

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Manor - Lagrange		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. 44387 Based on observation, interview, and record review, the facility failed to safely transfer a resident while using a mechanical lift. As a result of this failure, R1 sustained a laceration to the head and fracture of the thoracic 8 and 12 vertebral bodies after falling. R1 was transferred to the local hospital and received 2 staples to the back of R1's head. This applies to 2 of 6 residents (R1 and R7) reviewed for falls and accidents. The findings include: On 10/22/24 at 11:15 AM, R1 was observed in bed in her room. R1 said fall incident happened on a Thursday, which was her shower day. R1 said 2 Certified Nurse Aides (CNAs) transferred her using the mechanical lift from the bed to the shower chair and gave her a shower. R1 has a shower in her room. R1 said after the shower, the same CNAs were transferring her back to the bed using the mechanical lift. R1 said while they were attempting to put her back in bed, she fell to the floor on the bathroom side of her bed. R1 said she hit her head and there was some bleeding, and the staff called the ambulance, and she was sent to the hospital. R1 said had staples on her head and was at the hospital for 7 days. R1 said she is still experiencing pain on her middle and lower back from the fall. On 10/23/24 at 11:20 AM, R1 said she has not been out of bed since she returned from the hospital. R1 said she now requires a back brace when she is out of bed. R1 said she is not sure when she will get out of bed, adding being in the mechanical lift sling would cause her more pain and her body would be limp since there is no support with the sling. On 10/22/24 at 12:58 PM, V8 (CNA) said on the day of the incident, she assisted V11 (CNA) with giving R1 a shower. V8 said they transferred R1 using the mechanical lift and a shower sling. V8 said after R1's shower while transferring her to the bed, R1 slipped out of the shower sling and fell . V8 said the incident happened so quick, there was no time to catch R1. V8 said R1 landed on top of the legs of the mechanical lift. V8 stated R1 has a tendency of leaning towards her left side. V8 said she was guiding R1 during the transfer while V11 was maneuvering the mechanical lift. V8 said after the fall they notified the nurse, and the nurse assessed R1. V8 stated they called the ambulance and R1 was sent to the hospital. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 3:26 PM, V11 (CNA) said they used a mechanical lift to transfer R1. V11 said on the day of the incident after she and V8 had given R1 a shower, they were transferring her back to bed, and right before they got to R1's bed, R1 slipped out of the sling and fell . V11 said she was the one maneuvering the mechanical lift while V8 was guiding R1. V11 said the incident happened fast. V11 stated R1's body shifted left out of the sling and R1 landed on top of the legs of the mechanical lift. V11 said after the fall she called the nurse to assess R1 while V8 stayed with R1. V11 said R1 was taken to the hospital. On 10/23/24 at 10:02 AM, V12 (Licensed Practical Nurse/LPN) said she was informed by the CNA that R1 had a fall. V12 said when she got to R1's room, R1 was on the floor and had a laceration to her head. V12 stated she said she assessed R1 and R1 complained of pain in her back. On 10/22/24 at 2:50 PM, V3 (Director of Nursing/DON) said she was informed R1 slipped from the mechanical lift shower sling during a transfer after her shower. V3 said R1 was sent to the hospital after the fall, where she had 2 staples to her head, and the X-ray report showed there was a fracture to T8 and T12. V3 said when she investigated the incident, she found that the shower sling strap was giving way. V3 stated there was a small tear at the top blue part by the loops that is hooked onto the mechanical lift. On 10/23/24 at 2:14 PM, V1 (Administrator) said they do not have a time frame for replacing resident's mechanical lift slings; if it does not look good, they replace it. V1 said she purchased R1's shower sling and full body sling a year ago because R1 was complaining that her sling was missing. V1 said that it was R1's personal sling. R1's Fall Incident Report of 10/3/24 stated, On 10/3/24 during the morning care, the resident slipped with the presence of the staff inside the resident room. Analysis is maybe the blue strap starting to give away and the resident body shifted, slipped and fell . The sling used for R1's transfer had already been thrown away. R1's Face Sheet shows that the following diagnoses of wedge compression fracture of unspecified thoracic vertebra initial encounter for closed fracture, quadriplegia, disorder of bone and multiple sclerosis. R1's Restorative Evaluation of 10/14/24 shows that R1 is dependent on staff for transfers. R1's hospital records of 10/4/24 stated R1 was sent to the hospital following a fall; R1 was being bathed earlier in the morning, when resident was being placed back into the bed, the transfer device sling broke and she slipped to the ground. R1 hit back of head and dropped on her back. R1 had laceration repair to the scalp and was noted with thoracic vertebral fractures/closed fracture of thoracic vertebra. R1's CT (Computed Tomography) scan of 10/3/24 shows there are fractures of the T8 and T12 vertebral bodies which appear acute and subacute and there is minimal compression of the T9 vertebral body. The facility's Safe Lifting and Movement of Residents policy (revised July 2017) states that resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.		