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assigned nurse many times, and described R1 as		had diagnoses includisease, unsteady g	uding degenerative joint gait, severe protein calorie					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		assigned nurse ma	ny times, and described R1 as					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/15/2015

	FORM): 10/15/2015 1 APPROVED). 0938-0391					
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		145043	B. WING			C / 08/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE OF KANKAKEE	<u>:</u>	900 WEST RIVER PLACE KANKAKEE, 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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	high functioning, wh but doesn't talk. E2 prior to the incident such that R1 did no assist staff in ambu had some toys whic awake hours, and s prevent R1 from dis which nutrition, fluid provided. R1 was at the facilit was unable to partie to the resident's leve that the resident do Review of the R1's notes show up to the the incident, there we behavior, skin issue of R1. The progress the incident no unu to 3:30PM. The progress notes and shave at Septer which time an un-ne the left knee and no (Registered Nurse) a large red/purple b bruise covering kne stated "resident did Did not complain of crying or grimacing E5 noted R1 was a timeline of events for R1, showed following	ho understands what is said e stated R1's ambulation status t of September 18, 2015 was of try to walk alone, but could ulation and pivot. E2 stated R1 ch occupied much of R1's served as a distraction to slodging the feeding tube by ds, and medication were ty during the investigation, but cipate in the investigation due vel of cognition, and the fact bes not speak. interdisciplinary progress nree days prior to the date of was no notation of any unusual es or changes in the condition s notes showed on the date of sual activities were noted prior a show R1 received a bed bath ember 18, 2015 at 3:30 PM, at amed CNA found bruising of otified the nurse. E5 then assessed R1 and "found pruise to left thigh," "and gray eecap." E5's documentation if any pain. Was not moaning	F 32	,			

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 3

DEPARTMENT OF HEAL CENTERS FOR MEDICA	FORM	10/15/2015 APPROVED 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	145043	B. WING _		C 10/08/2015		
NAME OF PROVIDER OR SUPPLI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORCARE OF KANKAK	EE	900 WEST RIVER PLACE KANKAKEE, IL 60901				
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 evaluation of the bruised areas. A call from the hos with a left hip fra the hospital for s On September 6 Nursing) stated of investigation into staff interviews widetermined on the 2015 a transfer for by E3 (CNA) and (Registered Nursiconcluded the transfer determined staff to be the transfer determined staff to be the transfer determined staff to be the transfer, the a demonstration the transfer performed by E5 R1's care plan. The transfer determined by E3 (EVA) and the transfer determined staff to be the transfer performed by E5 R1's care plan. The transfer determined by E5 R1's care plan. The transfer performed by E5 R1's	cal emergency room for medical facility's assessment of R1's t 7:45PM the facility received a pital to inform R1 was diagnosed cture and would be admitted to	F 32				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6000269

If continuation sheet Page 3 of 3