

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  05/07/2025
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409</b></p> <p>Based on interview and record review, the facility failed to follow safe medication administration practice to avoid a significant medication error. This applies to 1 of 3 residents (R1) reviewed for significant medication error in a sample of 3.</p> <p>The findings include:</p> <p>On May 6, 2025 at 12:03 PM, R1 said a few weeks earlier, he was given three white pills which he was not supposed to take and were supposed to be for another resident. R1 said he went to the hospital to be evaluated for the reaction to the pills.</p> <p>On May 6, 2025 at 1:33 PM, V3 (RN/Registered Nurse) said she had floated onto a different unit than her normal and had received a phone call from the cardiologist. V3 said she had worked with R1 before but had misheard the cardiologist and did not realize there was another resident who had the same first name and same letter for the last name. V3 said she pulled the medication and went to R1's room and said the labs showed he needed his potassium replaced. V3 administered the potassium to R1 and after taking the medication, R1 said he had not had his labs drawn. V3 said she realized she had administered the medication to the wrong patient and called the cardiologist back. V3 said R1 was sent out to the hospital, where his potassium level showed a normal level of 4.1.</p> <p>On May 6, 2025 at 1:57 PM, V6 (LPN) said when she received an order from the doctor, she would verify the resident's name as well as their date of birth. V6 said when the doctor gives an order, she would read back the orders to the doctor to make sure it was the correct resident. V6 said if a resident had too much potassium, the resident could have cardiac arrhythmias. V6 said if she had administered potassium to a resident who was not supposed to, she would call the doctor, do vital signs, keep monitoring the residents' blood pressure, call 911, notify the family and director of nursing, and fill out an incident report. V6 said she was told R1 was given the wrong medication and was sent to the hospital.</p> <p>(continued on next page)</p>		

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 6, 2025 at 2:03 PM, V7 (RN) said when she received orders from the doctor, she would say the residents' first and last name. V7 said she would also repeat the orders back to the doctor to ensure she had the correct information. V7 said receiving potassium could cause heart arrhythmias. V7 said R1 had labs collected after returning from the hospital. V7 said R1 did not require kayexalate and he was monitored for a few days after returning, and the highest his potassium levels went were 5. V7 said if she had administered too much potassium, she would call the doctor right away, who would either say to monitor in the facility or send the resident to the hospital. V7 said she would have to fill out a medication error report and call the family.</p> <p>On May 6, 2025 at 3:35 PM, V5 (Director of Restorative/LPN) said she was working as the restorative nurse when V3 came to her and said she gave potassium to the wrong patient. V5 said she instructed V3 to call the doctor. V5 said residents who receive too much potassium can cause a heart attack or die. V5 said too much potassium was life threatening.</p> <p>On May 6, 2025 at 2:37 PM, V2 (DON/Director of Nursing) said residents who receive too much potassium can cause irregular heartbeats, muscle cramping, and could cause a heart attack. V2 said if a nurse gave the potassium erroneously, low or high dose, the nurse should notify the physician, patient, and family. V2 said they should monitor the resident's heart rate and muscle cramping and send the resident to the hospital per the doctor's orders. V2 said the resident's labs should be monitored upon return from the hospital. V2 said when a doctor gives a telephone order, the nurse should read back the order to make sure it was the right resident, dose, medication, route, time, frequency, and form.</p> <p>R1's progress notes showed the following:</p> <p>On March 17, 2025 at 5:13 PM, V3 wrote, Received resident during initial rounds in room no pain or distress noted. At about 4:30 received call from resident cardiologist [Name] stating another resident [Name] potassium is low and to give 60 meq (Milliequivalents) STAT. Writer heard last name [R1] and proceeded to start giving the STAT dose. After resident took medication resident stated he did not receive a blood draw. At that time, it was noted that he was not the correct [Name]. Resident assessed. V/S (Vital Signs) all WNL (Within Normal Limits) limits. Per resident he stated he felt fine. Call was then made to Dr (Doctor) [Name]. He gave order to send resident out to [Name] hospital for blood draw for a STAT potassium level and he stated that when resident returns to do a BMP (Basic Metabolic Panel) on 3-18. Call placed to 911. Resident left facility via stretcher in stable condition.</p> <p>On March 17, 2025 at 10:48 PM, V3 wrote, Resident returned to facility in stable condition from [Name] hospital. Resident potassium was 4.1 at that time. BMP was ordered for resident.</p> <p>R1's face sheet showed diagnoses including congestive heart failure, hypertensive heart disease with heart failure, syncope and collapse, and atrial fibrillation. R1's care plan showed R1 has altered cardiovascular status CHF (Congestive Heart Failure), Afib (Atrial Fibrillation), hypertension and HLD (Hyperlipidemia) with a goal that R1 will be free from s/sx (Signs and symptoms) of complications of cardiac problems through the review date.</p> <p>R1's Lab Results Report dated March 18, 2025 at 7 PM showed R1's potassium was 5. R1's Lab Results Report dated March 21, 2025 at 4:40 AM showed R1's potassium was 4.5.</p> <p>(continued on next page)</p>		

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