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	06/11/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the required 30 day notice to a resident discharged involuntarily. This failure affects one resident (R2) out of seven reviewed for discharges on the sample list of eight. Findings include: On 6/9/26 at 9:05 AM, V1, Administrator, stated R2 was still in the hospital. V2 stated R2 was not under an official involuntary discharge process but there was a corporate level decision not to allow R2 to return to the facility. V1 stated the facility could not meet R2's clinical needs and continued to relate conflicts with R2's daughter (V7), an extensive investment of facility resources, direct care staff necessarily providing care to R2 with two staff members to protect themselves against false accusations and allegations from R2 and V7. V1 stated all R2's personal belongings had been packed up and were waiting in her office for someone to come pick the items up. On 6/9/26 at 2:32 PM V7, Family of R2, stated R2 had been sent to the emergency room on 5/21/26 after having a bad day mostly due to her medications. V7 stated R2 had been sent from a local hospital to a more distant hospital to receive treatment. V7 stated R2 had been cleared to be discharged from the hospital for over a week but the facility would not allow R2 to return. V7 stated the hospital had been trying to find another nursing home in the same local area but none were available. V7 stated the hospital was looking in more distant towns for another nursing home. V7 stated the facility had not provided a 30-day notice for R2's discharge from the facility. V7 stated the administrator (V1) told her they couldn't meet R2's needs but the facility was meeting R2's needs prior to being sent to the hospital, and the hospital was seeking another nursing home for R2. V7 stated she had contacted the State Ombudsman (V11) to intervene with the facility, but the Ombudsman had reported back that the administrator told her the same thing, that R2 would not be allowed to return to the facility. R2's Census Detail dated 6/9/26 documents R2 was originally admitted to the facility 6/8/23, then discharged [DATE]. R2 re-admitted to the facility 11/1/23, then discharged [DATE]. R2 was again re-admitted [DATE], experienced 12 short-term hospitalizations with readmissions each time, and discharged [DATE]. R2's Profile Face Sheet dated 6/9/26 documents V7 as R2's legally established power of attorney. R2's Minimum Data Set Resident Assessment (MDS) dated [DATE] documents R2 experienced a range of motion impairment of 1 lower extremity. R2 requires supervision while eating, conducting oral hygiene, upper dressing, and personal hygiene. R2 requires moderate assistance for toileting, showers, lower body dressing, placing footwear, bed mobility, transitions from sitting to lying, and lying to sitting. R2 requires maximum assistance to transition from sitting to standing, to accomplish transfers from chair to bed, toilet, or shower. R2 does not ambulate. R2 required set up to propel her own wheelchair 50 feet to 150 feet. R2 is frequently incontinent of bowel and bladder. R2 had no skin ulcers or associated treatments. All similar conditions to each of the reviewed residents (R1, R3, R4, R5, R6, and R7) who reside at the facility. R2's Nursing Progress Notes dated 6/8/2026 at 3:42 PM document: COMMUNICATION - with Family/NOK (next of kin)/POA (power of attorney). Note Text: Writer attempted to call (R2) two times on 06-08-2026 to find out when she would be picking up her belongings. SSD (Social Services Director) present during phone call attempts. R2 did not answer either call, no message was left due (continued on next page)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to voice messages not being set up on her phone. R2's Nursing Progress Notes dated 6/1/2026 at 12:11 PM document: COMMUNICATION - with Family/NOK/POA. Late Entry: Note Text: This writer and admissions director attempted to contact (R2) and (V7) via facility phone; both calls when (sic, went) straight to voicemail. Attempted to call (R2) via admissions cellphone; call went to voicemail. Called (V7) via admissions cell phone to discuss when (R2's) items would be picked up. (V7) states that she does not plan to pick (R2's) items up at this time. Informed (V7) that belongings are secured in the Administrators office. This writer present with admissions director for duration of call. R2's Nursing Progress Notes dated 5/30/2026 10:25 AM documents: Nursing Note. Note Text: (V13, unknown reference) here to pick up (R2's) mail. Observed (R2) on the phone with (V13) at the time of mail being picked up. This writer asked if (V13) would be picking up (R2's) personal belongings; (V13) stated that she wanted to talk to (V7) before picking up belongings. Requested corporate number; number given to (V13). On 6/10/26 at 12:28 pm, V1, Administrator, and V9, Regional Consultant, jointly and severally stated R2 has an extensive history of litigation including medical professionals to the point where the facility had to find new surgeon for R2, and R2 has a lot of refusals of insulin. V9 specifically stated she was fully aware the facility had missed the opportunity to do an involuntary discharge notice for R2. Jointly, V1 and V9 stated there were a lot of inaccuracies reported by R2 and V7 during a prior survey which caused the facility to receive citations. On 6/11/26 at11:18 am, V11, Ombudsman, stated she was contacted by R2's daughter (V7) who said the facility had sent R2 to the hospital but now were not allowing R2 to come back. V11 stated she went out to the facility on behalf of R2 and V7 to speak with the administrator who confirmed the facility was not going to allow R2 to return to the facility. V11 stated she asked if the facility had provided a 30 day notice and was told that the situation was past that point. V11 stated she gave all that information to V7 and said from this point it would have to be a phone call to IDPH for more regulatory enforcement. V11 confirmed she had not received the required copy of a 30-day notice of involuntary discharge from the facility. On 6/11/26 at 11:25 AM, V1 confirmed R2 would not be allowed to return to the facility, and there was no 30-day notice issued to R2 or R2's family. The facility's Discharge/ Transfer policy dated 1/2025 documents that involuntary transfers or discharge (discharges against the wishes of the resident or family) will be with proper notification to the resident and family or legal representative by registered or certified mail. A notice of Involuntary Transfer or Discharge and Opportunity for hearing will be provided to the resident/ resident representative. All involuntary discharges will be conducted in accordance with the Nursing Home Care Act. The Clinical Director or CEO (Chief Executive Officer) shall be consulted before any involuntary transfer/ discharge notices are sent. Involuntary transfers or discharges of a resident shall be preceded by a discussion with the resident or responsible party and by a written notice of 30 days. The written notice must be given on a form prescribed by the Illinois Department of Public Health.