| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145439 | A. Building<br>B. Wing | 05/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accolade Healthcare of Savoy | 302 West Burwash<br>Savoy, IL 61874 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on record review and interview the facility failed to ensure a resident right to dignified care and treatment. This failure affects one of three residents (R3) reviewed for dignity/abuse on the sample list of three.<br><br>Findings include:<br><br>R3's Minimum Data Set (MDS) dated [DATE] documents R3 has a brief interview of Mental Status score of 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents R3 is incontinent of bowel and bladder, frequently.<br><br>R3's Diagnoses Sheet dated 3/11/24 documents the following: Anxiety Disorder Unspecified, Other Fatigue, Irritable Bowel Syndrome with Diarrhea, and Benign Neoplasm of Unspecified Part of Small Intestine.<br><br>R3's Care Plan dated 4/9/24 documents (R3) has Bowel & bladder incontinence, R3 will remain free from skin breakdown due to incontinence and brief use through the review date, and (R3) has a need for assistance during transfers.<br><br>On 5/7/24 at 12:30 pm V10, Auxiliary Assistant was interviewed regarding abuse. V10 stated the following: Anything abuse, I heard myself or seen, I overheard (R3) say something to a nurse. I think it was (V7, Licensed Practical Nurse) the Nurse. She is an LPN. I don't know if it was true or not. I think I heard (R3) said something like a (racial description) CNA (later identified as V13, Certified Nursing Assistant) asked her (R3) why she was wearing a diaper and ask (R3) why she needed to go to the bathroom with a diaper on.<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 4:20 pm R3 stated There was a situation this past weekend, Friday (5/3/24) overnight (described the CNA and identified the CNA by first name). I want to make sure you know it is not the other (CNA with the same first name). She is very nice to me. Friday overnight (later identified as V13, Certified Nursing Assistant) with the (specific description) is always coming in here (R3's room) rolling her eyes, when I ask for things. That night (V13, CNA) said, 'Why are you wearing a diaper and why do I still have to take you to the bathroom.' R3 then stated I told the morning nurse that next day. I felt humiliated. I asked who the CNA's supervisor was and the day nurse (unidentified) said 'I guess I am.' I don't remember her name (remains unidentified), but she has long dark hair. (V13, CNA) was in here again last night and she was fine. Friday night she made me feel like I was two inches tall. I didn't feel abused. I did feel (V13, CNA) was very disrespectful.<br><br>The facility Grievance/Complaint Form signed by V1, Administrator/Abuse Prevention Coordinator dated 5/7/24 documents R3 reported that a CNA (unidentified) said You don't need to go to the bathroom, you have a diaper on.<br><br>On 5/7/24 at 4:35 pm V1, Administrator stated he talked to R3 and received the same information. R3 told V1 that she did not feel her interactions with V13, CNA were abuse, just very poor customer service. V1 confirmed the incident between V13, CNA and R3 was a dignity issue.<br><br>On 5/8/24 at 8:40 am V1, Administrator re-iterated the situation with R3 was a dignity issue. V1 stated V13, Certified Nursing Assistant was suspended until she completes education on customer service.<br><br>The facility Subject: Policy Resident Privacy and Dignity dated as revised 10/15/23 documents the following:<br><br>PURPOSE:<br><br>To provide all residents with a home like environment that promotes dignity and respect to the residents of the facility.<br><br>POLICY:<br><br>To ensure that all residents are provided with dignity and privacy.<br><br>RESPONSIBILITY:<br><br>It is the responsibility of all staff to ensure that all residents have privacy and dignity.<br><br>PROCEDURE:<br><br>1. All residents will be addressed and spoken to with dignity and respect at all times. All residents will be addressed by their preferred name during conversation. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on observation, interview, and record review the facility failed to protect a residents' right to be free from verbal/mental abuse by another resident. This failure affects two of three residents (R1 and R2) reviewed for abuse on the sample list of three.<br><br>Findings include:<br><br>R2's Diagnoses Sheet dated 5/1/24 documents the following: Unspecified Dementia, Unspecified Severity Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety.<br><br>R2's Brief Interview of Mental Status (BIMS) on Admission 5/1/24 score is documented as 4 out of a possible 15, indicating severe cognitive impairment.<br><br>R2 Admission Note dated 5/01/24 at 3:07 pm documents R2 ambulates with a walker.<br><br>R1's Diagnoses Sheet dated 5/5/22 documents the following: Hemiplegia and Hemiparesis Following a Cerebra Infarction Affecting Left Non-Dominant Side, Chronic Obstructive Pulmonary Disease Unspecified, Major Depressive Disorder Recurrent, and Unspecified and Anxiety. R1's diagnoses sheet does not document a diagnoses of Dementia or related cognitive impairment diagnoses.<br><br>R1's Minimum Data Set, dated dated dated [DATE] documents R1 has a BIMS score of eight out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R1 has limited range of motion to one upper and one lower extremity and uses a wheelchair for mobility.<br><br>R1's Care Plan dated 3/28/24 documents the following: (R1) is at risk for abuse and neglect, per assessment tool. (R1) will not experience any abuse/neglect.<br><br>The facility initial report to the State Agency dated 5/6/24 at 11:40 am documents Suspected Abuse and Argument /Incident between R2 and R1.<br><br>The facility alleged abuse investigation included the following Resident/Staff Statement dated 5/6/24 at 10:15 am, signed by V23, Assistant Administrator Resident (R1) states roommate (R2) began going through her (R1's) side of the closet and accusing her (R1) of stealing her belongings. (R1) states she can't get up to stop her, so (R1) told her (R2) to stop. States roommate (R2) started yelling slurs and got in her (R1) face but never hit her or anything. Stated roommate had two men in her room with her (R2) but they did not do anything.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's Incident Note dated 05/05/2024 at 2:21 pm, by V4, Licensed Practical Nurse (LPN) documents that V3, Housekeeper reported a resident to resident altercation between R1 and R2 that occurred in their resident room. The note documents (R1) threw her water jug at R2 to stop R2 from pulling R1's hair. The note documents R2 was removed from the room and redirected to the television lounge. The note documents Resident (R2) keeps accusing her bedridden roommate (R1) of stealing her (R2's) clothes and other things but she (R2) was reassured multiple times that those belongings aren't hers. Right before shift change the resident (R2) peeked outside her room and waved for myself (V4, LPN) and the oncoming nurse (V5, LPN) to come to her. When we got there, she (R2) continued to complain about the same thing. Accusing her roommate (R1) of stealing her (R2) things. Her roommate (R1) then reported to us that (R2) called her (R1) a racial slur. (R2) didn't deny it, in fact she apologized to myself and the other nurse for the racial slur that was said. Again, she (R2) was removed from the room, we told her to remain in the tv lounge until we figured out what to do next. The administrator was also contacted about the situation, currently waiting on a response.<br><br>On 5/7/24 at 8:10 am V4, LPN confirmed the details of the 5/5/24 Incident Note.<br><br>On 5/8/24 at 11:53 AM V3, Housekeeper stated (R1) was worried about (R2) getting into her clothes. They both argued with each other. This was Sunday (5/5/24), a fight of words, going back and forth. (R2) was getting really agitated. (R1) did keep arguing with (R2). She kept saying the clothes in the closet were her (R1) own. They were arguing and (R2) was on (R1's) side of the room. (R1) cannot get out of bed. She is always in bed. (R1) was afraid as any resident would be that (R2) was going to hit her. I did not see her hit her and did not see (R2) pull (R1's) hair. We, the nurse (V4) and I, explained to (R2) that (R1's) things were her own and showed (R2) her side of the closet and her own things. (V4) then told (R2) to stay on her side of the room. (R2) laid down on her bed. A little while later (R2) was back over on (R1's) side of the room and yelling at (R1) who was in bed. (R2) was saying (R1) needed to give (R2) back her clothes. (V4) went back in (R1 and R2's room) with another nurse (V5, LPN)). I went on with my work. V3 stated I did hear racial slurs. I did hear one of them call the other a hillbilly. I did hear (R2) call (R1) a (racial slur). There was no physical connection (contact). It was all words.<br><br>5/7/24 at 2:34 pm V5, LPN said V4, LPN provided information of the alleged abuse to V5 at shift change on 5/5/24. V5 stated, V4 and V5 heard R2 call R1 an ugly (racial slur). V5 stated (R1) confirmed what we heard. She (R1) told me and (V4) at the same time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 3:55 pm. R1 was lying in bed, the left side of R1's body appeared flaccid. R1 stated My roommate (R2) is downstairs now. She thought I took her clothes. I kept telling her I did not take her clothes. I don't need her clothes. I have been here a long time. Staff all treat me really good. The woman's name, I don't remember, but she was my roommate (R2). That woman (R2) just kept fussing. She came all the way over here by this table (taps on bedside table) and shook it. R1 stated She (R2) did not hit me or pull my hair. I thought she was going to though. I thought she was wanting to fight me. She was loud and abusive. She was very mean. A real nice nurse (unidentified) came in and got her away from me. Then, that woman (R2) came back in my room, and stood by my bed yelling, again. She was really close to my table and shaking it again. That is when I threw my water pitcher towards her. I can't walk. My legs don't work. I am unable to move away from her. I did not know what to do. Two nurses came back and got her out of here. They were in the hall and heard her (R2) yelling and call me (R1) a (racial slur). They (unidentified nurses) got her out of here, again. Then, awhile later her, her brother (later identified as V16, R2's Family Member) and his friend (unidentified) came in here (R1 and R2's room). Her brother saw she was cursing at me again and saying I took her clothes. It was not true. She (R2) even took clothes out of my (R1) bag in the closet. Staff took them back. She was insisting my blanket was hers one day. It is not. My nephew (unidentified) got this blanket for me. With her brother and friend in here, she called me a (racial slur) again. I was very upset. I was afraid that day, all day. Not knowing what she would do next. She came over to my bed twice. Every day she would say I took her stuff. That day she got close enough and had her hand right here on my table. She was way too close for comfort. I can't walk. I did not know what to do. She really scared me. I thought she was going to hit me.<br><br>On 5/8/24 at 4:00 pm V1 Administrator/Abuse Prevention Coordinator and V12, Regional Nurse Consultant were present during the interview. V1 acknowledged the incident between R1 and R2 occurred 5/5/24, and stated the investigation is ongoing. V12, Regional Nurse Consultant stated V12 had talked to R1. (R1) says she feels safe here and staff treat her well. (R1) was scared, immediately during the confrontation. (R1) is fine now and said she was happy and not afraid of anyone in the facility.<br><br>On 5/8/24 at 4:15 pm R1 was lying in bed. R1, recognized this surveyor and stated she knew I was from the State. When asked if she remembered what R1 and the surveyor talked about the day before (5/7/24 at 3:55 pm) R1 stated Of course I do R1 then repeated the same details R1 had shared regarding R1 being verbal/mentally abused by R2 on 5/5/24.<br><br>The facility Abuse Prevention Program dated 10/20/22 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: conducting pre-employment screening of employees and pre-admission screening of residents; orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>31642<br><br>Based on record review and interview the facility failed to ensure an allegation of physical and verbal abuse by R2 towards R1, was reported to the Administrator/Abuse Prevention Coordinator. This failure resulted in R1 and R2 continuing to reside in the same bedroom, potentially subjecting R1 to further abuse by R2. R1 and R2 are two of three residents reviewed for abuse on the sample list of three.<br><br>Findings include:<br><br>R2's Incident Note dated 05/05/2024 at 2:21 pm, by V4, Licensed Practical Nurse (LPN) documents the following: After lunch the Resident (R2) became physically violent with her roommate (R1). The housekeeper (V3) reported that the resident (R2) was pulling her roommates (R1's) hair before her roommate (R1) threw her water jug at her (R2) to stop her from pulling her (R1's) hair. Resident (R2) was removed from her room and redirected to the tv (television) lounge. POA (V22, Power of Attorney/Family Member) was notified about the incident, and her (R2's) other (Family Member, V16) came to help calm her (R2) down. Resident (R2) keeps accusing her bedridden roommate (R1) of stealing her (R2's) clothes and other things but she was reassured multiple times that those belongings aren't hers. Right before shift change the resident (R2) peeked outside her room and waved for myself (V4, LPN) and the oncoming nurse (V5, LPN) to come to her, when we got there she (R2) continued to complain about the same thing. Accusing her roommate (R1) of stealing her (R2) things. Her roommate (R1) then reported to us that (R2) called her (R1) a racial slur. (R2) didn't deny it, in fact she apologized to myself and the other nurse for the racial slur that was said. Again, she (R2) was removed from the room, we told her to remain in the tv lounge until we figured out what to do next. The administrator was also contacted about the situation, currently waiting on a response.<br><br>On 5/7/24 at 8:10 am V4, LPN stated she notified V1, Administrator, by text 5/5/24 at 2:02 pm that R2 was being combative.<br><br>On 5/7/24 at 1:38 pm V2, Director of Nursing said the first V2 news of an allegation of physical and verbal abuse, related to R1 and R2 was on 5/6/24. V2 stated, V8, Registered Nurse (RN) Manager found a note in R2's medical record. V2 stated she interviewed V4, who told V2 she sent a text to V1, Administrator on 5/5/24. V4 then read the text to V2 which documented R2 was combative, but the text did not identify R2 was combative with R1. V2 stated V1, Administrator had directed V4 to move R2 to another room.<br><br>On 5/7/24 at 2:07 pm V8, RN stated I was the on-call manager on the weekend. We do a rotation. I did not hear anything other than staff call ins, falls and residents being sent out to the hospital. I did not hear anything regarding (R2) and the other resident (R1). I should have, as the nurse manager on call. I would have followed our policy and immediately called (V1, Administrator/Abuse Prevention Coordinator). I found the note yesterday.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 2:34 pm V5, LPN said V4, LPN provided information of the alleged physical abuse to V5 at shift change. V5 stated V4 and V5 heard R2 call R1 an ugly (racial slur). V5 stated V4 told V5 that V4 reported both verbal and physical abuse to V1, Administrator/Abuse Prevention Coordinator, so V5 did not report.<br><br>On 5/8/24 at 11:53 V3, Housekeeper stated (on 5/5/24) I did hear racial slurs. I did hear one of them call the other a hillbilly. I did hear (R2) call (R1) a (racial slur). There was no physical connection (contact). It was all words. V3 stated V3 did not report the incident to the administrator.<br><br>The facility Notification of Termination of Employment dated 5/6/24 documents V4, Licensed Practical Nurse ceased employment with the facility due to Failure to follow protocol related to abuse prevention and reporting.<br><br>On 5/8/24 at 1:45 pm V1, Administrator/Abuse Prevention Coordinator and V12, Regional Nurse Consultant stated V4 was terminated because she did not report the abuse allegation to the on call Manager (V8, Registered Nurse) or V1 as V4, LPN should have. V1 and V12 stated a vague text to V1, referred to a combative resident. It did not mention the allegation of verbal or physical abuse between the two residents (R1 and R2).<br><br>The facility policy Abuse Prevention Program dated 10/20/2022 documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.<br><br>The same policy documents: Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Employees, without fear of retaliation, may also independently report to the state survey agency any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property, and to local law enforcement or the state survey agency if they have a suspicion that a crime was committed. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property to the administrator or an immediate supervisor who must then immediately report it to the administrator or the designated individual in the administrator's absence. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. |