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	10/24/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 -- Based on record review and interview, the facility failed to notify a resident's family representative of positive laboratory test results for an infectious disease and failed to notify both the family representative and a physician/nurse practitioner of a significant decline in a resident's level of consciousness, abnormal lung assessment, and a productive cough. This failure affected one of four residents (R4) who were reviewed for changes in condition on the sample list of seven. Findings include: R4's Diagnoses Sheet, dated 10/22/24 at 12:13 pm, documents the following: Alzheimer's Disease and Unspecified Dementia Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R4's Minimum Data Set, dated dated dated [DATE] documents R4's Brief Interview of Mental Status score as four out of a possible 15, indicating severe cognitive impairment. R4's Orders - General Note dated 10/18/24 at 1:46 pm (day shift) documents: Late Entry (unidentified time of covid test): Note Text: NP (V18, Nurse Practitioner) is aware of Covid positive results. There is no documentation in R4's medical record that V33, R4's Family Representative/Power of Attorney (POA) was notified of R4's COVID-19 positive diagnosis on 10/18/24. R4's Infection Note dated 10/18/24 at 9:44 pm (evening shift) (seven hours and 58 minutes after the above late entry note), signed by V11, Licensed Practical Nurse (LPN), documents the following: Note Text: resident (R4) lethargic (declined in level of consciousness), appetite poor, lung sounds diminished lower lobes, productive cough, responds to physical and verbal stimuli, started on COVID Isolation (day shift), afebrile, droplet precautions in place. There is no documentation that V33, R4's Family Representative/POA, or any facility providers (Nurse Practitioners/ Physicians) were notified of R4's Lethargy, lung sounds diminished the lower lobes, and R4's productive cough. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:20 am V2, Director of Nursing (DON) reviewed R4's medical records and acknowledged R4 had changes of condition on 10/18/24 of testing positive for Covid on day shift of 10/18/24. V2 also acknowledged no documentation of R4 presenting with lethargy, diminished lung sounds, and a productive cough on the 10/18/24 evening shift, which was a change in the resident's condition. V2, DON stated a physician or nurse practitioner and family should have been notified of R4's changes in condition. On 10/23/24 at 2:10 pm V11, LPN stated, I stand by what I wrote. He (R4) was lethargic but did respond to verbal and tactile stimuli. He was alert earlier in my shift. It was a change because he was sick. He had Covid. I figured the lethargy was related to Covid. He was not in respiratory distress. The Nurse Practitioner (unidentified) was aware he had Covid. She was notified prior to my shift. There was no reason to notify her (V18, Nurse Practitioner) or the family (V33, R4's POA) since the previous shift would have already done the notifications (as noted above, there is no documentation of family notification when R4 tested Covid positive). On 10/23/24 at 3:20 pm V31, Licensed Practical Nurse / Infection Control Preventionist stated R4 tested positive for Covid and was not symptomatic when tested . V31 said she notifies the provider, and the floor nurse is expected to notify the residents family when a resident test positive for Covid. The facility policy Subject: PHYSICIAN NOTIFICATION OF RESIDENT CHANGE OF CONDITION dated as revised August 15, 2023, documents the following: PURPOSE: To provide guidelines for facility staff to follow to ensure that there is appropriate physician notification of any change in a resident's condition. POLICY: The resident's attending physician will be notified of changes that occur in the resident's condition by Licensed Personnel as warranted. Physician notification is to include, but is not limited to the following: e. Symptoms of infectious process. j. Changes in Level of Consciousness. The facility policy Subject: RESPONSIBLE PARTY NOTIFICATION OF RESIDENT CHANGE OF CONDITION, dated as revised August 2021, documents the following: PURPOSE: To ensure that residents' responsible parties are notified of changes in conditions that occur. POLICY: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents responsible parties will be notified of changes that occur in residents condition as warranted. If a resident is deemed mentally competent, and exercise his/her right to privacy, not wishing for the family to be notified, then the facility must respect this right, and therefore would not be required to notify the family, however, attending physician must still be notified. If the resident chooses not to exercise this right, then the family must be notified of the change in condition. RESPONSIBILITY: It is the responsibility of All Licensed Personnel to notify the family or responsible parties of a change in residents' condition. PROCEDURE: 1. Family Members or responsible party will be notified of a change in residents condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31642 Based on observations, interviews, and record reviews, the facility repeatedly failed to implement fall interventions for R1, R2, and R3 and repeatedly failed to complete R2's quarterly fall risk assessments. These failures affected three of the three residents (R1, R2, and R3) reviewed for falls on the sample list of seven. Findings include: 1.) R1's Census Record dated 10/18/24 documents that R1 was admitted to the facility on [DATE]. The same census record documents the following: Special Instructions: 1 (one) person transfer with gait belt and RW (roller walker). Ensure TLSO (Thoracolumbar sacral orthosis, type of support to promote healing of spinal fractures) brace is on when OOB (out of bed). R1's current Diagnoses Sheet, with multiple dates, documents the following diagnoses: Repeated Falls (dated 9/26/24), Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety (dated 02/18/24), Multiple Fractures Of Ribs, Right Side, Subsequent Encounter For Fracture With Routine Healing, Non-Surgical Orthopedic/Musculoskeletal (dated 9/25/2024), Unspecified Fracture Of First Lumbar Vertebra, Subsequent Encounter For Fracture With Routine Healing, Major Joint Replacement or Spinal Surgery (dated 9/25/2024), Sprain Of Ligaments Of Lumbar Spine, Subsequent Encounter (dated 9/25/24), and Spinal Stenosis, Lumbar Region Without Neurogenic Claudication (dated 9/25/24). R1's Physician Order Summary Report dated 10/18/24 documents the following: UP with one assist with gait belt; TLSO brace ON when out-of-bed; Increase activity as tolerated. Active (start date) 09/26/2024. On 10/18/24 at 4:30 pm V7, R1's Family Member/ Power of Attorney (POA) was seated next to R1, at a dining room table, on the Dementia unit of the facility. R1 was in a wheelchair. R1 was wearing a hard plastic brace that extended over R1's right shoulder down to R1's right hand. R1 did not have on R1's TLSO back brace. V7, POA stated the facility staff have not been putting R1's back brace on every day, and she is supposed to wear the back brace when she is up out of bed. V7 also stated, You can see she doesn't have it today. Staff (unidentified) said they couldn't find it. My mother (R1) fractured several vertebrae in a fall at the assistive living facility (prior to admission to this facility) after she was discharged from here (this facility) last month. She came back here for therapy. She (R1) is not supposed to be up without the back brace. On 10/18/24 at 4:35 pm, V2, the Director of Nursing (DON), was in the Dementia unit and confirmed that R1 does not have R1's TLSO back brace to support R1's spine. V2 stated, 'The back brace should be on.' V7 (R1's POA) stated to V2, DON, Everyone at the facility should know to keep (R1's) back braces on when she is out of bed. She has a fracture to her vertebrae. She is also supposed to have her arm brace on at all times (in bed and out of bed). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R2's Current Diagnoses Sheet (multiple dates) documents the following diagnoses: Unspecified Dementia, Unspecified Severity With Other Behavioral Disturbance, Delusional Disorders, Personal History of Falling, Ataxia (poor muscle control that causes clumsy movements), Anxiety, Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure With Hypoxia. R2's Minimum Data Set, dated dated [DATE], documents that R2 has moderate cognitive impairment and requires partial to moderate assistance when standing from a seated position and for transfers. R2's Fall assessment dated [DATE], documents R2's score of 95. The same assessment documents: Fall Risk is based upon Fall Risk Factors, and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete (assessment) on admission, quarterly, at change of condition, and after a fall. The same evaluations document R2's score of 95 as High risk, 46 or higher. R2's medical record does not document a quarterly fall risk assessment for March 2024 or June 2024. On 10/24/24 at 5:05 pm, V2 the Director of Nursing, stated, (R2's) quarterly fall risk assessments since December 2023 could not be found in his (R2's) medical record. V2 also stated, If it wasn't charted, it was likely not done. R2's Fall note dated 9/9/24 documents the following: Incident Description: Nursing Description: The was observed on the fall mat of the Resident's roommate; the Resident denies any pain. Resident Description: The Resident is Unable to give a Description. Was this incident witnessed? N (no). Immediate Action Taken: Description: got vitals, asked if was ok, denies any pain, discomfort, was able to get in bed Resident Taken to Hospital? N Injuries Observed At The Time Of The Incident: Injury Type: No Injuries were observed at the time of the incident. Predisposing Physiological Factors: Incontinent (box checked) Impaired Memory (box checked) Weakness/Fainted (box checked.) Predisposing Situation Factors: Ambulating Without Assist (box checked) During Transfer (box checked) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The same 'Fall' noted documents: IDT (Interdisciplinary Team) reviewed: Resident attempted to stand by self, landing on fall mat in room. Recent GDR (Gradual Dose Reduction) on 09/06/2024 for doxepin (antidepressant medication) was reduced to every other night. Post-fall intervention continues. CP (Care Plan) updated. R2's Care Plan, dated as revised on 9/9/24, documents the following: Focus: (R2) can potentially have a fall incident and may have an injury for being in a new environment, poor safety awareness, history, and recent fall episodes, limited Mobility and weakness. High Fall risk. Interventions include the following: Continue current interventions, Assist Resident with transfers (name brand, non-skid material) in a wheelchair, Visual Cues (sign) hung in Resident's room to remind the Resident to use call light for assistance. On 10/22/24 at 4:55 pm V19, Licensed Practical Nurse (LPN) entered R2's room and confirmed R2's wheelchair had no (name brand non-skid material) in the seat, above or below the wheelchair cushion, R2's wheelchair was not locked as it sat at the side of R2's bed, and there was no visual cue signage hung in residents bedroom room or bathroom to remind R2 to use his call light for assistance. R2 was laying in low bed with call light draped over the head of his bed and within reach. R2 stated to V19 LPN that he used to have a piece of paper on the wall in the bathroom to remind him to push the call button when he needed help, and he didn't know what happened to it. R2 also stated he does not remember ever having a reminder sign in his bedroom. On 10/23/24 at 9:35 am, V2, the Director of Nursing (DON), entered R2's bedroom. R2 was laying in bed. R2's wheelchair was not within reach and sat unlocked, approximately one foot from the footboard of R2's bed. Above and below R2's wheelchair cushion, there was no non-slid material placed (also observed 10/22/24 above). The silky material on the cushion slid easily forward and back on the wheelchair seat. There were still no signs on R2's bathroom or bedroom walls to remind R2 to call for assistance when getting up (as observed on 10/22/24 above). V2, DON confirmed the lack of R2's fall intervention. V2 stated, (R2's) wheelchair needs to be within his (R2's) reach and locked. (R2's) walls will have signs in the bathroom and bedroom, and I will get (non-skid material) in his chair immediately. 3.) R3's Current Diagnoses sheet documents the following: Repeated Falls, Deaf Non-speaking, Acute Respiratory Failure With Hypoxia, and Chronic Respiratory Failure With Hypoxia. R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status score as 14 out of a possible 15, indicating no cognitive impairment. The same MDS documents that R3 has had one fall but no injury since the previous assessment. R3's General Note dated 10/06/2024 at 11:23 am documents the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note Text: Writer was alerted that Resident was on the floor in Resident's bathroom. The writer assessed the Resident. Resident denies pain. Vitals WNL (within normal limits). The Resident stated she slid to the floor and, was not hurt, and did not hit her head. Nurse assessed patient. CNA (Certified Nursing Assistant) and Nurse used (full body mechanical) lift to transfer resident from floor back to the chair. R3's Care Plan revised 10/6/24 document the following: (R3) exhibits self-care deficit and requires assistance with activities of daily living such as bed mobility, transfers, toileting, eating, dressing/grooming, bathing, and personal care needs due to current medical condition. On 10/22/25 at 2:00 p.m., R3 could be seen through a wide-opened door in a shared hall bathroom, standing in front of the toilet. R3 unsteadily and slowly transferred herself to a seated position in her wheelchair. Multiple unidentified staff members passed the opened bathroom door without offering R3 assistance. R3 self-propelled her wheelchair to the hallway. R3 used a communication board as she cannot clearly speak or hear. R3 wrote that she must take herself across the hall to the bathroom because the call light does not come on for staff assistance from her own room. (R3 then points to the light fixture above her bedroom door). R3 then writes on her communication board. I wait and wait, as long as I can hold it. I have to go to the bathroom across the hall. There is more room in that bathroom for me to go by myself. The surveyor attempted to activate R3's bedroom bathroom light. When triggered, R3's bathroom call light did not activate the light above her door. The bathroom was a shared with the room next to R3's room. The light came on above the other bedroom door. There was still no sound activated. V17, the Social Service Director, stopped in the hall outside R3's bedroom door. V17 confirmed the light did not come on above R3's door and did not sound to alert staff of residents' need for assistance. V17 stated V17 would report to the Maintenance department for repair. V17 also stated (R3) takes herself to the bathroom without waiting for staff assistance, and as had several previous falls doing so. On 10/22/24 at 2:08 pm, V16, Certified Nursing Assistant (CNA), was in the hallway, just down from R3's room. V16, stated V16, CNA knows R3 well. R3 is not safe to transfer herself. R3 is unsteady and is supposed to wait for staff assistance. R3 has had many falls. On 10/22/24 at 2:20 pm V15, Licensed Practical Nurse stated (R3) is not supposed to be taking herself to the bathroom. V15 stated, 2:00 pm is a shift change. The staff going by the bathroom should have helped (R3) or let next shift staff know (R3) needed to go to the bathroom. The facility policy Fall Prevention Policy, dated October 2023, documents the following: Policy: * To provide guidelines on preventing Resident falls or injuries. PROCEDURE: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Complete the fall assessment initially on admission and then quarterly. The same policy document: Individualized Care Plan I. Identify the Problem or need 2. State measurable goal 3. Specify Target Date 4. List interventions 5. Provide Resident and family education as appropriate Action Steps 1. Provide ongoing risk-reducing interventions 2. Initiate physician orders as needed 3. Identify and implement related care link interventions 4. Provide ongoing evaluation of resident response to interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31642 Based on record review and interviews, the facility repeatedly failed to maintain complete and accurate resident medical record, by failing to document the application of a physician ordered back brace. This failure affected one of seven residents (R1) reviewed for complete medical records, on the sample list of seven. Findings include: R1's current Diagnoses Sheet documents the following diagnoses: Dementia, and Vertebral fractures. R1's Physician Order Summary Report dated 10/18/24 documents the following: UP with one assist, with gaitbelt and RW (roller walker); TLSO (speciality, back) brace ON when out-of-bed; Increase activity as tolerated. Active (as of) 09/26/2024. R1's Electronic Medication/Treatment Administration Records dated 9/26/24- 9/30/24 (five days) and 10/1/24 - 10/19/24 (19 days) dose not have nurses initials in the administration box to confirm R1's physican order for the TLSO back brace was in place, when R1 was out of bed. On 10/23/24 at 8:25 am V2, Director of Nursing reviewed R1's MAR/TAR and stated I have updated the error in (R1's) back (TLSO) brace order. That was entered incorrectly by the admission nurse (V24). The order had no verification that the nurses were following the order. The nurses will be signing off the physician order for (R1's) brace every shift. Since, it was not documented as applied, I cannot prove it was always on when she (R1) was out of bed. On 10/23/24 at 10:05 am V24, Registered Nurse/Admissions Nurse stated she messed up when entering R1's physician order for the back brace, by failing to make the administration record option, open for the nurses to initial R1's brace was being applied when R1 was out of bed.