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	04/17/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide interventions to prevent the development and worsening of skin breakdown. This failure resulted in two residents developing pressure ulcer (also known as a bedsore or pressure wound is an injury to the skin and the tissue below the skin that are due to pressure on the skin for an extended period). This applies to 2 residents, R1 and R2 reviewed for facility acquired pressure ulcers in a sample of 8.Findings include:1.R1 was admitted to the facility on [DATE] with diagnoses that include disease of the spinal cord, cervical radiculopathy, chronic obstructive pulmonary disease, acute respiratory failure, pneumonia, morbid obesity, muscle wasting and atrophy, major depressive disorder, and diaper dermatitis. R1's EMR (Electronic Medical Record) documents she was sent to the local emergency room for rectal bleeding on 03/04/26.On 04/14/26 at 9:20 AM, V18 Family Member stated R1 developed multiple bedsores while in the facility because the staff was not turning R1. V18 stated R1 was chair bound and required total care assistance from the staff. V18 stated R1 did not have any open wounds when she came to the facility.On 04/15/26 at 1:30 PM, V13 Wound Nurse stated R1 was chair bound and was able to feed herself but required staff assistance to move her legs and incontinence care. R1 admitted to the facility with a left gluteal skin tear, bilateral upper extremity bruising, a skin tear on her left forearm, a fungal rash to her back and posterior arms MASD (Moisture Associated Skin Damage) to gluteal fold and hyperkeratosis to her bilateral lower extremities. V13 stated R1 developed a cluster wound on her left gluteal area that measured 0.58 cm x 0.56 cm x 0.1 cm (Centimeters) documented on 2/26/26. V13 denied classifying any of R1's wounds as pressure related. V13 stated the floor nurses would be responsible for documenting the daily skin assessments and prescribed treatments ordered by the physician. The CNAs (Certified Nursing Assistant) are required to document any skin concerns noted during care and care activities in the tasks section of the EMR (Electronic Medical Record). The CNAs should verbally inform the nurse of any new skin concerns.On 04/14/26 at 2:51 PM, V13 Wound Nurse stated nystatin was ordered for R1's fungal rash and Silvadene cream was ordered for hyperkeratosis to the bilateral lower extremities daily. V13 stated the triad cream was an order that came with R1 from the hospital for incontinence, but the facility would does not supply triad cream the remedy protect zinc cream is used instead.On 04/15/26 at 4:48PM, V2 DON (Director of Nursing) stated the admitting nurse will do an initial skin assessment and implement a baseline care plan. The wound care nurse will see the resident by the next business day if they are admitted after hours. The wound nurse stages wounds not the floor nurse. V2 stated V13 Wound Nurse saw R1 on 2/17/26 the fourth day after her admission. V2 stated the triad cream would have been sent from the pharmacy. V2 acknowledged there were missed skin assessments and administrations of the triad cream on R1's TAR (Treatment Administration Record). V2 stated missing prescribed treatments could lead to the worsening of skin breakdown. V2 stated there are multiple interventions that could be implemented to prevent skin breakdown. V2 stated the CNAs should document skin issues and notify the nurse of skin concerns. Upon reviewing EMR V2 could not locate CNAs care documentation in the EMR (Electronic Medical Record).On 04/16/26 at 4:00 PM, V10 RN (Registered Nurse) stated she did not recall R1 having a pressure ulcer on admission. V10 stated if (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 0686 Level of Harm - Actual harm Residents Affected - Few	there was a pressure wound on admission she would have messaged the wound nurse for follow up. V10 stated she did not recall the topical treatments ordered for R1, but triad cream would have been sent from the pharmacy.On 04/17/26 at 10:35 AM, V12 NP (Nurse Practitioner) stated she recalls R1 having complaints of pain related to her neck but was unaware of her skin breakdown. V12 stated R1 was care dependent. V12 stated she expects CNAs to provide incontinence care and turning assistance for care dependent residents to prevent skin breakdown and report new skin concerns to the nurse. V12 stated she expects the staff to follow the facility policy to prevent skin breakdown. V12 stated she would have expected the wound doctor to see R1 prior to 2/26/26. V12 stated missing ordered treatments can lead to the worsening of skin breakdown worsening. V12 stated she had never heard of cluster used to classify the type of wound.On 04/14/26 at 4:45 PM, during record review the CNAs documentation for R1 was not accessible in the EMR. R1's TAR documentation had missing physician ordered skin assessment documentation and missing documentation of triad cream application.On 04/15/26 at 7:07 PM survey records were requested again from V1 Administrator including the nursing TAR documentation and CNAs care documentation for R1. The TAR and CNAs documentation was not provided.The pharmacy requisition for medication delivered to the facility for R1 was requested from V1 Administrator.On 04/17/26 at 2:51 PM, V1 stated she could not provide a requisition documenting triad cream being delivered for R1. V1 stated there was no requisition in the facility and none was provided by the pharmacy. V1 stated she was informed by the wound doctor that the remedy protect cream is used in place of the triad cream. V1 stated a new order should have been obtained if a different product was being used.R1's admission wound documentation on 2/13/26 completed by V10 documents MASD (Moisture Associated Skin Damage) The admission documentation entered by V10 RN on 2/13/26 did not document any pressure ulcer in the admission note or skin assessment.The product information for triad states it is a hydrophilic wound dressing that adheres to wet or irregular surfaces with pressure injuries, broken skin in the presences of urinary incontinence, macerated skin, and facilitates autolytic debridement of necrotic skin. Remedy skin protectant zinc oxide product information states it protects and helps relieve chapped or cracked skin and seals out moisture.R1's Physician orders dated 2/13/26 include skin assessment every shift for 3 days skin risk assessment weekly for 4 weeks starting one week after admission. Wound care bilateral ischial and coccyx after providing skin hygiene apply Triad cream to open wound beds ad silicone barrier cream to intact skin twice daily and as needed for incontinence.R1's care plan includes wound management dated 02/18/26 wound will show signs of improvement. Notify provider if there is no sign of improvement on current wound regimen. Provide wound care per treatment order.The facility provided a list of residents with pressure ulcers from February and March 2026. R1 was not identified as having a pressure ulcer.R1's emergency room records dated 03/04/26 documents stage 2 injury (pressure injury with partial thickness skin loss with exposed dermis) of sacral region. 2.On 04/14/26 at 1:36 PM, R2 was assisted to bed by V4 CNA (Certified Nursing Assistant). Incontinence care was observed for R2. R2 had a regular mattress in place on her bed. V4 stated R2 did not have any pressure ulcers and her skin was intact. When R2's brief was removed she had an open area on her sacral coccyx area. The peri wound, buttocks and perineum were beet red. R2 did not have any visible protective cream in place or dressing in place.On 04/14/26 at 3:14 PM, V6 RN (Registered Nurse) assigned to R2 stated she did not have any residents with a pressure wound. V6 stated she did not receive any notification from V4 CNA of R2 having skin break down or wounds.On 04/15/26 at 1:18 PM, V13 Wound Nurse stated she saw R2 on 04/14/26 for a stage 3 (pressure injury full thickness skin loss) pressure wound on her sacral area. V13 stated there was no previous documentation of pressure wound prior to then. V13 stated the staff should have identified the skin breakdown prior to it developing to stage 3. V13 stated as far as she can see that all facility acquired wounds are avoidable.On 04/17/26 at 10:35 AM, V12 NP (Nurse Practitioner) stated she was not made aware of R2's stage 3 pressure wound. R2 requires staff assistance for care. V12 stated she would have expected staff to notice R2's skin before it became a stage 3 pressure wound. V12 NP (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	stated pressure wounds can be painful and can lead to infection.On 04/17/26 at 12:12 PM, V13 Wound Nurse stated a low air loss mattress is a pressure relieving device. V13 stated the facility does have some low air loss mattresses, but when they are all in use they go to an outside vendor to provide them. V13 stated she should have obtained the low air loss mattress for R2, but she had not.R2's care plan initiated on 01/11/26 states R2 has potential for pressure ulcer development related to incontinence of bowel and bladder. The resident will have intact skin, free of redness, blisters or discolorations. Interventions include educating the resident / family / caregiver as to the cause of skin breakdown including transfers /positioning requirements; importance of taking care during ambulating / mobility, good nutrition and frequent repositioning. Follow the facility policy / protocols for the prevention / treatment of skin breakdown. Pressure relieving devices to bed and chair.A progress note entered by V6 RN dated 04/14/26 at 5:24 PM states around 2pm R2 observed to have a skin issue on her coccyx area. Redness found and non-blanchable. R2 felt pain when touched 4/10.The facility policy Pressure Injury dated 01/2026 states the pressure ulcer prevention protocol on the resident's plan of care includes the following in an attempt to stabilize, reduce or remove underlying risk factors. Nursing judgement may be used to determine what preventative measures are to be used for each resident: manage moisture, manage friction and shearing, reduce pressure optimize nutrition / hydration status. The skin risk assessment is to be completed on admission and weekly for four (4) weeks for all new residents, and quarterly thereafter or upon severe deterioration change in condition or sever deterioration in physical activity. Residents who have wounds on admission would have the skin risk assessment completed on admission and staff are to document on the wound assessment progress flow sheet weekly until healed. TAR (Treatment Administration Record) is considered part of plan of care.The facility policy Wound assessment dated 01/2026 states it is the policy of the facility to do a systemic, ongoing wound assessment on all wounds I order to determine the response to care and treatment modalities.