PM for bupropion 75 milligrams two times a day for depression and 15 milligrams two times a day for anxiety. The MAR showed an order start dated 6/18/24 at 5 PM for clonazepam 2 milligrams every eight hours as needed for anxiety. The MAR documentation showed the first doses of the medications were not given until 6/19/24. R3's pharmacy proof of delivery receipt showed the clonazepam was delivered on 6/18/24 at 9:56 PM. The receipt showed the bupropion was delivered 6/19/24 at 3:38 AM. On 6/27/24 at 12:33 PM, V2 (Director of Nurses) stated the pharmacy delivers medications two to three times daily. Medication orders can also be verbally called in if they are needed STAT (immediately). Those are delivered within four hours or less. V2 said there can be a lag time between the admission time and getting a prescription from the physician. V2 said there is a convenience box of medications available if something is needed before the four hour delivery time. Nurses should call the physician and then the pharmacy to get a special code to access the convenience box. V2 said it is important to administer medications as ordered to ensure their diagnoses are treated. Medications are important to reduce the problem the resident is having. (continued on next page)

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
	146093	A. Building B. Wing	06/27/2024

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Administering Medication policy date 4/2019 states: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 2. R4's face sheet printed on 6/27/24 showed diagnoses including but not limited to multiple sclerosis and history of femur fracture. R4's facility assessment showed no severe cognitive impairment. On 6/27/24 at 10:50 AM, R4 stated she has been missing her eye medication for the last several days. R4 said the nurse told her yesterday she would look for them. The pharmacy was called and said they had been delivered to the facility, but no one can find them. R4's MAR showed an order start dated 6/22/24 at 9 AM for erythromycin ointment instill 0.5 ribbon in right eye two times a day for infection for 10 days. The MAR showed the ointment was not given on 6/25 and 6/26 at the 5 PM administration. The ointment was not given on 6/27 at the 9 AM administration. A corresponding nurse note dated 6/27/24 at 11:14 AM stated the medication was not available.