Final Observations

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.
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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:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status,
**Illinois Department of Public Health**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** IL6000269

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING: ____________________

B. WING: ______________________

**(X3) DATE SURVEY COMPLETED**

C 06/27/2014

**NAME OF PROVIDER OR SUPPLIER**

MANORCARE OF KANKAKEE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

900 WEST RIVER PLACE
KANKAKEE, IL 60901

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<td>Continued From page 2 and drug therapy. 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 requirements are not met as evidenced by: Based on record reviews and interviews the facility failed to reassess and evaluate one resident in the sample for new pain after an incident. This failure resulted in R1 experiencing unrelieved pain for six hours during transfers after an incident. This applies to one resident (R1) out of a sample of three residents reviewed for incidents. The findings include: Most recent MDS (minimum data set) dated 3/27/14 shows R1 requires extensive, 2 person assist with bed mobility and transfers and extensive, 1 person assist with all other activities of daily living. R1 is non-ambulatory. The final incident report submitted to the department dated 6/24/14 documents that R1 was sent to the hospital emergency room on 6/20/14 at 5:00 pm with complaints of right knee and ankle pain and returned at 11:15pm with diagnosis of fracture to tibia/fibula. This report does not state that the original incident and complaints of pain began around 9:30am on 6/20/14 and the injury was not identified by the facility until over 6 hours later. In the interim, R1 was transferred back to bed and up again to the wheelchair, complaining of pain. The initial report submitted to IDPH on 6/20/14 states R1 complained of pain at an 8 out 10 scale. When asked how R1 sustained fracture to right tibia/fibula, E2, (director of nursing) stated on</td>
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6/21/14 at 12:45pm that yesterday, (6/20/14) around 9:30am, E3 (nurse’s aide) placed R1’s right leg on the leg rest but R1 did not want her leg on the leg rest 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(spouse) came in at 4:00pm and brought R1 to the nursing station, stating that R1 was saying “they cracked my leg.” E3 stated via phone interview on 6/26/14 at 12:10pm that she was R1’s nurse’s aide the morning of 6/20/14. 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, E3 picked up R1’s leg to place it on the footrest and R1 yelled “ow, ow, you snapped my leg.” E3 stated that R1 did not want her leg on the foot rest 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 that she did not tell E4 what had happened with the transfer or that R1’s leg had hit the table. Facility interview dated 6/21/14, with E3 states that she heard R1 tell Z1 (R1’s spouse) over the phone at 10:30am “my leg hurts; it feels like it’s snapped.” E3 informed E4 that R1 was still complaining of pain at 11:30am. E3 said that she transferred R1 back to bed after lunch between 1:30pm and 2:00pm, still complaining of pain.

E4 confirmed on 6/26/14 at 12:40pm that she heard R1 say “ow, ow, you snapped my leg” on 6/20/14 around 9:30am. E4 stated she went in and assessed R1’s leg and administered R1 Norco 9 (pain medication) at 9:30am. The facility interview with E4 about the incident states E4 also acknowledged that E3 informed her (E4) at 10:30am that R1 was making accusations that E3 broke her (R1) leg. E4 did not document in the
Continued From page 4

nursing notes until 4:32 pm, when the ambulance was on the way to take R1 to ER. In phone interview, E4 stated she had been very busy that day with another resident who was dying. E4 stated that she had assessed R1 around 2:30pm and did not see anything abnormal. According to the facility’s investigation, E6 (3-11pm nurse) stated in the facility interview that on 6/20/14 at about 4:20pm, Z1 brought R1 to her (E6) saying that R1 is complaining of pain to her right leg. E6’s statement continues saying that as she started to lift the pant leg up to examine R1, R1 yelled. E6 went on to add that, "could see purple discoloration of the right and outer aspects of her leg below the knee and swelling. The leg alignment was abnormal below the knee. (R1) was not able to move her leg."

E4 stated during phone interview on 6/26/14 that R1’s complaint of pain throughout the day on 6/20/14 to the right lower leg and knee area was new. E4 stated she had no idea how R1’s right leg could have been injured to that extent within a 2 hour timeframe, from 2:30pm to 4:30pm when per E7’s (nurse) assessed R1. The facility statement dated 6/20/14 documents that R1’s "right leg was rotated and she had very large bruises up her right leg to her knee cap."

Interview with Z2 (R1’s physician) on 6/26/14 at 11:40am said he could not recall when the facility notified him about R1’s complaints of pain. Z1 said that if a known and/or witnessed incident followed by new complaints of pain occurs, staff should assess the resident and watch her closely. Facility’s pain policy and procedure states that "whenever possible the underlying cause of pain is identified and addressed through review of relevant medical history (R1 had known history of severe osteoporosis, spinal stenosis, bone/cartilage disorder, pathological fracture of vertebrae) and completion of comprehensive pain
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evaluation." Facility did not follow this protocol for R1’s complaint of new pain on 6/20/14.
E2 (Director of Nursing) confirmed on 6/25/14 at 1:40pm that the only documentation regarding
this incident was the nurse’s note dated 6/20/14 at 4:30pm, when R1 was being sent to ER.
There was no evidence that R1 had been assessed after the incident and when the resident
experienced new pain symptoms.
E5 (R1’s nurse’s aide on 3-11 pm shift on
6/20/14) stated via phone interview on 6/26/14 at
10:35am that about 4:15pm she heard R1 yelling
out from her bed that her leg was hurting. E5
entered R1’s room and observed that R1’s right
leg was very red and swollen from the knee cap
don. E5 went on to add that R1 was then
transferred into the wheelchair and started to
scream, “it hurts.” E5 wheeled R1 to the nurse’s
station and informed E6 (nurse) that this was a
different pain reaction from R1, causing her to
scream out in pain and be combative and that
R1’s leg needs to be assessed.
Z1 (family member) stated via phone on 6/26/14
at 11:10am that R1 called and asked him to come
to the facility. R1 stated to Z1 "they were
transferring me from bed to wheelchair and
cracked my leg." Z1 stated that R1’s right leg
does not bend and her left leg bends a little. Z1
said that he got to the facility about 4:10pm on
6/20/14 and found R1 sitting in the foyer. Z1
noticed right away that something was wrong with
her right leg because it was flopped over. Z1
called the nurse to look at R1’s leg and both saw
that R1’s leg was bruised, swollen and crooked.
They told me a portable xray was on the way and
I said I wanted her sent to the hospital now
because whatever is wrong with her leg, they
(facility) wouldn’t be able to fix it. Then I was told I
should have called the nurse when (R1) told me
her leg was cracked when they got her up. They
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<th>ID</th>
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<th>TAG</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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<th>Complete Date</th>
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