

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 02/24/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide 2 assists for a full mechanical lift transfer in accordance with their policy. This applies to 1 of 3 residents (R1) reviewed for full mechanical lift transfer in the sample of 5. The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], and discharged from the facility on February 14, 2026. R1 was admitted with multiple diagnoses including quadriplegia C6-C7 incomplete, post laminectomy syndrome, muscle wasting, chronic venous insufficiency, cellulitis of the right lower leg and stage 4 pressure ulcer of the sacral region. R1's MDS (Minimum Data Set) dated February 3, 2026, showed R1 was cognitively intact and required assistance with ADLs (Activities of Daily Living) including independent with eating, set up assistance with oral hygiene and personal hygiene, partial assistance with upper body dressing, substantial assistance with bathing and bed mobility and dependent on staff for lower body dressing, toileting and transfer. R1 had an indwelling urinary catheter and was incontinent of bowel. The facility list of fall incident reports showed R1 had witnessed fall on February 6, 2026, at 11:40 AM. The post fall huddle report, undated, showed during a transfer at R1's bedside, R1 had slid forward in the chair. V3's (Certified Nursing Assistant, CNA) written statement dated February 6, 2026, showed V3 transferred R1 to the motorized wheelchair and R1 started to slide out and V3 had to leave the room to get help. On February 20, 2026, at 10:42AM V8 (LPN) stated while walking in the hall outside of R1's room, V8 saw V3 (CNA) coming out of R1's room asking for assistance. V8 stated V8 and V3 went into R1's room and V8 saw R1 sliding out of the chair with her legs extended in front of R1 on the floor. V8 stated the mechanical lift was in the room. V8 reported the top part of the sling was attached to the lift hooks but the bottom part of the sling was not underneath R1 and not attached to the lift. V8 reported V3 stated she had transferred R1 from the bed to the chair using the full mechanical lift by herself (with only V3 as the assistant). V8 stated V3 had attempted to move R1 up in the chair herself with the sling when the sling came out from underneath R1. V8 stated later she and V3 were in the room with R1 and R1's two daughters and witnessed V3 tell the family that V3 could not find anyone to assist with the transfer. On February 19, 2026, at 3:40 PM, V4 (Restorative RN) stated V4 instructs new staff on transfer techniques and the policy of the facility is to have 2 assists when using the full mechanical lift. On February 19, 2026, at 4:00 PM, V2 (Interim DON) stated the expectation for staff when using the full mechanical lift is for 2 staff to provide assistance. The facility's policy titled Lift-Mechanical dated January 2026, the policy statement showed Two staff members are required during a full body lift transfer.</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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