STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013120	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR	431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2274236/IL147462	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor and supervise residents to prevent injury. This failure affected 2 of 3 residents (R1, R2) reviewed for resident injury in a sample of 3, and resulted in injury for 1 (R1) of 3 residents reviewed for injuries.

Findings include:

1. R1 is an 85-year-old female admitted on 1/10/2021 with admitting diagnoses including Dementia, fall, and a history of traumatic fracture. R1 was not in the facility during this survey.

On 5/31/22 at 11:45 AM, V5 (Wound Care Nurse) stated, "On 5/27/22 early morning at around 6:00 AM, I provided left heel wound care to R1 and noticed R1's left lower leg flaccid and crepitus ("crunching" sound or sensation). I notified [V10] (Nurse Practitioner-NP) that R1'S foot is flaccid and has crepitus. She ordered an X-ray, and the floor nurse followed upon that."

Record review on facility-provided radiology result dated 5/29/22 indicates an acute to subacute

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S9999	Continued From page 2 fracture of the left distal tibia and fibula. Record review on hospital left leg X-ray result dated 5/29/22 document an acute displaced fracture of left tibia and fibula. On 5/31/22 at 11:45 AM, V2 (Director of Nursing) stated, "V3 (R1's Attending Physician/MD) and V10 (NP) assessed R1 on 5/27/22. R1 was bedridden and won't be able to walk around. This is not a fall. We don't know exactly what caused her injury." On 6/1/22 at 10:30 AM, V10 (NP) stated, "R1's X-ray for the left lower leg showed an acute displaced fracture of her left tibia/fibula fracture. There might be some incident causing acute displaced fracture for both the tibia and fibula- some kind of external force from a fall or blow can cause that injury. Trapping the resident's leg with the bedframe/side rail when they turned and repositioned R1 can also cause that injury. There is no reported fall or trauma, and we don't know exactly what caused that injury." On 6/1/22 at 11:45 AM, V3 (R1's Physician) stated, "On Friday (5/27/22), I went to assess R1, and there was nothing visible to tell fracture. But I could tell something was going on from her left leg crepitus. So, I ordered an X-ray, and it showed a left tibia/fibula fracture. I don't know what happened or caused her leg fracture. I don't know her leg stuck somewhere ...or any trauma happened." 2. Record review of a reportable incident dated 1/28/22 documented R2 fell, resulting in a right hip fracture. Record review on fall risk assessment dated 11/12/21 documented that R2 was at moderate risk for fall. Record review on another reportable incident indicated that R2 fell	S9999		

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S9999	Continued From page 3 again on 3/18/22, causing a left femur fracture. Fall risk assessment dated 1/28/22 documented that R2 was at high risk for falls. Record review on R2's fall care plan interventions includes ensuring the call light is within reach and encouraging to use it for assistance as needed. The fall interventions also include providing a bed pad alarm when in bed and continuing with a clip alarm. On 5/31/22 at 10:40 AM, R2 was on her bed with a call light push button hanging behind the headboard. In response to the surveyor's question (in the presence of R2's nurse V13), "How do you use the call light to call for assistance?" R2 stated, "I don't know...I am looking for it ...I can't see it." V13 stated, "The call light should be reachable to R2." On 5/31/22 at 10:45 AM, observed no bed alarm padding or bed alarm activated for R2 while R2 was in bed. Observed a chair alarm set hanging from bedframe with string not clipped to resident gown (not activated). V13 stated, "R2 is at high risk for falls. The alarm should be activated to monitor/supervise R2." Record review on Fall and Fall Risk Management policy revised in March 2018 document: The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. (A)	S9999		