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	02/10/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess a resident after CNA (Certified Nurse Assistant) was unable to obtain resident's blood pressure or heart rate and failed to document resident's code status in the medical record.This failure resulted in an Immediate Jeopardy (IJ). The Immediate Jeopardy began on [DATE] around 6:30 AM when V33 (Agency RN) did not assess R18 after V35 (CNA/Certified Nurse Assistant) notified V33 that she was unable to obtain a blood pressure or heart rate on R18. Around 7:45 AM, V33 (Agency RN) found R18 unresponsive and left R18 to find V16 (RN/Registered Nurse). V16 said V33 told her she thought R18 expired and R18 was DNR (Do Not Resuscitate). Around 8:00AM, R18 was found unresponsive by V41 (Respiratory Therapist) and V3 (LPN/ Acting ADON/Assistant Director of Nursing) and CPR (Cardio-Pulmonary Resuscitation) was initiated. 911 was called at 8:33 AM by V42 (Dietary Aide/CNA). Per ambulance run report, Paramedics arrived on scene at 8:38 AM and resuscitative efforts including intubation attempts ceased at 8:59 AM and R18 was pronounced deceased . This applies to 1 resident (R18) reviewed for emergency response and code status availability in medical record and has the potential to affect all residents in the facility.V1 (Administrator) was notified of the IJ on [DATE] at 12:01 PM and the IJ template was provided.The facility presented an Immediacy Removal Plan on [DATE] at 2:45 PM that was returned for revisions at 3:57 PM. The second Removal Plan was accepted on [DATE] at 6:12 PM.The surveyor confirmed the immediacy was removed on [DATE] at 2:49 PM; however, the facility remains out of compliance at a severity level II due to the need to evaluate the new agency orientation checklists for completion including initiation of CPR and code status documentation, all staff reeducation on Change in Resident Condition Policy, Emergency response escalation, CPR Policy, DNR Order Policy, nurse responsibilities for new admissions, and Quality Assurance Monitoring.The findings include:On [DATE] at 3:46 PM, V33 (Agency RN) said on the morning of [DATE] around 6:30 AM, V35 (CNA) told her that she could not get a blood pressure or heart rate for R18. V33 said she continued to pass her morning medications to other residents and around 7:45 AM when she went in to give R18 medications, she found R18 unresponsive. V33 said she then attempted, unsuccessfully, to recheck R18's vital signs with the vitals machine and listened for R18's heartbeat with her stethoscope, but found R18 did not have a heartbeat. V33 said she then left R18's bedside and went to find V16 (RN), who was working a different hall. On [DATE] at 1:24 PM, V33 (Agency Nurse) said she was R18's admission nurse and V12 (LPN) took report from the hospital on R18 for V33. V33 said V12's report paper had R18's code status on it, but V33 didn't remember what the code status was. V33 said it is the admission nurse's responsibility to enter the resident's code status in the electronic medical record. On [DATE] at 11:17 AM V16 (RN) said V33 came to her on the morning of [DATE] during her medication pass and told her, I think my patient expired. V16 said she then asked V33 what R18's code status was and while walking away from V16, she heard V33 say DNR. V16 said she then went to R18's room to verify she had (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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital prior to her admission to the facility was partial code as of [DATE]. In the hospital, prior to R18's admission to the facility, her code status order showed: No Mechanical Ventilation with Intubation, Selective Cardio Resuscitation, No Chest Compressions, and No Defibrillation/Cardioversion.R18's Face sheet shows she was admitted to the facility on [DATE] with primary diagnosis of Acute Respiratory Failure with Hypoxia and she had no Advance Directive or code status listed. R18's POS (Physician Order Sheet) shows she had no physician order for code status. R18 had been admitted to the facility for approximately 16 hours at the time of her code blue and she did not have any nursing assessment documented or vital signs.On [DATE] at 10:24 AM V2 (DON) said if the CNA notifies the nurse they could not obtain a blood pressure and heart rate on a resident, the nurse should assess that resident immediately. V2 said if a resident is found unresponsive and there is no code status listed in the medical record, the staff should immediately proceed with compressions. V2 said timely initiation of CPR is important because there is a short period of time the staff have to get the resident back and they want to minimize any damage to the organs caused by lack of blood flow and oxygen. V2 said every minute is detrimental once the resident is found unresponsive. On [DATE] at 3:17 PM, V2 (DON/Director of Nursing) said the resident's code status should be entered into the computer right when the resident arrives when they are entered into the computer system. V2 said the code status needs to be entered right away so staff do not have to spend time looking for the resident's code status in the event of an emergency, and this is important because they want to honor the resident's wishes if they are found unresponsive. On [DATE] at 5:08 PM, V1 (Administrator) verified R18's facility record did not show any advance directive or code status. V1 said the resident's code status should be obtained first thing when a new admission comes, before any other parts of the admission are done. V1 said she was not aware V45 (R18's Son) told V4 R18 did not want to be intubated. On [DATE] at 1:16 PM, V43 (Admissions Director) said a resident's code status should be obtained before the admission comes and if there isn't a code status on file, there should be a physician order entered saying full code so the nursing staff know how to proceed until social services is able to discuss Advance Directives with the resident. V43 said she cannot locate any documentation showing that R18 wanted to be a full code. V43 said in R18's hospital chart it said she was a partial code, and that was not discovered until after she had died.The facility's policy titled, Resident Admissions last revised 5/2024 states, .Procedure: The admitting nurse shall use the PCC (PointClickCare) EMR (Electronic Medical Record) system admission process for all resident admissions. These processes include, but are not limited to the following tasks within the system: A. Add resident/Patient B. Create admission C. Assign Bed D. Advance Directives.The facility's policy titled, Advance Directives- [NAME] last revised 1/2020 states, Policy: [NAME] Rehabilitation supports the right of all residents to participate in their own health care decision making including the right to decide whether they wish to accept or refuse life-prolonging measures or other treatments. [NAME] Rehab also supports the right of residents to prepare an Advance Directive declaration or statement which clearly expresses the resident's wishes regarding the use of life-prolonging procedures and designating another person to make treatment decisions in the event that the resident becomes incapable of communicating his or her choices or wishes. Procedure: A. Upon admission, written information will be provided to residents informing them of their rights under State law regarding health care decision-making, including the right to prepare advance directives. A signed acknowledgement that such information has been received will be required, and notation will be made in the resident's medical record as to whether or not an advance directive has been prepared and presented.The facility's policy titled, Cardio-Pulmonary Resuscitation (CPR) last approved 01/2026 states, Policy: Basic life support is an emergency first (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aid procedure that consists of recognizing respiratory and cardiac arrest and starting the proper application of cardio-pulmonary resuscitation to maintain life until the resident recovers sufficiently or until advanced life support is available. This includes the C-A-B steps of CPR: A. Circulation B. Airway C. Breathing Any trained staff members should initiate basic life support immediately upon recognition of the need to do so.The IJ that began on [DATE] was removed on [DATE] at 6:12 PM when the facility took the following actions to remove the immediacy:Audit of resident code status was completed, to ensure all current residents had a code status.V3 provided education on code status and emergency response expectations were reinforced with all nursing staff.Cessation of any practice of delaying CPR due to verbal assumptions of DNR status.The facility implemented a directive that all residents will be treated as full code unless a valid physician DNR order is present and accessible in the medical record.100% audit of all current resident charts was completed to verify presence of physician code status orders.V3 provided an audit to ensure the DNR status was accurately reflected on nursing shift to shift reports and matching the DNR status in the chart.Emergency code status roster placed at all nurse's stations for rapid access.New language added to the facility's change in condition policy: Nursing staff must immediately assess when vitals signs cannot be obtained. Nurse must not delay in assessment of escalation.Nursing leadership will educate all staff, including agency, on shift by 6PM on the following policies: Do not Resuscitate Order Policy, Cardio-Pulmonary Resuscitation (CPR) Policy, and Change in Resident Condition Policy. Nursing leadership will educate all remaining staff prior to their next worked shift.Nursing staff will be reeducated on rooming responsibility for new residents including: clinical assessment completion within 2 hours of patient's arrival to the building, and completion of a move-in note. This will be audited daily by DON.Implement checklist for admissions including DNR status to validate patient wishes prior to arrival. Director of Sales and Marketing to audit daily.Immediate requirement for licensed nurse assessment without delay upon inability to obtain vital signs or change in condition.Immediate re-education of staff that CPR must be initiated unless a physician DNR order is confirmed.Verified all current agency staff have completed orientation checklist prior to taking an independent patient assignment.QAPI Action Plan to be completed including the following audits: admission code status complete upon admission, admission checklist with code status known prior to admission, nursing assessment completion within 2 hours of admission by admitting nurse, nursing completion of move-in note upon admission, agency checklist completion audit for new agency staff-checklist complete prior to taking full assignment, Mock CPR code completion weekly on each shift.

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F 0684 Level of Harm - 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** Based on interview and record review, the facility failed to assess and notify the provider of changes in a resident's condition after fall incident with injuries and pain for R2 and R6. This resulted in a delay of treatment for R2 and R6 for pain and a fracture from a fall incident. The facility failed to notify the provider of R4's change of condition that included vomiting blood and black tarry stools that resulted in the need for hospitalization and blood transfusions. This applies to 3 of 3 residents (R2, R4, and R6) reviewed for resident injury and improper nursing. The findings include: 1. R2 was admitted to the facility on [DATE] with multiple diagnoses which included mesothelioma, peripheral vascular disease, neoplasm-related pain, muscle weakness, difficulty in walking, osteoarthritis, and periprosthetic fracture around internal prosthetic right hip joint per the EMR (Electronic Medical Record). R2's Progress Note, Late Entry, created on 06/02/24 at 2:25 PM, effective date of 05/29/24 at 2:12 PM, showed On 05/29/24 about 1650 (4:50 PM) I witnessed/heard alarm as R2 got up from recliner in the day room and started to walk. I was at the nurses station and went to stop him. Before I could reach him, he fell forward hitting the right side of his head on the table, and he started to bleed. I applied pressure to the wound while (Nurse) did vitals, called family, physician, and sent him to the hospital for eval. On 01/21/26 at 2:33 PM, V8 (RN/Registered Nurse) stated on 05/29/24, during shift change, R2 had a fall. V8 stated she did not witness the fall but assisted the nurse who witnessed the fall. V8 stated she obtained R2's vitals and waited with R2 until EMS (Emergency Medical Services) arrived to transport R2 to the ER (Emergency Room). V8 stated R2 returned to the facility from the ER the same night. V8 stated R2's return from the ER was not documented in the medical record. V8 stated after a resident has a fall, the nurses complete a three-day, head-to-toe assessment on the residents. V8 stated if a resident reports new pain after a fall, the provider should be notified. V8 stated the provider should have been notified of R2's complaints of pain in the right thigh. V8 stated R2 should have had x-rays after the fall on 05/29/24. On 01/21/26 at 3:35 PM, V9 (RN) stated R2's wife informed her that R2 had fallen a few days ago and had been complaining of pain in the right leg and foot. V9 stated she noticed R2 did not get an x-ray of the right leg or hip when he fell a few days prior and went to the hospital. V9 stated if a resident falls and is complaining of a new onset of pain, the provider should be contacted. On 01/21/26 at 11:09 AM, V7 (Physical Therapy Assistant) stated R2 was evaluated for therapy on 05/23/24. V6 stated upon evaluation, R2 was able to ambulate 200 feet without pain. V7 stated R2 was seen again for physical therapy on 05/24/24, 05/27/24, 05/28/24, and 05/30/24 without complaints of pain. V7 stated on 05/30/24, a change with R2's gait was noticed. V7 stated there was no documentation of the nurse being notified of the change in gait. V7 stated on 05/31/24 R2 was seen for physical therapy. V6 stated while R2 was ambulating, R2 presented with an antalgic gait pattern (painful, slow gait speed, and decreased stance on his right lower extremity). V7 stated R2 described the pain level as five out of ten to the right lower extremity. V7 stated when residents have a change in their gait or complaints of pain, the nurse should be notified of the change in condition. On 01/27/26 at 3:40 PM, V2 (DON/Director of Nursing) stated the nurses are expected to document on falls for 72 hours after the fall. V2 stated if there are any changes with pain, new symptoms, or new injuries, the doctor must be notified. On 02/02/26 at 1:30 PM, V49 (MD/Medical Doctor) stated the nurses should immediately report to the medical providers caring for the residents when there is new pain after a fall. V49 stated he expects the nurses to thoroughly assess the residents, monitor new symptoms, and notify the provider of changes. V49 stated if they are not notified, more injuries could occur.R2's EMR (Electronic Medical Record) showed: Vitals and Pain only (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	note dated 05/30/24 at 12:47 AM, showed, Vocal complaints of pain. New location: right thigh generalized. Pain socre:2. Skilled Evaluation dated 05/30/24 at 3:56 AM, showed, Pain: Right thigh generalized. Pain core 2. Advanced Skill Evaluation dated 05/30/24 at 11:53 PM, showed, Pain: Right thigh generalized. Pain score: 2. Advanced Skilled Evaluation dated 05/31/24 at 11:31 PM, showed, Pain: Right thigh generalized. Pain score: 2. Advanced Skilled Evaluation dated 06/01/24 at 9:30 PM, showed, Pain: Right thigh generalized. Pain score: 5. Aching. R2's Progress Note dated 06/02/24 at 1:06 PM, showed, Patient complaining of right hip pain and states he is unable to move right foot. Patient wife reports that patient was sent to (Hospital) ER on 05/29 from a fall here at (Facility). Patient's chart from (Hospital) shows head CT, results were negative, but no Xray of right hip. MD paged at this time. Progress Note dated 06/02/24 at 1:38 PM, showed, MD (Name) called back. Stated reasonable to send patient to ER for Xray. Ambulance called and arrived to (Facility) at 1:30. Patient left via ambulance at 1:35, wife accompanying. Report called to (Hospital) ER. Progress Note dated 06/02/24 at 4:36 PM, showed, Writer checked Epic for update on patient. Results are periprosthetic fracture of hip. On call nurse, (Name), called and informed.R2's MAR (Medication Administration Record) for May 2024 showed prior to R2' fall on 05/29/24, R2 had active orders for Oxycodone 5 mg. The same MAR showed R2 did not take any Oxycodone in May 2024. R2's progress notes and skilled evaluation notes showed no complaints of pain to the right thigh or leg prior to the fall on 05/29/24. R2's progress notes and assessments showed no documentation of notifying any provider of the change in R2's gait, or the onset of pain to R2's right extremity until 06/02/24. R2's (Hospital) Emergency Department Provider Notes dated 05/29/24 at 10:37 PM, showed, Patient is an [AGE] year-old male who presents to the emergency room, chief complaint of head injury. Patient states that he hit the back of his head, states that he otherwise had no injury anywhere else. Patient denies any pain throughout any other aspect of his body, states that he had cut to the back of the head, which has since stopped bleeding. Musculoskeletal: Negative for neck pain. and neck stiffness. Injury to the back of the head. Head: Normocephalic. Comments: Patient has a laceration on the right parietal aspect of the head; however, laceration is shallow and is not bleeding at time of assessment. Medical Decision Making: patient presents to the emergency room, chief complaint of head injury, this time CT (Computed Tomography) head will be obtained. Throughout the rest of his exam, there is no evidence of trauma or injury. Patient CT head is negative. Patient is provided fluids and is then discharged home. (Hospital) Healthcare Emergency Department Provider Notes dated 06/02/24 at 5:15 PM, showed, R2 is an [AGE] year-old male with a history of CAD (Coronary Artery Disease), mesothelioma, hyponatremia presenting for right hip pain after a ground-level fall 2 days ago. Patient was seen in the ER at that time, however, did not have hip pain, and complained of head pain, and a had laceration which was repaired in the ER. Patient had a CT of his brain at that time which was also unremarkable. Patient discharged back to the facility where he even completed a day of physical therapy. He was transferred back to the facility that he was in. Musculoskeletal: Limited range of motion of right hip due to discomfort. Full range of motion of hip flexion extension of left hip. Patients notably have minimal discomfort with passive range of motion of the right hip. There is questionable shortening of the right hip approximately 1 cm (centimeter). X-ray hip right 2 views: Final Result, Findings/Impression: The bones are demineralized. Status post right hip arthroplasty with an acute comminuted periprosthetic fracture through the proximal diaphysis extending to the level of the tip of the femoral stem. Fracture also involves the base of the lesser trochanter, which is distracted by at least 8 mm (millimeter). Additional displaced fracture component through the greater trochanter. Clinical impression: Periprosthetic fracture of hip. Medical Decision Making: Discussed with our orthopedic surgeon as well as (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	orthopedics who state they do not have the ability to repair this type of fracture. Discussed with (Hospital) Ortho who are agreeable to transfer at this time for likely operative fixation. Family notified of the plan to transfer to (Hospital). (Hospital) Encounter Summary, Orthopaedic Surgery Progress Note dated 06/07/24, showed, Underwent ORIF (Open Reduction and Internal Fixation) R femur with Doctor (Name) on 06/03/24. Progress Notes dated 06/08/24 at 12:00 PM, showed, Patient returned to facility per vehicle in wheelchair. Vital signs stable, reports not happy to be back. Family in to see. No report received from (Hospital). Orders entered. Progress Note, Medical Professional Note, dated 06/10/24 at 1:36 PM, R2 is an [AGE] year-old male who is admitted to (Facility) for further rehabilitation needs, he previously had a witnessed fall at the end of May. He was found to have difficulty moving right leg and complained of right hip pain. He was further evaluated in the ER and was found to have acute comminuted periprosthetic fracture through the proximal diaphysis extending to the level of the tip of the femoral stem. Fracture also involves the base of the lesser trochanter, which is distracted by at least 8 mm. Patient was then transferred to (Hospital) for further management. He underwent ORIF of the right femur on 06/03/24. R2's EMR showed no documentation of the medical provider or nurse practitioner being notified of right lower extremity pain that occurred after R2's fall on 05/29/24. R2 had complained of pain to the right thigh and/or leg beginning 05/30/24 which was not reported to the provider until 06/02/24. 2. R4 was admitted to the facility on [DATE] with multiple diagnoses which included acute kidney failure, end stage renal disease, malignant neoplasm of colon and rectum, melena, and gastrointestinal hemorrhage per the EMR. R4's Progress Notes dated 11/29/25 at 11:44 AM, showed, Resident complained of feeling nauseated since early this morning and did not eat her breakfast. Message sent to (Doctor) re: (regarding) this matter and to obtain anti-nausea meds. Awaiting return call. On 01/22/26 at 1:05 PM, V15 (CNA) stated he was the CNA taking care of R4 on the night of 11/28/25. V15 stated R4 vomited three times during the night. V15 stated the vomit had blood and blood clots in it. V15 stated R4 had a bowel movement that was dark in color. V15 stated the vomit was dark red and had an odor. V15 stated he informed the nurse of the vomit and bowel movement. V15 stated the nurse did not immediately go into the room to assess R4. V15 stated he was not sure if the nurse went in the room at all to assess R4. On 01/23/26 at 10:31 AM, V18 (RN) stated she took care of R4 during the night on 11/28/25. V18 stated R4 did not say she was sick or nauseated. V18 stated V15 did not tell her that R4 was vomiting blood or had black stools. V18 stated R4 was new, and the facility did not know much about R4. On 01/27/26 at 3:40 PM, V2 (DON) stated if a resident is throwing up and has black tarry stools, the CNA should report a change in condition to the nurse. V2 stated after it is reported to the nurse, the nurse should notify the doctor. V2 stated if the nurse does not notify the doctor, the resident could have abnormal lab values, a health decline, or death can occur. V2 stated the nurses should report to the provider immediately if a resident has a change in condition. On 02/02/26 at 1:30 PM, V49 (MD) stated it is expected that the nurses immediately assess residents with changes in condition, monitor new symptoms, and immediately report to him or any other providers caring for the residents when there is a change in condition. V49 stated if the providers are not notified, more injuries can occur. R4's Progress Notes dated 11/29/25 at 11:02 PM, showed, Gastrointestinal: Abdomen is non tender. Complaint of nausea. Progress Notes dated 12/01/25 at 7:44 AM, showed, Received call from lab with critical hgb (hemoglobin) 3.8 and hematocrit 12.4. Placed call to resident's nurse (Name) RN to notify. Progress Notes dated 12/01/25 at 8:42 AM, showed, Critical hgb 3.8, b/p (blood pressure) 106/44, hr (heart rate) 61, 91% 2L (Liters), resp even & non labored, t (temperature) 98.0, lightheaded, sent AM (American Messaging) to (Doctor) at 0755, no response. Called answer service and had him paged at 8:05, no response. Prior to EMT (continued on next page)

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	145843	A. Building B. Wing	02/10/2026

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Emergency Medical Technician) arriving, had large bloody stool. Notified ADON (Assistant Director of Nursing) at 8:06 that this nurse is sending patient to ER (Emergency Room) and why. Gave report to (Hospital) ER RN (Name) at 8:10. Notified son (Name) at 8:15, dialysis notified at 8:17. R4's (Hospital) Order Tracking, Complete Blood Count final result dated 12/1/25 showed the lab was ordered on 12/1/25. Red Blood Cells 1.24 (normal range 4.00-5.20), Hemoglobin 3.8 (normal range 12.0-16.0), Hematocrit 12.4 (normal range 36.0-46.0). Lab ordered on 11/27/25 showed, Red Blood Cells 2.66, Hemoglobin 8.1, and Hematocrit 25.4. Hospital Blood Bank Results showed R4 had a blood transfusion on 12/01/25. Three units of packed red blood cells leukoreduced transfused. R4's ED (Emergency Department) Triage Notes dated 12/1/25 at 8:49 AM, showed Assessment & Plan showed Reports persistent vomiting of blood when first transferred to the facility, subsided over the last few days. Zofran started at the facility, helped tolerate pills. Imaging normal. Hemoglobin low. Differential Diagnosis; Gastrointestinal bleed: vomiting blood, low hemoglobin. Plan: Admit to IMCU (Intermediate Care Unit), GI (Gastrointestinal) consult, possible endoscopy, colonoscopy, hemoglobin stabilization, monitoring, PPI (Proton Pump Inhibitor) drip started. Three units of blood ordered. R4's MDS (Minimum Data Set) dated 01/06/26 showed R4 was cognitively intact. R4's EMR showed no documentation of the physician or the nurse practitioner being notified of R4 vomiting blood or having black tarry stools on 11/28/25. R4's order Summary Report for November 2025 showed R4 had an order for Ondansetron 4 mg (milligrams) by mouth every four hours as needed for nausea and vomiting written on 11/29/25. R4's Order Administration Note dated 11/30/25 at 8:00 PM, showed, R4 complained of nausea/vomiting and received Ondansetron 4 mg. R4's EMR showed no notification of the provider being notified of the nausea/vomiting. 3. R6 was admitted to the facility on [DATE] with multiple diagnoses which included encounter for surgical aftercare following surgery on the digestive system, pneumonia, muscle wasting and atrophy, muscle weakness, cognitive communication deficit, difficulty in walking, chronic kidney disease per the EMR. R6's Progress Notes dated 09/17/25 at 6:15 PM, showed CNA called for nurse to come to patient's room. CNA had already assisted patient up off of the floor and into her recliner. CNA had been transferring the patient with her walker. Patient lost her balance and fell onto the floor with guided assistance from the CNA. Patient's family member was in the room when I entered the room. Patients appear to be shaken up from the fall. Denies any new pain. Patient denies hitting her head. Pink mark noted to middle of back and right upper shoulder. Dr. (Name) notified of fall. On 02/02/26 at 4:09 PM, V32 (CNA) stated she was taking care of R6 when she fell. V32 stated R6 lost her balance while standing, fell backwards, and was guided to the floor. V32 stated V30 (RN) assessed R6 while on the floor and was lifted off the floor by V32 and V30. V32 stated R6 did not complain of pain at the time of the fall. V32 stated R6 was a stand pivot with transfers. On 01/27/26 at 12:00 PM, V30 stated R6 had a witnessed fall on 09/17/25 around 6:15 PM. V30 stated when she went in the room to assess R6, V32 had already assisted R6 back in the chair. V30 stated R6's family assisted with helping to get R6 off of the floor with V32. V30 stated she should have assessed R6 first before being lifted from the floor. V30 stated R6 denied pain initially at the time of the fall but had a pink mark in the middle of her back and to her right upper shoulder. V30 stated V32 told her R6 had hit her back on the dresser when she fell. V30 stated she did not consider the pink marks to her back and shoulder an injury because it was not open or an abrasion. V30 stated on 09/17/25 at 6:37 PM, she administered Tylenol 650 mg for back pain. I don't think that I should have informed the doctor of back pain after I gave her the medication. V30 stated on 09/17/25 at 8:04 PM, she administered Tramadol for left hip pain. V30 stated she did not update the doctor that R6 was having pain in her hip or back after the fall. On 01/27/26 at 12:37 PM, V31 (Rehab Director) stated on 09/18/25 during therapy, R6 (continued on next page)

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	145843	A. Building B. Wing	02/10/2026

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	complained of back pain, five out of ten. V31 stated R6 stated her pain was due to a fall the previous day. V31 stated on 09/19/25, R6 complained of pain again with movement, and the nurse was notified. V31 stated on 09/21/25, R6 complained low back pain, seven out of ten. V31 stated therapy would have been on hold if they knew R6 had fractures to her back. V31 stated R6 was discharged to the hospital. On 01/27/26 at 3:40 PM, V2 stated residents should not be lifted from the floor after a fall until the nurses assess them. V2 stated R6's pink mark to her shoulder and her back could have been an injury related to the fall on 09/17/25. V2 stated the doctor should have been notified sooner of the pain to R6's back related to the fall. On 02/02/26 at 1:10 PM, V48 (Nurse Practitioner) stated she was not aware of the increasing pain that R6 was experiencing to her back and hips after the fall. V48 stated the providers should have been contacted about the increasing pain sooner. V48 stated x-rays could have been obtained earlier. V48 stated if the providers are not notified of a change in a condition, the problem could get worse and go in the wrong direction. V48 stated it is expected the nurses to notify the providers immediately with changes in pain after a fall or any other changes in condition for all residents. R6's Progress note- Administration Note dated 09/17/25 at 6:37 PM, showed Acetaminophen Oral Tablet 325 mg, give 650 mg by mouth every six hours as needed for pain-back. Progress note- Administration Note dated 09/17/25 at 8:04 PM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain moderate (4-6) severe (7-10). Progress note- Administration Note dated 09/18/25 at 10:05 AM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain moderate (4-6) severe (7-10). Progress note- Administration Note dated 09/18/25 at 9:00 PM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain moderate (4-6) severe (7-10). Progress note- Administration Note dated 09/19/25 at 8:36 PM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for moderate pain (4-6) severe (7-10). Progress note- Administration Note dated 09/20/25 at 11:04 AM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain moderate (4-6) severe (7-10). Progress note- Administration Note dated 09/20/25 at 7:35 PM, showed Tramadol HCL oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain moderate (4-6) severe (7-10). Progress Note- Adv Skilled Evaluation dated 09/21/25 at 10:42 AM, showed, Pain: Indicators of pain: Vocal complaints of pain. Pain issue: 001: New: Location: Lower back. Pain score: 6. Pain Note: 8. Progress Note dated 09/21/25 at 9:29 PM, showed Patient c/o (complaints of) right hip and right low back pain increasing since fall on 09/17/25. Increase in pain with movement. Foot is not externally rotated. Does not want to go to the ER. Paged on call Doctor (Name). Order for x-ray of right hip and CT scan w/o (without) contrast of lumbar spine. Patient prefers (Hospital). Explained to her the caravan can take her tomorrow. But, if the CT scan cannot be scheduled tomorrow, she needs to go to the ER to be evaluated, so physical therapy will not be delayed. Call patient's sister, (Name), and informed her. (Sister) lives 45 minutes away if she needs to accompany the patient to the appointment. Progress note dated 09/22/25 at 5:42 AM, Patient decided to go to (Hospital) ER for right hip pain. Doctor (Name) notified, sister, notified. Ambulance left at 5:00 AM. Progress note 09/22/25 at 9:29 AM, Family here to pick up some of patient's belongings. Stated she was admitted to (Hospital) for hypoxia. X-ray and tests were okay. Progress note dated 09/26/25 at 4:00 PM, showed, Patient returned from hospital. Imaging there showed an acute L2 (Lumbar) fracture. Patient to wear TLSO (Thoracolumbar Sacral Orthosis) brace during ambulation, can remove when sitting and laying down. Hospital Diagnostic Imaging, MRI (Magnetic Resonance Imaging) of the lumbar spine without contrast, dated 09/23/25, showed, Clinical History: low back pain. Status post fall. Findings: There is an acute to subacute compression fracture of the L2 vertebral (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	body with approximately 45 % height loss. There is no significant posterior retropulsion into the spinal canal. Chronic compression deformities of the L1 and L3 vertebral bodies. R6's EMR showed no documentation of notification to the providers regarding the increasing back and lower extremity pain after the fall. R6 was administered pain medication on different dates for pain related to the fall with no notification of the provider. R6 was not assessed by a provider after the fall until the hospital admission on [DATE]. The facility's Change in Resident's Condition Policy, last revised 01/2026 showed, Policy: It is the responsibility of the nursing staff to report any significant change in a resident's condition to the physician in order to provide continuity of care, and to the responsible family member. A change in condition may include the following but is not limited to: C. Persistent vomiting and/or diarrhea. E. a fall or other injury. F. Any other unusual symptoms.

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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 0689 Level of Harm - Actual harm 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** Based on interview and record review, the facility failed to implement fall precautions for a high fall risk resident admitted with a history of fall and left hip fracture.This failure resulted in R5's fall in the facility on 12/25/25, transfer to the hospital, and diagnosis of right hip fracture.This applies to 1 resident (R5) reviewed for falls with injury in a sample of 3.The findings include:R5's Face sheet shows she was admitted to the facility on [DATE] with primary diagnosis of fracture of left pubis. R5's other diagnoses include: unsteadiness on feet, abnormalities of gait and mobility, cognitive communication deficit, dizziness, osteoarthritis, and falls.On 1/28/26 at 2:35 PM, V40 (LPN/Licensed Practical Nurse) said she was the nurse taking care of R5 on 12/25/25 when she fell. V40 said she heard R5 yelling and found her lying on the floor at the foot of her bed on her right hip and supporting herself with her right hand. V40 said R5 was confused and tried to stand up to walk to her closet and told V40 she was trying to get her clothes to go home. V40 said she was not aware of any fall precautions that R5 had in place at the time of her fall.V39 (Agency LPN) completed R5's admission Fall Risk Evaluation on 12/17/25 which documented R5 had a history of 1-2 falls in the past 3 months, was incontinent, had 1-2 predisposing conditions, had recently been hospitalized , and had taken 1-2 medications currently or within the previous 7 days that put her at greater risk for falls. The score of V39's Fall Risk Evaluation showed R5 was a high fall risk. V39 did not trigger/implement any fall precautions from this evaluation. On 1/28/26 at 11:41 AM V39 said if a resident is high fall risk, certain precautions should be implemented such as bed alarm or chair alarm, fall mats, and/or frequent rounding. V39 said she remembered R5 getting more confused the longer she was in the facility, then looked through her documentation on R5 and verified that she did not add any fall precautions/interventions after she completed R5's Fall Risk Evaluation. V39 said R5 was a high fall precaution because she had a history of falls but she did not implement any fall interventions because she didn't know R5 very well. V39 then stated based off R5's fall risk score she could have implemented something.R5's Care Plan initiated 12/25/25, after her fall in the facility, states the resident has had an actual fall with serious injury related to unsteady gait. The goal of this Care Plan states the resident's right hip fracture will resolve without complications and interventions include: call don't fall sign placed in room, one time order to send the resident to the emergency room for evaluation and treatment, and continue interventions on the at-risk plan.On 2/2/26 at 2:04 PM, V3 (Acting ADON/Assistant Director of Nursing) said the facility completes a fall risk assessment as part of their standard admission, which highlights anything that puts the resident at greater risk for fall. V3 said a history of falls and a recent hospitalization both put a resident at greater risk for falls. V3 said after the initial fall risk screen is done, if the resident is showing they are at risk for falls, the nurse will be prompted to add a fall risk care plan and fall interventions to help reduce or prevent any future falls from happening. V3 then looked through R5's electronic health record and said V39 (Agency LPN) never implemented any fall precautions when prompted and V29 (RN/ADON) initiated R5's Fall Care Plan on 12/25/25 after her fall and wrote to continue interventions in her at-risk plan, but there was never any interventions documented in the at risk plan. V3 said there were not any fall precautions/interventions in place prior to R5's fall in the facility on 12/25/25. V3 said if a resident comes to the facility for rehab after hip fracture from a previous fall, the first thing that should be implemented for the resident's safety is fall precautions, to prevent any future injuries or falls.On 2/2/26 at 1:07 PM, V48 (NP/Nurse Practitioner) said it is the facility protocol to put fall precautions in place for any resident admitted and assessed to be high fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	risk, and this should have been done for R5. V48 said fall precaution implementation is essential for any resident admitted post fall and hip fracture to prevent another fall or injury and for all staff to know the resident is a fall risk for safety.R5's emergency room X-ray hips 2 views bilateral with pelvis imaging dated 12/25/25 at 9:43 PM shows: Impression: Acute right intertrochanteric hip fracture. The facility's policy titled, Fall Risk Prevention/Reduction last revised 7/2025 states, Policy: Riverside [NAME] Rehabilitation will provide a safe environment by taking actions to reduce the risk of falls during a resident's stay.Procedure: A. On admission a fall risk assessment will be completed.Any resident at high risk of falls will be put on fall risk precautions.C. If a resident is at risk for falls, then the interdisciplinary team will initiate the following protocol: 1. Place a yellow dot on the resident's door and chart to identify fall risk precautions 2. Place the bed in the lowest position and lock the wheels 3. Place the call light within reach of the resident at all times 4. Assess the resident's environment for any hazards and remove them promptly 5. Provide appropriate supervision/assistance while ambulating or transferring 6. Keep environment well lit in the room, bathroom and resident areas 7. Document interventions in the clinical record.11. Complete fall intervention checklist.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide mechanical soft diet as per physician orders.This applies to 1 of 3 residents (R11) reviewed for safe diet consistency in a sample of 23 residents.On 1/21/26 at 11:58 AM, R11 was observed in the dining room, being fed lunch by V28 (CNA/Certified Nurse Assistant). R11's plate had the following on it: sauteed broccoli, mandarin oranges, chicken salad sandwich, potato chips, and nectar thick root beer.R11's POS (Physician Order Sheet) shows an order dated 1/24/25: regular diet, mechanical soft texture, nectar/mildly thick liquid consistency. R11's Care Plan created 4/4/23 and last revised 2/3/25 states resident is at risk for alteration in nutrition/hydration status secondary to frequent propelling, coughing/choking episodes, increased lethargy, and need for feeding assistance. Interventions include: provide and serve diet as ordered .Resident is receiving mechanical soft, nectar thick liquids.On 1/21/26 at 12:11 PM, V20 (Dietician) said potato chips are not appropriate for a resident on a mechanical soft diet because they have a crunchy texture and a resident on a mechanical soft diet needs to receive all soft foods. V20 said serving potato chips to a resident on a mechanical soft diet poses a risk of difficulty chewing and choking. V20 said if a family member fills out a menu for the resident on a mechanical soft diet and wants chips, the facility should offer the resident mashed potatoes instead because potato chips are not safe to serve. V20 said R11 should not have received potato chips and the kitchen staff should not have served R11 chips. On 1/21/26 at 1:32 PM, V26 (Dining Room Supervisor) said R11's daughter fills out her menus for R11 in advance and V26 just transcribed what R11's daughter requested. V26 said she did not realize she was making a mistake when she wrote chips on R11's menu. On 1/21/26 at 1:38 PM, V27 (Dining Room Service Director) said she is the second set of eyes in the kitchen during meal service that double checks to make sure what is plated is appropriate for the prescribed diet, but she missed R11's tray being plated incorrectly. V27 and V26 said potato chips should not have been served to a resident on mechanical soft diet because chips are a choking hazard.The facility's policy titled, Oral Nutrition & Feeding Assistance last revised 01/2026 states, .Policy: It is the policy of [NAME] Healthcare to ensure that all residents receive required oral nutrition and hydration in a safe, dignified manner that minimizes discomfort, fatigue, and risk of aspiration. Feeding assistance shall be provided in accordance with the resident's comprehensive care plan, diet order, swallowing precautions, and guidance from the interdisciplinary team, including Dietary and Speech Language Pathology.