

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  09/24/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on observation, interview, and record review, the facility failed to provide appropriately sized incontinence briefs to a resident to prevent skin irritation. This applies to 1 of 3 residents (R1) reviewed for quality of care in a sample of 11. The findings include: On September 23, 2025 at 11:36 AM, R1 said she had requested the white incontinence briefs but were not given them. R1 said she had the green incontinence brief on, which were not comfortable for her. At 1:59 PM, R1 said she had skin irritation from the green incontinence brief, as they were too small for her. At 2:16 PM, R1's skin was checked by V6 (CNA/Certified Nurse Assistant) and V7 (Infection Control nurse), and her perineal area and bilateral groin areas were excoriated and red. R1 said the redness was because the brief was too small. When V6 was wiping R1's perineal and groin areas, R1 was wincing and said those areas hurt. On September 23, 2025 at 1:55 PM, V5 (CNA) said she had taken care of R1 before, and the green briefs did not fit her. V5 said R1's thighs were irritated, and she had notified the nurse, who gave her a cream to apply. V5 said she had notified central supply about R1's incontinence brief size and was told R1 was not on the list for the white, 3XL (Extra Large) incontinence briefs. V5 said she was told management based the sizing on her weight. V5 said the brief sizing should not be dependent on their weight alone, but on the actual size of her stomach and legs. On September 23, 2025 at 3:01 PM, V11 (CNA) said she had been in the facility for one year and frequently cared for R1. V11 said R1 preferred the white, bariatric 3XL incontinence briefs as the green and tan briefs cut between her legs and sides of her groin. V11 said the white bariatric briefs gave her more breathing room. V11 said she could see the difference the white bariatric briefs made versus the green ones, as the green ones caused her more skin issues. V11 said she notified central supply of R1's needs and was told there was a list and R1 was not on the list for the 3XL, white incontinence briefs. V11 said she notified V7, and V11 was told there was a list for brief sizes, and they needed to wear the size according to the list. On September 23, 2025 at 2:50 PM, V8 (Central Supply Manager) said he was given a list with the residents' names and sizes of incontinence briefs a few weeks ago. V8 said the list showed R1 required an XL brief. V8 said he was told by a few CNAs about a week ago that R1 wanted the 3XL white incontinence briefs. V8 said he was told to order and give the residents the sizes that were on the list. V8 said he provided the green 2XL briefs for R1. V8 said the 3XL briefs were more expensive and they were hand delivered to the rooms on the list. V8 said all the smaller briefs were available to the CNAs in the supply rooms. On September 23, 2025 at 2:50 PM, V8 provided a census sheet dated September 3, 2025 with all the residents' names and brief sizes. The document showed R1 was sized to receive XL incontinence briefs. On September 23, 2025 at 2:25 PM, V10 (Wound Care Nurse/LPN/Licensed Practical Nurse) said she was not aware R1 had excoriation on her groin and perineal areas. V10 said it was possible if the incontinence brief was too tight, it could cut into her skin and cause skin breakdown. V10 said there were only certain residents who had the white, 3XL briefs assigned to them, and R1 was not on the list. V10 said she was not sure who determined the sizes for the residents. On September 23, 2025 at 2:41 PM, V2 (DON/Director of Nursing) said every person's body was different and if the resident was more comfortable with a larger sized incontinence brief, the staff would let management know and they would change what they ordered for the resident. V2 said R1 was pear shaped and bigger on the bottom half. V2 said she was told by the staff on September 23, 2025 (during the survey) R1 had irritation to the leg and groin area. V2 said if a resident was larger than 250 pounds, they would measure the girth, and R1 did not meet the criteria to be measured for her girth. The EMR (Electronic Medical Record) shows R1 was admitted to the facility with diagnoses including hemiplegia and hemiparesis, stage 4 chronic kidney disease, paralytic syndrome, and pain in right shoulder. R1's MDS (Minimum Data Set) dated July 24, 2025 showed R1 had moderate cognitive impairment and required substantial assistance for toileting hygiene and personal hygiene. The facility's Resident Personal Preferences policy dated April 2025 showed it is the policy of the facility to accommodate the personal preferences of the residents that are essential to creating an individualized, home-like environment. The resident's individual preferences will be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.</p>		