

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2024
NAME OF PROVIDER OR SUPPLIER Miller Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746</p> <p>Based on interview and record review the facility failed to resolve residents' concerns.</p> <p>This applies to 3 of 6 residents (R2, R4 and R5) reviewed for call light concerns in the sample of 8.</p> <p>The findings include:</p> <p>1. On July 2, 2024 at 3:33 PM, R5 was in bed, alert, oriented and verbally responsive. R5 stated that the staff takes too long to answer his call light and that there are times that it takes more than 30 minutes for the staff to respond. According to R5 he would activate his call light when he needed assistance from the staff.</p> <p>R5's MDS (minimum dated set) dated June 28, 2024 showed that the resident was admitted to the facility on [DATE]. R5 was cognitively intact and would require maximum assistance from the staff with most of his ADLs (activities of daily living), including lower body dressing and transfer. The same MDS showed that R5 was frequently incontinent of both bowel and bladder functions and required total assistance from the staff with regards to toileting hygiene.</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's alarm response report for R5's bed call light system from June 21, 2024 through July 1, 2024 showed the following: on June 22 at 9:37 AM, it took 59 minutes to respond to R5's call light; on June 22 at 6:39 PM, it took 51 minutes to respond to R5's call light; on June 22 at 10:15 PM, it took 33 minutes to respond to R5's call light; on June 23 at 1:17 PM, it took 48 minutes to respond to R5's call light; on June 23 at 3:29 PM, it took 43 minutes to respond to R5's call light; on June 24 at 2:28 AM, it took 29 minutes to respond to R5's call light; on June 24 at 6:39 PM, it took 51 minutes to respond to R5's call light; on June 25 at 2:36 PM, it took 30 minutes to respond to R5's call light; on June 25 at 5:56 PM, it took 21 minutes to respond to R5's call light; on June 25 at 7:04 PM, it took 29 minutes to respond to R5's call light; on June 25 at 8:25 PM, it took 38 minutes to respond to R5's call light; on June 26 at 7:29 AM, it took 35 minutes to respond to R5's call light; on June 27 at 8:26 PM, it took 25 minutes to respond to R5's call light; on June 28 at 1:34 AM, it took 27 minutes to respond to R5's call light; on June 28 at 6:56 AM, it took 1 hour and 13 minutes to respond to R5's call light; on June 29 at 3:55 PM, it took 27 minutes to respond to R5's call light; on June 30 at 6:35 AM, it took 39 minutes to respond to R5's call light; on June 30 at 8:33 AM, it took 31 minutes to respond to R5's call light; on July 1 at 7:15 AM, it took 55 minutes to respond to R5's call light and on July 1 at 8:24 AM, it took 32 minutes to respond to R5's call light. Further review of the same alarm response report for R5's bathroom call light system showed that on June 22, 2024 at 10:03 AM, it took 34 minutes for the staff to respond to R5's call light.</p> <p>2. On July 2, 2024 at 3:37 PM, R4 was sitting in her wheelchair inside her room. R4 was, alert, verbally responsive and was able to answer questions appropriately. R4 stated that the staff takes too long to answer her call light. According to R4 she would use her call light when she needed help from the staff.</p> <p>R4's admission MDS (minimum dated set) dated June 21, 2024 showed that the resident was admitted to the facility on [DATE]. The MDS showed that R4 was moderately impaired with cognition and required maximum assistance from the staff with regards to upper body dressing, bed mobility and transfer. The same MDS showed that R4 was incontinent of both bowel and bladder functions and required total assistance from the staff with regards to lower body dressing and toileting hygiene.</p> <p>Review of the facility's alarm response report for R4's bed call light system from June 15, 2024 through July 2, 2024 showed the following: on June 17 at 6:59 AM, it took 20 minutes to respond to R4's call light; on June 21 at 7:46 AM, it took 29 minutes to respond to R4's call light; on June 21 at 8:33 AM, it took 21 minutes to respond to R4's call light; on June 21 at 1:25 PM, it took 19 minutes to respond to R4's call light; on June 22 at 9:17 AM, it took 53 minutes to respond to R4's call light; on June 22 at 11:51 AM, it took 24 minutes to respond to R4's call light; on June 22 at 2:49 PM, it took 20 minutes to respond to R4's call light; on June 22 at 6:33 PM, it took 39 minutes to respond to R4's call light; on June 27 at 8:36 AM, it took 23 minutes to respond to R4's call light; on June 27 at 12:29 PM, it took 41 minutes to respond to R4's call light; on June 28 at 5:47 PM, it took 25 minutes to respond to R4's call light; on June 29 at 9:20 AM, it took 25 minutes to respond to R4's call light; on July 1 at 6:21 AM, it took 22 minutes to respond to R4's call light and on July 2 at 5:35 AM, it took 26 minutes to respond to R4's call light. Further review of the same alarm response report for R4's bathroom call light system showed that on June 28, 2024 at 6:06 PM, it took 25 minutes for the staff to respond to R4's call light.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. On July 2, 2024 at 2:55 PM, R2 was in bed, alert, verbally responsive and was able to answer questions appropriately. V7 (sister) was at the bedside. R2 stated that the staff takes too long to answer his call light and there are times that it took the staff at least 15 minutes or more to respond to his call light. According to R2 he would use his call light when he needed help from the staff.</p> <p>R2's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognition and required total assistance from the staff with most of his ADLs including bed mobility, transfer, toileting hygiene and personal hygiene. The same MDS showed that R2 was totally incontinent of both bowel and bladder functions.</p> <p>Review of the facility's alarm response report for R2's bed call light system from June 15, 2024 through July 2, 2024 showed the following: on June 15 at 2:20 PM, it took 15 minutes to respond to R2's call light; on June 16 at 1:21 PM, it took 22 minutes to respond to R2's call light; on June 17 at 8:19 AM, it took 31 minutes to respond to R2's call light; on June 17 at 10:27 AM, it took 18 minutes to respond to R2's call light; on June 18 at 11:10 AM, it took 22 minutes to respond to R2's call light; on June 18 at 7:21 PM, it took 15 minutes to respond to R2's call light; on June 21 at 2:19 PM, it took 28 minutes to respond to R2's call light; on June 22 at 2:43 PM, it took 17 minutes to respond to R2's call light; on June 23 at 6:26 PM, it took 17 minutes to respond to R2's call light; on June 24 at 10:36 PM, it took 16 minutes to respond to R2's call light; on June 27 at 8:45 AM, it took 31 minutes to respond to R2's call light; on June 29 at 9:21 AM, it took 21 minutes to respond to R2's call light; on June 30 at 12:52 PM, it took 15 minutes to respond to R2's call light; on June 30 at 4:00 PM, it took 16 minutes to respond to R2's call light; on June 30 at 9:30 PM, it took 17 minutes to respond to R2's call light and on July 1 at 7:33 AM, it took 38 minutes to respond to R2's call light.</p> <p>On July 5, 2024 at 11:00 AM, V2 (Director of Nursing) stated that she expected all staff including nursing, social service, activity and housekeeping staff to answer the resident's call light to find out what the resident needed and then inform the appropriate staff about the resident's need. V2 further stated that she expects the resident's call light to be answered within 15 minutes or sooner to check the resident and ensure that their needs are attended timely.</p> <p>Review of the resident council report from April through June 2024 showed that individual questions were posed to residents during a 1:1 meeting as part of the resident council. The same resident council report showed multiple individual concerns from residents with regards to having to wait too long for their call lights to be answered by the staff. Further review of the resident council report showed no documentation that the individual concerns of the residents with regards to the call lights were investigated. There was no documentation available regarding the conclusion of their investigation. There was also no documentation of any action and/or resolution taken by the facility to resolve the concerns.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 6, 2024 at 1:00 PM, V1 (Administrator) stated that the residents prefers a no-group setting and wanted a 1:1 meeting with the activity director during the resident council, to voice their concerns/grievances for privacy. V1 acknowledged that there are no documentation that the call light concerns/grievances made during the resident council were investigated and what actions were taken to resolve the concerns. According to V1, after she received the concerns/grievances from the resident council regarding the delayed call light response, she delegated the said concerns to the nursing department, to investigate and resolve the issues but admitted that she does not know if the call light concerns were investigated and that necessary actions were taken to resolve the problem. According to V1, they will say, I took care of that. During the same interview, V1 stated that any staff including nursing, activity, social service or housekeeping can answer a resident's call light and that she expects the staff to answer the call light within 15 minutes or sooner to attend to the resident's needs in a timely manner. According to V1, the facility does not have any policy and procedure with regards to call light response time, however, the facility staff is expected to attend and provide the needs of the residents timely.</p>		