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 10/25/2024

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MEADOWBROOK MANOR - LAGRANGE	339 9TH AVENUE LA GRANGE, IL 60525

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S 000	Initial Comments Facility Reported Incident of 10/3/2024- IL179303 Complaint Investigation Survey 2478145/IL178997	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 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. 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	S9999		

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S9999	Continued From page 1	S9999		

care needs of the resident.

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 requirements were not met as evidenced by:

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

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S9999	Continued From page 2	S9999		

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.

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

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S9999	Continued From page 3	S9999		

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

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S9999	Continued From page 4	S9999		

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. (A)

Statement of Licensure Violations (2 of 2):

300.1810l)
300.1810m)
300.1810n)

Section 300.1810 Resident Record Requirements

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S9999	Continued From page 5 l) All Cook County facilities with Colbert Class Members shall submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, on a monthly basis, an accurate census of all Medicaid-eligible residents, the previous month's voluntary and involuntary discharges conducted under Section 300.3300, including any voluntary and involuntary discharges scheduled to be conducted within 48 hours after the end of the reporting month. This monthly census must be submitted on the form prescribed by the Colbert Lead Defendant Agency using secure (encrypted) email, no later than the fifth business day of each month. m) All Cook County facilities with Colbert Class Members shall provide educational materials and information to all Colbert Class Members voluntarily or involuntarily discharging from the facility at the time of completing the discharge paperwork, informing them of their rights and services under the Colbert Consent Decree, as prescribed by the Colbert Lead Defendant Agency. All Cook County facilities shall provide written verification of educational materials and information given to the Colbert Class Members, as requested by a Colbert Defendant Agency. n) All Cook County facilities shall notify any agency providing transition services to a Colbert Class Member of such Class Member ' s discharge at least 48 hours prior to the discharge taking place. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to report and submit required data of	S9999		

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S9999	Continued From page 6	S9999		

Colbert Consent Decree Dementia Reviews for Medicaid eligible residents residing in the facility. This applies to 16 of 32 residents (R7, R11, R13-R26) reviewed for Colbert Consent Decree compliance.

The findings include:

On 10/22/24 at 9:19 AM, V1 (Administrator) said case managers from Colbert Williams Decree only come out to see the facility's Medicaid residents. V1 said they have not requested any information from her recently.

On 10/23/24 at 9:00 AM, V1 said she was not aware of the requirements for the Colbert Class Member Dementia Review program that started in March 2024. V1 said she was not aware that the facility staff had to enter information in the Maximus website. V1 said that she does not have access to the Maximus website, however, the facility's Admissions Director is in charge of entering Medicaid residents who have a dementia diagnosis into the system, however their Admission's Director is newer to the role, and was not aware that she had to discharge/remove residents from the Maximus website once the resident no longer resides at the facility.

On 10/22/24 at 2:09 PM, V9 (Admissions Director) said once a resident is referred to the facility, she enters the resident's information into Maximus website in the Path Tracker. V9 said she was not aware that she had to discharge residents from the Maximus website once they are no longer at the facility; she was not aware of they had to submit reviews for Colbert residents at the facility. V9 said she was also not aware she had to enter data into Assessment Pro.

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S9999	Continued From page 7 On 10/24/24 at 11:00 AM, V1 and V9 reviewed the facility census and identified 32 residents that had Medicaid/Public Aide that had either dementia or cognitive disorder diagnosis; 16 of those residents were not recorded in the Maximus website. V1 said she was not aware of the "Notice of Administrative Warning" that was sent out to the facility on 9/3/24. The Notice showed the facility "failed to comply with the Act and Code" for the reporting requirements. (C)	S9999		