STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145843	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller Health Care Center	1601 Butterfield Trail Kankakee, IL 60901

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to provide timely incontinence care. This applies to 1 of 4 residents (R2) reviewed for incontinence. Findings include: R2 was admitted to the facility on [DATE]. R2 has primary diagnoses that includes spondylosis with myelopathy, functional quadriplegia, type 2 diabetes, hypertension, major depressive disorder and tremor. R2's care plan dated 4/5/24 includes ADL (Activities of Daily Living) self-care performance deficit related to limited mobility, musculoskeletal impairment and functional quadriplegia. Functional bladder incontinence related to impaired mobility, and physical limitations. Interventions include to clean peri area with each incontinent episode. On 4/30/24 at 11:25 AM R2 stated the staff had not checked in on him and he needed to be washed. R2 stated the staff do not always check and turn him every two hours. On 4/30/24 at 11:33 AM V4 CNA (Certified Nursing Assistant) was asked by surveyor to provide incontinence care to R2. R2's top sheet was covered in brownish gray stool. His blanket was saturated with urine R2 had a copious amount of stool sitting between his legs down to his knees. When V4 opened R2's disposable brief there was stool entirely covering his penis, pubis and up to his lower abdomen. When R2 was turned over he had stool to just below his shoulder blades. R2's scrotum appeared reddened. The waterproof pad was covered with stool and the bottom sheet was soaked with urine. On 4/30/24 at 11:58 AM V5 CNA assigned to R2 stated he is a heavy wetter and has heavy stools. V5 stated she checks residents every 2 to 3 hours. V5 stated she should probably check him every 1 to 2 hours because he voids heavily and frequently. On 4/30/24 at 4:31 PM, V3 (Wound Nurse) stated V3 stated if someone is left in urine and stool for extended periods time or not turned every two hours, they can develop skin break down. Peri care should be provided every two hours or sooner if necessary. On 5/1/24 at 3:16 PM, V1 (Administrator) stated staff should be turning and checking residents every two hours. V1 stated there have been a lot of complaints from residents stating they aren't being assisted every two hours the longest was four hours. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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Miller Health Care Center	1601 Butterfield Trail Kankakee, IL 60901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Incontinence dated 6/2023 states residents who are incontinent of urine and feces, or both are kept clean dry and comfortable while maintaining their dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to provide skin assessments for skin injuries. This applies to 3 of 4 residents (R1, R3 and R4) reviewed for skin conditions. Findings include: 1. R1 admitted to the facility on [DATE] and discharged from the facility on 4/22/24. R1 has diagnoses that includes cellulitis, chronic obstructive pulmonary disease, chronic gout, malignant neoplasm of prostate, type 2 diabetes, obstructive sleep apnea, chronic kidney disease, hypertension and atherosclerotic heart disease of native coronary artery. Care plan dated 4/17/24 has Risk for impaired skin integrity. Interventions includes evaluate skin for blanching, redness, excoriation and skin integrity. Provide skin care per facility guidelines and as needed. The MDS (Minimum Data Set) dated 4/22/24 shows R1 is cognitively intact. R1 required partial staff assistance with toilet transfers. R1 was assessed to be always continent of bowel and bladder. R1's hospital discharge paperwork includes an infectious disease progress note dated 4/16/24. Note states bilateral feet with diffuse skin scaling, bilateral feet with edema left greater than right but no longer TTP (Thrombotic Thrombocytopenic Purpura) in the feet or ankles. No rash skin is dry. Right calf wound dressed clean dry and intact. No nursing skin observation of wounds were documented until 4/19/24 by V3 Wound Nurse. The chronic traumatic right medial calf wound measured area of 6.57 cm2, length 4.19cm, width 2.32 cm, depth 0.1cm. The left dorsum foot measured area of 0.17cm2, length 0.45 cm, width 0.47cm and depth of 0.1 cm. Facility CNA (Certified Nursing Assistant) documentation of skin observations from 4/18/24 thru 4/21/24 documents no scratches, red area, discoloration, tear or open area. On 4/26/24 at 2:54 PM V11 (Family Member) stated every time she came to the facility V11 stated wounds on R1's feet developed in the facility and was soiled with urine. On 5/1/24 at 11:39 AM, V3 (Wound Nurse) stated she saw R1 and assessed his wounds on 4/19/24. V3 stated the admitting nurse should have done a skin and wound assessment on admission 4/17/24. 2. R3 was admitted to the facility on [DATE]. R3 has diagnoses that includes type 2 diabetes, chronic obstructive pulmonary disease, chronic kidney disease, functional quadriplegia, cerebral atherosclerosis and history of transient ischemic attack. R3's physician orders include a head-to-toe evaluation every day shift on the 27th. None was provided by the facility. The care plan dated 3/39/24 includes an ADL self-care performance deficit related to functional quadriplegia, dementia and cerebral atherosclerosis. C.N.A documentation not skin redness. No nursing skin assessment documentation was available for review for R3. On 4/30/24 at 11:54 R3 stated she had a sore on her buttocks. R3 stated staff do not check her every two hours. On 4/30/24 at 12:06 PM V4 CNA was observed performing incontinence care for R3. Surveyor noted a pea sized open area on the skin to R3's left inner buttock. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 4:15 PM, V4 CNA stated she had cleaned R3 up but had not seen the open area before it was pointed out by surveyor. 3. R4 was admitted to the facility on [DATE]. R4's diagnoses include cerebral atherosclerosis, Alzheimer's disease, congestive heart failure age related osteoporosis, and osteoarthritis. R4's physician orders include admit to hospice care, head to toe assessment monthly on the 19th, turn and reposition every 1.5 to 2 hours. R4's care plan dated 3/1/24 states R4 has a self-care performance deficit related to Alzheimer's and cerebral atherosclerosis. Resident requires extensive assistance by staff to turn and reposition in bed. R4's MDS dated [DATE] show cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 6. On 4/30/24 at 12:35 PM, V6 (Family Member) stated she comes to visit R4 3 to 4 times per week and stays 3 to 4 hours. V6 stated there have been visits she has had to ask staff to turn and clean R4 because they had not done it after 3 hours. V6 stated she and the hospice nurse are the ones who have notified facility staff of skin issues. On 4/30/24 at 12:59 PM V7 RN (Hospice Registered Nurse) stated R4 is [AGE] years old and very thin, but she could not say her skin wounds and irritation were [NAME] wounds. V7 stated not being moved for 3 to 4 hours will cause skin break down. V7 provided incontinence care to R4. R4 had a border foam dressing in place on coccyx dated 4/26. V7 removed the dressing. R4's buttocks and sacrum were reddened. R4 had blanchable redness to her right hip. On 4/30/24 at 5:27 PM, V9 LPN (Licensed Practical Nurse) stated V7 Hospice RN informed her R4 had skin redness. V9 stated she has seen border foam dressings in place for as long a 5 to 7 days when used for protection. V9 stated skin assessments are done weekly by the nurse on shower days. CNAs / shower aids do skin assessment twice per week during the shower or bed bath. On 4/30/24 at 4:31 PM, V3 (Wound Nurse) stated the coccyx wound for R4 had healed and she signed off on 4/24/24. If something new develops she depends on staff to alert her. CNAs and Nursing staff should be doing skin checks during cares, bed baths and showers. V3 stated R4 should have had a skin assessment since she saw her on 4/24/24. V3 stated if someone is left in urine and stool for extended periods time or not turned every two hours, they can develop skin break down. Peri care should be provided every two hours or sooner if necessary. On 5/1/24 at 10:35 AM, V10 LPN (Licensed Practical Nurse) stated Nurses don't do skin checks, on shower days the CNA's do the skin checks. If there is a skin concern the CNA's let the nurse know. Nurses do the quarterly skin assessments. On 5/1/24 at 2:43 PM, V2 ADON (Assistant Director of Nursing). V2 stated nurses should do a skin assessment on admission and shower days. The CNA should document on the shower sheet and notify the nurse of any new issues. The nurse is responsible to notify the Nurse Practitioner or Physician of any issues. V2 stated the facility nursing staff is still doing skin assessments for resident receiving hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 3:16 PM, V1 (Administrator) stated staff should be turning and checking residents every two hours. V1 stated there have been a lot of complaints from residents stating they aren't being assisted every two hours the longest was four hours. V1 stated the admissions nurse do a head-to-toe assessment and document any wounds on admission. If there is a wound the wound nurse should be notified. The facility policy General Requirements for Nursing and Personal Care [NAME] date 6/2023 states .an evaluation of each resident shall be conducted upon admittance and as necessary to determine the susceptibility of the resident to skin breakdown. Preventative measures and treatment shall be carried out by the facility staff .