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	07/28/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to assess a resident's wound, failed to initiate treatment as ordered by a physician for a resident (R1) that obtained a skin tear. This applies to 1 of 3 residents reviewed for wounds in the sample of 19. The findings include: R1's electronic face sheet printed on 7/28/24 showed R1 has diagnoses including but not limited to heart failure, pressure ulcer of sacral region stage 4, anxiety disorder, major depressive disorder, and dementia with behaviors. R1's facility assessment dated [DATE] showed R1 has mild cognitive impairment and does not have non-pressure wounds. R1's nursing progress notes dated 7/1/24 showed, 7/1/24 Writer alerted by CNA (certified nursing assistant) that resident was being transferred into bed and now has a skin tear. Writer entered resident room and observed a long laceration noted to right leg. Writer assessed area of laceration .resident right leg dressed with pressure dressing physician ordered to send to hospital for evaluation . R1's Wound Assessment Details Report dated 7/5/24 showed, 9x0.1x0.1cm (centimeter) laceration. (This assessment was completed 4 days after R1 sustained a laceration to her right leg). R'1 local hospital records dated 7/2/24 showed, Cleanse wound with wound cleanser, dry, and cover with dry dressing daily .suture removal in 7-10 days. R1's Treatment Administration Record showed R1's treatment was initiated on 7/18/24 (16 days after R1 returned from the hospital). R1's Wound Assessment Details Report dated 7/17/24 showed, Stiches removed. (15 days after R1 returned from the hospital with orders for suture removal to be completed in 7-10 days). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/24 at 3:12PM, V5 (wound care nurse) stated, I just reviewed (R1's) chart and saw that we completely missed the hospital orders for the care of her skin tear as well as the suture removal. I don't know how it got missed because the receiving nurse should be reviewing the discharge orders and entering them into the chart. This is a problem because (R1's) wound could have become infected from lack of care and we could have potentially had difficulty removing her sutures due to the increased length of time they were left in. On 7/28/24 at 3:29PM, V2 (Director of Nursing) stated, I was notified that orders were missed for (R1's) wound care for her skin tear. This is a problem because we increased her risk for infection by leaving the dressing on and not cleaning the area as ordered. This was a large skin tear that should have been treated appropriately. When a resident is admitted or returns from the hospital, the receiving nurse should be reviewing the discharge orders to ensure we are providing the correct care for the residents. There is no reason why this would have been missed. (R1) has a wound and we clearly should have orders for the care of that wound. The facility was unable to provide a policy related to non-pressure wounds as requested.

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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 - Minimal harm or potential for 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** 41639 Based on interview and record review, the facility failed to provide treatment as ordered by a physician for a resident (R1) with a stage 4 pressure ulcer. This applies to 1 of 3 residents reviewed for wounds in the sample of 19. The findings include: R1's electronic face sheet printed on 7/28/24 showed R1 has diagnoses including but not limited to heart failure, pressure ulcer of sacral region stage 4, anxiety disorder, major depressive disorder, and dementia with behaviors. R1's facility assessment dated [DATE] showed R1 has mild cognitive impairment and has 1 stage 4 pressure wound. R1's care plan dated 4/10/24 showed, (R1) has potential for further pressure ulcer development/impaired skin integrity related to decreased mobility and comorbidities. Currently has a stage 4 pressure injury on sacrum. Administer treatments as ordered and monitor for effectiveness. R1's wound physician note dated 4/25/24 showed, Stage 4 pressure injury to sacrum .recommend calcium alginate with dry dressing daily and as needed. R1's treatment administration record for April 2024 showed, Compress Island Dressing 6x6 pads, apply 1 pad, change dressing 3 times weekly. Wash with wound cleanser, betadine pain to open area, apply island dressing. Nurse to reinforce as needed one time a day on Monday, Wednesday, Friday for sacral wound. (This treatment for R1 was initiated on 4/12/24 but was not implemented until 4/26/24 and is not the wound care ordered by R1's wound physician on 4/25/24) R1's wound physician note dated 5/6/24 showed, Stage 4 pressure injury to sacrum .recommend changing to collagen with calcium alginate with dry dressing daily and as needed. R1's treatment administration record for May 2024 showed R1's wound physician order from 5/6/24 was not implemented until 5/28/24 (26 days after it was ordered). R1's treatment administration record for June 2024 showed R1's wound treatments were not completed 6 days out of the entire month with no supporting documentation as to why the treatment was not completed. R1's treatment administration record for July 2024 showed R1's wound treatments were not completed for 8 days out of the entire month with no supporting documentation as to why the treatment was not completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/24 at 3:12PM, V5 (wound care nurse) stated, I can see where the wound physician gave orders for (R1's) sacral wound and they are definitely not the same order that is in her chart. When the wound physician does rounds, one of the members of the wound care team go with him or her and any recommendations are entered into the resident's chart as an order from the wound physician. This is typically a smooth process and there isn't a whole lot of room for error as we are typically with the wound physician as they are giving the recommendations. We can also refer to their note at any time and see the recommendations. If we are not providing the care as ordered by the wound physician, we could potentially delay the wound healing. On 7/28/24 at 3:29PM, V2 (Director of Nursing) stated, All wound care should be provided as ordered by the resident's wound physician or primary physician if they are not followed by the wound physician. I'm not sure how the orders for (R1) got so confusing and messed up. This is definitely a problem that we need to work on, and the managers should be identifying these errors before a surveyor does. The facility's policy titled, Medication Orders dated November 2014 showed, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders .6. Treatment orders- when recording treatment orders, specify the treatment, frequency and duration of the treatment. Example: apply 4x4 dressing with border to stage 1 ulcer on coccyx; change every 3 days and as needed per wound care protocol .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to administer medications at ordered times. There were 31 opportunities with 8 errors resulting in a 25.8% medication error rate. This applies to 5 of 6 residents (R12, R13, R17, R18, R19) observed in the medication pass. 1) R12's electronic face sheet printed on 7/28/24 showed R12 has diagnoses including but not limited to dementia without behaviors, type 2 diabetes, diverticulitis, gastroesophageal reflux disease, major depressive disorder. R12's medication administration record for July 2024 showed R12 receives famotidine 10mg at 8:00AM and memantine 10mg at 8:00AM and 4:00PM. On 7/28/24 at 10:30AM, V3 (Licensed Practical Nurse) administered R12's memantine 10mg. (2 hours and 30 minutes past the scheduled administration time). V3 was unable to locate R12's famotidine 10mg that was due to be administered at 8:00AM and stated it was reordered from the pharmacy on 7/27/24. On 7/28/24 at 11:25AM, V3 stated she normally comes in at 7AM but today she didn't get to the facility to start work until about 10AM due to an emergency. V3 stated there was another nurse who started her med pass but did not get many medications administered because they were not a regular nurse on the unit that V3 was working on. On 7/28/24 at 3:29PM, V2 (Director of Nursing) stated, Medications are to be given within 1 hour before or 1 hour after the scheduled administration time or else it is considered a medication error. Medications should be ordered about 5 days before they run out to be sure the pharmacy can deliver them on time. I'm not sure why the medications aren't here. (V3) was late coming into work today and didn't arrive until 10:00AM. There were other nurses in the building that could have helped her pass her medications if she would have asked. The facility's policy titled, Administering Medications dated April 2019 showed, Medications are to be administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 2) R13's electronic face sheet printed on 7/28/24 showed R13 has diagnoses including but not limited to pulmonary hypertension, anemia, chronic atrial fibrillation, anxiety disorder, and major depressive disorder. R13's medication administration record for July 2024 showed R12 receives apixaban 2.5mg at 8:00AM and 8:00PM. On 7/28/24 at 11:25AM, V3 was passing medications for R13 and stated she was unable to find any apixaban 2.5mg to administer to R13. V3 stated this would be considered a medication error due to R13 being unable to receive her ordered medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R17's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include hepatic encephalopathy, alcoholic cirrhosis of liver with ascites, chronic obstructive pulmonary disease, severe protein calorie malnutrition, Stage 4 chronic kidney disease, and cognitive communication deficit. R17's current physician order sheet showed an order for rifaximin 550 mg to be given twice daily at 8:00 AM and 4:00 PM. R17's eMAR (electronic medication administration record) showed on 7/28/24 R17's rifaximin was documented as not given. On 7/28/24 at 9:45 AM, V9 RN (Registered Nurse) was administered R17's medications. V9 said R17's rifaximin was on order and had been for a couple of days. V9 said the rifaximin was not in the medication cart because she thinks there was something going on with the pharmacy because the family had been previously providing the medication. 4. R18's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease, hyperkalemia, and paroxysmal atrial fibrillation. R18's July 2024 eMAR showed an order for Apixaban 5 mg to be given at 8:00 AM and 8:00 PM, gabapentin 100 mg to be given at 8:00 AM, 12:00 PM, and 8:00 PM, and metoprolol tartrate 25 mg to give 1/2 tablet twice daily at 8:00 AM and 1/2 tab at 8:00 PM. On 7/28/24 at 9:59 AM, V10 RN was administering R18's 8:00 AM scheduled doses of Apixaban, gabapentin, and metoprolol tartrate (nearly 1 hour after the allowable timeframe for administration). 5. R19's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include chronic diastolic congestive heart failure, permanent atrial fibrillation, Alzheimer's disease, hypertensive heart disease with heart failure, sick sinus syndrome, ventricular tachycardia, and bradycardia. R19's July 2024 eMAR showed an order for Metoprolol Tartrate 25 mg and Losartan Potassium 100 mg to be given at 8:00 AM. R19's eMAR showed neither of medications as being given. R19's order did not include parameters for R19's blood pressure to review at time of administration. On 7/28/24 at 10:35 AM, V11 LPN (Licensed Practical Nurse) was checking R19's vital signs and administering R19's 8:00 AM medications. V11 said R19's blood pressure reading was 109/62 with a pulse of 99. V11 said she was holding R19's blood pressure medications because R19's blood pressure was a little on the low side. R19's July 2024 MAR showed a new order entered 7/28/24 for Metoprolol Tartrate and Losartan Potassium that included the following parameters, Hold if SBP (systolic blood pressure) is less than 100, DBP (diastolic blood pressure) is less than 50, Heart Rate less than 40 or greater than 90 (call MD prior to holding). R19's blood pressure reading on 7/28/24 was not outside of the new parameters entered for holding the medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/24 at 3:45 PM, V2 DON (Director of Nursing) said she expects medications to be administered within one hour before and one hour after the scheduled administration time. V2 said the nurse should not hold medication without contacting the physician. V2 said blood pressure medications should have parameters to follow for holding medications.

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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. 41639 Based on observation, interview, and record review, the facility failed to ensure a resident (R13) was free from a significant medication error. This applies to 1 of 6 residents observed in the medication pass. The findings include: R13's electronic face sheet printed on 7/28/24 showed R13 has diagnoses including but not limited to pulmonary hypertension, anemia, chronic atrial fibrillation, anxiety disorder, and major depressive disorder. R13's medication administration record for July 2024 showed R12 receives apixaban 2.5mg at 8:00AM and 8:00PM. On 7/28/24 at 11:25AM, V3 was passing medications for R13 and stated she was unable to find any apixaban 2.5mg to administer to R13. V3 stated this would be considered a medication error due to R13 being unable to receive her ordered medication. V3 stated R13's apixaban was ordered on 7/27/24 and it must have been after the last dose was given. On 7/28/24 at 3:29PM, V2 (Director of Nursing) stated, We do not keep apixaban in our extra supply of medications. This would be considered a significant medication error to it being an anticoagulant medication. The medication should have been ordered before the last dose was used yesterday so the pharmacy had enough time to get the medication delivered and V13 wouldn't have missed a dose.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure menus were followed. This applies to 1 of 3 residents (R4) reviewed for menus in the sample of 19. The findings include: R4's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include hemiplegia, vascular dementia with anxiety, vision loss, and protein calorie malnutrition. R4's care plan initiated 7/6/2023 showed, Nutrition: On Therapeutic diet . Obtain food preferences/dislikes . Provide some encouragement to increase oral intake as needed. Offer substitute on food dislikes . R4's Dietary Profile dated 7/12/24 showed, . Likes to eat/drink . coffee, juice, bacon, eggs, oatmeal with brown sugar . R4's Dietary Ticket for Sunday, July 28 showed, . choice of vitamin C juice, fresh fruit; choice of hot or cold cereal, Entree: Scrambled Egg; Sides: Crispy bacon strip . Likes/serve: Oatmeal (2 bowls), coffee, juice, Double Protein. Dislikes: Sausage . On 7/28/24 at 10:05 AM, V10 RN (Registered Nurse) went into R4's room to assist him up out of bed. V10 brought R4 out of his room to the nurses station and told him they would be bringing his breakfast tray up to the nurses station for him. At 10:27 AM, V10 was at the nurses station and called down to the kitchen and asked for oatmeal to be sent up for R4. V10 told R4 they will be sending up oatmeal and bacon, but they do not have bacon. V10 said to R4, You have sausage though. Is sausage okay? R4 replied, I guess I don't have a choice. I like bacon, oatmeal with 2 brown sugars, coffee, and orange juice every day. On 7/28/24 at 10:55 AM, R4 was still at the nurses station asking for oatmeal with 2 brown sugars. On 7/28/24 at 12:00 PM, V14 (Dietary Aide) was assisting serving lunch. V14 stated the soup on the steam table was chicken noodle. The facility's menu showed the soup of the day for Sunday, July 28 was Creamy Vegetable Soup. On 7/28/24 at 4:15 PM, R10 said he really likes the tomato soup, and he orders it when it's on the menu. R10 said he does not always get the tomato soup as he orders, they will just send him a different soup or no soup at all. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/24 at 2:30 PM, V7 Dietary Manager said they follow the menus for each meal. V7 said the soup today was a creamed chicken base and that is what made the soup creamy vegetable soup. (The soup had clear yellow broth.) V7 then said there was a call off for the cook position today, so she made regular chicken noodle soup because she needed to make something quick and easy. V7 said they made bacon this morning, but it was all gone by the time the staff had called downstairs and requested it for [R4] but bacon could have been made and sent up. V7 said they make oatmeal every morning and that they knew someone had called from the second floor and requested the oatmeal today, but they didn't know who it was for. V7 said it does not matter that R4 was eating his breakfast later, he still would have been able to have oatmeal and bacon. On 7/28/24 at 4:15 PM, V1 Administrator said she spoke with V7 Dietary Manager and V7 told her she made the creamy vegetable soup recipe but forgot to put the cornstarch mixture into the broth to make it creamy. At 4:30 PM, V1 said V7 made the chicken noodle soup recipe and added extra vegetables because they were out of mixed vegetables to make the creamy vegetable soup. V7 said the time that the staff had called down and requested the bacon for R4 the bacon was already gone because it was after the normal breakfast time. The facility's policy and procedure titled Menu Changes showed, Menu items will be served as planned whenever possible. Due to unavoidable circumstances, temporary changes may be made on the menu . The facility's policy and procedure titled The Dining Experience showed, Policy: Meals served will respect the client's dignity as an individual . The food offered takes into account the client's food preferences . Clients requests are responded to in a timely manner .