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 07/11/2025

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

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S0000	Initial Comments Investigation of Facility Reported Incident of 5/29/25/IL194817 Investigation of Facility Reported Incident of 6/14/25/IL195089	S0000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)6) Section 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 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. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following	S9999		

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

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S9999	Continued from page 1 procedures: 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 were not met as evidenced by: Based on interviews and record reviews, the facility failed to implement safety interventions and provide supervision to prevent two residents from injury. These failures resulted in R2 sustaining a laceration and a displaced bilateral nasal bone fracture and acute fracture of the bony nasal septum and R3 sustaining a head laceration requiring 5 staples and being admitted to the hospital. This applies to 2 of 6 residents (R2 and R3) reviewed for falls in a sample of 12. The findings include: 1.R2’s records showed that she was a 91-year-old female admitted to the facility on 12/27/21, with diagnoses including dementia, psychosis, restlessness and agitation. R2’s record showed that on 5/29/25, R2 fell from her bed. R2’s 5/29/25 FRI (Facility Reported Incident) to the Illinois Department of Public Health showed that V5 CNA (Certified Nurse’s Assistant) reported that she removed the floor mats and began providing ADL (activities of daily living) care to R2. During care, V5 realized she did not have all the necessary supplies. V5 turned towards the dresser to retrieve the remaining items, the resident fell from the bed and struck her face on the floor. R2 was taken to the local community hospital. R2’s 5/29/25 hospital records showed that R2 sustained a laceration to her forehead and acute mild displaced bilateral nasal bone fracture and acute fracture of the bony nasal septum with leftward bowing. R2’s 5/29/25 progress notes showed that R2 returned to the facility with sutures (number of sutures not indicated) in place to be removed in 7 days. R2’s 10/18/24 care plan showed a focus on high risk for falls/injury/trauma with interventions including provided with high/low bed with floor mattress to further meet resident’s safety needs.	S9999		

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S9999	Continued from page 2 On 6/25/25 at 2:57 pm V5 said that she was providing care for R2, and she had removed the mat from the side of R2's bed, had R2's bed in a high position and then took 1 or 2 steps away from R2's bed to get wipes and a brief off the dresser. V5 said that she had her back turned away from R2 when R2 fell off the bed and hit the floor. V5 said that she saw blood and went and got the nurse. V5 said that R2 was awake at the time and that R2 has a tendency of trying to get out of the bed and falling. On 6/25/25 at 1:58 pm V9 NP (Nurse Practitioner) said that R2's laceration and nasal fracture was caused by the staff not putting the mat back next to the bed and putting bed rails up before walking away from the resident. V9 said by V5 not having the safety measures in place it caused R2 to fall causing a laceration and fractured nose. On 6/27/25 at 4:15 pm V1 (Administrator) said that V5 should have gotten the wipes and briefs before attempting to provide incontinence care for R2. V1 said that V5 should have lowered the bed and put the mats back in place and made sure the bed rails were up before she stepped away to get the needed items. V1 said that when R2 fell out of the bed it caused a fracture to her nose and a laceration. V1 said that R2 has a history of falling and attempting to get out of the bed causing falls. V1 said that staff should have been monitoring her even closer knowing she had the behaviors of attempting to get out of bed. V1 said that if V5 had put all those interventions in place, it could have prevented R2 from falling. On 6/27/25 at 1:34 pm V2 (Assistant Director of Nursing) said that when R2 fell on 5/29/25 the fall caused a nasal fracture to R2. V2 said that V5 should have brought the items to provide care before starting. V2 said that V5 should not have walked away, leaving the bed in a high position, the bed rails not up, and not putting the mats back. V2 said if those safety precautions were in place, V5 would have been proactive and that would have kept R2 safe and kept her from falling. 2. R3's electronic health records showed that he is a 94-year-old male admitted to the facility with diagnoses including Parkinson's disease, dementia, restlessness, agitation, and history of falls. R3's 6/14/25 FRI Final report that was sent to the Illinois Department of Public Health showed that on 6/14/25 around 7:30 PM R3 was being pushed in his wheelchair when he fell forward out of his wheelchair hitting his head on the floor and sustained a laceration to his	S9999		

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S9999	Continued from page 3 forehead. R3 was sent to the hospital and admitted to the hospital. R3 received five staples to his forehead from the laceration. R3's 6/14/25 hospital report shows that on 6/14/25 R3 was being pushed in a wheelchair by staff when R3 caught his foot on the floor and fell forward out of the wheelchair, hitting the front of his head on the ground. R3 sustained a large laceration to the frontal scalp and was admitted to the hospital. R3's 6/15/25 5:43 pm progress note showed that R3 returned to the facility with five staples to his forehead. R3's 6/14/25 care plan showed R3 had a risk for falls related to Parkinson's disease, dementia with agitation, anxiety, confusion and a history of falls. R3's intervention's included anticipate resident's needs, resident needs a safe environment with even floors, and staff to recline high back chair when moving resident and ensure proper positioning in chair. On 6/25/25 at 2:46 PM V7 CNA (Certified Nurse's Assistant) said that she was the CNA for R3 on 6/14/25 and she had asked V3 CNA to help her transfer R3 to bed. V7 said that V3 was pushing R3 in his wheelchair and she saw that R3's feet were on the floor and not on the footrest. V7 said that she did not tell V3 that R3's feet were on the floor and not on the footrests and she should have. On 6/25/25 at 4:37 PM V3 CNA said that on 6/14/25 when he was pushing R3 in his wheelchair he did not look were R3's feet were when he started pushing him. V3 said as he was pushing R3, R3 started going forward trying to get out of the wheelchair and then fell out of the wheelchair. On 6/26/25 at 1:58 pm V9 NP said that if R3's feet were on the footrest they would not have caught on the floor causing R3 to fall. The fall caused the laceration to R3's forehead. On 6/27/25 at 4:15 pm V1 (Administrator) said that V7 should have told V3 that R3's feet were on the ground when she saw V3 pushing R3. V1 said that could have prevented R3 from falling. V1 said V3 should have stopped pushing R3 when he saw R3 trying to get out of the chair. V1 said if staff had provided those two interventions it could have prevented R3 from falling and obtaining a laceration to his forehead. On 6/27/25 at 1:34 PM V2 (Assistant Director of Nursing) said that R3's feet should have been on the footrest. V2 said that the CNA should have put R3's feet on the footrest before pushing him down the hall so his foot would not have caught on the floor causing him to fall. V2 said that V7 should have told V3 that	S9999		

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S9999	Continued from page 4 R3's feet were on the floor when he was pushing the wheelchair to prevent R3 from falling. (B)	S9999		