STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Savoy	302 West Burwash 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to ensure fall interventions were in place, safely position a resident on a low air loss mattress, keep necessary items within reach for a resident, and store a rolling chair away from resident areas. The facility also failed to complete post fall assessments, transfer a resident post fall according to facility policy, and thoroughly investigate falls. These failures affect three of three residents (R1, R4, R5) reviewed for falls on the sample list of seven. Findings include: 1. R1's undated Medical Diagnosis List documents R1's medical diagnoses as Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Neurological Neglect Syndrome, Paralytic Syndrome following Cerebral Infarction affecting Left Non-Dominant side, Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side, Seizures, Kidney Failure, Protein Calorie Malnutrition, Dysphagia, Cognitive communication Deficit and Vascular Dementia. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring maximum assistance for bed mobility and dependent on staff for assist with eating, toileting, transfers, personal hygiene, dressing and bathing. R1's Physician Order Sheet (POS) dated March 2024 documents a physician order for a Low Air Loss (LAL) mattress dated 1/9/24. R1's Care plan includes interventions dated 7/14/23 that document R1 requires extensive assistance of two staff for turning and positioning at least every two hours. R1's Fall Scale assessment dated [DATE] documents R1 as being at risk for falls. No further Fall Risk Assessments were documented. R1's Nurse Progress Note dated 2/1/24 at 11:33 PM documents Observed (R1) face down on the floor with Right Arm pinned under his body. Staff lifted resident back into bed. Upon assessment, (R1's) eyes were pinpoint and nonreactive to light. Resident began complaining of pain every place nurse touched. (R1) sent to emergency room for evaluation. (R1) returned from hospital at 8:10 PM. (R1's) tests /x-ray negative for breaks. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Computerized Tomography (CT) of the brain without contrast for head trauma moderate/severe unwitnessed fall results dated 2/1/24 document Impression Mild frontal scalp soft tissue swelling without associate Calvarial injury. R1's fall investigation dated 2/1/24 documents R1 had an unwitnessed fall on 2/1/24 at 2:00 PM. This same investigation documents R1 was found lying face down on the floor by his bed with Right Arm under his body. R1's Right side of face was on the floor. This same investigation documents an Interdisciplinary Team (IDT) note on 2/2/24 which documents (R1) slumps/leans and has poor trunk control. (R1) is unable to move the left side of his body due to Cerebral Vascular Accident (CVA). (R1) was positioned in high fowlers and began to lean on air mattress and slid out of bed. On 5/19/24 at 11:15 AM V17 Certified Nurse Aide (CNA) stated V17 was in R4's room at 1:45 PM to provide incontinence care before shift change at 2:00 PM. V17 CNA stated When I left (R1) he had just been changed (incontinence care) and I put his bed in the low position. I had left (R1's) head of bed up 60 degrees or so and the foot of the bed was flat. I had (R1) nice and propped up. V17 stated R1 had been positioned on his Left side on the 'door' side of the bed but 'kind of in the middle.' V17 stated R1's head and knees were more towards the middle of the bed and R1's hips/buttocks were closer to the door side of the bed. V17 stated (R1) was always so stiff. (R1) would not move in bed. (R1) had a previous stroke and couldn't move so wherever we (staff) put him in bed is where he would stay. V17 CNA stated I walked into R1's room and he was face down on the floor. Somehow (R1) had fallen out of bed and landed right on his face. V17 stated R1 could have been positioned better if there had been two people to assist with positioning. V17 stated I didn't do anything wrong on purpose but (R1) still fell out of bed. Those air mattresses sometimes make people fall out of bed. They (resident) have to lay on them just right or they (LAL mattress) will pop people right out of that bed. V17 stated after R1 was assisted back to bed, (V10) Registered Nurse (RN) did a physical assessment on R1. On 5/18/24 at 3:15 PM V10 Registered Nurse (RN) stated V10 was R1's nurse the day he fell out of bed. V10 RN stated (R1's) fall on 2/1/24 was unwitnessed so (R1) had to have been left unattended. The staff should have either stayed with (R1) or lowered the head of his bed down before leaving his room. V10 stated there was nothing for R1 to have hit his head on except for the floor. V10 stated V10 sent R1 to the emergency room . On 5/18/24 at 2:25 PM V3 Director of Nurses (DON) stated V3 did not work for this facility when R1 fell on [DATE]. V3 stated after reviewing R1's unwitnessed fall investigation report V3 could confirm R1 was positioned by staff in a high fowler's position when R1 utilized a low air loss mattress. V3 stated R1 should not have been left unattended in that position on an air mattress. V3 DON stated Most likely (R1's) air mattress had a shift in air and bumped (R1) right out of bed. 2. R4's undated Medical Diagnosis List includes Chronic Osteomyelitis, Diabetes Mellitus (DM) Type II, Chronic Systolic Congestive Heart Failure (CHF), Ischemic Cardiomyopathy, Pleural Effusion, Sacral Stage IV Pressure Ulcer, Alzheimer's Disease, Anemia, and Vitamin D Deficiency. R4's Minimum Data Set (MDS) dated [DATE] documents R4 as moderately cognitively impaired. This same MDS documents R4 as requiring maximum assistance of two people for bed mobility, dressing and transfers and R4 is dependent on staff assistance for all other areas assessed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Care plan intervention dated 11/16/23 documents R4 requires two staff and a total body mechanical lift for transfers. R4's Clinical Mobility assessment dated [DATE] documents R4 has extremely impaired mobility. R4's Fall Risk assessment dated [DATE] documents R4 as a high fall risk. R4's Nurse Progress Note dated 3/22/24 at 3:34 AM documents (R4) was heard yelling for help. (R4) was found sitting on bottom on floor with floor mat pushed aside. (R4) assisted to bed with (V16 CNA) and gait belt. (R4) stated 'I was asleep then I fell . I was on the ground'. This same progress note documents R4 was assessed with no injuries and Floor mat was positioned alongside of bed so that mat is unable to be pushed away. On 5/18/24 at 10:20 AM R4 was lying in bed in R4's room. R4's fall was mat was doubled over standing up on end at the end of R4's bed. There was no fall mat in place on the floor in front of R4's bed. On 5/19/24 at 10:43 AM R4 was lying in bed with covers over her. call light was laying on the floor at the end of R4's bed out of R4's reach. R4's fall was mat folded up standing on end at the end of R4's bed. On 5/18/24 at 10:21 AM R4 stated I remember the night I fell . I was trying to reach for my drink, but the table was just too far away. I was lying in bed and trying to reach but my arms aren't that long. The call light was laying across the table so I couldn't put the light on either. So, I yelled out and a couple of nurses (V19, V21) Registered Nurse (RN) came in to check on me because I was yelling out. I told them (V19, V21) that my leg and butt hurt. I don't remember who but two of the (staff) lifted me up and put me back in bed. I normally have to have that big swing machine (total body mechanical lift) but they didn't use that. R4 stated after V19 RN and V21 RN both left the room, then V20 RN came into R4's room to do a physical assessment. On 5/19/24 at 5:15 AM V20 Registered Nurse (RN) stated V20 was assisting another resident when R4 fell on [DATE]. V20 stated (V19, V21) both RN's assisted R4 after she fell . V20 stated the first time V20 saw R4 was after R4 was already back in her bed. V20 stated R4 normally has a lot of pain and does remember R4 complaining of generalized pain on her buttocks after R4's fall. V20 stated she was not certain who might have assisted R4 back into bed after her fall. V20 RN stated I remember getting the pen light out and taking her blood pressure one time. I honestly don't remember doing the Neurological Assessments after that first time. Normally we (facility) would not move a resident who has fallen and complaining of pain until the nurse saw and assessed them but (V19, V21) are both RN's. They (V19, V21) were both in the room with (R4) before I was. I am sure one of them (V19, V21) would have assessed (R4) before moving her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/24 at 9:30 AM V21 Registered Nurse (RN) stated V21 heard R4 yelling out from R4's room. V21 stated when V21 entered R4's room, R4 was sitting on the floor on her buttocks with her left leg outstretched and R4 was sitting on her Right Leg her Right leg bent at the knee with R4's right foot on the outer side of R4's right thigh. V21 stated R4 complained of pain in 'her leg or buttocks.' V21 stated R4 was alert and responding. V21 RN stated R4 reported that R4 was trying to reach something on her table, but the table was too far away. V21 RN stated R4's fall mat was pushed to the side and R4 was sitting directly on the floor. V21 stated V21 did not complete a physical or neurological assessment. V21 stated V19 RN entered R4's room shortly after V21. V21 RN stated V21 left the room with V19 remaining in R4's room. On 5/19/24 at 11:35 AM V19 Registered Nurse (RN) stated V19 RN and V16 Certified Nurse Aide (CNA) assisted R4 up after R4's fall. V19 RN stated V19 and V16 did not use a lift (total body mechanical lift) machine to assist R4 up. V19 stated V19 entered R4's room right after V21 RN. V19 stated V19 did not complete any type of physical assessment or neurological assessment prior to moving R4. V19 stated (R4) was moving ok and talking so I thought she would be ok. I didn't get out my pen light or anything but (R4) was talking to me. I don't know if (R4) was having any pain. No one said anything to me if she was. In hindsight, I should have made sure to use the lift to get (R4) up. The neurological exam should have been done by (R4's) nurse (V20) RN. I wasn't (R4's) nurse, (V20) was. 3. R5's undated Medical Diagnosis List includes Alzheimer's Disease, Cerebral Infarction, Apraxia following other Cerebrovascular Disease, Muscle Weakness, Hallucinations, Essential Hypertension, and Insomnia. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as severely cognitively impaired. This same MDS documents R5 requires maximum assistance for toileting, bathing, dressing, Supervision or touching assistance for transfers and moderate assistance of one staff for bending/stooping from a standing position to pick up a small object from the floor. R5's Care plan intervention dated 4/12/24 instructs staff to cue, orient and supervise as needed. R5's Fall Risk assessment dated [DATE] documents R5 as a moderate fall risk. R5's Nurse Progress Note dated 4/17/24 at 7:32 PM documents (R5) was attempting to sit in a computer chair with wheels, fell on to bottom. No injury noted. Cause: Rolling chair moved when (R5) was trying to get into it. Immediate intervention: helped (R5) into a stable chair. On 5/18/24 at 2:15 PM V12 Licensed Practical Nurse (LPN) stated R5 normally wanders about the Dementia Unit independently all day long. V12 stated R5 fell on [DATE] after trying to sit in a chair 'that was not stable.' V12 LPN stated R5 needs a lot of supervision due to her poor safety awareness. V12 stated there was a dining room table sitting outside of the nurse's station. V12 stated the table and chairs were positioned 10-15 feet away from the nurse's station. V12 LPN stated (V11) Certified Nurse Aide (CNA) had been sitting at one of those chairs. (V11) stood and walked away and left the wheeled chair out in the open for anyone to sit at. (R5) walked over and tried to sit on one of those wheeled chairs and ended up falling. (R5) did not get hurt thank goodness but those types of chairs do not belong back on our Dementia Unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/18/24 at 10:29 AM V5 CNA stated residents on a dementia unit have to have 'all the clutter' removed for their protection. V5 stated R5 walks around 'all the time.' V5 stated R5 is always on the go. V5 stated (R5) needs redirected a lot. (R5) keeps us busy. On 5/18/24 at 2:25 PM V3 Director of Nurses (DON) stated if the resident is complaining of any type of pain, the nurse should assess the resident prior to moving that person. V3 stated staff should do a thorough physical assessment and neurological assessment if needed for all residents who have fallen prior to any staff moving that resident. V3 stated the staff should be using the lift (total body mechanical lift) to assist residents off of the floor after a fall. V3 DON stated staff should have completed neurological assessments on R4. V3 DON stated the facility is not able to provide documentation of the neurological assessment being completed on R4's unwitnessed fall. V3 DON stated it is the policy of this facility to complete full neurological assessments after any resident has an unwitnessed fall. V3 DON stated the facility management team/Interdisciplinary Team (IDT) puts in a lot of effort to review falls and fall interventions. The staff should be making sure the interventions are in place to help prevent falls. V3 Director of Nurses (DON) stated V3 recently started at the facility and was not present when R1 and R4 fell . V3 DON stated after reviewing the falls for R1, R4 and R5 it was hard to determine what exactly happened. There were no staff interviews other than what was on the risk management report itself, but more people were involved in (R1 and R4) falls. I had to go back and find out what happened because the original investigations were not thorough. V3 DON stated (R5's) fall is straight forward. (R5) went to sit down on a wheeled chair and slipped and fell . The chair should not have been there to begin with. The facility policy titled 'Fall Prevention Program' revised 10/2023 documents the facility will complete the fall assessment initially on admission, and then quarterly, initiate risk reducing interventions, provide ongoing risk reducing interventions, and provide ongoing evaluation of resident response to interventions. The undated facility policy titled 'Safe Resident Transfer Program' documents the resident transfers will be designated into one of the following categories: Independent=no verbal or physical assistance, one person transfer=one person transfers with gait belt (assistance from the caregiver and ability to statically stand for four seconds), two person transfer =should only be used when the resident is not medically appropriate Sit to Stand or Total Lift, sit to stand=requires two caregivers, Full Mechanical Lift=total lift transfer with two caregivers, sliding board-1-2 caregivers as care planned and use of sliding board with gait belt. When a resident has fallen to the floor, a nurse will assess the resident. If the resident is deemed medically appropriate to transfer from the floor, a total body mechanical lift will be used.