STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

IL6014294

MULTIPLE CONSTRUCTION

A. BUILDING: _____________________________

B. WING _____________________________

DATE SURVEY COMPLETED

01/24/2014

NAME OF PROVIDER OR SUPPLIER

MILLER HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1601 BUTTERFIELD TRAIL
KANKAKEE, IL  60901

STATEMENT OF LICENSURE Violations:

300.610a)
300.1010h)
300.1210b)
300.1210d(2)
300.1210d(3)
300.1210d(5)
300.3220f)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by
the facility which shall be formulated by a Resident Care Policy Committee consisting of at
least the administrator, the advisory physician or the medical advisory committee and
representatives of nursing and other services in the facility. These policies shall be in compliance
with the Act and all rules promulgated thereunder. These written policies shall be followed in
operating the facility and shall be reviewed at least annually by this committee, as evidenced by
written, signed and dated minutes of such a meeting.

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
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) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

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.
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</td>
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<td>Section 300.3220 Medical Care</td>
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<td>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</td>
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<td>Section 300.3240 Abuse and Neglect</td>
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<td>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</td>
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<td>These Regulations were not met as evidenced by:</td>
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<td>Based on interview and record review the facility failed to provide nursing services by not assessing and monitoring R1's right foot vascular wound until day 5 of admission to facility. Facility failed to obtain timely wound care evaluation and</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
MILLER HEALTH CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1601 BUTTERFIELD TRAIL
KANKAKEE, IL 60901

**PROVIDER'S PLAN OF CORRECTION**

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*These failures resulted in 1 resident (R1), reviewed for wound management, wound status to decline. R1’s right foot vascular wound developed necrotic tissue over 60% of the wound surface and required surgical intervention to remove the necrotic tissue.*

The Findings include:

R1 was admitted to facility 12/25/2013 at 2:32PM from the hospital.
R1’s hospital records document, R1 was hospitalized 12/12/2013 through 12/25/2013.

R1’s 12/12/2013 hospital history and physical report includes: chronic wound on the top of right foot that has been worsening. Medical history of Peripheral Vascular Disease, history of multiple revascularization surgeries, aortofemoral bypass and right above the knee popliteal bypass.

Z4 (Infectious disease physician), 12/19/2013 consult report documents presence of a "4cm x 4cm x 0.2cm deep with exposed fascia, tendons and muscle. It is unclear if there is any portion of the bone exposed." Z4 also documented; R1 was found to have an occlusion and underwent a revision of her bypass graft on 12/18/2013. The patient has a right chronic dorsal wound with exposed tendons and the tissue appearing healthy.

Z6 (Vascular physician), 12/22 and 12/23/2013 progress notes include "Right foot with open dorsal wound, clean base with exposed tendons and healthy appearing tissue."
## Summary Statement of Deficiencies

### S9999

Continued From page 4

R1’s 12/23 and 12/24/2013 hospital nursing skin integrity assessment includes, presence of an “ulceration”, "non intact open, pink, red, other: tendon."

Facilities wound management protocol includes:
- Residents admitted with wounds are to be assessed on admission and weekly until healed. Document wound assessment on wound assessment progress flow sheet. A copy of residents wound assessments are to be provided to the wound care team.
- Document dressing changes / wound care on treatment administration record (TAR). Note type of dressing or topical applied, note weekly status to assess the progress toward healing and impact of interventions being implemented.
- Existing wounds are to be described by location, type, stage, depth, length, width, tunneling/undermining, color/ type/ amount of drainage, odor, presence of infection, appearance of peri-wound and pain.
- Wound Care Team Consultation may be ordered by physician for evaluation and treatment. Any treatment recommendations made by the wound care team are based on the clinical guidelines outlined in the “AHCPR” (agency for health care policy and research, with the department of human services), manual for treatment of pressure ulcers.
- Treatment protocol includes monitoring skin condition for signs of healing and signs of increased involvement and deterioration of area.

On 01/15/14, at 9:30AM, E1 (Administrator) and E2 (Director of nurses), stated that facility wound care team consist of E3 (wound certified physical therapist), E6 (wound nurse) and Z2 (wound certified physical therapist).
### MILLER HEALTH CARE CENTER

**1601 BUTTERFIELD TRAIL**  
**KANKAKEE, IL 60901**

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E2 said that E3 and E6 are full time employees and Z2 is in facility 3 days per week.

R1’s 12/25/2013 physician orders, include right foot wound treatment of "Wet to dry dressings with Hydrogel, three times a day (TID), facility wound physician to evaluate resident and for nursing to complete head to toe skin assessments and place in binder every shift for 3 days, on admission."

R1’s 12/2013 TAR includes Wet to Dry dressings with Hydrogel to be administered 3 times / day. R1 was administered these treatments 12/25/13 at 7:30PM, 12/26/13 and 12/27/13 at 10:30AM, 2PM and 7:30PM, 12/28/13 at 10:30AM, 12/29/13 at 2PM and 7:30PM and 12/30/13 at 10:30AM.

During individual interviews on 01/22/14 of E3 at 10:00AM, E6 at 11:04AM and E2 at 11:30AM the following information obtained:

E2, E3 and E6 said R1’s right foot wound was not assessed 12/25/13 admission through 12/30/13.

R1’s right dorsal foot wound was initially evaluated on 12/30/13, by E6 and assessed by Z2 on 01/03/14.

E2, E3 and E6 also said that facility nursing staff do residents wound treatments but they do not assess, measure and document wound status. E3 and E6 do all the wound assessments in facility.

E6 said she does wound assessments on Mondays and the rest of the week works as a staff nurse on the floor.

E2 and E3 said E3 was off sick 12/25 through 12/30/13 and E6 was not working that weekend.

E3 does physical therapy as well as wound treatments for skilled care residents.

R1’s 12/30/13 right foot wound assessment
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<td>Continued From page 6 includes 5.9 cm X 8cm X 0.2cm, moderate amount of serous drainage, 40% visible tendons and 60 % black eschar, rolled pink edges and puffy dark brown peri wound.</td>
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<td>R1's physician orders include a 12/31/13 order to discontinue wound care TID to right foot. clean and dry right foot wound, apply &quot;No sting&quot; to peri-wound area and apply gel cover with Mepilex, every other day and as needed. This wound treatment change was ordered after initial wound assessment by E3.</td>
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<td>R1 was initially evaluated by Z2 on 01/03/14. Z2 changed wound treatments.</td>
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<td>On 01/03/14 Z2 changed R1's wound treatment after assessing the wound to Regenecare and Mepilex to right foot every other day and to soak dressing with Saline prior to removing as needed.</td>
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<td>On 01/16/14 at 9:45AM, Z2 said, R1's admission wound treatment of Wet to Dry dressing changes was not an appropriate treatment for a vascular wound with exposed tendons. This type of treatment can cause more damage to the tendons. Z2 also said, &quot;I see medicare patients after they are evaluated by therapy and follow-up visits every 1 1/2 weeks. I’m a consultant, not the primary physician.&quot; Z2 said, she assists E3 and E6 as needed but does not just care for wounds.</td>
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<td>Z2's 01/03/14 progress note includes tendons visible and eschar present on right dorsal foot wound and surrounding erythema.</td>
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<td>During telephone interview 01/22/14 at 9:45AM, Z3 (R1's attending physician), stated, Z3 did not see R1 while a resident at facility (12/25/13 -</td>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** IL6014294

**Date Survey Completed:** 01/24/2014

**Name of Provider or Supplier:** MILLER HEALTH CARE CENTER

**Address:** 1601 BUTTERFIELD TRAIL

**City, State, Zip Code:** KANKAKEE, IL 60901

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<td>01/08/14</td>
<td>R1 was not evaluated by the wound care team until 12/30/14, due to the wound care nurse being off for the holiday. R1 does have very poor circulation. Z3 said &quot;I heard from R1's family that the residents wound deteriorated at the facility.&quot; Z3 said upon review of R1's medical records, timely wound assessments were not documented. Z3 also said the facility failed to notify Z3 of the 5 day delay of wound care team evaluation by the wound care specialist and of deterioration of R1's right dorsal foot wound.</td>
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On 01/16/14 at 10:10AM, E5 (admission nurse director), said on 12/25/13, R1 was admitted to facility for wound care and strengthening. R1 and her daughter thought facility was going to provide Hyperbaric wound treatments and became upset when told facility does not provide this therapy. R1 was so upset, she wanted to be discharged. E5 said "I explained to the resident and her daughter that facility will provide wound care for her foot."

E5's 12/25/13 progress note included; R1 was upset about inability to get Hyperbaric treatments at facility while an in-patient. R1 wanted to leave facility related to, the rational for her admission was for Hyperbaric wound treatments. E5 reviewed treatment plan with R1 and daughter and told them, R1 would receive therapy and wound care from facilities wound care team.

R1’s 12/25/13, 3:47AM progress note includes, R1 very upset about inability to receive “proper wound care (Hyperbaric treatments),” while in facility. R1’s 01/06/14 1:25PM progress note includes R1’s daughter requesting out patient wound care referral for Hyperbaric treatments.
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| R1's 01/06/14 progress note and 2:00PM physician order includes, new physician order obtained, for referral to an out patient wound care facility for Hyperbaric treatments. R1's Wound Measurement Flow sheet includes; 01/07/14 "The tendons continue exposed. The black, tough eschar remains 66% or greater of the wound."
| | | | | | | | |
| R1's 01/08/14 progress notes include; 11:23AM out to Z1 (Cardio vascular surgeon), follow-up appointment. 4:47PM, R1's daughter called with many concerns about wound care provided and saying the wound is black. Daughter said R1 was being readmitted to the hospital for possible right foot amputation. 5:28PM, R1's daughter called, saying Z1 told her R1's right foot should have never gotten as bad as it has and that proper wound care was not provided at facility. | S9999 | | | | | | |
| R1's 01/09/14 progress notes include, on 01/08/14, R1 was readmitted to hospital for right foot wound debriedment. | | | | | | | |
| (B) | | | | | | | |