STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0041285	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - NAPERVILLE	**720 RAYMOND DRIVE , NAPERVILLE, Illinois, 60563**

(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 Investigations: 2575970/IL195546 2575752/IL195228	S0000		
S9999	Final Observations Statement Of Licensure Violations : (1 Of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)5) 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 300.1210. General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's	S9999		

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

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S9999	Continued from page 1 guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a diabetic resident's feet were monitored to prevent complications. This failure resulted in the resident acquiring a necrotic diabetic ulcer on her left heel. This applies to 1 out of 3 residents (R5) reviewed for foot care.	S9999		

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S9999	Continued from page 2 The findings include: R5's EMR (Electronic Medical Record) showed R5 was admitted to the facility on 10/17/2024 with multiple diagnoses, including hemiplegia and hemiparesis following cerebral infarction, diabetes, stenosis, and vascular disease. R5's EMR said she was dependent on staff assistance with her mobility and hygiene care, and at risk for developing ulcers. On 6/30/2025 at 9 AM, V24 (Wound Care Nurse/WCN) changed R5's left heel wound dressing. R5's wound was open with serosanguinous drainage. V24 said R5's diabetic wound was acquired on 3/31/2025, and now required an outpatient vascular consultation for possible vascular surgical intervention because of her wound. V24 said nursing staff was expected to perform and document routine resident skin checks, including their feet. V24 said CNAs (Certified Nurse Assistants) were also expected to check residents' skin daily when providing care and report changes such as redness or discoloration. V24 said R5's heel wound was acquired with 100% hard eschar (necrotic) tissue measuring 4.5 centimeters (cm) x 4.5 cm x depth unknown. V24 said R5's wound should have been identified prior to becoming necrotic or at a smaller size. On 6/30/2025 at 3:25 PM, V10 (Nurse) said on 3/28/2025 she assessed R5's heel. V10 said R5's heel did not appear normal because it had a hard, black wound. V10 said R5 was new to the unit, and it was unclear when she acquired the wound. V10 said CNAs were expected to complete skin checks during routine care and report any changes to prevent skin complications. On 7/01/2025 at 12 PM, V6 (Podiatrist) said her team provided routine foot care services and facility foot care recommendations. V6 said residents with diabetes and vascular disease were at a higher risk for skin deterioration to pressure point areas because of their impaired circulation and sensation. V6 said facility staff was required to check skin routinely and report any changes to the providers because residents with these comorbidities were at a higher risk for accelerated skin deterioration and complications. R5's care plan initiated on 10/29/2024, said she was at	S9999		

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S9999	Continued from page 3 risk for developing skin breakdown due to her immobility, diabetes, impaired circulation, and altered neurological status. R5's care plan included multiple skin monitoring preventions including "Inspect foot/ankle/calf skin per facility protocol/as provider orders for changes; maceration (white, wrinkly, moist), redness, purple tinge, blue, rust coloring, weeping, edema, puffiness, tenderness, area with no sensation." R5's podiatry consult note dated 3/04/2025 said R5's skin on her feet was noted dry. The consultation included general foot hygiene recommendations, including "daily look for swelling in the feet and ankles", "use lotion daily", and "reviewed the importance of getting regular foot care." R5's new skin condition note dated 3/28/2025 said R5's left heel was noted with hard, dry discoloration and swelling. R5's daily skin monitoring log from 3/01/2025-3/31/2025 showed no skin alterations were observed on her feet. R5's Skin Monitoring: Comprehensive CNA Shower Review sheets provided by the facility, dated 3/17/2025, 3/21/2025, and 3/24/2025, showed no skin alterations were observed. R5's Wound Assessment Details Report dated 3/31/2025 said R5 was at high risk for skin breakdown and had a newly acquired diabetic ulcer to her left heel. The report said the wound measured 4.5 cm length x 4.5 cm width x unknown depth, with 100% necrotic, hard, firm adherent tissue. R5's Wound Assessment Details Report dated 6/24/2025 said R5's left heel wound now measured 4.5 x 4 x 1.5 cm with 50% bright beefy red and 50% necrotic soft adherent tissue. The facility's policy titled Foot Care dated 03/2018, said "Residents will receive appropriate care and treatment in order to maintain mobility and foot health. Policy Interpretation and Implementation 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care will include the care and treatment of medical conditions associated with foot complications (e.g., diabetes, peripheral vascular disease, etc.)."	S9999		

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S9999	Continued from page 4 The facility's policy titled Prevention of Pressure Injuries dated 04/2020, said "Skin Assessment ...2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels ...). Monitoring 1. Evaluate, report and document potential changes in the skin." (B) Statement Of Licensure Violations: (2 Of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 300.1210. General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and	S9999		

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S9999	Continued from page 5 timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 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 interview and record review, the facility failed to supervise a resident with high risk for falls. This failure resulted in the resident falling and requiring hospitalization for acute traumatic brain injury, seizures, and altered mental status. This applies to 1 out of 3 residents (R1) reviewed for accidents. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on 2/29/2024 with multiple	S9999		

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S9999	Continued from page 6 diagnoses including history of falls, traumatic subdural hemorrhage, hydrocephalus with presence of cerebrospinal fluid drainage device, hallucinations, vascular dementia with moderate agitation, abnormalities of gait and mobility, unsteadiness on feet, difficulty in walking, cognitive deficit, and hearing loss. R1's EMR did not show a history of seizures. R1's MDS (Minimum Data Set) dated 8/22/2024 said R1 was severely cognitively impaired and required staff assistance with transfers. On 6/30/2025 at 3:15 PM, V9 (Nurse) said on 10/23/2024 at 12:30 PM, R1 was observed sitting on the floor in front of his wheelchair in his room. V9 said R1 was at a high risk for falls because he had a known history of falls, was confused, and impulsive. V9 said he assessed and initiated neurological checks for R1 after his unwitnessed fall. V9 said R1's neurological assessment was normal and did not appear to have any injury or change in condition. V9 said staff then assisted R1 into his wheelchair and transported him to the main dining area for lunch, where he was supervised. On 6/30/2025 at 1:50 PM, V2 (Director of Nursing/DON) said R1 was monitored after his fall per protocol, and at 3:15 PM, he was noted with a bump to his head. V2 said V5 (Nurse Practitioner/NP) was updated and gave orders to send R1 to the hospital for further evaluation. V2 said routine paramedics then transferred R1 into the ambulance when he started to have a massive seizure. V2 said the paramedics then contacted the emergency paramedics for additional support, and R1 was transferred to the hospital. V2 said R1 was admitted for altered mental status, seizure, and traumatic brain injury. V2 said the facility felt they could not determine if R1's acute change in medical condition was related to his fall incident because the facility elected to admit R1 into inpatient hospice care and not proceed with additional diagnostic testing. V2 said R1 had a known history of recurrent falls and head trauma with an intracranial bleed. V2 said fall incidents were investigated and fall prevention interventions were implemented in the residents' plan of care. On 6/30/2025 at 3:50 PM, V5 (NP) said she expected facility staff to complete a root cause analysis after a resident's fall to investigate the cause and then implement interventions to prevent reoccurrences. R1's fall care plan report initiated on 3/08/2024 said	S9999		

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S9999	Continued from page 7 R1 was at risk for falls related to his confusion, deconditioning, gait and balance problems, poor comprehension, unaware of safety needs, dementia, hallucinations, and recurrent falls. R1's care plan included multiple fall interventions, including "conduct rounds", "toilet resident and place in dining room, hallways or nurses' station for more visual supervision", and "increase supervision in the room. Monitor any attempt of self transfer." R1's fall incident reports showed he had 8 unwitnessed falls in his room prior to 10/23/2024. Falls had occurred on 3/12/2024, 4/13/2024, 5/28/2024, 7/17/2024, 8/11/2024, 8/23/2024, 8/23/2024, and 8/30/2024. The fall incident reports showed R1 falls occurred because he was trying to self-transfer in and out of his wheelchair. R1's fall incident report dated 10/23/2024 said R1 had another unwitnessed fall in his room after attempting to stand up from his wheelchair unassisted. The report said R1 was observed at 12:35 PM sitting on the floor facing his wheelchair with his legs flexed and holding on to his wheelchair. The report said after R1's fall assessment, he was then transported to the main dining room for his lunch. The report continued to say at 3:15 PM, a bump was noted to R1's right side of the head, and when being transported by medical paramedics to the hospital, he had a seizure. The report said emergency paramedics were then contacted for additional support, and R1 was transported to the hospital for further management. V17's (R1's assigned Certified Nurse Assistant/CNA) incident statement dated 10/23/2024 said, "When the incident happened, I did not witness it happening. I was helping in the dining room with passing trays and feeding residents." V9's (R1's assigned Nurse) incident statement dated 10/23/2024 said, "At the time of fall, I was at the nurse's station. Fall not witnessed." R1's hospital notes dated 10/24/2024 said R1 was admitted post-fall with a suspected significant head trauma likely subdural hematoma, acute encephalopathy, seizures, and dilated left pupil and flaccid left side. The note said R1 remained unresponsive and family elected for hospice care.	S9999		

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S9999	Continued from page 8 The facility's policy titled Falls and Fall Risk, Managing undated, said "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ...Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors(s) of falls for each resident at risk or with a history of falls ...If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ..." (A)	S9999		