STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare Danville	801 North Logan Avenue Danville, IL 61832

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide fingernail care for one of three residents (R3) reviewed for hygiene in the sample list of four. Findings include: R3's Minimum Data Set, dated dated dated [DATE] documents R3 has moderate cognitive impairment and requires substantial/maximal assistance from staff for bathing and personal hygiene. R3's Care Plan with reviewed date 7/26/24 documents R3's diagnoses include right sided Hemiplegia/Hemiparesis following Cerebral Infarction and Type 2 Diabetes Mellitus. On 7/29/24 at 9:45 AM V6 Certified Nursing Assistant entered R3's room, provided incontinence cares, and washed R3's face and under arms. R3's fingernails were long, past R3's fingertips, and a black substance was visible underneath. V6 did not offer or provide nail care for R3. On 7/29/24 at 10:04 AM R3 stated the staff trim/clean R3's fingernails about every three days and they have been this long/dirty for about two days. R3 stated R3 would like R3's fingernails cleaned and trimmed. On 7/29/24 at 1:08 PM R3 was lying in bed and R3's fingernails remained long and dirty. At 1:30 PM V6 stated fingernail care is done twice per week as part of bathing/showers. V6 confirmed R3's fingernails were long and dirty. V6 stated V6 will clean R3's nails. V6 asked V4 Registered Nurse if R3 is diabetic. V4 and V6 stated the nurses are responsible for trimming nails of diabetic residents. The facility's Nail Care (Finger & Toes) policy dated February 2024 documents: Nail care will be provided for all residents in order to provide cleanliness, prevent spread of infection, for comfort, and to prevent skin problems. Resident nails will be kept neat and clean.

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 0684 Level of Harm - 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** 40385 Based on interview and record review the facility failed to routinely assess and monitor a bruise/hematoma (bruising with blood pooling underneath the skin), update the physician, and assess and measure post-surgical wounds upon readmission for one of three residents (R1) reviewed for wounds in the sample list of four. This failure resulted in R1's left foot bruise/hematoma becoming infected and requiring hospital operative incision and draining (I&D). Findings include: R1's Care Plan dated as reviewed 5/13/24 documents R1's diagnoses include Peripheral Vascular Disease and Type 2 Diabetes Mellitus. R1's Nursing Note dated 6/1/2024 at 9:48 AM documents a fresh, purple bruise was found on the top of R1's left foot that measured 3 centimeters (cm) by 1 cm. R1 reported that R1's foot was likely bumped during R1's mechanical lift transfer yesterday. R1's Weekly Skin assessment dated [DATE] documents R1's anterior foot bruise measured 5 cm by 2.5 cm and there was no break in skin. R1's Weekly Skin Assessments dated 6/11/24 and 6/18/24 document there were no new or worsening skin conditions, but there is no documentation of R1's left foot bruising or a description of this area. R1's electronic medical record (EMR) does not contain documentation that R1's foot bruising was reported to a physician after 6/1/24 or assessed by a physician until R1's hospitalization on [DATE]. There are no documented assessments or monitoring of this bruise after 6/4/24 until after R1 was hospitalized on [DATE]. R1's Hospital History & Physical dated 6/20/24 documents on 6/19/24 R1 presented with left foot swelling, fluctuance (boggy feeling due to buildup of fluid), redness and warmth. R1's admitting diagnoses included septic shock and left foot abscess, and intravenous antibiotics were initiated. R1's Infectious Disease Note dated 6/26/25 documents R1 was in septic shock secondary to gram negative bacteria and the source of the infection is gastrointestinal versus left foot infection. This note documents on 6/23/24 purulence was expressed from R1's abscessed hematoma and a large hematoma was operatively removed. R1's Readmission nursing assessment dated [DATE] documents R1 had multiple stage one pressure ulcers on the right outer foot. There is no documentation to indicate how many wounds, wound characteristics, or measurements. R1's Weekly Skin assessment dated [DATE] documents three pressure sores to left lateral foot/ankle and sutures to the top left foot where a hematoma was prior to hospitalization . This assessment does not document measurements or wound descriptions for these wounds. There are no other documented assessments for these wounds after 7/6/24 until 7/9/24 when R1 was evaluated by V3 Registered Nurse (RN)/Wound Nurse. R1's Wound Assessment Details Report dated 7/9/24 documents the following: R1's left dorsal (top) foot full thickness surgical wound measured 1.5 cm by 1.3 cm. R1's left proximal dorsal vascular wound measured 1. 9 cm by 1.3 cm. R1's left distal, lateral (side) unstageable pressure ulcer measured 2.2 cm by 0.9 cm. R1's left proximal, lateral foot unstageable pressure ulcer measured 2.5 cm by 1.3 cm. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Wound Assessment and Plan dated 7/11/24, recorded by V18 Wound Physician, documents these wounds are related to an avulsion injury (skin tear), and this was the initial consultation by V18 for R1's left foot hematoma. On 7/29/24 at 10:35 AM V4 RN stated on 7/17/24 R1 had open areas to the left foot and one with sutures due to a hematoma that was lanced during R1's prior hospital stay in June 2024. On 7/29/24 at 11:56 AM V4 confirmed V4 completed R1's skin assessment on 7/7/24. V4 stated at that time R1's left foot wounds were red with callous like tissue and were not open. V4 stated V3 Wound Nurse is responsible for obtaining and documenting wound measurements and assessments. On 7/29/24 at 1:04 PM V4 stated R1's left foot bruising was red/purple in color, was swollen with blood collected forming a bump. V4 stated the area stayed the same from when it was first identified until R1 was hospitalized in June, and the area had not shown any signs of improvement. V4 stated there should be documented monitoring and assessments for this area recorded on the Treatment Administration Record or progress notes. On 7/29/24 at 12:00 PM V5 RN confirmed V5 completed R1's readmission assessment on 7/6/24. V5 stated V5 incorrectly documented R1's left foot wounds as the right foot. V5 stated V5 did not obtain measurements of the wounds which V5 described as multiple stage one pressure ulcers that were reddened and not open. V5 stated V5 was unsure how many wounds were present since V5 did not document that information. V5 stated V5 reported these wounds to V3. V5 stated wounds should be documented on the readmission assessment, but usually V3 obtains and documents the wound assessment. V5 stated if V3 is not here, then V3 completes the assessment the next day. V5 confirmed V3 was not on duty when R1 readmitted to the facility and V5 did not document a thorough assessment of R1's foot wounds. On 7/29/24 at 12:49 PM V3 RN/Wound Nurse stated the nurses should notify V3 of newly identified wounds and when V3 is not in the facility the nurses should notify the physician and document a description/assessment of the wound. V3 stated the protocol is the same for when residents are new admissions or readmissions to the facility. On 7/29/24 at 1:24 PM V3 stated R1 returned from the hospital with two wounds on the lateral and two wounds on the dorsal sides of her foot, which were closed when R1 readmitted . V3 stated R1 also had sutures to the top of her left foot where the hematoma was. V3 stated V3 evaluated R1's wounds on 7/9/23 since R1 readmitted on a Saturday. V3 stated V3 initially thought the wounds were pressure ulcers that were scabbed areas, but V18 classified them as vascular. V3 stated the bruise/hematoma was not in (wound monitoring software) for monitoring prior to R1's return from the hospital, and V3 was not aware of R1's bruise/hematoma since V3 had been on vacation until 6/10/24. V3 stated the nurses should have been monitoring the area and documenting a weekly description on the weekly skin assessments, including color and other characteristics, until it was resolved. V3 confirmed the nurses should have notified the physician if the area was not improving or if it had worsened. V3 stated physician notification is documented in the nursing notes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/29/24 at 3:43 PM V15 Nurse Practitioner stated R1 was hospitalized in June for sepsis that was caused either from the hematoma or bowel related. V15 stated the facility staff should have been monitoring and assessing R1's hematoma, including characteristics, measurements/assessments, and monitoring for fever. V15 stated the area should have been monitored daily and the staff should have made sure it was healing and had no signs of infection. V15 stated V15 was not aware of R1's left foot hematoma prior to R1's hospital I&D and V15 relies heavily on the nurses to report things. V15 stated V18 should have been notified as well of any decline in the wound or if no signs of improvement. V15 would have referred R1 to be seen by V18 if V15 was made aware, and it is a strong possibility that R1's hospital I&D may have been prevented if R1 was evaluated by V18 and antibiotics were ordered. On 7/29/24 at 3:55 PM V18 Wound Physician stated 7/11/24 was V18's initial evaluation of R1's foot wounds and R1 had four left foot wounds at that time. V18 stated R1 had been previously hospitalized for the left foot hematoma and R1's wounds were not pressure related. V18 stated V18 coded the wounds as avulsions which were the result of the hospital I&D. V18 stated the facility should have been monitoring the hematoma and notified V18. V18 stated V18 would have lanced and drained the hematoma at the facility, which could have prevented R1's hospital I&D. R1 stated the nurses should be documenting thorough wound assessments at the time of admission/readmission. On 7/30/24 at 1:00 PM V2 Director of Nursing stated V2 looked through the medical records and has no additional documentation to provide. The facility's Bruises and Rashes policy dated April 2023 documents significant bruises will be monitored in (wound monitoring software) weekly until healed and physician notification will be completed. The facility's (wound monitoring software) policy dated April 2023 documents the admitting nurse will document the presence of wounds on the nursing admission form and obtain a treatment order. This policy documents the wound nurse is responsible for documenting the wound measurements/description and interventions and reviewing treatment orders within 72 hours. The facility's Physician Notification of Resident Change Of Condition dated 8/2/24 documents the charge nurse is responsible for notifying the resident's physician of changes in the resident's condition, and documenting the change and notification in the resident's medical record. This policy documents the resident will be placed on the 24 hour report for close monitoring of condition each shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to implement pressure relieving interventions to prevent the development of pressure ulcers, and failed to measure, assess, and report pressure ulcers for two of three residents (R2, R3) reviewed for wounds in the sample list of four. Findings include: 1.) On 7/29/24 at 8:47 AM R2 was lying in bed on R2's back. R2 stated staff change R2 once per day. R2 has a sore on R2's bottom that has been there for about a month, and the staff apply cream to the area. At 10:00 AM R2 was lying in bed. At 10:58 AM R2 was lying in bed on R2's back. R2 stated R2 is currently incontinent of urine, but no one has come in recently to check R2 or reposition R2. On 7/29/24 at 12:16 PM V17 and V10 Certified Nursing Assistants (CNAs) entered R2's room to provide incontinence cares. R2 was lying in bed on R2's back, and there were no pillows positioned underneath of R2 to offload pressure. R2's brief was wet with a moderate amount of urine. There was a small open wound to R2's coccyx and a superficial open wound to R2's right buttock. V10 referred to R2's right buttock wound and stated, That wasn't there on Saturday when V10 last worked. V10 asked R2 how long the wound had been there and R2 replied, two days. V10 stated the right buttock wound has been there for at least a week and staff have been applying barrier cream. V10 left the room to notify the nurse. V3 Wound Nurse entered R2's room to cleanse, assess, and measure R2's wounds. V3 stated the coccyx wound measured 2.1 centimeters (cm) long by 0.4 cm wide by 0.01 cm deep and the right buttock wound measured 2.4 cm by 0.3 cm. V3 told R2 that V3 would enter a daily treatment order for the nurses to administer. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact, requires substantial/maximal assistance from staff for toileting and bed mobility, and is always incontinent of bowel and bladder. R2's Care Plan dated 2/1/24 documents a focus area for Activities of Daily Living (ADLs) self-care deficit related to activity intolerance and limited mobility and includes interventions for incontinence checking/changing and turning/repositioning every two hours and as necessary. This Care Plan includes a focus area for impaired skin integrity related to obesity, Type 2 Diabetes Mellitus, and cognitive decline, and includes interventions to follow the facility's protocol for preventing skin breakdown; observe/document/report any changes in skin status: appearance, color, wound healing, signs of infection, wound size, and stage; and to provide incontinence care after each incontinence episode/per toileting plan. This Care Plan does not include R2's wounds, any new pressure relieving interventions after 2/2/24, or that R2 is resistive with cares or repositioning. R2's July 2024 Treatment Administration Record (TAR) documents Venelex External Ointment ([NAME]-[NAME] Oil) is applied to right buttock three times daily for open area since 2/5/24. This is the only current wound treatment documented on this TAR. R2's last recorded Weekly Skin assessment dated [DATE] documents no new or worsening skin conditions were identified. There is no documentation in R2's medical record that R2's right buttock and coccyx wounds were identified, assessed, or reported to the physician prior to 7/29/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Skin/Wound Note dated 7/29/2024 at 12:30 PM documents the following: R2 was found to have a stage two pressure ulcer to coccyx and moisture associated skin damage (MASD) to right buttock. The physician was notified, and treatment orders were received. R2 was encouraged to allow staff to turn with pillows and R2 was agreeable. On 7/29/24 at 12:49 PM V3 Wound Nurse stated R2's right buttock wound is MASD, and the coccyx wound is a stage two pressure ulcer, related to moisture/incontinence, immobility, and friction/sheering. V3 stated R2 requires staff assistance for ADLs including incontinence cares and repositioning/turning, which should be done every two hours. V3 stated the staff should be using pillows or shifting R2's hip to offload pressure from R2's back/buttocks. V3 stated V3 was not aware of R2's wounds prior to today and the nurses should report wounds to V3. V3 stated during V3's off hours the nurses should notify the physician and document a description/assessment of the wound. At 1:24 PM V3 stated the CNAs are supposed to notify the nurse when residents are resistive to cares so that a note can be documented. V3 confirmed V3 was not aware of R2 being resistive to cares/repositioning. V3 stated physician notification is documented in the nursing notes. On 7/29/24 at 12:59 PM V10 CNA confirmed V10 is R2's assigned CNA today. V10 stated R2 was last changed around 10:00 AM and R2 prefers not to get out of bed until after lunch. V10 was asked about R2's repositioning. V10 stated, we can put pillows alongside of (R2), but she refuses. V10 confirmed pillows were not used to reposition R2 while R2 was in bed during V10's shift today. V10 stated we are supposed to notify the nurses of refusal of cares. V10 stated V10 had previously reported R2's right buttock wound to an unidentified nurse and barrier cream was being applied during incontinence cares. On 7/30/24 at 10:00 AM V2 Director of Nursing stated there was no documentation that R2 refuses repositioning. V2 stated V2 spoke with the CNAs, and it was only reported that R2 will refuse to get out of bed, but nothing about repositioning or refusing to use pillows to offload pressure. At 1:00 PM V2 stated V2 looked through the medical records and had no additional documentation to provide (regarding R2's pressure ulcer assessments and physician notification). 2.) On 7/29/24 at 9:45 AM V6 CNA entered R3's room and provided incontinence cares and dressing assistance. R3 was lying in bed with a wedge cushion positioned underneath of R3's knees/upper legs, R3's heels were in direct contact with the mattress and not floated. There was a dressing covering R3's right heel. On 7/29/24 at 1:08 PM and 2:40 PM R3 was lying in bed. At 2:42 PM V7 RN stated R3's heels should be floated/offloaded. V7 entered R3's room and confirmed the wedge cushion was positioned underneath R3's knees causing R3's heels to rest on the mattress and not offloaded. V3 stated additional education will need to be done with the CNAs on positioning of the wedge cushion to float R3's heels. R3's MDS dated [DATE] documents R3 has moderate cognitive impairment, has a facility acquired stage three pressure ulcer, and requires substantial/maximal assistance of staff for bed mobility. R3's Care Plan with reviewed date 7/26/24 documents R3's diagnoses include Type 2 Diabetes Mellitus, Peripheral Vascular Disease (PVD), and right sided Hemiparesis/Hemiplegia following Cerebral Infarction. This Care Plan documents R3 is at risk for impaired skin integrity related to Diabetes, PVD, incontinence, and Hemiplegia; and R3 has a right heel stage three pressure ulcer as of 4/3/24. This care plan includes an intervention to encourage floating heels through use of pillows or wedge cushion. There is no documentation that R3 is resistive to repositioning/offloading. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's initial Wound Assessment and Plan dated 4/4/24, recorded by V18 Wound Physician, documents R3's right heel stage three pressure ulcer measured 3.1 cm by 3.8 cm with undetermined depth, and had 80% eschar (dead tissue). R3's Wound Assessment and Plan dated 7/25/24 documents R3's right heel stage three pressure ulcer measured 2.7 cm by 1.2 cm by 0.1 cm with 80% epithelial and 20% granulation tissue. On 7/29/24 at 3:30 PM V3 Wound Nurse stated a positioning cushion is used to float R3's heels and the CNAs are notified of interventions which are pulled from the care plan and documented on the Kardex for the CNAs to view. On 7/29/24 at 3:55 PM V18 Wound Physician stated compromised blood flow/vascular issues contributed to the development of R3's right heel pressure ulcer, and the staff should be offloading R3's heels. V18 stated the wedge cushion is supposed to be positioned underneath of R3's calves to elevate R3's heels; and it isn't helping R3 if the cushion isn't positioned correctly and R3's heels are touching the mattress. V18 stated the CNAs need to be educated to make sure R3's heels are floated at least a half inch off the mattress. The facility's Skin and Wound Management Guidelines dated April 2023 documents the following: When a new facility acquired wound is identified the wound nurse will be notified, the physician will be notified to obtain treatment orders, a wound physician consult is ordered, and ensure pressure relieving interventions are immediately implemented. Monitor wounds weekly and ensure residents are positioned correctly and heels are floated. The wound nurse is responsible for assessing, measuring, and photographing wounds in the (wound monitoring software), ensuring treatment orders are in place, and updating the resident's care plan with wound location and interventions. The facility's Skin Care Prevention policy dated April 2023 documents residents with increased risk for potential breakdown should be repositioned based on the resident's assessment and pillows or positioning devices may be used to elevate bony prominences, including ankles, offload pressure from surfaces and prevent potential pressure injuries.