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	05/06/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure a resident and resident's family was provided a notification of a room move, with rational for the move, prior to transferring the resident to a different room in the facility for one of three residents (R2) reviewed for resident rights in the sample of three.Findings include:On 5/4/26 at 1:30 PM, V9 (R2's Family) stated (R2) was in the facility for a few months for rehabilitation. On 2/24/26, she was out at lunch, when she came back to her room there had been a room change. There was a note and all of her things had already been moved. Later I found out that there was work that needed to be completed in her room. I was not notified of her room change. (R2) just found out when she came back to her room that was already moved. She had several room moves while in the facility and I wasn't aware of them beforehand. (R2) had confusion and was having some Dementia at times, I am her first contact and Power of Attorney. I could not be there all the time. I didn't feel like I was getting informed of everything I needed to be.R2's electronic Census Report, documents R2 was admitted to the facility on [DATE], moved rooms on 1/1/26, 2/27/26 and 3/11/26.R2's electronic medical record does not contain documentation that R2 or V9 were notified of the room move on or before 1/1/26. R2's Room Transfer/New Roommate form, dated 2/27/26, documents R2 was moved from room [ROOM NUMBER] to 402 due to new admission. This form documents date of notice 2/27/26 and is left blank without a date for date of room change.On 5/5/26 at 12:16 PM, V12 (Licensed Practical Nurse) stated When a resident is being transferred rooms, we tell the residents and phone call families with the reason and document that in nursing notes. There isn't any written form that we (nursing) give to the family or the resident.On 5/5/26 at 12:25 PM, V13 (Social Service Director) confirmed that when a resident is transferred rooms, they should receive the notice in writing, and the notice should be scanned into the computer. On 5/5/26 at 2:00 PM, V1 (Administrator) confirmed that residents should be notified of a room move prior to the transfer and if they are not alert and orientated, then the notification should be provided to family with the reason for the room move.The Ombudsman Program Resident Rights handbook, dated 11/2018, and provided to residents on admission to the facility, documents As an individual living in a long-term care facility, you retain the same rights as every citizen of the (state) and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. You have the right to be told in advance and in writing if your room is being changed. You have the right to receive notice, including the reason for the change before you room or roommate in the facility is changed.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record review, the facility failed to ensure a resident who is dependent for all turning and positioning, was safely positioned in bed during cares to avoid falling, conduct vital signs and a body assessment, initiate neurological checks, notify all appropriate parties, complete a fall assessment and update a residents care plan to adequately reflect their fall risk for three of three residents (R1, R2, R3) reviewed for falls in the sample of three. Findings include:1. R1's Care Plan, dated 4/10/26, documents R1 was admitted to the facility on [DATE] and has diagnoses of Heart Failure, Dementia, and Parkinson's Disease, this care plan also documents (R1) is at high risk for falls related to readmission, diagnoses of Parkinson's, and Dementia.R1's Nursing Progress notes, dated 4/10/26 and completed on 4/12/26 at 9:34 PM by V4 (Licensed Practical Nurse, LPN), documents Late Entry: CNA (Certified Nursing Assistant) reported to me that resident was on the dining room floor. This note continues on to document the resident was assessed and assisted back to a chair.R1's electronic medical record does not document any nursing notes for the 4/10 fall, a post fall assessment, neurological checks or notifications of the fall to the physician, family or director of nursing prior to 4/12/26.R1's Nursing Progress notes, dated 4/11/26 at 8:30 PM, documents R1 was transferred to the local emergency room for pain and swelling to R1's left leg.R1's Nursing Progress notes, dated 4/12/26 at 1:24 AM, documents R1 was admitted to the hospital with a diagnosis of left hip fracture.On 5/4/26 at 2:30 PM, V1 (Administrator) confirmed that R1 had a fall on 4/10/26 and there is not a fall assessment, nursing progress notes or documentation of the facility's post fall requirements until 4/12/26. V1 stated (V4, LPN) did not document a fall assessment, initiate neuro checks, 72-hour vital signs and post fall assessments, document that the fall occurred or notify nursing management until two days after the incident when the resident was in the hospital and found to have a fractured hip. V1 also stated The DON (Director of Nursing, V2) or a nurse manager was not made aware when the fall occurred (4/10/26) so upon learning of the fracture on 4/12/26, we talked with staff and found about (R1's) fall.2. R3's Care Plan, dated 3/23/26, documents R3 was admitted to the facility on [DATE] with diagnoses of Muscle Wasting, Neuromuscular Dysfunction, Paraplegia, Multiple Sclerosis, and Stage III Pressure Ulcer. This same care plan also documents (R3) is cognitively intact and has limited physical mobility related to decreased stamina and physical deconditioning, and multiple sclerosis. (R3) has a pressure ulcer to Left Ischium, sacrum related to disease process, Immobility, resident preference of bed position is back/head of bed elevated, air mattress. (R3) is at risk for falls related to impaired mobility.R3's Nursing Progress notes, dated 3/23/26, documents Resident experienced a witnessed fall during routine wound care this shift. Staff was assisting resident in bed when she slid from the surface. Resident stated she's not sure how she lost her grip. On 5/5/26 at 11:55 AM, R3 was sitting in her room in bed. R3 confirmed that her bed has an air mattress and that she recently had a fall from bed during wound care. R3 stated I can't control my lower legs so when the nurse (V11, Licensed Practical Nurse/ Wound Nurse) rolled me to my side during care, my momentum sent me over the other side. My leg was positioned over the leg underneath for my treatment and then I fell. That happened on 3/23/26. I feel scared when I am getting my treatment now unless someone stands in front of me. I don't want to fall out of bed again.3. R2's Care Plan, dated 12/16/25, documents R2 was admitted to the facility on [DATE] with diagnoses of Muscle Wasting and Atrophy, Unsteadiness on Feet, and Lack of Coordination. This same care plan documents (R2) is at Moderate risk for falls related to fall history.R2's Nursing Progress notes dated 12/16/26, document R2 suffered an unwitnessed fall in her room.R2's Fall Assessment, dated 12/16/25, documents R2 was identified at a High Risk for falls.On 5/5/26 at 2:00 PM, V1 (Administrator) confirmed R3 and R2 suffered falls while in the facility. V1 confirmed that R3 is paraplegic and unable to control her lower body and was placed on her side before falling from the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. V1 confirmed R2's fall was unwitnessed in her room. V1 stated Staff are supposed to make sure that there are two in the room during (R3's) wound care now and (R2) was assessed to be at a high risk for falling. V1 confirmed that R2's care plan was not updated from moderate risk to high risk after falling in December 2025 and stated that it should have been updated to reflect her heightened risk of falling.The facility's Accidents and Incidents policy, dated 8/2/17, documents To provide staff with guidelines for investigating, reporting, and recording accidents and incidents. All accidents/ incidents involving a resident, visitor or volunteer will be investigated and then recorded in risk management of (electronic record). Incident reports will be retained in accordance with state statute of limitations and record-retention laws. It is the responsibility of the nurse to complete the accident and incident risk management report and notify physicians and responsible parties and document information accordingly. Accidents and incidents, including injuries of an unknown origin and accident/ incident report form must be completed on the shift that the accident or incident occurred. An employee witnessing an accident or incident involving a resident, employee, or visitor, must report such occurrence to his or her immediate supervisor as soon as practical. Do not leave an accident victim unattended unless it is necessary to summon assistance. The nurse must be informed of all accidents or incidents so that medical attention can be provided. This policy also documents The nurse shall examine all accidents/ incident victims. The medical director or the resident's personal physician shall be notified of the accident/ incident. The nurse must conduct an immediate investigation or the accident/ incident and implement appropriate interventions to affected parties. The risk management must be filled out completely. The nurse must also document the accident/ incident in the progress notes using the fall incident progress note if a resident is involved. SBAR (Situation, Background, Assessment, Recommendation), Fall Risk, and Pain assessments will be filled out following each fall. Neurological assessments will be initiated if fall is unwitnessed and there is suspected head injury or known head injury is identified. Physicians, resident representatives, and director of nursing will be notified of each fall.The facility's Care Planning policy, dated 8/2/17, documents Purpose: To utilize the results of the comprehensive assessment to develop resident's care plan. To provide a method for all staff to have needed information in caring for the residents. Policy: Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. The resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate, and planned to meet the individual needs of the resident consistent with the physicians plan of care. Procedure: Each resident upon admission or a significant change of conditions will be assessed by all necessary disciplines. The Interdisciplinary Team along with the resident and/or family members will identify resident problems, needs and strengths. Sources are, but not limited to: Problems related to provision of safety. All problems identified on all assessments. All problems that require care. Problems related to physical deficits. All care plans must be updated at least quarterly and as needed.