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	02/19/2025

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

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(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. 51951 Based on observation, interview, and record review the facility failed to ensure a dependent resident received repositioning for one (R2) of three residents reviewed for repositioning on a sample list of 4. Findings include: On 2/18/25 at 9:49 AM, 10:35 AM, 10:48 AM, 11:12 AM, 11:49 AM, 12:01 PM, and 12:30 PM, R2 was in his room sitting upright in a reclining geriatric chair. On 2/18/25 at 1:54, V8 Certified Nursing Assistant stated she did not lay R2 down this morning because he got up later than usual, around 9:30 AM to 9:45 AM and wasn't laid down until 1:15/1:30PM. V8 confirmed R2 was in reclining geriatric chair from around 9:30/9:45 AM to 1:15/1:30 PM. Resident/Family Concern Grievance Form documents that a grievance was made on 1/10/25 by V9 spouse of R2. V9 reported she had concerns that R2 was not being repositioned throughout the day. R2's Care Plan dated 1/17/25 documents R2 requires total assist from staff with transfers and requires repositioning every two hours and as needed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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 develop and implement skin and pressure relieving interventions, evaluate nutritional status, maintain wound dressings, and accurately document wound assessments for three (R1, R3, R4) of three residents reviewed for pressure ulcers in the sample list of four. These failures resulted in R4 developing a stage two pressure ulcer that deteriorated into an unstageable pressure ulcer. Findings include: The facility's Skin and Wound Management Guidelines dated April 2023 documents preventative measures will be implemented for residents who are at risk for developing wounds and aggressive wound management will be initiated for wounds/pressure ulcers. This guide documents to complete Braden assessments upon admission and then weekly for four weeks, ensure the resident is added to the shower schedule and review shower documentation and weekly skin checks to ensure compliance and identify new wounds at an early stage. This guide documents to assess, measure, photograph and document wounds in the electronic software system, refer to the dietitian for recommendations for wound healing, obtain an order for wound physician consult and update the resident's care plan. The facility's Pressure Injury Preventions Guidelines and Suggested Interventions dated April 2023 documents poor diet may cause pressure injuries and nutrition should be evaluated. This guide documents residents who are dependent on staff for assistance should e assisted to reposition at least every two hours or per plan of care, position the resident at a 30 degree angle when turning on one side or the other, and residents at risk should avoid sitting in a chair for long periods without repositioning. 1.) On 2/18/25 at 10:37 AM V10 and V15 Certified Nursing Assistants (CNAs) entered R4's room and transferred R4 with a full mechanical lift from the bed to the shower chair. R4 had an open, pink/yellow wound, approximately quarter sized, that was not covered with a dressing. V15 stated R4 did not have a dressing over the wound since V15 came on shift and the dressing must have come off sometime on night shift. On 2/18/25 at 11:26 AM V16 Licensed Practical Nurse stated no one had reported that R4's wound dressing had come off prior to R4's shower. V16 stated V16 would expect the CNAs to notify V16 when a dressing has come off so that a new one can be applied. R4's Admission Minimum Data Set (MDS) dated [DATE] documents R4 has moderate cognitive impairment, impaired range of motion to one upper and one lower extremity, is dependent on staff transfers, requires substantial/maximal assistance from staff for turning in bed and bathing/showering, is always incontinent of urine. R4 has no pressure ulcers and is not on a turning and repositioning program. This MDS lists pressure relieving device for chair as the only skin/ulcer intervention. R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, R4 is dependent on staff for turning in bed, transfers and bathing, and R4 has one stage three facility acquired pressure ulcer. R4's Braden assessment dated [DATE] documents R4 is at moderate risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Care Plan with initiated date of 12/24/24 and revised date of 2/5/25 documents R4 has potential for skin impairment related to decreased mobility, incontinence, and cerebrovascular accident, and R4 has a coccyx stage three pressure ulcer as of 1/16/25. This care plan documents an intervention dated 2/5/25 for turning and repositioning every two hours and as needed. R4's diagnoses include vascular dementia, type two diabetes mellitus, hemiplegia and cerebrovascular accident. There are no documented implementation of pressure relieving interventions on R4's care plan or in R4's medical record prior to R4 developing a pressure ulcer. R4's ongoing weight log documents R4's weights as follows: 12/23/2024 160.2 pounds (Lbs.) 12/31/2024 150.6 Lbs. (5.99% loss) 1/7/2025 147.5 Lbs. 1/14/2025 145.0 Lbs. (9.49% loss since 12/23/24) 1/21/2025 147.6 Lbs. 1/28/2025 145.4 Lbs. 2/4/2025 150.4 Lbs. 2/11/2025 148.8 Lbs. R4's shower documentation for December 2024 and January 2025 was requested on 2/19/25. R4's Shower Sheets, provided by V2 Director of Nursing (DON) document showers were given/offered on 12/31/24 and then not again until 1/21/25 (3 weeks later). R4's Weekly Skin Assessments dated 12/31/24 and 1/7/25 document R4 had no new skin issues and there are no preventative interventions marked as indicated, which includes a turning schedule, specialized mattress, positioning devices, and seating surface. R4's Weekly Skin assessment dated [DATE] documents R4 had no new skin issues and heels floated was the only preventative intervention documented. R4's Weekly Skin assessment dated [DATE] documents R4 had a 3 centimeter (cm) wide by (x) 1 cm long open sacral wound. R4's Wound Assessment Details Reports document the following: On 1/17/25 R4's coccyx stage two pressure ulcer measured 2.7 cm x 1 cm x 0.1 cm deep. On 1/24/25 R4's stage two pressure ulcer was 1.9 cm x 0.8 cm x 0.1 cm. On 2/6/25 R4's coccyx pressure ulcer as a stage three that measured 2 cm x 0.7 cm x 0.1 cm with 70% slough (dead tissue). On 2/13/25 R4's pressure ulcer as unstageable with 100% slough and the wound measured 1.6 cm x 1 cm x 0.1 cm. There is no documentation that R4's wound was assessed by V4 Wound Physician prior to 1/27/25, when R4's wound had declined to an unstageable pressure ulcer. R4's Wound Assessment and Plan dated 1/27/25, recorded by V4, documents R4's coccyx wound as an unstageable pressure ulcer with 100% slough and the wound measured 2 cm x 1 cm. R4's Wound Assessment and Plan dated 2/10/25, recorded by V4, documents R4's unstageable pressure ulcer was 100% covered with slough and measured 1.6 cm x 1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Physician Order dated 1/28/25 documents to cleanse coccyx wound, pat dry, apply medicated honey gel and cover with a dressing daily and as needed. R4's Albumin (protein found in the blood) level was 3.1 grams per deciliter (normal range 3.5-5) on 12/11/24. There is no documentation in R4's medical record that R4's nutritional status was evaluated by a Registered Dietitian (RD) prior to and after 1/16/25 (when R4's pressure ulcer was identified). R4's Dietary Note dated 1/16/25 at 8:56 PM documents V7 RD evaluated R4's nutritional status and weight loss. This note documents R4 had no skin concerns, R4 was on health shakes twice daily, V7 had no new recommendations and to notify V7 with any significant changes. On 2/18/25 at 11:37 AM V3 Assistant DON/Wound Nurse stated R4's wound was facility acquired and classified as a stage two on 1/17/25 and it worsened on 1/24/25 with slough present, but the 1/24/25 wound assessment incorrectly documents the wound was a stage two. V3 stated the wound was a stage three on 1/24/25, but the electronic software system does not allow amendments to V3's assessments. V3 stated R4's wound is currently an unstageable pressure ulcer. V3 stated R4's poor appetite was the cause of the wound and has contributed to R4's wound decline. On 2/19/25 at 9:58 AM V3 stated R4 should be turned and repositioned every two hours and this should be documented on the CNA task charting and on R4's care plan. V3 stated R4 should have an at risk care plan with pressure relieving interventions if R4's Braden identified R4 to be at risk for pressure ulcers. V3 stated we review wounds weekly with V2 DON and follow up with the RD when wounds decline. V3 stated the RD is sent an electronic mail with any changes in condition. V3 was unsure if R4 has been evaluated by an RD after 1/16/25. V3 stated the facility recently changed RDs within the last month. On 2/19/25 at 1:03 PM V3 stated V3 has been the facility's wound nurse since January 2025. On 2/18/24 at 3:47 PM V18 CNA stated the CNAs can view how much assistance residents need and pressure relieving interventions in their electronic charting system. V18 stated there is also a binder at the nurse's station that documents pressure relieving interventions. This binder was viewed with V18 and confirmed it did not contain information regarding R4. On 2/18/24 between 4:04 PM and 4:13 PM V20 and V21 CNAs stated they would look at the resident's care plan to determine what pressure relieving interventions are used. On 2/19/25 at 10:58 AM V6 MDS/Care Plan Coordinator stated if the Braden determines the resident to be at risk for pressure ulcers, then there should be a care plan for pressure ulcer risk and pressure relieving interventions. V6 viewed R4's care plan and confirmed there were no documented pressure relieving interventions prior to R4's pressure ulcer. V6 confirmed the turning and repositioning intervention was not added until 2/5/25, after R4's wound had deteriorated to an unstageable pressure ulcer. On 2/19/25 at 11:17 AM V2 DON stated V2 has not followed up with the RD for R4's wounds after 1/16/25. V2 confirmed 1/16/25 was the only documented RD evaluation for R4. At 1:45 PM V2 stated V2 had no other shower documentation to provide for R4 and confirmed missed showers between 12/31/24 and 1/22/25. V2 confirmed showers would be part of pressure ulcer prevention. At 3:50 PM V2 stated V4 Wound Physician was at the facility on 1/20/25, but we did not have a consent that day for R4 to be evaluated by V4, so R4 was seen by V4 on 1/27/25. V2 stated V2 would expect a wound consult to be ordered when wounds are showing a decline and no improvement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 11:40 AM V5 Nurse Practitioner stated the facility's RD makes nutritional recommendations and a wound physician for wound evaluation and orders. V5 stated pressure relieving interventions would be individualized and based on the resident's mobility and if they get out of bed. V5 stated R4 should have had turning and repositioning by using wedge/pillows to offload pressure and laid down between meals, and R4's nutrition should have been evaluated prior to R4 developing the pressure ulcer. V5 stated the facility should develop a care plan once a stage one pressure ulcer is identified. V5 stated V5 believes R4's wound deteriorating so quickly into a stage three and unstageable pressure ulcer could have been avoidable. V5 stated not maintaining wound dressings can contribute to wound decline. On 2/19/25 at 12:28 PM V4 Wound Physician stated the facility should follow their protocol when residents are at risk for pressure ulcers, they should develop a care plan and implement pressure relieving interventions. V4 stated it is better to prevent than to treat and pressure relieving interventions should be implemented ahead of time. V4 stated nutrition should be assessed and referred to the dietitian. V4 stated when wounds aren't covered urine and feces can get into the wound which could pose a risk of infection, and the potential of sheering from sheets that could cause a wound to worsen. On 2/19/25 at 1:09 PM V7 RD stated V7 has been the facility's RD from June 2024 until the first week of February 2025. V7 works remotely and does not round at the facility. V7 stated V7 questioned whether there was a change in wound nurses since V7 used to receive updates from the former wound nurse, but in February V7 had to run a wound report and V7 thought R4's wound had improved. V7 stated V7 would appreciate being updated and notified of changes and declines in wounds. V7 confirmed R4's 1/16/25 nutritional evaluation was the only documented nutritional assessment. V7 stated V7 documents nutritional assessments in a progress note. V7 stated if V7 had been notified of R4's wound decline, V7 would have recommended adding double portions of protein during meals and additional protein snacks/foods since V7 was already on protein supplement, zinc, multivitamin, and health shakes. 2.) On 2/19/25 at 9:30 AM V23 CNA assisted V3 Assistant DON with R3's pressure ulcer treatment administration. R3 had one open, pink/yellow wound to the left buttock with two small superficial wounds next to it. R3 had a wound on the coccyx that was deep, and the wound bed had pink and yellow tissue. R3's Wound Summaries dated 2/18/25 document R3's coccyx pressure ulcer and left buttock pressure ulcers were unstageable between 12/18/24 and 2/13/25. These assessments do not match R3's wound assessments completed by V26 and V4 Wound Physicians. R3's Wound Assessment and Plan dated 12/31/24, recorded by V26, documents R3 had a right buttock unstageable pressure ulcer and R3's coccyx wound was initially a stage two that had declined to a stage three. R3's Wound Assessment and Plan dated 1/6/25, recorded by V4, documents R3 had a left buttock unstageable pressure ulcer and R3's coccyx wound was a stage three. On 2/19/25 at 9:58 AM V3 stated R3's coccyx wound was staged by prior wound nurse as unstageable on 12/18/24, but that was incorrect as V4 staged the wound as a stage two on 12/19/24. V3 stated the wound declined to a stage three on 12/31/24. V3 stated V3 completed R3's 12/27/24 coccyx wound assessment and it was a stage two at that time, but because it was previously entered as an unstageable the electronic software system would not allow V3 to change the assessment. V3 stated V26 had R3's left buttock pressure ulcer incorrectly documented as the right buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	51951 3.) R1's Wound Assessment and Plan dated 1/6/25 documents an order from V4 wound doctor, to initiate a low air loss mattress on R1's bed. R1's Wound Assessment and Plan dated 1/20/25 documents a preventative wound recommendation for an air mattress. R1's Wound Assessment and Plan dated 1/27/25 documents that an air mattress is recommended for wound prevention. R1's electronic medical record does not include any documentation that the low air mattress was initiated for R1. On 2/18/25 at 11:20 AM, V11, Certified Nursing Assistant (CNA) stated that she cared for R1 on a couple of occasions and doesn't recall if R1 had an air mattress on his bed. On 2/19/25 at 9:19 AM, V12 CNA stated she doesn't remember if there was an air mattress on R1's bed. On 2/19/25 at 2:00 PM, V2 Director of Nursing confirmed there was no documentation that an air mattress was implemented for R1.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to identify and assess for significant weight loss and ensure nutrition/weight loss was evaluated by the physician and dietitian for one (R3) of three residents reviewed for weight loss in the sample list of four. Findings include: On 2/18/25 at 12:07 V24 Certified Nursing Assistant (CNA) was feeding R3's meal which consisted of creamed corn, mashed potatoes, ground country fried steak and cake. At 12:25 PM V24 brought R3's meal tray to the hall cart and stated R3 only ate about 10% of the meal and R3 didn't like the food. V24 stated V24 offered to order R3 alternative food, but R3 declined. R3's meal tray showed R3 ate a few bites of corn, meat and cake. On 2/19/25 at 9:30 AM V23 CNA assisted V3 Assistant Director of Nursing with R3's pressure ulcer treatment administration. R3 had one open, pink/yellow wound to the left buttock with two small superficial wounds next to it. R3 had a deep coccyx wound and the wound bed had pink and yellow tissue. R3's Minimum Data Sets (MDS) dated [DATE] and 2/10/25 documents R3 has not had a significant weight loss within the last six months. R3's active care plan does not document R3 has had significant weight loss. R3's active physician's orders documents orders for Trulicity (diabetic medication) since 3/22/24, Protein supplement 30 milliliters twice daily since 12/18/24, mechanical soft diet as of 12/26/25, and health shakes twice daily since 11/27/24. R3's meal intakes ranging from 1/22/25-2/19/25 document percentages of meal consumed with 18 entries for 0-25%, 18 refusals, and 15 entries for 25-50% out of 86 meals. There are 26 meals that are not recorded during this time frame. R3's active weight log documents R3's weights as follows: 5/8/24 295.5 pounds (Lbs.) 6/5/35 295.4 Lbs. 7/9/24 284 Lbs. 8/6/24 280.2 Lbs. 9/10/24 281.8 Lbs. 10/8/24 270 Lbs. 11/5/24 265.4 Lbs. (10.19% loss in six months) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/27/24 257 Lbs. 12/10/24 252.4 Lbs. 12/31/24 237 Lbs. 1/7/25 236.4 Lbs. 1/14/25 237.8 Lbs. 2/4/25 234.6 Lbs. (11.61% loss in three months) 2/11/25 230.8 Lbs. 2/18/25 232 Lbs. (20.61% total loss from 5/8/24) R3's Albumin level was 3.1 grams per deciliter on 11/29/24. Normal range is 3.4-4.8. The facility's Weight Report dated 2/18/25 documents R3 has an unstageable pressure ulcer of the left buttock that was identified on 12/27/24 and an unstageable pressure ulcer of the coccyx identified on 12/18/24. R3's Nurse Practitioner Note dated 2/19/25 at 3:15 PM, recorded by V5 Nurse Practitioner, documents R3's weight loss is stable, continue health shakes, continue Trulicity for Diabetes Mellitus which is likely the cause of R3's weight loss. R3's Dietary Note dated 2/4/2025 at 8:22 PM documents review of nutrition and weight loss, and R3 is above R3's ideal body weight. R3 is dependent on staff for eating assistance, R3 consumes approximately 25% of meals and refuses meals at times, has pressure ulcers and receives health shakes twice daily and protein supplement. There is no documentation in R3's medical record that R3's ongoing weight loss/nutrition has been evaluated by a dietitian prior to 2/4/25 or evaluated by a physician/practitioner after 11/26/24. On 2/18/25 at 2:08 PM V17 Registered Nurse stated R3 is not on a prescribed weight loss regimen. R3 stated R3 had facial fractures due to a fall a few months ago and has had a poor appetite since and V17 did not think the physician had been notified of R3's weight loss. V16 Licensed Practical Nurse stated administered R3's health shake today and R3 drank all of it. On 2/19/25 at 11:17 AM V2 Director of Nursing confirmed R3's weight loss and stated it is believed to be related to Trulicity use. V2 stated R3 was started on health shakes on 11/27/24 and speech therapy upgraded R3's diet from puree to mechanical soft in December 2024. V2 stated V2 was unable to locate any documentation that R3's weight loss/nutrition was evaluated by a physician/nurse practitioner or that R3 was evaluated by a dietitian prior to 2/4/25. At 1:45 PM V2 reviewed R3's care plan and confirmed it does not document R3's significant weight loss. V2 stated V6 MDS/Care Plan Coordinator is responsible for updating the care plan problem since V2 only updates interventions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/25 at 11:40 AM V5 Nurse Practitioner stated V5 started working for the facility in November 2024, V5 was full time but recently cut back to rounding in the facility two days per week. V5 stated R3 is on Trulicity for Diabetes Mellitus, which is approved for weight loss and beneficial for R3. V5 stated this medication was prescribed for R3 for weight loss. V5 stated R3 hasn't been eating well and health shakes were implemented. V5 stated V5 didn't see documentation where a provider was aware of R3's weight loss and V5 was not notified prior to today. V5 stated the facility has a registered dietitian who makes nutritional recommendations. On 2/19/25 at 12:53 PM V6 reviewed R3's 11/12/24 and 2/10/25 and R3's weight report and confirmed R3's MDS assessments do not document R3's significant weight loss. On 2/19/25 at 1:09 PM V7 Registered Dietitian stated V7 was the facility's dietitian from June 2024 through the first week of February 2025. V7 stated V7 completes nutritional assessments remotely and does not round at the facility. V7 stated V7 evaluated R3 on 2/4/25 and noted R3's significant weight loss, R3 was on health shakes started in November 2024, and R3 was on a protein supplement. V7 stated R3's last documented nutritional assessment note prior to 2/4/25 was in February 2024. V7 stated residents with significant weight loss at one, three, and six months should have a nutritional evaluation by a dietitian and recommends that the physician be notified to evaluate as well. V7 stated V7 was not notified of R3's significant weight loss prior to 2/4/25 and V7 would have recommended to increase R3's health shakes or determined R3's food preferences. The facility's Weights policy dated August 2024 documents weekly weights should be done with significant changes in condition and food intake decline that has persisted for more than one week, and weights will be given to the Director of Nursing to determine if reweighs are needed. This policy documents any resident with unexplained significant weight loss will have a supplement ordered until they are reviewed during the risk meeting when appropriate interventions will be determined. This policy documents dietary recommendations will be forwarded to the nurse practitioner or physician for approval. The facility's Skin and Wound Management Guidelines dated April 2023 documents to refer resident wounds to the dietitian for recommendations for wound healing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40385 Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for three (R1, R3, R4) of three residents reviewed for pressure ulcers in the sample list of four. Findings include: The facility's Enhanced Barrier Precautions policy dated 10/21/22 documents EBP expands the use of gloves and gowns to be worn during high-contact care activities that provides opportunities for Multidrug Resistant Organisms (MDROs) to be transferred between staff hands or clothing and between residents during these high-contact cares. This policy documents residents with wounds and indwelling medical devices are at high risk of acquisition and colonization of MDROs. This policy documents to wear gown and gloves when assisting residents on EBP with high-contact care activities, including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, providing device care or wound care. The Centers for Disease Control and Prevention Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated June 2021 documents Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE (Personal Protective Equipment) required and defining high risk resident care activities. Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room). 1.) R3's Wound Summaries dated 2/18/25 documents R3 has pressure ulcers to the left buttock since 12/27/24 and coccyx since 12/18/24. R4's active care plan and physician's orders do not document R3 is on EBP. On 2/18/25 at 9:50 AM, 10:32 AM, 11:52 AM, 12:25 PM there was no EBP signage posted on R3's room door and there was no cart containing PPE near R3's room. At 11:52 AM V16 Licensed Practical Nurse (LPN) and V11 Certified Nursing Assistant (CNA) were in R3's room and were not wearing gowns during repositioning of R3. At 12:25 PM V24 CNA removed R3's meal tray from R3's room. On 2/19/25 at 8:47 AM there was a sign posted on R3's room door that documented EBP and to wear gown and gloves for high-contact care activities listed. On 2/19/25 at 9:48 AM V24 CNA confirmed R3 did not have an EBP sign posted on 2/18/25. V24 stated V24 was not aware that R3 was on EBP. V24 stated the staff aren't told who is on EBP, but V24 would look for a posted sign to determine if EBP is needed. On 2/19/25 at 8:49 AM V16 LPN confirmed V16 and V11 were not wearing gowns during R3's repositioning observed on 2/18/25. V16 stated there used to be a cart containing PPE outside of R3's room, but there isn't one. V16 stated V16 usually obtains gowns from those carts which are supposed to be near the resident's room door. V16 stated EBP signs are supposed to be posted as well and she was unsure when R3's EBP signs were posted. V3 stated there should be a physician's order for EBP. (continued on next page)

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	02/19/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 8:56 AM V3 Assistant Director of Nursing (ADON) confirmed R3's room door did not have EBP signage posted on 2/18/25. V3 stated the sign was posted that evening since an unidentified resident had removed the signs. V3 confirmed staff should be wearing gowns for any of the high-contact care activities listed on the signs. V3 stated there doesn't have to be a cart of PPE near the resident's room door, the staff can get gowns from the linen rooms and other isolation carts. At 9:04 AM V3 confirmed R3 did not have a physician's order for EBP. V3 stated R3 was on contact isolation that ended the beginning of February 2025, and the order probably wasn't reinstated to resume EBP when the contact isolation ended. 2.) The facility's Wound Report dated 2/18/25 documents R4 has a coccyx pressure ulcer that was identified on 1/16/25. R4's care plan does not document EBP. R4's physician's orders do not document orders for EBP prior to 2/19/25. On 2/18/25 at 9:56 AM and 10:37 AM there was no EBP signage posted on R4's room door and there was no PPE cart near R4's room. At 10:37 AM V10 and V15 CNAs entered R4's room and were not wearing gowns. V10 and V15 removed R4's incontinence brief and R4 had an open wound that was not covered with a dressing. V10 and V15 transferred R4 with a full mechanical lift from the bed into the shower chair and transported R4 into the shower room. On 2/18/25 at 8:47 AM R4's doorway contained an EBP sign that indicated to wear gown and gloves during the high-contact care activities listed. There was no PPE cart near R4's doorway. On 2/19/25 at 8:49 AM V16 LPN stated EBP signs are supposed to be posted and was unsure when the sign was posted on R4's door. V3 stated there should be a PPE cart near R4's room which is where V16 would obtain gowns. On 2/19/25 at 8:56 AM V3 ADON confirmed R4 did not have EBP signage posted on 2/18/25. V3 stated the sign was posted on R4's doorway last night since an unidentified resident had removed the signs. At 9:04 AM V3 confirmed R4 did not have an order for EBP prior to 2/19/25. 51951 3.) R1's Electronic Medical Record (EMR) shows no documentation for Enhanced Barrier Precautions (EBP). On 2/19/25 at 2:00 PM, V2 Director of Nursing confirmed that she couldn't find any documentation that showed EBP was initiated for R1. On 2/18/25 at 11:20 AM, V11 Certified Nursing Assistant (CNA) stated she provided care for R1 a few times. V11 stated she would reposition R1 in his bed. V11 reported she gave R1 a bed bath on two occasions. V11 stated, I think R1 had a spot on his bottom, but it always had a bandage on it. V11 stated she wore a mask and gloves when providing care to R1 but can't recall if she wore a gown. V11 didn't remember if an EBP sign was posted for R1. On 2/19/25 at 9:19 AM, V12 CNA stated she provided feeding, bathing, and repositioning care to R1. When V12 was asked about EBP for R1, V12 said, what's that? V12 stated she can't remember if R1 was on EBP. V12 stated she thinks she wore gloves and a face shield when providing cares to R1. (continued on next page)

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	145243	A. Building B. Wing	02/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 10:21 AM, V13 stated she had provided care for R1. V13 reported she had fed, bathed and checked urinary catheter for output for R1. V13 recalls repositioning R1 at least three times on V13'a shift. V13 stated, I put on gloves and a mask but nothing else that I can recall. V13 stated that there is usually a sign posted for EBP with a supply cart at that resident's door but V13 doesn't remember if there was a EBP sign posted or a cart with PPE supplies.