Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016281	A. BUILDING: ____ B. WING ____	C 03/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - LAGRANGE	339 9TH AVENUE LA GRANGE, IL 60525

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S 000	Initial Comments Complaint Investigations: 2372154/IL157547 2372179/IL157588 Facility Reported Incident of 2/22/2023/IL157378	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow plan of care regarding needed assistance for a resident requiring 2 plus person physical assist. The facility also failed to ensure that a bed rail was in functioning order when used as an enabler to ensure resident's safety. This applies to 1 of 3 residents (R2) reviewed for falls. These failures	S9999		

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S9999	Continued From page 2 resulted in R2 sustaining a laceration to his head and left eyebrow requiring sutures and staples at the hospital. The findings include: The EMR (Electronic Medical Record) shows that R2, a 69-year-old with diagnoses that includes hemiplegia and hemiparesis due to effect of cerebral infarction, right above knee amputee, malignant neoplasm of left lung, tonsil, larynx, diabetes mellitus, peripheral autonomic neuropathy, PVD (peripheral vascular disease), COPD (coronary obstructive pulmonary disease), AHSD (atherosclerotic heart disease), atrial fibrillation, weakness and major depression. R2's original admission to the facility was on 8/1/2016 with most current reentry on 2/27/2023. On 3/13/2023 at 10:30 A.M., R2 was observed lying in bed. R2's bed mattress was an air loss pressure reducing device. R2's upper bed rails were on upward position. R2 was wearing a left-hand splint due to a hand contracture. R2 did not verbally response when conversation was initiated. R2 was connected to a gastrostomy feeding. R2 was also connected to an oxygen tubing. R2 was positioned in the middle of the bed. It was observed that there was approximately 4-6 inches width distance from R2's body to the edge of the bed. R2 was observed with multiple staples to the scalp between the middle and right side of the head. R2 also was noted with several small sutures to the left upper eyelid. V2, DON (Director of Nursing) was present during this time. V2 said that the staples and sutures were the lacerated wounds acquired by R2 from the fall of 2/22/2023. V2 said that R2 fell to the floor on 2/22/2023 during the provision of care by V5 (CNA).	S9999		

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S9999	Continued From page 3 The incident report dated 2/22/2023 shows R2 fell to the floor from bed, during provision of care by V5. R2 was noted with bleeding on the face, head and was sent to the hospital. R2 was admitted with diagnoses of fall and hypoxia. R2 returned to facility on 2/27/2023 with staples on the middle of the head and sutures to left upper eyelid. On 3/13/2023 at 3:23 P.M., both V4 (Nurse) and V5 (CNA) were interviewed in the facility's conference room. V5 said R2 fell from bed to the floor on 2/22/2023 when he was providing care to R2. V5 said that it was only him and no other staff assistance when he turned R2 to the left side of the bed and R2 was holding unto the left side bedrail that was on upward position. V5 said he turned his back to get a bed sheet from R2's drawer, which was just next to R2's bed. V5 said the upper left bed rail went to the downward position, because the "screws that attached to the bed were loose", and (R2) fell to the floor. V5 said V54 changed R2's incontinence brief and noted the bed sheet was soiled. V4 said she immediately went to R2's room when V5 called for help. V4 said she saw R2 lying on the floor, with bleeding from the head and left lower eyebrow. V4 said the left side of the upper bed rail was on downward position. V4 said, "I assumed the screws that attached to the bed were loose because it did not hold to the intended and secured position, which was supposed to be upward. This was why maintenance had replaced the bed. (R2) is a big guy. When turning (R2) to the side while in bed and there was not enough bed space and (R2) lying on an air loss mattress, which can be slippery, it would be like a water wave. Gravity will pull him 9R2) down. This is what caused (R2) to end up on the floor."	S9999		

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S9999	Continued From page 4 On 3/13/2023 at 3:45 P.M., V6 (Maintenance Director) said he inspected R2's bed the next day after the fall. V6 said that due to "(R2) being a big guy. The screws from the bed rail that attached to the bed frame came loose and did not hold secured position. The bed rail went to downward position." R2's most recent MDS (Minimum Data Set) was 1/3/2023 which was the most recent assessment prior to R2's fall on 2/22/2023. The MDS indicated R2's functional assessment as follows: R2 with extensive assistance with 2 plus person physical assistance for bed mobility. The MDS described bed mobility as "how resident moves to and from lying position, turns side to side, and positions while in bed." R2 was assessed as extensive assistance with 2 person plus physical assistance for toilet use. The MDS described toilet use as "when a resident uses toilet, commode, bed pan, urinal, cleanses self after toilet use or elimination, including changing incontinence pad." Review further of R2's MDS assessment shows that R2 has mood disorder exhibited by low interest in activity, feeling empty, has trouble concentrating, feeling tired and low energy level. R2 also has limited range in motion on one side of upper extremity (left hand contracture) and one side of the lower extremity (right above knee amputee.). Review of R2's most recent care plan dated 1/3/2023, shows that there were no revised interventions to prevent further falls. The history of care plan shows that it was on 7/23/2020 that R2 was assessed for risk for fall; with intervention for education to staff for safety; 8/9/2020; staff education for safety; 3/26/2023 for dycem (non-skid seat cushion). R2 had histories of falls. R2 was sent out for CT (Computerized Tomography) of the head on 7/23/2020.	S9999		

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S9999	Continued From page 5 The hospital admission record dated 2/23/2023 shows R1 was seen and treated for fall and hypoxia. The record also shows that due to the fall incident, R2 sustained a laceration to the left side of his scalp and a laceration below left eyebrow that were stapled and sutured. (B)	S9999		