PRINTED: 07/29/2014 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: ___ C B. WING IL6000269 06/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST RIVER PLACE MANORCARE OF KANKAKEE KANKAKEE, IL 60901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Final Observations S9999 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)2) 300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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.

> TITLE (X6) DATE

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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IL6000269		B. WING		06/2	7/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MANOR	A DE OE KANKAKE	900 WES1	Γ RIVER PLA	CE		
WANCK	CARE OF KANKAKEE	KANKAKI	EE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
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	Section 300.1210 (Nursing and Perso	Seneral Requirements for nal Care				
	and services to atta practicable physica well-being of the re each resident's cor plan. Adequate and care and personal	provide the necessary care ain or maintain the highest all, mental, and psychological sident, in accordance with apprehensive resident care a properly supervised nursing care shall be provided to each total nursing and personal esident.				
	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:					
	resident's condition emotional changes determining care re further medical eva	vations of changes in a I, including mental and I, as a means for analyzing and equired and the need for Illuation and treatment shall be aff and recorded in the record.				
	Section 300.1220 S Services	Supervision of Nursing	The control of the co			
		upervise and oversee the the facility, including:				
	the residents' need defined conditions a sensory and physic status and requiren discharge potential	comprehensive assessment of s, which include medically and medical functional status, al impairments, nutritional nents, psychosocial status, dental condition, activities tion potential, cognitive status,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			/ Solebino.			_
		IL6000269	B. WING		i i	C 27/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MANORO	CARE OF KANKAKEE	900 WES	ST RIVER PLA	CE		
	TARE OF NAMAREL	KANKAR	KEE, IL 60901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
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	and drug therapy.		**************************************			
	Section 300.3240 A	buse and Neglect	Portrait History of the Control of t			
		-				Widolog City Address .
	a) An owner, licens	ee, administrator, employee or nall not abuse or neglect a	C Control of the Cont			
	resident. (Section 2	-107 of the Act)	A DISTORTERANCE			
	(700
	These requirements	s are not met as evidenced by				
	Based on record re	views and interviews the	•			
	facility failed to reas	sess and evaluate one				
	resident in the sample	ple for new pain after an				
	incident. This failur	e resulted in R1 experiencing				
	unrelieved pain for an incident.	six hours during transfers after				
		resident (R1) out of a sample				
	of three residents re	eviewed for incidents.				
	The findings include					
		ninimum data set) dated				
		equires extensive, 2 person				
	assist with bed mob	pility and transfers and	**************************************			
	of daily living. R1 is	assist with all other activities				
	The final incident re	port submitted to the				
	department dated 6	/24/14 documents that R1	Section (Section (Sec			
	was sent to the hos	pital emergency room on				
	6/20/14 at 5:00 pm	with complaints of right knee				
		returned at 11:15pm with	O. In constant			
		to tibia/fibula. This report				
		he original incident and	ATTENDED TO A STATE OF THE STAT			
		pegan around 9:30am on ry was not identified by the	Parameter 1			
	facility until over 6 h	ours later. In the interim, R1	THE RESIDENCE OF THE PERSON OF			
	was transferred bac	k to bed and up again to the	Billiannia neles			
	wheelchair, complai	ning of pain. The initial report	**COMMENTAL STATE OF THE STATE			
	submitted to IDPH of	on 6/20/14 states R1	- Indiana in the second in the			
	complained of pain		194 And America			
		1 sustained fracture to right	пального			
	tibia/fibula, E2, (dire	ctor of nursing) stated on				

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Illinois L	Department of Public	<u>Health</u>				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000269	B. WING		1	C 27/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
		900 WES	FRIVER PLA			
MANOR	CARE OF KANKAKEE		EE, IL 6090			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T		ON	
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S9999	Continued From pa	ge 3	S9999			
	6/21/14 at 12:45pm	that yesterday, (6/20/14)	ndit-			
	around 9:30am F3	(nurse 's aide) placed R1 's				
	right leg on the leg	rest but R1 did not want her				
	leg on the leg rest a	and pulled it off, banging her				
	ankle onto the bar	of the bedside table that was				
	placed over her. E2	said both E3 and E4 (nurse)				
	heard R1 say " ow,	ow, you snapped my leg. " ´				
	E2 said that Z1(spc	ouse) came in at 4:00pm and				
	brought R1 to the n	ursing station, stating that R1				
	was saying "they o	cracked my leg. "				
		e interview on 6/26/14 at				
		as R1's nurse's aide the E3 said that she (E3) placed				
	the gait belt around	R1 (sitting on edge of bed)				
	and pivoted R1 into	the wheelchair. Once R1 was				
	in the wheelchair, E	3 picked up R1's leg to place				
	it on the footrest an	d R1 yelled "ow, ow, you				
	snapped my leg." E	3 stated that R 1 did not want				
	her leg on the foot r	est and when she slid it off,				
	the ankle smacked	the bar of the over bed table.				
	E3 said she notified	E4 that R1 was having pain.				
	E3 went on to add t	hat she did not tell E4 what		*		
	had hit the table. E	the transfer or that R1 's leg				
	with F3 states that a	acility interview dated 6/21/14, she heard R1 tell Z1 (R1 ' s				
	spouse) over the ph	ione at 10:30am "my leg				
	hurts: it feels like it's	s snapped." E3 informed E4				
	that R1 was still cor	nplaining of pain at 11:30am.				
	E3 said that she train	nsferred R1 back to bed after				
	lunch between 1:30	pm and 2:00pm, still				
	complaining of pain					
	E4 confirmed on 6/2	26/14 at 12:40pm that she				
	neard R1 say "ow, o	ow, you snapped my leg" on				
	o/20/14 around 9:30	Dam. E4 stated she went in				
	Norce Q (noin modi-	leg and administered R1		*		
	interview with E4 ah	cation) at 9:30am. The facility out the incident states E4				
		that E3 informed her (E4) at				
	10:30am that R1 wa	inat E3 informed her (E4) at is making accusations that E3			İ	
	broke her (R1) leg. I	E4 did not document in the	T AND			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE COMP	SURVEY LETED
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		IL6000269	B. WING		06/2	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MANOD	CADE OF KANKAKEE	. 900 WES1	RIVER PLA	ACE		
WANCR	CARE OF KANKAKEE	KANKAKI	EE, IL 6090	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
				DEFICIENCY)	-	
S9999	Continued From pa	ige 4	S9999			
	nursing notes until	4:32 pm, when the ambulance				
		ake R1 to ER. In phone				
		I she had been very busy that				
	day with another re	sident who was dying. E4				
		assessed R1 around 2:30pm				
		thing abnormal. According to				
		igation, E6 (3-11pm nurse)				
	stated in the facility	interview that on 6/20/14 at				
		prought R1 to her (E6) saying				The state of the s
		ing of pain to her right leg. E6 '				and remarks to
		ies saying that as she started				The provided in common districts
		p to examine R1, R1 yelled.				
		hat, "could see purple				
	discoloration of the	right and outer aspects of her				
		and swelling. The leg				
		ormal below the knee. (R1)				
	was not able to mo					
		hone interview on 6/26/14 that				
		pain throughout the day on				
		lower leg and knee area was				
		had no idea how R1's right				
	2 hour timeframe f	n injured to that extent within a rom 2:30pm to 4:30pm when				
		sessed R1. The facility				
		20/14 documents that R1's				
		ed and she had very large				
		leg to her knee cap."				
		R1's physician) on 6/26/14 at				
	11:40am said he co	ould not recall when the facility				Name of the Control
	notified him about R1's complaints of pain. Z1					
		and /or witnessed incident				
		mplaints of pain occurs, staff				
	should assess the r	esident and watch her closely.				
	Facility's pain policy	and procedure states that				
	"whenever possible	the underlying cause of pain				
	is identified and add	dressed through review of				
		story (R1 had known history of				
	severe osteoporosis	s, spinal stenosis,				
	bone/cartilage disor	der, pathological fracture of				
vertebrae) and completion of comprehensive pain						

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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IL6000269		B. WING		06/27/2014	
				1 00/2	112017
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MANORCARE OF KANKAKEE	900 WEST	RIVER PLA	CE		
MANORCARE OF RANKAREE	KANKAKE	EE, IL 60901			
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
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S9999 Continued From pag	je 5	S9999			
evaluation " Facility (did not follow this protocol for				
R1's complaint of ne					
	ing) confirmed on 6/25/14 at				
	documentation regarding				
	nurse's note dated 6/20/14				
	was being sent to ER.				
	nce that R1 had been				
	ncident and when the resident				
experienced new par					a according a contract
	e on 3-11 pm shift on				
	phone interview on 6/26/14 at				
	4:15pm she heard R1 yelling				
out from her bed tha	t her leg was hurting. E5				
	and observed that R1's right				
	swollen from the knee cap				
	add that R1 was then				
transfered into the w	heelchair and started to				
scream, "it hurts. "	E5 wheeled R1 to the nurse's				on some one of
station and informed	I E6 (nurse) that this was a				
	on from R1, causing her to				
	nd be combative and that				
R1's leg needs to be					
Z1 (family member)	stated via phone on 6/26/14				
	called and asked him to come				
	ted to Z1 " they were				
transferring me from	bed to wheelchair and				
door not hand and h	1 stated that R1 's right leg				
	er left leg bends a little. Z1				
	e facility about 4:10pm on				A SAN A A DOUBLE
noticed right away th	6/20/14 and found R1 sitting in the foyer. Z1 noticed right away that something was wrong with				
her right leg because	e it was flopped over. Z1				
	ook at R1's leg and both saw				
	uised, swollen and crooked.				
	ible xray was on the way and				
	ent to the hospital now				
	wrong with her leg, they				
	able to fix it. Then I was told I	THE STATE OF THE S			
	ne nurse when (R1) told me				
	when they got her up. They				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
IL6000269		B. WING		C 06/27/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
MANOR	MANORCARE OF KANKAKEE 900 WEST RIVER PLACE						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
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	made me feel like it						
		(B)					
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