STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0037366	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR	**431 WEST REMINGTON BOULEVARD , BOLINGBROOK, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2574790/IL193462	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1) 300.1630d) 300.3210a)2) 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 provided to each resident to meet the total nursing and personal 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect the residents' right to be free from neglect when the facility failed to ensure medications were obtained and hospice orders were followed for 2 (R1, R2) residents, admitted to the facility for a hospice respite stay. This failure resulted in R1 experiencing seizures after not receiving anticonvulsant medications and requiring hospitalization. This applies to 2 of 4 residents (R1, R2) reviewed for neglect in the sample of 8.	S9999		

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S9999	Continued from page 2 The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on May 22, 2025 for a respite stay. The EMR continues to show R1 was transferred to the local hospital on May 23, 2025 due to experiencing a seizure at the facility. R1 did not return to the facility. R1 had multiple diagnoses including cognitive social deficit following cerebral infarction, epilepsy not intractable, with status epilepticus, depression, bilateral peripheral vertigo, Type 2 diabetes, chronic respiratory failure, dementia, frontotemporal neurocognitive disorder, cerebral infarction, aphasia, and hemiplegia affecting his right, dominant side. R1's Discharge MDS (Minimum Data Set) dated May 23, 2025 shows R1 had moderately impaired cognition, required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene, and was dependent on facility staff for toilet hygiene, lower body dressing, and personal hygiene. R1 was always incontinent of urine and frequently incontinent of stool. The EMR shows, on May 14, 2025, V21 (Admissions Director) uploaded R1's history and physical provided by the hospice provider to R1's medical record for R1's respite stay. V22's (Physician) history and physical documentation dated April 1, 2025 shows R1 took multiple medications, including, Lantus insulin, 20 units subcutaneously once a day, and levetiracetam (Keppra) (anti-seizure medication) 500 mg. (Milligrams), 1 tablet orally every 12 hours. On May 22, 2025, at 2:40 PM, V19 (RN-Registered Nurse) documented, "[R1] arrived by ambulance to the facility at 10:10 [AM] and was taken to [room number]. I performed a head-to-toe assessment. Patient is nonverbal but follows directions. He is alert to self. Calm and cooperative. He laughs at everything you say to him. Eyes are PERL (Pupils Equal and Reactive to Light). No glasses with him. Hearing is WNL (Within Normal Limits) bilaterally. He has his own teeth that are in poor condition. His lungs are clear in all fields. Heart tones are strong and rhythmic with no peripheral edema noted. Bowel sounds are active in four quadrants. Skin is intact. Resident does not display any signs of discomfort or distress. Resident was wet	S9999		

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S9999	Continued from page 3 before exam. Incontinent of bowel and bladder. Vitals taken and charted. Resident will not be able to use his call light effectively. Endorsed to oncoming nurse that we did not receive a diet, official med list, and no report was received about resident. Nurse stated understanding." The facility does not have documentation to show V19 (RN) attempted to locate R1's home medications in his belongings. The facility also does not have documentation to show V19 notified the physician or hospice provider that R1 did not have medications from home, or clarified R1's respite medication orders, or that V19 attempted to order R1's medications from the pharmacy. On May 22, 2025 at 10:45 PM, V20 (RN) documented, "Per Admission Director, med list and the rest of medications discuss with [V3] (Daughter of R1), who supposed to come later tonight, however, no show up. Writer then called hospice supervisor/manager and made aware, also left a message to the daughter with no return call yet. Comfort package available, the resident in good disposition and aura, no agitation/restlessness noted. Per CNA(Certified Nursing Assistant), the resident was fed with good food and fluid intake, diet verified with the hospice supervisor/manager to be regular/thin/take meds whole. Still anticipating daughter would come with the rest of meds to be reconciled and put in the system." The facility does not have documentation to show V20 (RN) attempted to locate R1's home medications in his belongings. The facility does not have documentation to show V20 notified the physician or hospice provider that she was unable to locate R1's medications from home, clarification regarding R1's respite medication orders, or that V20 attempted to order R1's medications from the pharmacy. On June 4, 2025, at 4:19 PM, V21 (Admission Director) said, R1's hospice company sent his admission paperwork to the facility prior to R1's admission. V21 continued to say she uploaded the hospice paperwork to the EMR so R1's medical information and medication list was available to the nurse who admitted R1. V21 said, "I confirmed with the hospice company that the medications listed were the most up-to-date list of medications. I provide an admission notification sheet with all of the resident's specific information and everything that is	S9999		

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S9999	Continued from page 4 important about the person and gave one to the receptionist and one to the nurse. The sheet showed [R1] was coming to the facility at 10:00 AM on May 22, 2025, and that the family was bringing the medications." On June 6, 2025, at 9:38 AM, V21 (Admissions Director) continued to say, "Every hospice respite resident has a written report from me that shows everything about the resident, including if the family is providing the medications. The written report is given to the nurses. The reason the family brings the medications from home is because the medications are paid for by the hospice company. We ask the families to bring the medications in their original pharmacy bottle that is labeled with the resident's name on it and the medication instructions. Everyone here knows this is how respite residents are done. I couldn't make it any easier for the nursing staff. The medications and the resident's medical information are all scanned into the medical record before the resident ever comes to the facility." On June 4, 2025 at 12:40 PM, V3 (Daughter of R1) said, "[R1] went to the facility from home. It was a respite stay for five days. Hospice arranged for him to go there. I sent the actual medications in a bag with his belongings, and they called and said they could not find them. I have done a respite stay at this facility before, and I know how it works. Even if they weren't able to find the medications, they could have looked at the medication list provided by hospice and ordered the medications. [R1] has not had a breakthrough seizure in over 20 years. [V10] (Hospice Manager of Admissions) said she called the facility and spoke to [V19] (RN), and he started reading the medications they didn't have. Obviously, he had the list if he was reading the medications from it, and he could have ordered the medications from that list if he couldn't find the medications I sent." On June 4, 2025 at 1:01 PM, V10 (Hospice Manager of Admissions) said, "On May 22, 2025, I received a call from [V19] (RN), and he said we have your patient here and the family only sent his comfort pack medications. I said the family was given clear instructions to send all the medications. I asked which medications they were missing, and we went through the list, including the insulin and seizure medication. I reached out to [V3] (Daughter of R1), and she said she realized she had forgotten to include the insulin in the package with the medications because it was in her	S9999		

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S9999	Continued from page 5 refrigerator, but the rest of the medications were in the resident's belongings. She said she would have her daughter drop off the insulin later in the day. I called the facility three times after that to speak to [V19] and each time I was never able to speak to him, just left on hold. I finally called again and left my name and number for him to call me back. Around 9:30 PM, I received a call from the facility that [R1's] medications had still not arrived. I said, check the bag because the family said the medications were in there. The nurse asked when the medications should be taken and was able to say the names of the medications. I said, please check his bag, or otherwise, we need to put in a stat order for the medications. She said she would get back to me, but she never did. The next morning, I received a call around 9:30 AM to 10:00 AM from the nurse and was told [R1] was different than usual. The next thing I know, I got a call around 12:30 PM from the facility that they had to send [R1] out 911 because he was found non-responsive and having a seizure. I reached out to the emergency room to tell them they were getting our hospice patient, and they told me he was already at the hospital and had a witnessed seizure and he required Versed (central nervous system depressant). This respite stay had been in the works for weeks before his arrival to the facility. The responsible and right thing to do was to provide the medications." On June 4, 2025 at 3:01 PM, V20 (RN) said she worked a double shift from 2:00 PM to 10:00 PM on May 22, 2025, and 10:00 PM on May 22, 2025 to 6:00 AM on May 23, 2025. V20 continued to say R1 was under her care during the two shifts she worked. V20 said, "When I came that day and got report from the nurse on the prior shift, the nurse was confused and overwhelmed. Apparently, [R1] came from home, and no one gave report or a recent medication list. I worked 16 hours and had the resident the whole time. I did not give him any medications that night. From the medication list that came with [R1], I saw he takes Keppra (anti-seizure medication). I did not look through [R1's] belongings for his medications. If I am not the admitting nurse, I don't have to go through the patient's belongings. This should have been taken care of prior. I did not think it was an emergency that [R1] was not getting his medications." On June 4, 2025 at 3:28 PM, V23 (RN) said, "I worked from 6:00 AM to 2:00 PM on May 23, 2025. The CNA came to me and said something was wrong with [R1]. I went to see the resident and he appeared to be having a seizure. I called for [V13] (NP-Nurse Practitioner) to	S9999		

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S9999	Continued from page 6 come see the resident and she said to send him out 911. I called [V10] (Hospice Manager of Admissions) and said I needed the medications for [R1]. We had a medication list in the admission packet, and it showed [R1] needed insulin and Keppra and other things. I dug through [R1's] belongings and found all of his medications. They were here with his things the whole time." On May 23, 2025 at 9:00 PM, V18's (Physician) hospital documentation shows R1 presented to the emergency room with a witnessed seizure requiring Versed 2 mg. "[R1] is a 79-year-old male presenting with witnessed seizure. EMS (ambulance) reports patient was post-ictal upon their arrival and had another seizure that required 2 mg. of Versed and resolved with this. Granddaughter is at bedside; states patient was recently transferred to the nursing home and has not had his medications for the past 36 hours. Patient's daughter is on the phone and states patient usually takes Keppra and has not had a breakthrough seizure for 30 years. No fall or injury from witnessed seizure per EMS." Hospital documentation shows R1's blood sugar was 219 (reference range 70-99 mg/dL (milligrams/deciliter) upon admission to the hospital. Facility documentation dated May 23, 2025 at 9:55 AM shows R1's blood sugar was 180 mg/dL (Milligrams/deciliter). R1's May 2025 MAR (Medication Administration Record) shows R1 did not receive any medications, including his insulin or levetiracetam while residing in the facility. On June 5, 2025 at 10:47 AM, V14 (Pharmacist) said, R1's insulin was a long-acting insulin, meant to control his blood sugar over the course of time, and that R1's Keppra medication should not be stopped and if a dose is missed, a seizure is possible. On June 5, 2025 at 3:14 PM, V15 (Pharmacist/General Manager) said, elevated blood sugars are possible when insulin doses are missed, and "some people will have breakthrough seizures" when anti-seizure medication such as Keppra doses are missed. V15 continued to say had the facility staff ordered R1's medications STAT,	S9999		

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S9999	Continued from page 7 the medications could have been available to the facility staff for administration to the resident within four hours. On June 5, 2025 at 9:59 AM, V13 (NP) said, "I went to see [R1] on May 23. He was seizing. I asked if he had an order for IV (Intravenous) Ativan (benzodiazepine medication). He did not. He was actively seizing, so he had to go the emergency room. If they would have called me for medication orders, I would have ordered them. He missed doses of his seizure medication, and he ended up having a seizure. What more is there to say?" 2. The EMR shows R2 was admitted to the facility on April 10, 2025 for a hospice respite stay and was discharged to her home on April 19, 2025. R2 had multiple diagnoses including heart failure, type 2 diabetes, hypertension, repeated falls, hallucinations, stress incontinence, and the presence of an automatic implantable cardiac defibrillator. R2's MDS dated April 19, 2025 shows R2 had severe cognitive impairment, required supervision with eating, partial/moderate assistance with oral hygiene, was dependent on facility staff for toilet hygiene, and required substantial/maximal assistance with all other ADLs (Activities of Daily Living). R2 was frequently incontinent of bowel and bladder. On April 10, 2025 at 4:05 PM, V20 (RN) documented R2 was admitted to the facility from home after going to the emergency room following a fall. V20 continued to document R2 was admitted to the facility under hospice care. On June 5, 2025 at 1:52 PM, V5 (Son of R2) said, on April 10, 2025 R2 was getting ready to leave home for a respite stay at the facility. V5 continued to say just before R2 left home, she sustained a fall in the bathroom and had to be taken to the emergency room prior to going to the facility. R2 received staples, in the emergency room, to close a laceration on her head prior to going to the facility. V5 said, R2's medications were with her belongings when she went to the facility. When she returned home from the facility on April 19, 2025, her home medications had remained with her belongings, untouched, with the same number of pills in the bottles, and other medications were present in her belongings, some of which R2 had not	S9999		

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S9999	Continued from page 8 taken for over four years. The Client Medication Report for R2, provided to the facility by the hospice company on April 10, 2025 shows multiple medication orders for R2, including the following: Quetiapine 50 mg. every night at bedtime for restlessness, and Ambien 5 mg. every night at bedtime for insomnia. The facility does not have documentation to show the order for R2's scheduled Quetiapine or Ambien were ever entered into the EMR or that R2 ever received the Quetiapine and Ambien as shown on the hospice Client Medication Report. The EMR shows the facility had two medication lists for R2; one list from the emergency room dated April 10, 2025, and one list from the hospice provider dated April 10, 2025. The facility does not have documentation to show the facility called the hospice provider to clarify which medications R2 should have received while residing at the facility. On June 9, 2025 at 9:18 AM, V4 (Hospice Nurse) said, R2 had her home medications with her when she went from the emergency room to the facility. V4 said, "I had called the facility to notify them [R2] had to be rerouted to the hospital due to her fall at home. I reminded them her medications were with her in her luggage, and she would be a little late getting to the facility." On June 10, 2025 at 10:22 AM, V4 (Hospice Nurse) said, "[R2] has not been of sound mind for a long time. As she was transitioning to her later stages in the hospice process, [R2] was getting more anxious and restless. At one point, at home, she was found outside, trying to shovel snow. We discontinued her Trazadone, and we put her on scheduled doses of Quetiapine and Ambien as comfort measures for her end-of-life process. She started having more falls, including two at the facility between April 10 and April 14, 2025, due to her restlessness with the dying process, and it was important she received those medications. If she was not receiving those medications, she would have become more anxious and uncomfortable. The plan for hospice patients is to keep them comfortable."	S9999		

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S9999	Continued from page 9 On June 9, 2025 at 10:04 AM, V24 (Former DON-Director of Nursing) said, he was always notified when a resident was coming to the facility for a respite stay. V24 said he assisted R2's nurse and entered all of R2's medication orders into the EMR. V24 said, "The nurse should have called the doctor and asked which medication list she should follow, the one from the emergency room, or the one from hospice. The nurse didn't communicate that to me. I was just helping out and put in the orders. I did not call the doctor to clarify the orders." On June 9, 2025 at 12:51 PM, V13 (NP) read the facility's Abuse and Neglect policy and said if the facility's Neglect Policy shows neglect is the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress, then the residents should have gotten their medications or "technically that is neglect." V13 continued to say, "The nursing staff should have brought up the medication concerns to higher up people such as the DON (Director of Nursing) or the supervisor and obtained the medications. They have the definition of neglect right in their policy." The facility's Abuse Policy and Procedure dated "10/24/2022" and reviewed on "2/18/25" shows: "The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual, or physical abuse, corporal punishment, and involuntary seclusion. The facility has a no tolerance philosophy: persons found to have engaged in such conduct will be terminated. Definitions: Neglect is a facility's failure to provide, or willful withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident. Neglect is also the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The facility's policy entitled Respite Care, dated "06/01/2024" shows, "Procedure: ...2. Medications will be ordered from the facility's pharmacy unless otherwise specified by the family. If the family failed to supply the medications on time, the facility will use its pharmacy, and the bill will be charged to the family."	S9999		

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S9999	Continued from page 10 (A)	S9999		