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	05/12/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for four (R1, R2, R3, R6) residents of six residents reviewed for call light response in a sample of ten residents.Findings includeThe facility's Call Light Answering policy dated 08/02/2017 documents: All residents will have a staff member that is able to answer/and or see to the residents' request and/or needs. It is the responsibility of the Certified Nursing Assistant (CNA) and or Nurses to answer the call lights/pagers to see what requests or needs the resident may have.R1's undated Care Plan documents an admission date to this facility as 7/31/2024 with the following diagnosis: Type Two Diabetes, Asthma, and Osteoarthritis. R1's care plan contains a focus area regarding R1 having an Activities of Daily Living self-care deficit related to impaired balance and pain with an intervention in place dated 11/3/2025 reading R1 requires moderate assist by one-two staff with gait belt for toileting and that R1 uses incontinence products and another intervention dated 11/19/2025 reading R1 is to use bell to call for assistance.On 5/7/2026 at 10:28 AM, R1 stated R1 experienced an extended wait time for incontinence care on 5/2/2026. R1 stated R1 had an episode of urinary incontinence on the morning of 5/2/2026 around 7:30 AM. R1 reported R1 activated R1's call light around the same time as the episode of incontinence. R1 stated multiple staff had entered R1's room, deactivated R1's call light, and exited without providing incontinent care during this time. R1 stated R1 has feelings of being degraded and disrespected whenever R1 experiences episodes of incontinence due to long call light wait times. R1 stated R1 has also suffered from increased itching, and redness in R1's peritoneal area due to the extended time R1 is forced to remain in urine-soaked incontinence briefs.R2's undated care plan documents R2 with an admission date to the facility as 08/04/2021 with the following diagnosis: Nontraumatic Intracranial Hemorrhage, Hemiplegia and Hemiparesis Following Nontraumatic Subarachnoid Hemorrhage Affecting Left Non-Dominant Side, and Diabetes.R2's undated Care Plan contains a focus area documenting R2 with Activities of daily living self-care performance deficit related to a traumatic brain injury and contractures with an initiation date of 7/23/2021 and an intervention/task documenting R2 uses incontinence products and is to be checked and changed every two hours and as needed.R2's undated Care Plan contains a focus area documenting R2 is moderate risk for falls related to deconditioning and gait/balance problems with an intervention in place to ensure R2's call light is within reach and encourage R2 to use it for assistance as needed. The resident needs prompt response to all requests for assistance.On 5/7/2026 at 10:04 AM, R2 stated R2 sometimes goes a whole shift without getting assistance with incontinence care, but the average call light wait time can be upwards of an hour wait. R2 stated when R2 experiences long wait times, R2 is often left sitting in urine-soaked clothing making R2 feel angry with increased anxiety at times. R2 stated these episodes of incontinence and long call light wait times cause R2 to lose sleep sometimes as well as increased use of R2's as needed anti-anxiety medication.R3's undated Care Plan documents an admission date to the facility as 1/29/2025 with the following diagnosis: Spinal Stenosis, Cervical Region, Hypokalemia, Gastroparesis, Hypertensive Crisis, Unspecified, Cerebral Infarction, Unspecified, Cardiomegaly, and Diabetes. R2's undated Care Plan documents a focus area (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documenting R2 with an Activities of Daily living self-care performance deficit related to weakness and limited mobility, and diabetic ketoacidosis with an intervention for this focus area, dated 1/30/2025 documenting R2 is to be encouraged to use bell to call for assistance.On 5/7/2026 at 9:46 AM, R3 stated R3 experiences long wait times for call lights to be responded to. R3 stated some staff will come in and shut off the call light without providing care. R3 stated this makes R3 feel insignificant like people don't care about R3 and it makes R3 feel dirty.R6's undated Care Plan documents an admission date to this facility as 5/8/2024 with the following diagnosis: Diabetic Foot Ulcer, Vitamin D Deficiency, Hyperlipidemia, and Diabetes. R6's undated care plan documents a focus area, dated 5/8/2024, documenting R6 with an Activities of Daily Living self-care performance deficit related to deconditioning, diabetic neuropathy, and recent right fifth digit amputation with an intervention dated 5/8/2024 documenting R6 is to use bell to call for assistance.On 5/11/2026 at 1:11PM, R6 stated R6 needs assistance from staff to transfer due to a wound on R6's foot. R6 stated R6 sometimes must wait upwards of 25-30 minutes, sometimes more, for R6's call light to be answered. R6 stated when R6 experiences long wait times for incontinence care R6 feels worthless, like R6 is not important.On 5/11/2026 at 9:53 AM, V4 Auxiliary Aide stated that when V4 works V4 will go into residents rooms to see what the resident needs, turns off call light, and will notify staff of the residents needs after the call light is turned off.Grievance log for the month of April 2026 was reviewed. Call light concerns noted on 4-16-2026 involving R1. Resident/Family Concern Grievance Form dated 4/16/026 contains information regarding R1's concern associated with long wait times for call light response times and untimely incontinence care. This document also addresses R1's concern regarding staff turning off the call light prior to care being provided.Grievance form dated 1/5/2026 documents a concern regarding long call light wait times involving R5. This form documents V4's concern about extended wait times for call lights to be answered.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one (R1) of three residents reviewed for employee-to-resident verbal abuse on a sample list of three residents. The facility failed to ensure R1 was protected from ongoing verbal abuse, degrading interactions, intimidation, and emotionally distressing treatment. The facility further failed to appropriately respond to prior concerns involving the same staff member and failed to ensure resident dignity and emotional well-being were maintained. These failures resulted in R1 feeling emotional distress, tearfulness, frustration, feelings of being degraded, and disbelieved. On 5/6/2026 at 9:24 AM, V11 (R1's) Power of Attorney (POA) stated that on 5/2/2026 at approximately 7:00 PM, R1 called V11 crying hysterically, upset, and in pain following an interaction with V9 Certified Nursing Assistant (CNA). V11 stated R1 was so emotionally distressed R1 could barely understand what R1 was saying. V11 stated there had been previous allegations involving V9 degrading R1 approximately two weeks prior to the incident. V11 stated a care plan meeting was held with R1, V11, and facility staff, including V2 Director of Nursing (DON), where concerns regarding V9's treatment of R1 were discussed. V11 stated R1 reported feeling degraded and emotionally mistreated by V9 CNA and requested V9 not provide care to R1. V11 stated V2 DON reported the allegations would be investigated; however, V9 continued to enter R1's room and provide care.V11 stated while V11 remained on the phone with R1 on 5/2/2026, V11 overheard V10 Licensed Practical Nurse (LPN) and V7 Registered Nurse (RN) enter the room and discuss the incident with R1. V11 stated V11 heard staff tell R1 the incident was an accident and that V9 would never do that. V11 stated R1 became increasingly upset and asked staff if they were calling R1 a liar. V11 stated staff then told R1 that R1 was overreacting. V11 stated the interaction caused R1 additional emotional distress and made R1 feel dismissed and disbelieved by facility staff. V11 further stated V11 text V3 Social Services Director (SSD) on 5/2/2026 at 8:07 PM regarding the incident and concerns involving V9 CNA. The text message documented, Mom just called and said that one of the nurses rammed a wheelchair into her (R1's) leg. V9 CNA said the wheelchair was stuck under the bed and V9 pulled it out and it ran over her (R1's) foot. V11 stated V11 received no response from facility staff.On 5/6/2026 at 10:00 AM, R1 stated V9 CNA repeatedly raised V9's voice, degraded R1, and treated R1 disrespectfully during care. R1 stated V9 would become argumentative and had previously stated, your kids wouldn't talk to me like that. R1 stated R1 generally got along with other CNAs but consistently experienced problems with V9. R1 stated R1 had previously requested that V9 not provide care to R1 because of degrading interactions on 4/16/26. Record Review documents that Care Plan dated 4/17/26 states R1 makes false accusations, but no behaviors or documentations from grievance logs, behavior logs before the care plan meeting on 4/16/26. R1 stated on the evening of 5/2/2026, V9 CNA entered R1's room despite previous requests that V9 not provide care. R1 stated V9 stood over R1 watching R1 and became argumentative while attempting to provide care. R1 stated R1 requested assistance respectfully; however, V9 raised V9's voice and responded dismissively. R1 stated R1 told V9 that R1 did not want V9 providing care because V9 was disrespectful toward R1. R1 stated V9 responded, you need to respect me. R1 described the interaction as degrading and humiliating and stated, is she (R9) trying to give me (R1) a heart attack? R1 stated R1 felt intimidated, emotionally overwhelmed, and humiliated during the interaction.R1 stated R1 believed staff did not believe R1's allegations and attempted to make R1 appear dishonest. R1 stated staff were asking all kinds of questions suggesting I (R1) was lying. R1 described V9 CNA as pouncing on me (R1) like a cat after prey and stated V9 intentionally attempted to upset and intimidate R1. R1 stated the interactions caused significant emotional distress and made R1 fearful and uncomfortable receiving care from V9.On 5/6/2026 at 11:18 AM, V9 CNA acknowledged R1 became very upset and was yelling during the interaction on 5/2/2026. V9 acknowledged exiting the room and stating to V10 LPN, thank god you got (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that all recorded, despite no recording occurring. V9 acknowledged R1 overheard the statement.On 5/6/2026 at 2:15 PM, V10 LPN stated V10 overheard V9 CNA speaking to R1 in a stern voice and repeatedly directing R1 to roll over during care. V10 stated after exiting the room, V9 stated, I'm glad you were recording all of that. V10 stated V10 believed the comment was intended to visibly upset R1 further.Record review revealed psychiatric documentation dated 5/7/2026 identified increased sadness, frustration, emotional distress, and conflict with staff following the incident. Documentation noted increased behaviors, emotional escalation, and the need for close psychiatric monitoring following the conflict with staff. Nursing documentation dated 5/11/2026 documented increased episodes of tearfulness and emotional distress requiring an increase in Sertraline medication dosage.Record review further revealed the facility failed to implement new interventions after the earlier care plan meeting regarding R1's concerns involving V9 CNA. There was no documented evidence that the facility ensured V9 would avoid providing care to R1 or monitored interactions between V9 and R1 after allegations of degrading behavior were reported.

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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. Based on interview, record review, and facility documentation, the facility failed to timely report allegations of abuse, neglect, injury of unknown source, and mistreatment involving one resident (R1) in accordance with facility policy and federal regulations on a sample list of three residents. The facility failed to immediately report allegations to the Administrator, physician, and other required officials after staff became aware of allegations involving verbal abuse, rough handling, and injury to R1's left foot by a Certified Nursing Assistant on 5/2/2026.Findings Include: On 5/2/2026, R1 alleged that V9 Certified Nursing Assistant (CNA) forcefully pulled a wheelchair and struck R1's foot during care, causing pain and bruising. R1 further alleged V9 had previously degraded and verbally mistreated R1.On 5/6/2026 at 9:24 AM, V11 (R1's) Power of Attorney (POA), stated R1 called V11 on 5/2/2026 at approximately 7:00 PM crying hysterically and emotionally distressed following the incident. V11 stated V11 subsequently contacted the facility and spoke with V9 CNA, who admitted the wheelchair struck R1's foot while being forcefully removed from beside the bed. V11 provided a text message sent to V3 Social Services Director (SSD) on 5/2/2026 at 8:07 PM documenting the allegation. The text message stated, Mom (R1) just called and said that one of the nurses rammed a wheelchair into her (R1's) leg. The nurse (V9) said the wheelchair was stuck under the bed and she (R9) pulled it out and it ran over her (R1's) foot. V11 stated V11 received no response from facility staff after reporting the allegation.On 5/6/2026 at 11:18 AM, V9 Certified Nursing Assistant (CNA) admitted V9 yanked the wheelchair from under the bed and accidentally struck R1's foot. V9 acknowledged R1 became upset and was yelling following the incident.On 5/6/2026 at 2:15 PM, V10 Licensed Practical Nurse (LPN) stated V9 informed V10 on 5/2/2026 that the wheelchair struck R1's foot. V10 stated V10 notified V8 Assistant Director of Nursing (ADON) regarding the incident and obtained statements from R1 and V9 CNA.On 5/6/2026, V8 Assistant Director of Nursing (ADON) stated V8 received notification from V10 LPN on 5/2/2026 regarding the wheelchair incident involving R1's foot. V8 ADON acknowledged V8 did not report the allegation to the Administrator on the date of the incident.Record review revealed an incident note dated 5/5/2026 documenting that administration, the physician, ombudsman, and local police department were not notified until 5/5/2026 after the POA came to the facility and met with administration. The incident note documented that V9 CNA was suspended pending investigation on 5/5/2026.Record review further revealed Nurse Practitioner documentation dated 5/4/2026 noted R1 reported a CNA hit R1's toe with a wheelchair. Additional documentation dated 5/6/2026 confirmed bruising, pain, and tenderness to the left toe and foot with x-rays ordered due to continued pain. V16 Nurse Practitioner (NP) confirmed on 5/6/2026 at 10:45AM, that physician notification should have occurred on 5/2/2026 when the allegation and injury were first reported.The facility failed to ensure allegations of abuse and injury were immediately reported to administration and other required officials, failed to ensure timely physician notification, and failed to initiate a timely investigation upon receipt of the allegation. These failures had the potential to delay resident protection, investigation, and implementation of interventions to prevent further abuse or mistreatment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, and facility documentation, the facility failed to thoroughly investigate allegations of abuse and failed to implement timely interventions to protect one (R1) from further potential abuse and emotionally distressing interactions involving Certified Nursing Assistant (CNA) on a Sample list of three residents. The facility failed to adequately respond to prior allegations of degrading behavior, failed to ensure effective follow-up after a care plan meeting addressing resident concerns, failed to remove the alleged staff member from resident care after repeated complaints, and failed to complete a timely and thorough investigation into allegations of verbal abuse and rough handling on 5/2/2026.Findings Include:On 5/6/2026 at 9:24 AM, V11 (R1's) Power of Attorney (POA), stated there had been prior allegations involving V9 CNA degrading and disrespecting R1 approximately two weeks before the incident on 5/2/2026. V11 stated a care plan meeting had been held with R1, V11, and facility staff, including V2 Director of Nursing (DON), where concerns regarding V9's treatment of R1 were discussed. V11 stated R1 expressed that R1 did not want V9 providing care due to feeling degraded and emotionally mistreated. Despite these concerns, V9 continued to enter R1's room and provide care.On 5/6/2026 at 9:24 AM, V11 stated that on 5/2/2026 at approximately 7:00 PM, R1 called V11 crying hysterically, emotionally distressed, and complaining of pain following another interaction with V9 CNA. V11 stated R1 reported V9 became upset during care and forcefully pulled the wheelchair into R1's foot. V11 further stated V11 overheard staff minimize R1's concerns and tell R1 that R1 was overreacting.On 5/6/2026 at 10:00 AM, R1 stated V9 CNA repeatedly raised V9's voice, degraded R1, and treated R1 disrespectfully. R1 stated R1 had previously requested that V9 not provide care to R1 because of prior degrading interactions. R1 stated that on 5/2/2026 V9 again entered (R1's) room, became argumentative during care, and spoke to R1 in a disrespectful and intimidating manner. R1 stated R1 felt humiliated, emotionally distressed, and fearful during the interaction.On 5/6/2026 at 11:18 AM, V9 Certified Nursing Assistant (CNA) admitted V9 yanked the wheelchair from beside the bed and struck R1's foot. V9 also acknowledged stating, thank god you got that all recorded, after leaving the room despite no recording occurring.On 5/6/2026 at 2:15 PM, V10 Licensed Practical Nurse (LPN) confirmed V10 overheard V9 speaking to R1 in a stern voice during care and stated V10 believed V9's comment about recording the interaction was intended to visibly upset R1.On 5/6/2026 at 1:30PM, V8 Assistant Director of Nursing (ADON) stated V8 was notified on 5/2/2026 regarding the incident involving R1's foot; however, V8 acknowledged V8 did not notify the Administrator at that time. Record review revealed the facility did not suspend V9 CNA or initiate formal reporting procedures until 5/5/2026 after the POA came to the facility and met with administration.Record review further revealed no evidence the facility implemented immediate protective interventions following the earlier care plan meeting regarding R1's concerns about V9 CNA. There was no documented evidence that the facility ensured V9 would avoid providing care to R1, monitored staff interactions, or completed a thorough abuse investigation after the earlier allegations of degrading behavior.The facility failed to thoroughly investigate allegations of abuse and mistreatment, failed to implement effective interventions to protect R1 after prior complaints involving the same staff member, and failed to prevent continued contact between R1 and the alleged perpetrator.