

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Accolade Healthcare of Savoy		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20892</b></p> <p>Based on record review and interview the facility failed to provide pain management by not having the correct pain medication available for R1 upon admission to the facility. This failure resulted in R1 experiencing severe pain from R1's recent joint replacement surgery when pain medication was not available. R1 is one of three residents reviewed for pain management in a sample of three. This past compliance occurred from 9/26/24 to 9/27/24.</p> <p>Findings include:</p> <p>The facility policy titled Management of Pain revise date 7/23 documents Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through: Screen for pain every shift. Encourage residents to self-report pain. Preventing and minimizing anticipated pain when possible and using pain medication judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences.</p> <p>R1's Progress note dated 9/26/24 documents R1 was admitted to the facility on [DATE] at approximately 6:30 PM. The same Progress note dated 9/26/24 at 6:39 PM documents (R1) was admitted to his room, alert and oriented times 4 and able to make needs known. The Physician's Order Sheet (POS) dated September 2024 documents R1 was admitted with the following diagnoses: Aftercare following Joint Replacement Surgery and Chronic Lymphocytic Leukemia of B-Cell type not having achieved remission.</p> <p>R1's hospital transfer/discharge orders dated 9/26/24 document the medications R1 was prescribed to receive at the nursing home. Per doctor's orders, R1 was to receive the following the following medication for pain Oxycodone 5 milligram (mg) 1 tablet by mouth every 6 hours as needed for severe pain.</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1 stated per phone interview on 10/09/2024 at 12:05 PM Yes, I was in pain the first couple of days I was at the nursing home. (V5, LPN (Licensed Practical Nurse) ) the nurse on duty that night came in and asked me if I had any pain and I told her not at that time because I received some pain medication at the hospital before I left to go to the nursing home. I told (V5,) I would need the pain medication when I go to bed so I would be able to sleep. At 9:00 PM I asked for my pain medication and (V5 ) told me they did not have my pain medication available and it was ordered from the pharmacy and it should be delivered around 4:30 to 5:00 AM, because this was the time they got their medication. I asked the night nurse (V6, RN (Registered Nurse)) if my pain medication was available and (V6) stated 'no your pain medication did not come.' I was in bad pain and did not get any pain medication until later that day.</p> <p>On 10/9/24 at 2:27 PM (V5) stated, Yes I was the nurse working the night (R1) was admitted . All of his medication orders were faxed to the pharmacy by the admitting nurse. I went in to (R1's) room and explained to him we did not have his pain medication here at the facility. V5 stated the medication should have arrived around 5:00 AM. V5 stated R1 reported R1 would need pain medication around 9:00 PM. V5 stated No I did not call the Nurse Practitioner (V7) or V11 (R1's Doctor) to get an order for a substitute medication. V5 stated we did not have Oxycodone in our Emergency Box, we only had Oxycodone with Tylenol.</p> <p>On 10/9/24 at 2:35 PM per phone interview V7, Nurse Practitioner stated, I went to visit (R1) in his room from 8:00 AM to 10:00 AM on 9/27/24 to see how he was doing. I was shocked because (R1) was in excruciating pain you could see it in his face and his movements. (R1) looked really bad due to his pain. I asked him if he received his pain medication, he stated 'no the facility does not have my type of pain medication.' He stated the medication did not arrive with his other medications according to the night nurse (V6). V7 stated V7 went to the nurse (V3, ADON ) ( Assistant Director of Nursing ) and asked her why R1 did not receive his medication for pain and V3 stated the medication was not received from the pharmacy, and the emergency box only had Percocet available. V7 stated V7 immediately called the pharmacy with an emergency order for R1 to have Percocet two doses which is available in the Emergency Box. V7 stated I then had the nurse remove the medication from the Emergency Box and give it to (R1). Then called the pharmacy and sent the prescription that was needed for R1 to receive his Oxycodone 5 mg. V7 stated R1 should not have been in pain like that. V7 stated no one called V7 or the doctor when R1 was admitted for an order for a different type of pain medication.</p> <p>On 10/9/24 at 12:11 PM, V8 Pharmacist confirmed V7 called in an emergency order on 9/27/24 at 12:03 PM for R1, and the pharmacy received the prescription for R1's Oxycodone 5mg at on 9/27/24 at 3:49 PM.</p> <p>On 10/9/24 at 1:32 PM V3, ADON stated Yes V7 wrote new prescriptions for (R1) to receive his pain medication and I faxed to our pharmacy the new prescriptions for (R1) to receive his Oxycodone 5 mg.</p> <p>On 10/4/24 at 1:40 PM V1, Administrator stated We did not have the medication in the Emergency Box and the nurse did not pick up the phone and call the nurse practitioner or the doctor for an order to get the medication.</p> <p>The facility's policy titled Admission Orders and Process with the revised date of 7/23 documents under Procedure # 1 and 2</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. Physician orders for the resident immediate care will be obtained prior to or upon admission/readmission.</p> <p>2. The Licensed Nursing staff shall obtain orders for the care of the resident from the resident's physician or his/her designee. If the resident's attending physician or his/her designee cannot be contacted, the DON (Director of Nursing) will be notified and the Medical Director will be contacted for immediate orders for care of the resident.</p> <p>Prior to the survey date of 10/10/24, the facility took the following actions to correct the noncompliance:</p> <p>1. On 9/27/24 R1 was interviewed by V3 ADON and R1 was informed an alternative medication had been ordered while the pharmacy was processing his orders and pain medication was administered by V3 on 9/27/24 at 1:32 PM.</p> <p>2. On 9/27/24 a plan was implemented to audit all newly admitted residents for narcotics orders and compare to the list of available medications in the emergency box. Completed by V3 ADON on 9/27/24.</p> <p>3. On 9/27/24 all nursing staff were educated on the narcotic process and how to obtain a one time order for a narcotic that is available in the emergency supply. The emergency supply list will be placed in the Nurse Resource Binder for quick reference. The admissions nurse will screen orders for narcotics when received. Completed by ADON on 9/27/24</p> <p>4. Audits are in place for each new admission to ensure alternative narcotics are available and ordered by the provider until original ordered narcotics arrived from pharmacy. This audit will be completed for each admission by the ADON. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and improvement. Completed on 9/27/24 and ongoing with each new admission by ADON.</p>		