STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint 1172609 / IL54238 - F309	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and observation the facility failed to provide necessary care and services for: one resident (R16) in the sample of 20 who sustained injury from a fall and complained of severe pain with breathing. Findings include: Medical record review shows R16 was 84 years old and admitted to facility on 3/30/10 following a fall at home with resulting right femur fracture. Hospital consultation dated 7/6/10 states R16 "fell at nursing home on 7/1/10 while she was trying to get to the bathroom. She fell on the right side with multiple rib fractures. R16 has severe chronic lung disease with chronic respiratory failure." Review of incident report and corresponding investigation shows on 7/1/10 at 10:45pm, R16 was found on the floor in her room "wedged	F 309		11/13/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 between the radiator and chair." Nurses notes dated 7/1/10 at 10:45pm state R16 was found sitting on floor leaning against wall bent over side ways with head against heater. Right head abrasion...assisted to bed, reddened area to mid spine, now complains of pain to right rib area..." The next documented observation at 11:45pm (one hour later) states R16 "now complains of pain with breathing, neb (nebulizer) treatment given." There is no documentation indicating how R16 responded to the breathing treatments or response to care over the next eight hours. The next nursing entry at 8:00am. R16 complains of pain to the side at a 9. X-rays ordered to be done today. Pain medications were given again at this time and one hour later the pain remained at a nine. A breathing treatment was given again. This would constitute a significant change and the physician should have been notified at this point . VS 98.9, 24, 128/68, O2 96. The next nurses note is at 10:30am, 2 1/2 hours later. R16 "lethargic, had a difficult time remaining awake during conversation. complained of right side pain especially with deep breathing. Denies hitting head but on observation (R16) had large bump on left side of head above ear." It is unclear how R16 sustained this bump to the left side of the head as the initial note after the fall only identified the bump on the right side of the head. R16 was sent to the hospital on 7/2/10, 12 hours after she initially fell. The hospital consultation dated 7/3/10 states R16 has multiple rib fractures and that multiple intercostal blocks to T4-T5, T6-T7, T8-T9, T10-T11 and T12 was performed to assist with decreasing the pain as a result of the rib fractures.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 E2 (director of nurses) stated on 10/14/11 at 1:40pm she did not know why the nurse on duty did not perform a more comprehensive assessment of R16, considering there were continuous complaints about severe pain with breathing even after medication. E2 stated she (E2) was not employed by the facility at this time. Reviewing the medical record, E2 stated she could find no other evidence of R16 having complaints of severe pain with breathing prior to the fall and that this would have constituted a change in condition. E2 also said there should have been more nursing documentation stating how R16 responded to the breathing treatments and more frequent monitoring and documenting how R16 progressed during the night.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to: Analyze the contributing factors for residents identified with urinary incontinence,	F 315		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 3 Complete a thorough assessment of factors that may predispose the resident to having urinary incontinence Develop individualized goals & implement specific plans or interventions in order to prevent or minimize decline. Identify whether the causes of resident's incontinence are reversible or irreversible. This is for three residents inside the sample of 20 (R14, 13 and 20) and five residents (R21-R25) from the supplemental. It also has the potential to affect all incontinent residents in the facility. Findings include: Review of 672 Resident Census and Condition shows the facility has 72 residents who are occasionally or frequently incontinent of bladder and 58 residents who are occasionally or frequently incontinent of bowel. Of the 72, six are on individual bladder training training, per 672 and none on individual bowel training. E4 (Restorative nurse) stated on 10/13/11 at 11:45am the facility does not have specific bladder and bowel assessments other than what the admitting data set (MDS) assesses for. E4 said all the residents (except the six who were identified on bladder training) are on prompted toileting every two hours in addition to check and change (66 residents). E4 stated only residents on training programs have voiding patterns completed and they must be alert and oriented. Review of care plans for the six residents (Rs 20 through 25) the facility has identified on bladder training show that each is on prompted toilet of every two hours. This is not an individualized bladder training program. In addition, the facility	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 4	F 315		

has not evaluated residents' incontinent factors that may predispose them to having urinary incontinence, develop individualized goals and implement specific plans or interventions in order to prevent or minimize decline.
Per E4, the facility has not identified whether the causes of resident's incontinence are reversible or irreversible.

Acello, Barbara RN MSN. The Long -Term Care Nursing Desk Reference HCPro, INC. 2005. Chapter 13 pg 215 states "Most believe that toileting residents every 2 hours is the best means of keeping them dry, when in fact this is a dated and ineffective method. Effective urinary incontinence is management based and individualized to the resident. Incontinence management is a "catch" program that keeps residents dry. It is assessment-based, but it does not involve retraining or relearning. It involves toileting the resident at times in which he or she is most likely to eliminate. Many residents will not be able to participate in an active bowel and bladder retraining programs, but most will benefit from a regular, assessment based toileting schedule."
During the initial tour of the facility on 10/12/2011 and on 10/13/2011 at 1:52 PM. R14 was interviewed in her room. R14 complained staff were slow in answering the call lights. R14 told surveyor she usually used the call light to get assistance to the bathroom. R14 said she could not wait and had to go in her adult incontinent pants. R14 also stated: "I'm alert, my mind's not gone. My body is just gone. I'm 87 years. I can't hold it, so I just go in my pull up's." R14 said she gets angry when she doesn't get help to the bathroom in time. R14 stated, "The most important thing is to get to the lights and help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 5 people get to the bathroom." R14's daughter was also present at the bedside during the initial tour on 10/13/2011. R14's daughter also complained her mother frequently had problems getting help to the bathroom. R14's nurse (E20) was interviewed on 10/13/2011 at 1:30 PM. E20 said: "R14 is alert and oriented. She's able to tell you when she needs to go to the bathroom." E20 was not aware of R14 being on any toileting program before 10/12/2011. The certified nurse aide (E5) caring for R14 was interviewed on 10/14/2011 at 2:03 PM. E5 reported R14 could tell staff when she needed to go to the bathroom. E5 said when she got R14 to the bathroom, R14 had no problem voiding. Review of R14's Admitting Data Sheet documented R14 had difficulty walking. Review of R14's care plan documented R14 had a potential for bowel/bladder incontinence. But, R14's nursing interventions were very generalized and not specific.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide gastrostomy tube care and services including the staff administering enteral tube feeding accurately at the rate as ordered by the physician. This is for one of two residents (R8) who are fed by gastrostomy tube in the sample of 20. Findings include: On 10/11/11 at 12:30 pm R8's tube feeding pump was turned off. There was 780 cc of feeding left in the bottle of 1500 cc. The label on the feeding bottle noted the feeding was hung on 10/10/11 at at 8:00 pm at the rate of 80 cc per hour. The feeding pump and stand has dust build up and dried feeding stains. On 10/12/11 at 1:30 pm R8's tube feeding pump was turned off. There was 700 cc of feeding left in the bottle of 1500 cc. The label on the feeding bottle noted the feeding was hung on 10/11/11 at 8:30 pm at the rate of 80 cc per hour. On 10/13/11 at 2:15 pm R8's tube feeding pump was turned off. There was 800 cc of feeding left in the bottle of 1500 cc. The label on the feeding bottle noted the feeding was hung on 10/12/11 at 8:00 pm at the rate of 80 cc per hour. R8 has physician order to infuse feeding 'Jevity 1.2 at 80 cc per hour via gastrostomy tube; start at 7:00 pm, run feeding until 1120 cc infused. On 10/13/11 at 2:15 pm the floor nurse confirmed these observations. The floor nurse stated the	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 7 evening nurse is to hang the feeding at 7:00 pm. After infusing for 14 hours the day shift nurse is to turn off the pump and ensure 1120 cc feeding is infused. The floor nurse stated she turns off the feeding pump at 9:00 am every day and documents in the Medication Administration Record. The floor nurse also stated each time when the feeding starts the nurse is to hang a new feeding bottle. It there is feeding left more than 380 cc, that means the feeding was not started on time. R8's weight record documented she is loosing weight, her weight documented for August 2011 94.2 pounds; September 2011 94.6 pounds and for October 91.4 pounds. R8's care plan for feeding formula, hydration initiated on 11/20/09 and revised on 9/7/10. The interventions are not specific to address the feeding rate and / or maintaining ideal body weight.	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to:	F 323		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 - develop and implement specific and individualized interventions to prevent falls for R4 and R17 who are identified at risk for falling. - ensure the staff had assistive devices including bed alarm and appropriate mattress for R4; and ensure R17's call light was functional and the mattress was appropriate. As a result: - R4 fell on 3/24/11, 4/30/11 and 5/5/11. On 5/8/11 the X-Ray results indicate she sustained fracture to her right femur. - R17 who was admitted to the facility on 7/21/11 with status post right knee replacement. R17 fell on 8/3/11, re-injured his right knee and dislocated shoulder (Acromioclavicular) joint. This is for two of five residents in the sample of 20 residents (R4 and R17) who were identified to be at risk for falling. Findings include: 1. On 10/11/11 at 12:30 pm R4 was seated in her adult recliner. She was restless. There was no staff in attendance in the dining room. R4 was confused and disoriented, mumbled when asked questions. R4's Nurses Notes noted the following: - 3/24/11 4:30 am found resident on her knees at the side of bed. No scoop mattress on her bed. - 4/30/11 9:00 am resident sitting in adult recliner at table for breakfast, Certified Nurse Aide (CNA) reported R4 stood up and fell on to the bed then on to back and rolled over onto right side. - 5/5/11 8:20 pm R4 was found on floor at the foot of her bed lying on her left side ... she began	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 moaning 'my head.' R4's bed alarm was not sounding. - 5/6/11 10:25 pm R4 complained of pain to right upper thigh, 'it hurts.' - 5/7/11 5:00 am R4 complained of pain to right hip area, has grimacing and stated 'it hurts.' -5/7/11 4:00 pm R4 complained of pain to right knee and right thigh, purplish bruising noted to right inner thigh. At 4:15 pm received order for X-Ray of right hip. - 5/8/11 1:40 pm X-Ray was done at the facility which showed right trochanteric fracture. At 7:15 pm R4 was admitted to the hospital with right femur fracture. Review of R4's fall incident assessment conducted on the dates of her falling (3/25, 4/30, and 5/5/11) did not indicate why she is at risk for falling or why she is falling. R4 has a care plan developed on 5/25/07 revised on 5/12/11. This care plan has interventions to use scoop mattress, have bed alarm and chair alarm. These interventions were not implemented on 3/24/11 and 5/5/11. E2, the Director of Nurses on 10/13/11 at 11:15 am stated R4's scoop mattress was supposed to prevent R4 from rolling out of the bed, but the scoop mattress was replaced with low air loss mattress because of her risk for the development of pressure sores. The facility did not consider alternatives for scoop mattress. There was no explanation of why R4's bed alarm did not sound when she fell on 5/5/11. R4's 5/5/11 incident care plan revision noted, putting resident too early to bed caused the incident and putting R4 to bed later is additional intervention. This intervention was not added to the care plan.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 2. R17's closed records indicated he was admitted to the facility on 7/14/11 with status post right knee replacement. R17's Nurses Notes on 8/3/11 at 3:30 am R17 was sitting on floor in room, his back was leaning on wheel chair, he was next to bed with legs slightly bent. R17 stated he was trying to move from his bed to wheel chair to use the bath room. R17 who was alert and oriented, voiced pain in his right knee, shoulder. His right knee was swollen. R17 was sent to the hospital for evaluation and treatment. At the hospital it was found R17's right shoulder joint (Acromioclavicular Joint) was separated and re-injured (sprained), his replaced right knee. R17's 8/3/11 incident investigation noted R17 stated his mattress contributed to his fall. During the investigation of the incident per staff and resident interview R17's call light did not work and he was yelling for help. The investigation report also mentioned a new mattress was provided, call lights functioning was evaluated, but did not determine why the call light was not functioning. The investigation did not address if R17's chair was locked when he transferred him self from bed to wheel chair and the breaks were functioning properly. The facility had a care plan dated 7/15/11 for R17 at risk for falls due to use of psychotropic medications, status post total knee right knee, osteoarthritis, morbid obesity and pain. The interventions are generalized and none of the interventions addressed the use of proper mattress or use of call light.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 On 10/13/11 at 11:15 am E2 stated the care plan interventions should have been specific to his transfer functional ability. E2 could not explain why R17's call light was not functioning on 8/3/11 when staff and resident tried the call light.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal	F 334		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 12 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have an effective system to track and immunize resident for	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 13	F 334		

Pneumococcal and Influenza Immunization. This failure occurred for 3 of the 5 sample residents in a sample of 20.

Findings include:

Review of the facility's immunization log had 138 residents listed. But, only 47 of the listed residents had any documentation they were given, received or refused Pneumonia Immunization. The other 87 residents listed had no information documented regarding their Pneumococcal Immunization status. Approximately 47 residents had no information documented pertaining to their Influenza Immunization status.

Review of R9's Admission Data Sheet documented that R9 was admitted to the facility on 1/04/2011. But, the immunization log and R9's clinical record had no information regarding R9's immunization for pneumonia. The director of nursing (E2) was interviewed on 10/14/2011. When asked about R9's immunization status, E2 told surveyor the facility was waiting for R9's family to provide information about her pneumococcal immunization. E2 reported residents and their family members are asked about their immunization status upon admission to the facility. However, R9 has been a resident in the facility since January and there's no evidence that staff followed up and obtained the information about her last Pneumococcal Immunization.

Review of R8's Admission Data Sheet documented R8 was admitted to the facility on 9/09/09. However, there was no documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 14 of when R8 was last given Pneumococcal Immunization. Review of R4's Admission Data Sheet documented R4 was admitted to the facility on 5/07/2004. But, there was no documentation of R4's last Pneumococcal Immunization.	F 334		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain an infection control system which: 1. Ensured the infection control tracking log was accurate and complete. 2. Developed an Infection Control Committee which identified, analyzed, and implemented interventions to decrease/eliminate facility acquired infections. This is for two of 20 residents (R10 and R26) in the sample of 20 residents. This has the potential to effect all residents in the facility who have an infectious process. Findings include: Review of infection control tracking log for the month of August, 2011, shows there were 11 UTIs (urinary tract infection), seven of which were facility acquired. Of the 11 total UTIs only three have the organism identified. E2 stated the facility usually does not identify the infectious organism. This is also true for other infections listed on the tracking log. For example, there are four skin/wound infections, three with no organism identified, including one being treated with IV	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 antibiotic. E2 stated the tracking log is incomplete and possibly not accurate when asked about these examples in addition to an entry for September 2011 showing R26 with a UTI identifying Herpes Zoster listed as the infectious organism. E2 stated she did not know if that was accurate, most likely not. Also on the infection control tracking log, R10 was shown to have a facility acquired urinary tract infection (UTI) identified on 8/29/11. There is no organism identified. This log also shows there was no culture performed and that R10 was placed on antibiotic. Review of medical record shows R10 is 103 years old. E2 stated (director of nurses and infection control co-coordinator) R10 did not have a urine culture and was placed on antibiotic prophylactically based on complaints of low back pain. Not identifying and tracking infectious organisms does not enable the facility to identify, analyze and implement interventions to decrease facility acquired infections. On 10/14/11, E2 was asked to show documentation of what the infection control committee has been working on. E2 provided 3 random months. QA minutes do not include infection control issues.	F 441		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as	F 497		11/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 17 determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of Certified Nurse Aide (CNA) files, tracking of their training and interview the facility failed to ensure the CNAs have at least 12 hours of skill training annually. This is for 13 of 13 CNAs personal files reviewed. Findings include: On 10/13/11 a total of 13 CNAs (E7 to E19) personal files and their annual skill tracking reviewed. The CNA annual performance evaluation in their personal files did not identify their skill deficits. The annual skill training tracking from the computer did not add up to 12 hours. The total hours on the computer skill test were less than six hours for the 13 CNAs. The Personnel Manager who is responsible for tracking CNA inservice stated she has some skills training for CNAs was kept out side of the computer. The skills training record kept out side the computer had no notation of how long was each inservice was and what was the topic. There was no system to track skill deficit or how many hours of inservice each CNA received annually. On 10/14/11 E2 the Director of Nurses and the	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 18 Personnel Manager confirmed the facility lacking to track CNA skills annually.	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010 h) 300.1210a) 300.1210b) 300.1210d)3) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 19 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review and observation the facility failed to provide necessary care and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 20	F9999		

services for: one resident (R16) in the sample of 20 who sustained injury from a fall and complained of severe pain with breathing.

Findings include:

1) Medical record review shows R16 was 84 years old and admitted to facility on 3/30/10 following a fall at home with resulting right femur fracture. Hospital consultation dated 7/6/10 states R16 "fell at nursing home on 7/1/10 while she was trying to get to the bathroom. She fell on the right side with multiple rib fractures. R16 has severe chronic lung disease with chronic respiratory failure."

Review of incident report and corresponding investigation shows on 7/1/10 at 10:45pm, R16 was found on the floor in her room "wedged between the radiator and chair." Nurses notes dated 7/1/10 at 10:45pm state R16 was found sitting on floor leaning against wall bent over sideways with head against heater. "Right head abrasion...assisted to bed, reddened area to mid spine, now complains of pain to right rib area..." The next documented observation at 11:45pm (one hour later) states R16 "now complains of pain with breathing, neb (nebulizer) treatment given." There is no documentation indicating how R16 responded to the breathing treatments or response to care over the next eight hours. The next nursing entry at 8:00am. states R16 complained of pain to the side at a 9. X-rays ordered to be done today. Pain medications were given again at this time and one hour later the pain remained at a nine. A breathing treatment was given again. This would constitute a significant change and the physician should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 21	F9999		

been notified at this point . VS 98.9, 24, 128/68, O2 96. The next nurses note is at 10:30am, 2 1/2 hours later. R16 "lethargic, had a difficult time remaining awake during conversation. complained of right side pain especially with deep breathing. Denies hitting head but on observation (R16) had large bump on left side of head above ear." It is unclear how R16 sustained this bump to the left side of the head as the initial note after the fall only identified the bump on the right side of the head. R16 was sent to the hospital on 7/2/10, 12 hours after she initially fell.

The hospital consultation dated 7/3/10 states R16 has multiple rib fractures and that multiple intercostal blocks to T4-T5, T6-T7, T8-T9, T10-T11 and T12 was performed to assist with decreasing the pain as a result of the rib fractures.

E2 (director of nurses) stated on 10/14/11 at 1:40pm she did not know why the nurse on duty did not perform a more comprehensive assessment of R16, considering there were continuous complaints about severe pain with breathing even after medication. E2 stated she (E2) was not employed by the facility at this time. Reviewing the medical record, E2 stated she could find no other evidence of R16 having complaints of severe pain with breathing prior to the fall and that this would have constituted a change in condition. E2 also said there should have been more nursing documentation stating how R16 responded to the breathing treatments and more frequent monitoring and documenting how R16 progressed during the night.

(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 22	F9999		

300.1210a)
300.1210b)
300.1210c)
300.1220b)3)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review and interview the facility failed to: - develop and implement specific and individualized interventions to prevent falls for R4	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 24	F9999		

and R17 who are identified at risk for falling.
- ensure the staff had assistive devices including bed alarm and appropriate mattress for R4; and ensure R17's call light was functional and the mattress was appropriate.

As a result:
- R4 fell on 3/24/11, 4/30/11 and 5/5/11. On 5/8/11 the X-Ray results indicate she sustained fracture to her right femur.
- R17 who was admitted to the facility on 7/21/11 with status post right knee replacement. R17 fell on 8/3/11, re-injured his right knee and dislocated shoulder (Acromioclavicular) joint.

This is for two of five residents in the sample of 20 residents (R4 and R17) who were identified to be at risk for falling.

Findings include:

1. On 10/11/11 at 12:30 pm R4 was seated in her adult recliner. She was restless. There was no staff in attendance in the dining room. R4 was confused and disoriented, mumbled when asked questions.

R4's Nurses Notes noted the following:
- 3/24/11 4:30 am found resident on her knees at the side of bed. No scoop mattress on her bed.
- 4/30/11 9:00 am resident sitting in adult recliner at table for breakfast, Certified Nurse Aide (CNA) reported R4 stood up and fell on to the bed then on to back and rolled over onto right side.
- 5/5/11 8:20 pm R4 was found on floor at the foot of her bed lying on her left side ... she began moaning 'my head.' R4's bed alarm was not sounding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 25 - 5/6/11 10:25 pm R4 complained of pain to right upper thigh, 'it hurts.' - 5/7/11 5:00 am R4 complained of pain to right hip area, has grimacing and stated 'it hurts.' -5/7/11 4:00 pm R4 complained of pain to right knee and right thigh, purplish bruising noted to right inner thigh. At 4:15 pm received order for X-Ray of right hip. - 5/8/11 1:40 pm X-Ray was done at the facility which showed right trochanteric fracture. At 7:15 pm R4 was admitted to the hospital with right femur fracture. Review of R4's fall incident assessment conducted on the dates of her falling (3/25, 4/30, and 5/5/11) did not indicate why she is at risk for falling or why she is falling. R4 has a care plan developed on 5/25/07 revised on 5/12/11. This care plan has interventions to use scoop mattress, have bed alarm and chair alarm. These interventions were not implemented on 3/24/11 and 5/5/11. E2, the Director of Nurses on 10/13/11 at 11:15 am stated R4's scoop mattress was supposed to prevent R4 from rolling out of the bed, but the scoop mattress was replaced with low air loss mattress because of her risk for the development of pressure sores. The facility did not consider alternatives for the scoop mattress. There was no explanation of why R4's bed alarm did not sound when she fell on 5/5/11. R4's 5/5/11 incident care plan revision noted, putting resident too early to bed caused the incident and putting R4 to bed later is additional intervention. This intervention was not added to the care plan. 2. R17's closed records indicated he was	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	900 WEST RIVER PLACE KANKAKEE, IL 60901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26	F9999		

admitted to the facility on 7/14/11 with status post right knee replacement.

R17's Nurses Notes on 8/3/11 at 3:30 am state R17 was sitting on floor in room, his back was leaning on wheelchair, he was next to bed with legs slightly bent. R17 stated he was trying to move from his bed to wheelchair to use the bathroom. R17 who was alert and oriented, voiced pain in his right knee, shoulder. His right knee was swollen. R17 was sent to the hospital for evaluation and treatment. At the hospital it was found R17's right shoulder joint (Acromioclavicular Joint) was separated and he re-injured (sprained) his replaced right knee.

R17's 8/3/11 incident investigation noted R17 stated his mattress contributed to his fall. During the investigation of the incident per staff and resident interview, R17's call light did not work and he was yelling for help. The investigation report also mentioned a new mattress was provided, and call light functioning was evaluated but did not determine why the call light was not functioning. The investigation did not address whether R17's chair was locked when he transferred himself from bed to wheelchair and whether the brakes were functioning properly.

The facility had a care plan dated 7/15/11 for R17 at risk for falls due to use of psychotropic medications, status post total knee right knee, osteoarthritis, morbid obesity and pain. The interventions are generalized and none of the interventions addressed the use of proper mattress or use of call light.

On 10/13/11 at 11:15 am E2 stated the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF KANKAKEE	**900 WEST RIVER PLACE KANKAKEE, IL 60901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 interventions should have been specific to his transfer functional ability. E2 could not explain why R17's call light was not functioning on 8/3/11 when staff and resident tried the call light. (B)	F9999		