STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146093	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Manor - Lagrange	339 9th Avenue LA Grange, IL 60525

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on observation, interview and record review, the facility failed to ensure a resident identified with confusion, poor safety awareness, ambulatory, and had verbalization of wanting to exit the facility, was provided supervision to prevent elopement from the facility. The facility also failed to ensure the door on the ground floor leads to courtyard and main street was in good repair and had a working alarm system to alert facility staff of a resident attempting to exit the facility. This failure resulted in R1 eloping from the facility without being witnessed by facility staff during the early hours on December 29, 2024. This applies to 1 of 7 residents (R1) reviewed for risk of elopement in the sample of 7. R1 was found standing on the sidewalk of a local street near an intersection with 4 traffic lanes, which was approximately 183 feet from the entrance of the facility by a bystander, who alerted the police on December 29, 2024, at 5:14AM. The local police and fire department found R1 wet, with no shoes and wearing only a pair of socks and pajamas. R1 had skin injury due to a fall occurred during the elopement. The weather showed at time of occurrence was 46 degrees Fahrenheit and raining. R1 was taken to the nearby hospital by paramedics. The hospital record dated December 29, 2024, showed R1 was diagnosed with cold exposure, small bump to left side of head with dried blood and laceration. The hospital's ED (Emergency Department) report dated December 29,2024 showed (R1) arrives to ED via EMS (Emergency Medical Serves) after being found outside by police across street from the facility. This failure resulted in Immediate Jeopardy. The Immediate Jeopardy began on December 29, 2024 at 5:14 A.M. when R1 was found by a bystander who then alerted the police. V1 (Administrator) was notified of the Immediate Jeopardy on January 3, 2025 at 1:02 P.M. The Immediate Jeopardy was removed on January 04, 2025, at 11:00 A.M. Noncompliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. The findings include: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The EMR (Electronic Medical Record) shows R1 was originally admitted to the facility on [DATE]. R1, an [AGE] year old with multiple diagnoses including adrenal insufficiency, type 2 diabetes mellitus, laryngeal cancer with status post laryngectomy and tracheostomy, coronary artery disease with status post x4 (coronary artery bypass graft on 2020), hypertension, gangrenous cholecystitis with status post insertion of irrigation drain, and insertion of gastrostomy tube (on October 2024), clostridium difficile infection, hard of hearing, unsteadiness on feet, lack of coordination, major depressive disorder, adult failure to thrive and spinal stenosis. R1's MDS (Minimum Data Set) dated November 25, 2024 shows R1 had moderate cognitive impairment with BIMS (Brief Interview Mental Status) score of 9/15. On December 31, 2024 at 11:00 A.M., together with V3 (Assistant Director of Nursing), the facility's nine exit doors were checked. Two doors on the ground floor which lead to courtyard and main street were not in good repair. The first door by TV lounge/ground floor was observed with a non-functioning alarm. This door leads towards the courtyard and main street. This door would not close shut, and door remained a few inches ajar. There was a panel alarm next to this door. The alarm did not sound off when opening and closing this door. The door and the alarm were not in working condition. V3 said the door should always be closed, and alarm should sound when opening or closing the door for the staff to be alerted and checked to ensure no resident/s was outside unsupervised. V3 said the alarm should continue sounding off without staff reactivating the code of the alarm. V3 added, both the door and alarm were not in working condition and no alarm had sound off when the door was open. V4 (Director of Maintenance) came to the TV lounge door with surveyor and V3 present. V4 said the door and alarm were non-working condition, and the alarm panel was not sensing the alarm by the mother board above the door. V4 said the alarm should sound off when the door opens and closes for the staff to be alerted. V4 said since the door was not latching and not totally closing, the alarm will not sound off. V4 said, This door (TV lounge) was not locked for quiet sometime now, and anyone can come and go, especially those who smoke. V4 said he cannot remember when the TV lounge door/alarm was last checked to ensure its functionality. V4 said he was informed on December 31, 2024 sometime in the morning that R1 eloped from the TV lounge door. V4 said he will call V18 (Regional Head for the Maintenance) to help fix the non-functioning alarm and door. V4 said he checks the doors and alarms randomly but does not document what doors were last checked since it was done in random. Observation continued by touring the facility with V3. The defective TV lounge door leads to an open courtyard and to a main street. There was a pathway in the courtyard that went steep down and then inclined. Upon walking this walkway, caution and foot brakes were needed to avoid stumbling or falling. From the pathway, there was the access to the main street. There was an intersection between main street with four lanes of traffic from north and south direction of the facility. The second door by the library room on the ground floor also leads to the courtyard and to the main street. The alarm was not sounding and was not in good repair. V1 (Administrator) came and explained the alarm by the door in the library room was not functional and said the library door was locked at nighttime around 8:00 P.M. There was no documentation/log the library door was locked every 8:00 P.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On December 31,2024 at 12:00 Noon, R1 was sitting in a regular chair in his room. R1 had a tracheotomy that was capped. R1 speaks with slow raspy voice. R1 was noted to be hard of hearing. During this time, V16 (R1's spouse) was at bedside. V16 said, I was called by the staff here (R1) had left the facility without them knowing it. They said he exited by the door from the TV lounge. They told me he was found by the police and their staff across the facility's main street. I know it, that TV lounge door was always unlocked, people go in and out to smoke. That door/TV lounge was close to my husband's room. I went to the hospital at once when the staff called me around 5:20 A.M. on December 29,2024. When I went to the hospital with my daughter, and saw him (R1), he was only wearing cotton pajama, socks no shoes, no jacket and the weather was cold, was raining and was still dark. I asked him what happened, and he said, I want to go home; then when I asked him again what he was doing outside the facility he said, I do not know. I was told he fell while he left the facility. Look at this, (V16, pointing skin injuries) he got a cut on the right eyebrow, left side of forehead, and bruises on knees and ankles. He was so impulsive, weak and does not know where to go especially when he needs to go to bathroom. Since that TV lounge door was always unlock and no alarm, he left without staff knowing it. (R1) had been saying he wanted to go home. I told him to get stronger, there was a nurse who heard this conversation, and this was like a month ago. I don't remember the name of the nurse. R1 said I don't know and responded he does not remember being out of the facility and was alone during the early morning of December 29, 2024. V16 assisted R1 to the bathroom with a walker device. R1's gait was observed to be unsteady. V16 said R1 was weak, and at facility for therapy. V16 said R1 is confused at times and had said his desire to go home but does not know how to get home. On January 2, 2024 at 10:30 A.M., together with V2 (Director of Nursing), the facility's video surveillance was reviewed for the date of December 28,2024 at 11:00 P.M. going to 5:12 A.M. of December 29, 2024. The video surveillance showed R1 came out of his room at 4:05 A.M. V7 (LPN/Licensed Practical nurse) started to look for R1 at 4:53 A.M. Several staff: V8 (CNA-Certified Nurse Assistant), V10 (RN/Registered Nurse), V5 (CNA) went out the main entrance at 5:12 A.M. and all came back to the facility. V2 said, They must have found (R1) was why they all were back to the facility and R1 was taken to the hospital by paramedics. The video surveillance showed no staff went inside R1's room to check from 11:00 P.M. of December 28, 2024 through 4:53 A.M. of December 29, 2024. On December 31,2024, multiple interviews were held with the staff worked on December 28-29, 2024, from 11:00 P.M. though 7:00 A.M and assigned to R1. On December 31, 2024, at 2:08 P.M., V6 (CNA) said she took care of R1 the evening shift (3-11 P.M.) on December 28, 2024. V6 said R1 was restless, confused, impulsive and was not aware of his safety. V6 said during the evening shift on December 28, 2024, the shift prior to R1's elopement, R1 had exhibited and repeatedly verbalized wanting to go home. V6 said R1 was cued, reoriented and was assisted to go back to bed. V6 said few moments later, R1 was verbalizing again he wanted to go home. V6 said she continued to work for the next shift which was the night shift. V6 said she was on the same unit where R1 resides, but it was V5 (CNA) who was assigned to R1. V6 said R1's room was next to the TV Lounge Room that had the defective door, and the alarm was not sounding off. V6 said, The door by the TV lounge has been like that, not locking, no alarm sounding off and people including residents go in and out to smoke. We sit by the lounge area whenever we get a chance, but taking care of residents especially early morning was busiest time. Nobody was supervising or monitoring that unlocked, no alarm door and we do not know if any residents go out without us knowing. (R1) must have exited that door. There was no other door he can leave the facility being undetected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V5 (CNA) said at 2:17PM on December 31, 2024, the TV lounge door was unlocked, without an alarm and no supervision from staff. V5 stated the TV lounge lacks supervision when staff is providing care to residents. V5 said R1 must have exited the malfunctioning door/alarm since no one had heard any alarm sounding off. V5 said R1kept saying he wanted to go home. V5 said she saw R1 at 3:30 A.M. prior to elopement. Review of the facility's video surveillance indicated staff was not seen checking R1 from 11:00PM December 28, 2024, until he was noted missing on December 29, 2024, by V7 (LPN-Nurse) at 4:53AM. V7 said when she went out of the facility to look for R1 at around 5:12 A.M., she saw R1 standing by the sidewalk across the street from the facility. V7 stated R1 had passed by the main street. V7 said a bystander had called the police. V7 said R1 was wet, was wearing pajamas and socks, weather was cold, and it was still dark at the time R1 was found. On December 31, 2024, at 4:20 P.M., V10 (RN/night supervisor) said she was called by V7 when R1 had eloped from the facility on December 29, 2024, early morning. V10 said R1 was found across the street from the facility. V10 said R1 was taken by the paramedics when found. On December 31, 2024, at 1:50 P.M., V8 (CNA) said the TV lounge was not latching, and no alarm was sounding off. V8 said she did not hear alarm when R1 had eloped from facility. On December 31, 2024 at 2:37 P.M., V11 (PT/Physical Therapist/Director of Rehabilitation) said R1 was receiving skilled therapy for deconditioning since R1 was weak. V11 said R1 needed his walker device with staff supervision for safe ambulation. V11 said R1 is with bouts of confusion with poor safety awareness. On January 2,2025 at 1:00 P.M., V13 (CNA), V15 (CNA) and V14 (LPN) said doors have access to outside to the facility going to street should be locked and always alarmed. They said there was no recent training to monitor the doors/alarms. V19 (CNA) said the TV lounge door has always been unlatched, was not closing properly and alarm was not sounding when the door was fully open nor when the door was closed. V19 said residents go in and out to unlock/unalarmed door to smoke. On January 2,2025 at 12:30 P.M., V17 (R1's family member) said they thought R1 left the building through the door by the ground floor and TV room. V17 added they never heard an alarm. V17 said R1 wanted to return home but he needed to recover and was weak. V17 was upset R1 was able to exit the building and was found outside wearing only socks and pajamas. V17 stated R1 can be confused and does not know his own safety. On January 2,2025 at 2:06 P.M., V18 (Regional head of Maintenance department) said the TV lounge door exit to the courtyard and to the main street was not in working order. V18 said the sensor board above the door was short circuited, and it does not give signal to the alarm panel. V18 said he was only informed by the V1 regarding the malfunction doors and alarms on December 31, 2024 at around 1:30 P.M. V18 explained the pathway route where R1 exited had a steep pathway sloped down to at least 20-degree angle and inclined after to another 20-degree angle. The care plan dated December 29,2024 showed non-specific interventions regarding supervision and monitoring of R1's elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy dated December 2007 for Elopement showed there were no preventative measures to prevent elopement, no process for monitoring alarm doors to prevent elopement there was no procedure identify and address assessment of residents for elopement risk. The facility presented an Immediate Jeopardy removal plan on January 3, 2025; however it was returned. The second version of the plan was approved at 7:30PM, January 3, 2024. Through observation, interview and record review conducted on January 4, 2025, the surveyor confirmed the facility took the following actions to remove the immediacy of the situation: -R1 was re-assessed for Elopement risk as of January 3, 2025 to complete accurate assessment. -R1's care plan was reviewed and updated as of January 3, 2025 to include: R1 placed on monitoring while out of resident's room; R1 placed on hourly monitoring. There will be a sign off sheet to reflect his behavior, what he is doing, how is acting if he is verbalizing wanting to leave while his family is not in the facility. Wife is in the facility daily from 8 am - 2 pm. R1's wife was educated to share with the staff to alert the staff when leaving. -Facility initiated in-service on R1's direct care staff on plan of care to address elopement risk and precautions. This will continue until all direct care staff for R1 have been provided with in-service. The staff will not be allowed to work the shift without being In-serviced prior. Facility Scheduler, Nurse Supervisor, Administrator, and/or Designee will check if in-services are all completed prior to beginning of the shift. -All residents in the facility who have cognitive impairments have scored moderate BIMS and are at risk high risk for elopement have the potential to be affected by the same deficient practice, initiated January 3,2025. -All residents are being reassessed for elopement. The facility will monitor any resident that is at moderate and high risk and will make sure proper care plan is in place and will monitor resident for any significant changes. -The measures the facility will take or systems the facility will alter to ensure the problem will be corrected and not recur: Facility initiated a binder with photos of residents who are at risk of elopement and will be checked weekly and as needed by Social Service and/or Designee. This will be on an ongoing basis. Facility DON and/or Designee will conduct a daily audit of all admissions and readmissions to ensure the elopement assessment has been completed. If a resident is at high risk for elopement, DON and/or Designee will ensure elopement precautions are in place and implemented. This will be conducted daily and will be ongoing. Facility initiated the audit of resident elopement assessments of residents who are at risk of wandering and elopement and residents with cognitive impairments to ensure proper care plan is in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility removed door lever as well from the problem doors, to ensure doors are locked until alarm company will provide the sensor board. The sensor company will be at the facility Monday (January 6, 2025) to assess the problem in the motherboard. Door alarms will be checked daily to be completed by Maintenance, or the Designee or the MOD and audited by Administrator or designee. Latch to the door was lubricated and noted functional day of the survey. Facility having door alarms modified to continuously alarm so staff would physically have to go to the location to reset the alarm in the event the alarm triggers. Facility initiated in-service on direct staff on Monitoring the Exit Doors, Assessing for Resident Departure, and Reporting to Maintenance Malfunctioning Equipment. -Any staff member who has not received in-service education by the completion date will be in-serviced before the start of their next shift. Continuing education will be provided on these policies and procedures as needed. Facility has contacted low voltage repairer to come to the facility to repair the motherboard on the courtyard doors. Facility initiated in-service on direct care staff on residents identified at risk for Elopement along with Elopement Policy. Any staff member who has not received in-service education by the completion date will be in-serviced before the start of their next shift. Continuing education will be provided on these policies and procedures as needed. -Facility may utilize verbal and in-person methods for in-services. -The facility has an Elopement Binder with policy and list of residents' high risk for elopement/wandering to ensure appropriate training and in-service is provided. -Facility will schedule a Resident Council Meeting on January 6, 2025, at 2:00 PM to discuss facility's policy on going out on pass, utilization of back patio (i.e., smoking, including signing in and out when exiting the building through the front door) and when courtyard patio would be utilized by residents. -Facility held an emergency QAPI meeting. Medical Director informed of the plan. Done January 3,2025. -Receptionist received in-service education to ensure all residents who go in and out of the facility follow the sign-in and out protocol. -Staff to conduct head count on assigned residents during rounds. -Staff will be assigned to monitor and supervise residents when out in the front of the facility and/or courtyards. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Quality Assurance plans to monitor facility performance to make sure the corrective actions are achieved and permanent: Administrator will review audits weekly to ensure compliance with the measures put in place to address the safety of residents at high risk for Elopement. Administrator will ensure the Abatement Plan will be implemented and completed until compliance date and as indicated. QAPI was initiated on January 3,2025 to discuss with QA Committee the Abatement Plan and ensure all corrective actions and safety measures are consistently implemented. Medical Director notified via phone of the plan.