

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2024
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare of Peoria		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Glen Elm Drive Peoria, IL 61614	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on record review and interview the facility failed to ensure the right resident received IV (intravenous) access hydration, micronutrient therapy and failed to obtain a physician's order to administer IV hydration and micronutrient (vitamin and mineral therapy) for one of three residents (R1) reviewed for IV therapy in the sample of three.</p> <p>Findings include:</p> <p>R1's Incident Report dated 1-17-24 at 1:23 PM and signed by V2 (Director of Nursing) documents, Incident Description: (IV therapy company) inserted an IV on (R1's) right wrist. (R1) did not receive much, maybe 100 ml (milliliter). (R1) pulled IV out and was waving it around. No injuries noted. Witnesses: V9 (IV Hydration RN/Registered Nurse) statement: I (V9) got the A and B (resident) bed mixed up and when I asked (R1) her name, she said yes. V8 (IV Hydration RN) statement: I had a trainee (V9) and (V9) mixed up the A and B bed.</p> <p>R1's Order Summary Report and Physician's Orders dated 1-1-24 through 1-31-24 do not include an order for R1 to receive IV hydration or micronutrient therapy, or for staff to obtain IV access.</p> <p>R1's Progress Notes dated 1-17-24 at 8:35 PM document R1 received a bruise to the right wrist due to an IV stick.</p> <p>On 4-12-24 at 10:10 AM V3 (R1's Power of Attorney) stated, I went to visit (R1) on 1-17-24 and I noticed (R1's) right arm had a bruise to the right wrist. I called the facility the next day and spoke to (V2/Director of Nursing) and she told me an outside group does vitamin infusions and a trainee for the vitamin infusion group gave (R1) an intravenous stick and infused some of a vitamin infusion in her right arm.</p> <p>On 4-12-24 at 10:30 V8 (Intravenous Hydration Registered Nurse) stated I was (V9's/Intravenous Hydration RN) preceptor and (V9) got the resident beds mixed up. I was down the hallway with another resident and (V9) asked (R1) her name and (V9) gave (R1) the infusion thinking (R1) was the right resident. (V9) came down to the room with me and (V2) came down and told me (R1) removed the IV. (V2) dressed the site so it was not bleeding anymore. I looked at our list and noticed (R1) was not supposed to get the IV and went and notified (V2). (R1) had gotten approximately 300 ml of our nutrition solution (vitamin C, b-complex, zinc, magnesium, calcium, amino acids). (V9) should have asked (R1) her first and last name, birthdate, and verified (R1's) picture in the medication administration record before administering the IV.</p> <p>(continued on next page)</p>

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.

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: 145039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2024
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare of Peoria		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Glen Elm Drive Peoria, IL 61614	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's IV Hydration and Micronutrient Therapy Guideline Contract dated 10/2023 documents, Nutrition Infusion: The nutrition infusion is an intervention for patients who are experiencing nutritional deficiencies, weight loss, decrease appetite, refusal to eat, or on weight management protocols. Ingredients: Vitamin C, B-Complex Vitamin, B-5 Vitamin, B-12 Vitamin, Calcium Gluconate, [NAME], Amino Acid Blends, and Branched-Chain Amino Acids (protein-based amino acids). V2 (Director of Nursing, V (Assistant Director of Nursing) or designee will contact the physician or nurse practitioner for review of the evaluation and recommendations and will secure specific orders for the specific type of IV infusion, fluid option, infusion rate, and administration route.</p>