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Form Approved OMB
No. 0938-0391

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 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Peoria	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32189 Based on observation, record review and interview, it was determined the facility failed to ensure call lights were answered in a timely manner and responded to accommodate the residents needs for 2 of 2 residents (R3, R4) with mobility restrictions observed for call light accessibility. Findings include: On 4/24/24, R3 was admitted to the facility for rehabilitation services status post lumbar fusion surgery. On 4/24/24, R3's Care plan indicates limited physical mobility related to surgical aftercare and spinal stenosis. On 5/6/24 at 12:10 PM, R3 was observed sitting in a wheelchair with Spine brace on; R3 had a hand over forehead, head down and grimacing; pulling and moving brace around and complained of pain. R3 stated We (R3 and R5 (R3's roommate) put the call light on twice. They (Certified Nurse Aides/CNA) said they would be back. At 1:04 PM, R3 was sitting in wheelchair with a back brace on R5 stated I put on the call light. They had to go find a mechanical lift. At 3:08 PM, R3 stated I'm still waiting for the gals to come put me on my side. I've been on my back since I got back in bed. R5 put the light on once but I still haven't had anyone come back. I called V10 (Healthcare Power of Attorney) earlier when they left me up in the chair and told V10. V10 called the front desk and told them to put me back in bed. That's why they came in. On 5/7/24 at 8:48 AM, V10 stated Yesterday around 11:00 AM or so, R3 called me crying saying R3 was left in the wheelchair with the back brace on for a half hour. They (staff) said they would be right back, but they hadn't been back. R3 has called me about 3 or 4 other times and says R3 pushes the call button but no one comes, I have pushed the call light a couple of times, and no one has answered but I'll go out there and complain. On 8/1/23, R4 was admitted rehabilitation services related to weakness, muscle atrophy, abnormality of gait and mobility. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's care plan dated 8/2/23 documented R4 was at risk for acute/chronic pain related to medical postoperative right lower leg fracture discomfort and an Activities of Daily Living self-care performance deficit related to displaced bi-malleolar fracture of right lower leg. The 4/25/24 through 5/7/24 Plan of Care Response History titled Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment documented R4 requires partial/moderate, substantial/maximal assistance or dependent on helper assistance. On 5/6/24 at 12:20 PM, R4 stated I got up to the commode with help from the Certified Nurse Aide/CNA and I didn't see the CNA again. I can't wipe my butt. The CNA told me she didn't see my light on, but it was on for 2 hours. I have trouble breathing and I need assistance. I need help with getting up and I have trouble holding my bowels and bladder. I can't walk because I broke my ankle and tail bone. I am so upset (about being left on the commode). I'm not getting out of bed for the rest of the day.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 32189 Based on observation, record review and interview, the facility failed to ensure call lights were available for resident use for 1 of 2 residents (R3) reviewed with mobility restrictions observed for call lights. Findings include: The Daily Care policy, dated 8/2/17, documented the guidelines and procedures for daily cares to all residents. The policy documented to Place call light within reach. On 4/24/24, R3 was admitted to the facility for rehabilitation services status post lumbar fusion surgery. On 4/24/24, R3's Care plan indicated limited physical mobility related to surgical aftercare and spinal stenosis. On 4/24/24, The Physical Therapy and Occupational Therapy Evaluation and Plan of Treatment documented Precaution Details: ** Spine Brace to be worn while patient is up doing transfers and/or ambulating. Does not need to be worn while in bed or chair. SPINAL PRECAUTIONS- NO BLT (NO BENDING, LIFTING more than 7 pounds), OR TWISTING. FALL RISK, 8/10 pain in right hip and bilateral knees. The evaluation documented R3 required substantial/maximal assistance with bed mobility, partial/moderate assistance with transfers and was dependent on staff with ambulation. On 5/6/24 at 12:10 PM, R3 was sitting in a wheelchair with back brace on. R3's call light was draped over the bed and unreachable. At 1:04 PM, R3 was sitting in wheelchair with brace on. R3's roommate (R5) stated I put on the call light because R3 wanted to go back to bed, and she can't reach it (call light). At 1:06 PM, V13 (Certified Nurse Aide) was observed to enter R3's room, providing cares and exited to go get another staff member for assistance. The call light was draped over the bed and unreachable. At 1:20 PM, R3 was lying in bed with call light on nightstand and unreachable. At 3:08 PM, R3 stated I'm still waiting for the gals to come put me on my side. I've been on my back since I got back in bed. R5 put the light on once but I still haven't had anyone come back. I called V10 (Healthcare Power of Attorney) earlier when they left me up in the chair and told V10. V10 called the front desk and told them to put me back in bed. That's why they came in. On 5/7/24 at 8:48 AM, V10 stated Yesterday around 11:00 AM or so, R3 called me crying saying R3 was left in the wheelchair with the brace on for a half hour. They (staff) said they would be right back, but they hadn't been back. Sometimes when I get there, we can't find the call light. One time it was wrapped up and hung up on the wall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 3:00 PM, V1 (Administrator) stated staff should ensure call lights are within reach of the residents prior to exiting the room.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on observation, record review and interview, the facility failed to provide resident-centered care for one resident (R3) who required rehabilitation services status post-surgical fusion of the lumbar spine, as evidenced by lack of physician orders for spinal precautions; no care plan intervention related to spinal precautions or back brace use; improper use of mobility devices and inadequate assessment of medication management. Findings include: R3 was admitted on [DATE] post a lumber fusion surgery and a history of Gastro Esophageal Reflux Disease (Heartburn/Indigestion/GERD). On 4/23/24, the facility received R3's Hospital Transfer Papers which documented Up to chair 3 (three) times per day. Spine brace (back brace designed to give support to thoracic and lumbar spine by preventing twisting and flexion (bending forward) to be worn while up ambulating. Does not need to be worn while up in chair or bed. On 4/24/24, The Physical Therapy and Occupational Therapy Evaluation and Plan of Treatment documented Precaution Details: ** Spine Brace to be worn while patient is up doing transfers and/or ambulating. Does not need to be worn while in bed or chair. SPINAL PRECAUTIONS- NO BLT (NO BENDING, LIFTING more than 7 pounds), OR TWISTING. FALL RISK, 8/10 pain in right hip and bilateral knees. The evaluation documented R3 required substantial/maximal assistance with bed mobility, partial/moderate assistance with transfers and was dependent on staff with ambulation. On 4/24/24, R3's Care plan documented R3 has limited physical mobility related to surgical aftercare, spinal stenosis and lacked interventions related to the Spinal Precautions and use of Spine brace. On 4/25/24, a Physician's Order for Spine Brace on when resident up every shift was implemented although lacked a physician's order for Spinal Precautions and to elevate the head of the bed to facilitate breathing. As of 5/6/24, the Order Summary lacked documentation of Spinal Precautions. On 4/25/24, a Physician's Order for WOUND: Back- Keep incision clean, dry and intact until follow up appointment, monitor for signs and symptoms of infection.' On 5/6/24 at 12:10 PM, R3 was sitting in a wheelchair with Spine brace on; R3 had a hand over forehead, head down and grimacing; pulling and moving brace around. R3 stated It (Spine brace) hurts. It's pushing on my belly, and I feel sick to my stomach. I'm not supposed to have this thing (brace) on when I'm in the wheelchair. It's just digging into me and hurting my back. At 12:38 PM, R3 was observed sitting in a wheelchair with brace on. At 1:04 PM, R3 was sitting in a wheelchair with brace on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:10 PM, V13 (Certified Nurse Aide) was observed to enter R3's room. Upon entrance V13 had hooked R3's sling up to the mechanical lift. V13 stated I need to go get a spotter. R3 and R5 (R3's roommate) both stated V13 got R3 and R5 both up by V13 only this morning. At 1:20 PM, R3 was lifted into bed by V13 and V14 (Certified Nurse Aide) via mechanical lift with the Spine brace on. V13 stated to V14 V15 (Physical Therapy) took R3's brace off this morning and I put the brace (R3's Spine brace) back on wrong. R3 was positioned in bed in supine position without the head of the bed elevated. At 3:08 PM, R3 stated R3's pain level was at an eight (0- no pain and 10- worst pain). R3 stated The brace rubbed on my back incision. I'm still waiting for the gals to come put me on my side. I've been on my back since I got back in bed. I have indigestion so bad; I feel like there's a big heavy lump here (pointed to upper sternum). At home I drink milk and take Pepcid, but I've asked for some milk and haven't gotten anything yet. I called V10 (Healthcare Power of Attorney) earlier when they left me up in the chair and told V10. V10 called the front desk and told them to put me back in bed. That's why they (staff) came in (at 1:20 PM to put R3 back in bed). At 3:25 PM, V16 (Licensed Practical Nurse) was at the nurse's station and was informed that R3 was requesting to be turned and to conduct a dressing check/skin assessment. At 3:28 PM, V11 (Certified Nurse Aide Supervisor) told V16 that R3 requested something for R3's upset belly. At 3:35 PM, V16 walked into R3's room and proceeded to administer medication without identifying R3, asking about R3's symptoms, level of discomfort or explaining what the medication was for. At 3:40 PM, V16 proceeded to have R3 put R3's bent left leg over the top of the of the right leg and pushed R3 to R3's right side (twisting motion) and R3 cried out. The dressing covering the back incision was balled up at the top of R3's back and was not covering the incision. V16 peeled off plastic tape which was stuck to R3's skin and rolled up. V16 then left the room to go get supplies for the dressing change and left R3 rolled over on right side with the bed in a high position and with the incision not covered. During this time R3 stated that earlier in the day, R3 had been constipated and R3's belly was bloated. R3 stated I begged them (staff) to get me up to the toilet instead of going in my bed. R3 stated They just tell me to go in my briefs. Approximately 10 minutes later (3:50 PM) V16 enters R3's room and performed the dressing change. On 5/7/24 at 8:48 AM, V10 stated Some girls came in about the 4th day (after admission) and yanked on R3's leg. It really hurt R3. They are doing stuff they aren't supposed to do. This was a different surgery and it's way more painful. R3 should wear the brace when up and when R3 does therapy. They use that hoist (mechanical lift), and I don't think they are supposed to do that. They aren't walking R3 very much. Yesterday around 11:00 AM or so, R3 called me crying saying R3 was left in the wheelchair with the brace on for a half hour. They (staff) said they would be right back, but they hadn't been back. I wasn't very happy about that. R3 doesn't tolerate pain well. I called (the facility) and complained and apparently, they put her back in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 3:33 PM, the Medication Administration Record/MAR documented V16 administered hydrocodone (opioid narcotic) for a pain level of 6 (0-no pain 10-worst pain). The record lacked an assessment of R3's complaints of indigestion or upset belly. The MAR lacked documentation medication for indigestion was administered on an as needed bases as ordered. On 5/7/24 at 12:30 PM, V15 (Physical Therapist) stated Orders come from the Admission Orders and put into (medical record) by V12 (Assisting Director of Nursing.). We (Therapy) communicate with staff regarding weight bearing status and such. Today we changed R3's wheelchair to a high-backed reclining wheelchair so that R3 doesn't have the brace pushing into R3's groin/stomach and chest. V15 stated Therapist do not attend care plan meetings; R3's record lacked a Physician Order for Spinal Precautions; and the staff were not educated on Spinal Precautions and the use of the Spine brace. V15 stated staff should be utilizing the log roll technique (no twisting). V15 stated the Spine brace should have been removed while R3 was in the wheelchair and prior to mechanical lift. On 5/7/24 at 3:00 PM, V1 (Administrator) stated V15 has already been out to educate staff about the Spine brace and Spinal Precautions. V1 stated V15 was concerned about the lack of staff education. The Transfers policy, dated 8/2017, documented it was the duty of the Director of Nursing or Designee to ensure that adequate training is provided to all nursing staff on the proper use of (mechanical lifts). The policy stated a minimum of two staff members is recommended when transferring with a (mechanical lift) and to follow the Plan of Care to ensure the use of proper transfer technique. The Management of Pain policy, dated 8/2/17, documented to encourage residents to self-report pain; assess pain in non-verbal and cognitively impaired residents; and prevent and minimize anticipated pain when possible. The policy documents the licensed nurse will assess pain under any of the following circumstances: Resident is on routine pain medication and pain is not controlled, persistent, or worsening. A change in pain related behaviors, cognition, or mood occurs. Nursing Observation Pain may be indicated when there are changes in the following: Facial expressions. Body movements.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32189 Based on observation, record review and interview, the facility failed to ensure interventions were implemented to prevent the development of pressure ulcers or worsening of wounds for 1 of 1 resident (R3) reviewed for wound and at high risk for a pressure ulcers. Findings include: On 4/18/24. R3 had a lumber fusion surgery and required Precaution Details:** Spine Brace (back brace designed to give support to thoracic and lumbar spine by preventing twisting and flexion (bending forward) to be worn while patient is up doing transfers and/or ambulating. Does not need to be worn while in bed or chair. SPINAL PRECAUTIONS- NO BLT (NO BENDING, LIFTING more than 7 pounds), OR TWISTING. FALL RISK, 8/10 pain in right hip and bilateral knees. On 4/24/24 R3's Braden Scale for Predicting Pressure Sore Risk Assessment was documented as a 12 (twelve), high risk. On 4/24/24, R3's Minimum Data Set (MDS) section M documented R3 had a stage 2 pressure ulcer (resolved as of 5/6/24), a surgical wound and was at risk for a pressure ulcer. On 4/24/24, R3's Careplan documented R3 has limited physical mobility related to surgical aftercare, spinal stenosis; has potential/actual impairment to skin integrity of the back and right buttock related to fragile skin and to encourage frequent repositioning. On 5/1/24, R3's Physician's order for Heel Protectors to bilateral heels every shift while in bed was obtained. On 5/6/24 at 12:10 PM, heel protectors were not observed in R3's room and the wheel chair lacked a pressure relieving pad. On 5/6/24 at 12:10 PM, R3 was observed sitting in a wheelchair without a pressure relieving pad On 5/6/24 at 1:10 PM, R3 was transferred from the wheelchair to the bed and was positioned in a supine position without heel protectors placed. On 5/6/24 at 3:08 PM, R3 rated R3's pain level at an eight (0- no pain and 10- worst pain). R3 stated I 'm still waiting for the gals to come put me on my side. I've been on my back since I got back in bed. and was observed to not have on heel protectors. On 5/6/24 at 3:25 PM, V16 (Licensed Practical Nurse) was asked to turn R3 and conduct a dressing check/skin assessment. On 5/6/24 at 3:40 PM, R3 was rolled to R3's right side and the dressing covering the back incision was balled up at the top of R3's back and was not covering the incision. V16 peeled off plastic tape which was stuck to R3's skin and rolled up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 8:48 AM, V10 (R3's Healthcare Power of Attorney) Yesterday around 11:00 AM or so, R3 called me crying saying R3 was left in the wheelchair with the brace on for a half hour. They said they would be right back but they hadn't been back. I wasn't very happy about that. R3 doesn't tolerate pain well. I called (the facility) and complained. On 5/7/24 at 9:30 AM, heel protectors were observed in R3's bed. R3 stated they were new and had not seen them before. On 5/8/24 at 3:00 PM, V1 (Administrator) stated R3 did have heel protectors, although they were in the closet because R3 didn't like to wear them. The Formulized Turning and Positioning Program, dated 8/2017, documented residents at moderate to high risk on the Pressure Ulcer Risk Assessment and who are immobile are turned, toileted and repositioned in a formulized manner per the plan of care. The policy documented the turning schedule will occur every 2 (two) hours or when a resident asks. The Preventative Skin Care policy, dated 8/2017, documented that residents identified as being at increased risk for potential skin breakdown shall be repositioned as needed based on assessment and Pressure Redistribution Mattresses may be used in chairs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on observation, record review and interview, the facility failed to ensure staff were competent to perform cares for a 1 of 1 resident (R3) reviewed for specialized equipment and spinal precautions. Findings include: R3 was admitted to the facility on [DATE] post a lumber fusion surgery and spinal stenosis. On 4/23/24, the facility received R3's Hospital Transfer Papers which documented Up to chair 3 (three) times per day. Spine brace (back brace designed to give support to thoracic and lumbar spine by preventing twisting and flexion (bending forward) to be worn while up ambulating. Does not need to be worn while up in chair or bed. On 4/24/24, The Physical Therapy and Occupational Therapy Evaluation and Plan of Treatment documented Precaution Details: ** Spine Brace to be worn while patient is up doing transfers and/or ambulating. Does not need to be worn while in bed or chair. SPINAL PRECAUTIONS- NO BLT (NO BENDING, LIFTING more than 7 pounds), OR TWISTING. FALL RISK, 8/10 pain in right hip and bilateral knees. The evaluation documented R3 required substantial/maximal assistance with bed mobility, partial/moderate assistance with transfers and was dependent on staff with ambulation. On 4/24/24, R3's Care plan documented has limited physical mobility related to surgical aftercare, spinal stenosis and lacked interventions related to the Spinal Precautions and the Spine brace. On 4/25/24 R3's Order Summary documented a Physician's Order for Spine Brace on when resident up every shift and lacked documentation of Spinal Precautions or the application of the Spine brace. On 5/6/24 at 12:10 PM, R3 was sitting in a wheelchair with the Spine brace on; R3's hand was over forehead, head down and grimacing; pulling and moving brace around. R3 stated We (R3 and R5) put the call light on twice. It hurts. It's pushing on my belly, and I feel sick to my stomach. I'm not supposed to have this thing (brace) on when I'm in the wheelchair. It's just digging into me and hurting my back. R3's call light was draped over bed and unreachable. At 12:38 PM, R3 was observed sitting in a wheelchair with brace on. On 5/6/24 at 1:04 PM, R3 was sitting in a wheelchair with brace on. R3's roommate R5 stated I put on the call light. They had to go find a mechanical lift. On 5/6/24 at 1:10 PM, V13 (Certified Nurse Aide) was observed to enter R3's room. Upon entrance V13 had hooked R3's sling up to the mechanical lift. V13 stated I need to go get a spotter. R3 and R5 both stated V13 got R3 and R5 both up by V13 only this morning. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 1:20 PM, R3 was lifted into bed by V13 and V14 (Certified Nurse Aide) via mechanical lift with back brace on. V13 stated V15 took R3's brace off this morning and I put the brace (R3's Spine brace) back on wrong. R3 was left laying supine, flat on the bed with call light on nightstand. On 5/6/24 at 3:08 PM, R3 stated R3's pain level was at an eight (0- no pain and 10- worst pain). R3 stated The brace rubbed on my back incision. I'm still waiting for the gals to come put me on my side. I've been on my back since I got back in bed. R5 put the light on once but I still haven't had anyone come back. I have indigestion so bad; I feel like there's a big heavy lump here (pointed to upper sternum). I called V10 (Healthcare Power of Attorney) earlier when they left me up in the chair and told V10 how much pain I was in. V10 called the front desk and told them to put me back in bed. That's why they came in (at 1:10 PM to put R3 back into bed). On 3/6/24 at 3:25 PM, V16 (Licensed Practical Nurse) was asked to turn R3 and conduct a dressing check/skin assessment. On 5/6/24 at 3:40 PM, V16 proceeded to have R3 put a bent left leg on top of the right leg and pushed R3 to R3's right side (twisting motion). The dressing covering the back incision was balled up at the top of R3's back and was not covering the incision. V16 peeled off plastic tape which was stuck to R3's skin and rolled up. V16 then left the room to go get supplies for the dressing change and left R3 rolled over on right side with the bed in a high position and with the incision open to air. During this time R3 stated that earlier in the day, R3 had been constipated and R3's belly was bloated. R3 stated I begged them (staff) to get me up to the toilet instead of going in my bed. R3 stated They just tell me to go in my briefs. Approximately 10 minutes later (3:50 PM) V16 enters R3's room and performed the dressing change. On 5/7/24 at 8:48 AM, V10 stated Some girls came in about the 4th day and yanked on R3's leg. It really hurt R3. They are doing stuff they aren't supposed to do. This was a different surgery and it's way more painful. R3 should wear the brace when up and when R3 does therapy. They use that hoist (mechanical lift), and I don't think they are supposed to do that. R3 called me one day and told me R3 was in the hoist for a half hour. They aren't walking R3 very much. Yesterday around 11:00 AM or so, R3 called me crying saying R3 was left in the wheelchair with the brace on for a half hour. They (staff) said they would be right back, but they hadn't been back. I wasn't very happy about that. R3 doesn't tolerate pain well. I called (the facility) and complained and apparently, they put her back in bed. R3 has called me about 3 or 4 other times and says R3 pushes the call button but no one comes. Sometimes when I get there, we can't find the call light. One time it was wrapped up and hung up on the wall. I have pushed the call light a couple of times, and no one has answered but I'll go out there and complain. It gets done then. On 5/7/24 at 12:30 PM, V15 (Physical Therapist) stated Orders come from the Admission Orders and put into (medical record) by V12 (Assisting Director of Nursing.). We (Therapy) communicate with staff regarding weight bearing status and such. Today we changed R3's wheelchair to a high-backed reclining wheelchair so that R3 doesn't have the brace pushing into R3's groin/stomach and chest. V15 stated Therapist do not attend care plan meetings, R3's record lacked Physician Orders for Spinal Precautions and the staff were not educated on Spinal Precautions and the use of the Spine brace and they should have had. V15 stated staff should be utilizing the log roll technique (no twisting). V15 stated the Spine brace should have been removed while in the wheelchair and prior to using the mechanical lift for transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145039	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Peoria	5600 Glen Elm Drive Peoria, IL 61614

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 3:00 PM, V1 (Administrator) stated V15 has already been out to educate staff about the Spine brace and Spinal Precautions. V1 stated V15 was concerned about the lack of staff education. The Transfers policy, dated 8/2017, documented it was the duty of the Director of Nursing or Designee to ensure that adequate training is provided to all nursing staff on the proper use of (mechanical lifts) lifts. The policy stated a minimum of two staff members is recommended when transferring with a mechanical lift and to follow the Plan of Care to ensure the use of proper transfer technique.