

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview, and Record Review the facility failed to prevent a fall with injury by failing to provide adequate staff assistance during a therapy session for one of three residents (R1) reviewed for falls on the sample list of three. This failure resulted in R1 falling forward out of a bed and landing on the floor and hitting R1's head on the floor. R1 sustained a laceration to the head which required emergency treatment and 15 staples to close. Findings Include: R1's Emergency Department Notes dated 10/31/25 at 6:15PM document R1 has a laceration and received 15 staples to the frontal part of the head due to a fall. R1's Progress Note dated 10/31/25 documents Therapy informed this nurse that resident fell. She reported that she had resident sitting on the side of the bed and she walked to other side of bed. Upon assessment resident was lying on her stomach with her head turned to the left in between both beds. Bleeding present from head. Resident reported she hit her head on her night stand. R1's Minimum Data Set assessment dated [DATE] documents R1 is cognitively intact. R1's Care Plan documents a fall intervention for therapy to have two assist on 10/31/25 when completing sessions. On 11/4/2025 at 12:15PM, R1 was eating lunch at the table. R1 had staples from the middle of R1's head and down the right side of her head. R1 stated that on 10/31/25 the therapist came in after dinner and R1 already had R1's gown on. R1 stated she was tired. R1 stated the therapist seemed very rushed and wanted R1 to sit on the side of the bed and then stand. R1 stated she could not stand, and the therapist had a very hard time getting R1 on the side of the bed. R1 stated she sat on the side of bed and felt like she was going to fall. R1 stated the therapist walked away from R1. R1 stated she fell forward hitting the bedside table and was lying in a pool of blood until the paramedics arrived. R1 stated the therapist was at the end of the bed and just watched R1 fall. On 11/5/2025 at 11:45 AM, R1 was lying in a bariatric bed with approximately three inches of space on each side of R1. Two Certified Nursing Assistants and a nursing student brought in a mechanical lift to transfer R1 from the bed to the wheelchair. R1 required maximum assistance with turning side to side to place the sling underneath R1. On 11/5/2025 at 11:55AM, R4 is cognitively intact per her minimum data set assessment dated [DATE]. R4 stated R4 watched the physical therapist assistant start therapy with R1 (on 10/31/25). R4 stated the therapist watched R1 fall forward and hit her head. R4 stated the physical therapist assistant did not try to help R1. R4 stated there are always two people in the room when getting R1 up to her wheelchair, and throughout the night to help turn R1. On 11/4/2025 at 10:05AM, V3 (Certified Nursing Assistant) stated R1 requires a mechanical lift for transfers and always requires two people for care due to R1's overweight status. R1 requires maximum assistance with turning and repositioning and getting into the wheelchair. On 11/4/25 at 10:20AM, V4 (Physical Therapist) stated she evaluated R1 on 10/28/25 due to R1's functional decline. V4 stated R1's goals were to improve ability to safely transfer from lying on the back to sitting on the side of the bed, with feet flat on the floor. V4 stated R1 is dependent on staff due to R1 being overweight. R1's limited ability and the physical therapist assistant completing therapy on 10/31/25 should have had another person with her due to R1's limited mobility in bed. On 11/4/2025 at 11:35 AM, V6 Physical Therapist Assistant (PTA) stated she was completing therapy with R1 on 10/31/25. V6 stated V6 asked R1 to sit on the side of the bed and had a walker in front of R1 to help stabilize R1. V6 stated R1 is dependent with bed mobility and does not stand. V6 stated she had R1 sitting on the side of the bed, but stated R1 was on the edge of the bed. V6 stated she let go of R1 and was walking to the other side of the bed to try to pull R1 into the middle of the bed when R1 fell forward off the bed and hit the bedside table. R1 fell forward face first. V6 stated before the therapy session started V6 looked outside of the room to see if anyone was available and didn't see anyone so went to work with R1. On 11/5/2025 at 9:37AM, V9 Licensed Practical Nurse (LPN) stated the physical therapist assistant (PTA) came and got her that night and stated there was blood all over the floor. V9 stated she immediately called 911. V9 stated the PTA never asked for assistance with R1. V9 stated due to R1's weight, and needing maximum assistance, the PTA should not have started the therapy session until someone was available to help balance R1. On 11/5/2025 at 11:05AM, V2 Director of Nursing (DON) stated V6 (PTA) should have had two people working with R1 for safety concerns as R1 is dependent and needs help with bed mobility, transfers and dressing. V2 stated V6 (PTA) should have waited to complete the therapy session until somebody could help her. V2 stated that the lack of safety concern and not having two people in with R1 resulted in the fall which caused R1 to need emergency medical treatment and including 14 staples to her head. On 11/4/2025 at 12:45 PM, V10 (R1's Nurse Practitioner) stated R1 has had a</p>		