		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULT	IPLE CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDIN	IG	COMPLETED	
		145710	B. WI	IG _			C 3/2012
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WBROOK MANOR - B	OLINGBROOK			31 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 4	F	323			
	Nursing) stated that facility's policy for the Stand " mechanical stated that E11 also care for 2 person as safety. Review of recorn scratches on her bat fracture of the humo transfer. R2 was se 12/31/2011 precipitat R2 was observe R2 stated " Yes, I fe machine(sit to stand	at 3:00 P.M., E2(Director of t E11 did not follow the ne proper use of the " Sit to transfer lift device. E2 also o did not follow R2's plan of ssist during transfer to ensure ad showed that R2 sustained ack and a non displaced neck erus due to the improper ont to the hospital on ated by the fall incident.					
F9999	Review of the f of mechanical trans	acility's policy for proper use sfer lift device revealed that 2 sist is required when ent. IONS	F9	999			

Facility ID: IL6013120

If continuation sheet Page 5 of 13

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IUL.		(X3) DATE SU	JRVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDI	NNG	COMPLETED	
		145710	B. WI	NG .			C 3/2012
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	VBROOK MANOR - B	OLINGBROOK			431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F9999	300.3240b) 300.3240c) 300.3240d) 300.3240e) Section 300.1210 G Nursing and Person a) Comprehensive I with the participation resident's guardian applicable, must de comprehensive card includes measurabl meet the resident's and psychosocial nor resident's comprehe allow the resident to practicable level of provide for discharg restrictive setting ban needs. The assess the active participat resident's guardian applicable. (Section b) The facility shall and services to atta practicable physical well-being of the resident's com- plan. Adequate and care and personal co- resident to meet the care needs of the resident to	General Requirements for hal Care Resident Care Plan. A facility, n of the resident and the or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with tion of the resident and the or representative, as n 3-202.2a of the Act) provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal	F9	999			
		s so that a resident who					

Facility ID: IL6013120

If continuation sheet Page 6 of 13

		AND HUMAN SERVICES				FORM	07/12/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
		145710	B. WI	NG _			C 3/2012
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOWBROOK MANOR - BOLINGBROOK					431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	motion does not ex motion unless the r demonstrates that a is unavoidable. All r and encourage resi limited range of mo treatment and servi motion and/or to pr range of motion. 4) All nursing perso encourage resident in activities of daily circumstances of th demonstrate that di This includes the re dress, and groom; i eat; and use speec functional commun who is unable to ca shall receive the se good nutrition, groo 5) All nursing perso encourage resident transfer activities as effort to help them practicable level of c) Each direct care- be knowledgeable a respective resident 6 All necessary pr assure that the resi as free of accident nursing personnel s	ithout a limited range of perience reduction in range of esident's clinical condition a reduction in range of motion hursing personnel shall assist idents so that a resident with a tion receives appropriate ices to increase range of event further decrease in onnel shall assist and ts so that a resident's abilities living do not diminish unless he individual's clinical condition iminution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; h, language, or other ication systems. A resident rry out activities of daily living prvices necessary to maintain oming, and personal hygiene. onnel shall assist and is with ambulation and safe s often as necessary in an retain or maintain their highest functioning. -giving staff shall review and about his or her residents' care plan. ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision	F9	999	9		

Facility ID: IL6013120

If continuation sheet Page 7 of 13

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTI	PLE CONSTRUCTION	(X3) DATE SL	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	IG	COMPLETED	
		145710	B. WI	\G			C 3/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	VBROOK MANOR - B	OLINGBROOK			31 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 7	F9	999			
	Section 300.3240 A	buse and Neglect					
	agent of a facility sh resident. (Section 2 b) A facility employed aware of abuse or r immediately report administrator. (Sect c) A facility adminis abuse or neglect of report the matter by the resident's repre the Act) d) A facility adminis becomes aware of shall also report the (Section 3-610 of the e) Employee as per investigation of a re resident indicates, b that an employee of perpetrator of the a immediately be bark with residents of the of any further invest disciplinary action a 3-611 of the Act) Based on observati review, the facility fa and plan of care for mechanical transfet transfer to 2 of 3(R)	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act) trator who becomes aware of a resident shall immediately v telephone and in writing to sentative. (Section 3-610 of trator, employee, or agent who abuse or neglect of a resident e matter to the Department. ne Act) petrator of abuse. When an port of suspected abuse of a based upon credible evidence, f a long-term care facility is the buse, that employee shall red from any further contact e facility, pending the outcome tigation, prosecution or gainst the employee. (Section on, interview and record ailed to follow facility's policy the proper use of the r lift device to ensure safety 1 and R2) residents reviewed					

If continuation sheet Page 8 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
A. BUILDING C A. BUILDING C B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIF	PLE CONSTRUCTION	(X3) DATE SL	JRVEY
145710 B. WING 02/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MEADOWBBOOK MANOB - BOI INGBBOOK 431 WEST REMINGTON BOULEVARD	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	G		
MEADOWBBOOK MANOB - BOLINGBBOOK 431 WEST REMINGTON BOULEVARD			145710	B. WIN	G			
MEADOWBBOOK MANOB - BOLINGBBOOK	NAME OF P	ROVIDER OR SUPPLIER						
BULINGBROOK, IL 60440	MEADOW	WBROOK MANOR - B	OLINGBROOK		-	31 WEST REMINGTON BOULEVARD OLINGBROOK, IL 60440		
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)(X5) COMPLET DATE	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
F9999 Continued From page 8 fractures precipitated by the the improper transfer. R1 and R2 had required hospitalizations due to the extent of the injuries. F9999 Findings include: 1) R1 is an 87 year old, with multiple diagnoses to include muscular dystrophy, degenerative joint disease and quadriplegia. Findings include: R1's recent MDS (Minimum Data Set) dated 11/23/2011 indicated that R1 has short and term memory impairment. R1 has also moderately impaired cognition with poor decision making. The same MDS indicated that R1 required total dependence x 2 or more persons physical assist during transfers. R1 also has impairment for range of motion on both sides to lower extremity (hip, knee, and col). Review of "Special Care Needs" and Care Plan dated 11/23/2011 showed that R1 uses total mechanical lift with 2 persons physical assist for transfers. Review of facility's "Final Report of Incident/Accident" dated 21/6/2012 showed the following descriptions: On 2/8/2011, after dinner time, E3 and E4 (CNA, certified nurse assistant) transferred R1 from recelining chair to bed with a "2 man lift." E3 and E4 did not use the total mechanical lift device. On 2/9/2012 at approximately 7:00 A.M., "(R1) complained of left hip/ back pain with pain scale of 2/10. (R1) assessment revealed left hip and thigh were swollen, left tower extremity appeared slightly shorter than the right."	F9999	fractures precipitate transfer. R1 and R2 due to the extent of Findings include: 1) R1 is an 87 year to include muscular disease and quadrip R1's recent MDS 11/23/2011 indicate memory impairmen impaired cognition v The same MDS ind dependence x 2 or during transfers. R1 range of motion on (hip, knee, ankle an Review of " Spec Plan dated 11/23/20 mechanical lift with transfers. Review of facilit Incident/Accident " of following description On 2/8/2011, afte (CNA, certified nurs from reclining chair and E4 did not use device. On 2/9/2012 at a complained of left fo of 2/10. (R1) assess thigh were swollen,	 ad by the the improper and required hospitalizations the injuries. r old, with multiple diagnoses r dystrophy, degenerative joint plegia. 6 (Minimum Data Set) dated d that R1 has short and term t . R1 has also moderately with poor decision making. icated that R1 required total more persons physical assist also has impairment for both sides to lower extremity and foot). cial Care Needs" and Care 011 showed that R1 uses total 2 persons physical assist for y's "Final Report of dated 2/16/2012 showed the ns: er dinner time, E3 and E4 se assistant) transferred R1 to bed with a "2 man lift." E3 the total mechanical lift approximately 7:00 A.M., "(R1) hip/ back pain with pain scale sment revealed left hip and left lower extremity appeared 	F99	99			

If continuation sheet Page 9 of 13

		AND HUMAN SERVICES				FORM	07/12/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		145710	B. WI	NG			C 3/2012
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - BOLINGBROOK				4:	REET ADDRESS, CITY, STATE, ZIP CODE 31 WEST REMINGTON BOULEVARD COLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	of the left femur. R 2/9/2012 and return with a splint to imm Final conclusion " (R1's) left femur c place during the tra p.m. shift, the facts transferred with tota rigidity, muscular dy placed (R1) at risk lifting and pivoting (and transferred (R1 pressure to (R1's) I resulting in the left On 2/22/2012 at Nursing) stated that transferred R1 from 2/8/2012 after dinne and E4 also did not use total mechanica further added that F that there was any transfer. E5 (CNA-certifie 2/22/2012 at 3:15 F pain on the left hip A.M. E5 also added noted on the left hip On 2/22/12 at 2: bed, awake, alert a	2/9/2012 and showed fracture 1 was sent to the hospital hed to the facility 2/11/2012 obilize the left lower extremity. of this investigation revealed could have possibly taken ansfer on 2/8/2012 on 2-10 are that (R1) has order to be al mechanical lift due to his ystrophy, quadriplegia which for fracture. The force from (R1) when (E3) and (E4) lifted 1) have caused an undue eft lower extremity thus femur fracture." 1:45 P.M., E2(Director of t E3 and E4 had improperly n a reclining chair to bed on er time. E2 also stated that E3 follow R1's plan of care to al transfer lift device. E2 R1 had no signs or indication injury prior to the improper ed nurse assistant) stated on P.M. that R1 complained of on 2/9/2012 at around 7:00 a that some swelling was also	F9	999			

If continuation sheet Page 10 of 13

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/12/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
		145710	B. WI	NG _			C 3/2012
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - BOLINGBROOK					TREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	both hands and was or turn self without interview held at the stated that he does transfer and was no information. 2) R2 is a 65 year to include CVA (cer- right hemiplegia, mo obstructive pulmona anxiety. R2's recent MDS 12/16/2011 indicate assistance x 2 or mo during transfers. R2 range of motion on elbow, wrist, hand) knee, ankle and foc Review of " Spec- Plan dated 12/16/20 "Sit to Stand Lift" m 2 person assist. Review of facilit 1/1/2012 showed th while on a "Sit to St device on 12/31/20 that R2 had "passed not able to hold on " lift device. It was als R2 was assisted by	 nity. R1 has contractures to s not able to move extremities staff assistance. On an e time of this observation, R1 not remember the improper of able to give detailed r old, with multiple diagnoses ebral vascular disease) with orbid obesity, COPD (chronic ary disease), depression and c (Minimum Data Set) dated d that R2 required extensive ore persons physical assist 2 also has impairment for the one side to upper(shoulder, and lower extremity (hip, 	F9	999			

Facility ID: IL6013120

If continuation sheet Page 11 of 13

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTI	PLE CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	IG	COMPLETED	
		145710	B. WI	۷G			C 3/2012
NAME OF P	ROVIDER OR SUPPLIER		_		REET ADDRESS, CITY, STATE, ZIP CODE	_	
MEADOV	VBROOK MANOR - B	OLINGBROOK			31 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa during the improper	-	F9	999			
	that R2 was found of around 4:35 P.M asked help when R sling of the "Sit to S that "(R2) passed of	at 3:10 P.M., E10 (CNA) stated on the floor on 12/31/2011 at E10 also stated that E11 only 2 had already slipped from the Stand" transfer lift. E10 added out and was not able to hold on pped from the sling , ending					
	Nursing) stated that facility's policy for th Stand " mechanical stated that E11 also	at 3:00 P.M., E2(Director of t E11 did not follow the ne proper use of the " Sit to I transfer lift device. E2 also o did not follow R2's plan of ssist during transfer to ensure					
	scratches on her ba fracture of the hum transfer. R2 was se	rd showed that R2 sustained ack and a non displaced neck erus due to the improper ent to the hospital on ated by the fall incident.					
	R2 stated " Yes, I fe machine(sit to stand	ed on 2/23/2012 at 12:30 P.M. ell when I slipped from the d lift). There was only one ed me when that happened."					
	of mechanical trans	facility's policy for proper use sfer lift device revealed that 2 sist is required when ent.					
	(A)						

If continuation sheet Page 12 of 13

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С		
		145710	D. WI	1		02/23	3/2012
	ROVIDER OR SUPPLIER VBROOK MANOR - B	OLINGBROOK		431 \	T ADDRESS, CITY, STATE, ZIP CODE WEST REMINGTON BOULEVARD INGBROOK, IL 60440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE

Facility ID: IL6013120