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	04/11/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to report an injury of unknown origin to the state agency (Illinois Department of Public Health) in the required two hour time frame. This failure affects one resident (R1) out of three reviewed for injuries on the sample list of three. Findings include: On 4/10/25 at 11:24 AM, R1 was lying in bed and did not make any verbal responses to a greeting by name and made no verbal responses to questions. R1's Census Detail dated 4/10/24 documents R1 was admitted to the facility 1/14/25, with a subsequent admission 3/7/25. R1's Diagnoses List dated 4/10/25 documents R1 had surgical repair of a right trochanter (hip) fracture which was present on R1's admission of 1/14/25, and surgical repair of a displaced spiral fracture of the right distal femur (knee area) present on R1's admission of 3/7/25. R1's Minimum Data Set, dated dated dated [DATE] documents R1 received a score of 4 out of a possible 15 during a brief interview for mental status, indicating severe cognitive impairment, inattention, and disorganized thinking. This same Minimum Data Set documents R1 is dependent on staff for toileting, lower body dressing, putting on footwear, all bed mobility, and transfers. R1's Progress Notes dated 2/20/25 documented a facility nurse (V6, Registered Nurse) contacted R1's Power of Attorney (V22) with notification that R1's right leg was shortened and rotated, and that the Nurse Practitioner (V21) had ordered x-rays. R1's Progress Note dated 2/20/25 documents V21, Nurse Practitioner, had assessed R1 at 9:35 AM due to a report from the facility nursing staff that R1 was experiencing a shortened and rotated right leg, wouldn't allow staff to move her leg, and screamed out in pain when V21 manipulated R1's leg. V21 included in this note that R1 had not experienced any falls or trauma and did have the previous surgery of the right hip. V21 also documented she had ordered x-rays for R1. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's radiological (x-ray) report dated 2/20/25 documents the facility had been informed of the x-ray results at 2:41 PM on 2/20/25. This report documents R1 had experienced a new comminuted (broken pieces) fracture of the distal (by the knee) femur, and that the prior hip fracture was stable and the hip repair hardware intact. R1's Diagnoses List (4/10/25) and hospital Discharge Report (3/7/25) further document this new fracture was a displaced spiral fracture. This hospital Discharge Report documents R1 was at the hospital for surgical repair of the new fracture from 2/21/25 through 3/7/25. On 4/10/25 at 11:52 AM, V3, Assistant Director of Nursing, related the time line of events involved with R1's assessment, x-ray, and results as documented in the nurses notes. V3 further stated the nursing managerial staff, including herself, had not been able to ascertain any cause associated with R1's fracture. V3 stated R1 could not explain anything except to say she had not fallen. V3 stated R1's physician (un-named) had stated the new fracture was pathological related to osteopenia (low bone density). V3 stated V21 thought there might be a fracture associated with the previous surgery site of R1's right hip. On 4/10/25 at 11:52 AM, V1 Administrator, she had conducted an investigation by interviewing staff and there was no evidence that R1 had fallen or twisted her leg. V1 stated the fracture was not reported to the Illinois Department of Public Health at all because the Nurse Practitioner (V21) examined R1 and since there was no bruising there was not a suspicion of abuse. V1 further stated the timeframe from when the nurse first noticed the right leg shortened and rotated to the Nurse Practitioner assessing R1, to the x-rays, to the doctor (un-named) saying the fracture was pathologic, was immediate. R1's Progress Notes dated 2/21/25 document the Director of Nursing (V2) entered a note to document R1's Physician (un-named) had made a statement that the new fracture experienced by R1 was pathological at 9:36 AM on 2/21/25, nineteen hours after the facility received the x-ray report, and 24 hours after V21's assessment. The facility's Abuse Prevention policy dated as revised January 2025 documents injuries should be classified as an injury of unknown source if there was no person who observed the source of the injury or if the resident could not explain the source of the injury, and if the injury is suspicious because of the extent of the injury.

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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 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. 34058 Based on observation, interview, and record review, the facility failed to implement a fall prevention intervention according to a resident's care plan. This failure affects one resident (R1) out of three reviewed for fall prevention on the sample list of three. Findings include: On 4/10/25 at 11:24 AM, R1 was lying in bed and did not make any verbal responses to a greeting by name and made no verbal responses to questions. There was an alarm sensor pad underneath R1 with a wire cord leading towards the foot end of R1's bed, however the cord was not plugged in to anything. There was an alarm box module on top of a four drawer bureau across the room approximately eight feet away from R1's bed. On 4/10/25 at 11:29 AM, V5, Registered Nurse, confirmed the alarm sensor was not plugged into the module as it should be. V5 further stated he had knowledge of R1's Care Plan containing a fall prevention intervention that R1 was to have the bed alarm and it should be maintained in a functional condition. R1's Care Plan documents a fall prevention intervention dated as initiated on 3/28/25 for a bed alarm placed for safety, and R1 needs increased supervision when in her room dated as initiated 3/27/25. On 4/10/25 at 11:52 AM, V3, Assistant Director of Nursing, stated she would make sure the nursing staff check R1's alarm. V1 Administrator stated something should be placed on R1's Physician Order Sheet to make sure the nurses check the alarm. V1 stated facility staff do 'Angel Rounds' every morning to check things like alarms. V1 stated R1 will occasionally unplug alarms, but then confirmed R1 would not be able to get the module across the room and on top of the bureau.