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	02/13/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to provide bathing, oral care, and toileting for three (R1, R2, and R4) of four residents reviewed for dependent activities of daily living from a total sample list of four. Findings include: The facility provided Activities of Daily Living Policy dated 7/2024 documents that all residents will have activities of daily living (bathing, oral care, perineal care) provided by nursing staff as needed in accordance with each individual's needs and that it is the responsibility of both the Certified Nursing Assistants and Charge Nurse to ensure that the care is being provided and documented in the electronic health record. 1.) R1's Minimum Data Set, dated dated dated [DATE] documents R1 is severely cognitively impaired. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is totally dependent for bathing, dressing, toileting and oral care. R1's local hospital admission record dated 2/4/25 documents that R1 was admitted to the local hospital with thick hardened oral secretions to the base of tongue and upper palate. R1's medical record documents a bath on 1/27/25 and another on 2/10/25. On 2/10/25 at 12:30PM, R1 was laying in bed with eyes closed and mouth open. R1 appears disheveled with the odor of urine noted and teeth have a white film on them along with R1's tongue. On 2/11/25 at 9:30AM, R1 had an old appearing, wrinkled, undated dressing to her coccyx. Additionally, R1 had bilateral wound dressings of the same kind on her heels covering from the mid foot to mid-calf that appear worn and old. On 2/11/24 at 9:55AM, V7 C.N.A. stated that before R1 went to the hospital on 2/4/25, she found a wad of brown gunk in R1's mouth and that she reported to V8 Licensed Practical Nurse and was told that R1's gums bleed and that it was probably blood, but V7 was not sure how it was handled after that. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/25 at 12:45AM, R1's roommate R2, who is cognitively intact stated that R1 had not been bathed or had her teeth brushed for weeks. R2 stated, (R1) was in a dirty dress for weeks before she went to the hospital, but she can tell them. On 2/11/25 at 4:30PM, V2 Director of Nursing stated that she did not believe that R1 had received a bath since readmission from the hospital on 2/8/25 because the dressings would have been addressed if they had gotten a bath. Additionally, V2 DON stated that she was told by the hospital that R1's oral care was so poor when she arrived at the emergency room , it took a hospital staff member 45 minutes to get R1's mouth properly cleaned. V2 stated that she expected oral care to be provided daily and baths to be given at least weekly. 2.) R2's Minimum Data Set, dated dated dated [DATE] documents that R2 is cognitively intact. R2's Minimum Data Set, dated dated dated [DATE] documents that R2 requires partial assistance with oral care. On 2/10/25 at 1:00PM, R2's teeth were observed to have food in them and appeared spiky and broken. On 2/10/25 at 1:01PM R2 stated that she would like to brush her teeth, but that she doesn't have a toothbrush or toothpaste. On 2/10/25 at 1:30PM, V2 Director of Nursing stated that it is her expectation that oral care is provided daily for residents who need assistance. R2's medical record does not document oral care assistance for R2. 3.) R4's Minimum Data Set, dated dated dated [DATE] documents that R4 is dependent for toileting. The facility provided grievance dated 1/29/25 documents that R4 complained to therapy services that he was saturated in urine, through his brief and gown to his upper back and was left in that condition. The facility response to this grievance dated 1/29/25 was to have staff check to see if R4 is wet, physically. R4's medical record dated 2/11/25 does not document toileting on the 6:00AM-2:00PM shift. On 2/11/25 at 2:55PM observed R4 receive pericare with V11 and V12 Certified Nursing Assistant (CNA). R4's brief was saturated with dark urine and R4 had old, sticky, partially dried feces between his buttocks. V12 CNA stated that based on the amount of urine and state of feces, R4 could not have been changed on the previous shift. V11 CNA stated that given the bed pad was saturated and the urine was cold, she agreed that R4 had not been changed for many hours and that the second floor of the building was out of wipes and wash cloths. On 2/11/24 at 3:00PM, R4 stated that he had not had his brief changed all day. On 2/11/25 at 3:00PM, V2 Director of Nursing stated that her expectation was for incontinent residents to be checked and changed every two hours as needed and that R4's care today was not acceptable.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42702 Based on observation, interview and record review the facility failed to identify, assess, make the appropriate notifications, obtain treatments and interventions for three pressure wounds for one (R1) of four residents reviewed for pressure wounds from a total sample list of four residents. Findings include: The facility provided Skin and Wound Management Guidelines Policy dated 4/2024 documents that upon admission or readmission a complete skin assessment is to be done and documented. If a wound is present on admission, ensure that there is a treatment order, notify the resident's representative, and initiate care plan interventions. The facility provided wound report dated 2/10/25 documents that R1's only wound is a wound on her right middle finger that was identified on 1/30/25. R1's progress notes dated 2/4/25 document that R1 was transferred to the local hospital for a change of condition including decrease consciousness and tachypnea. R1's hospital admission notes dated 2/4/25 document's R1 has stage one to two changes at the coccyx and a stage one pressure ulcer injury to bilateral heels. R1's hospital notes dated 2/6/24 document a pressure ulcer present on right medial coccyx (stage two), right medial gluteal pressure injury (stage two), and a right heel pressure injury (deep tissue). All covered with appropriate dressings. R1's progress notes document return to the facility from the local hospital on 2/8/25. On 2/11/25 at 9:56AM, V8 Licensed Practical Nurse stated that R1 has no wounds at present. On 2/11/25 at 9:30AM observed R1's pericare, performed by V6 and V7 Certified Nursing Assistants (CNA). A large old looking, wrinkled, undated wound dressing was covering R1's coccyx. Underneath the dressing were two, stage two openings approximately the size a of dime and nickel on R1's coccyx and right buttock. Both V6 and V7 CNAs stated that they were unaware of R1 having any opening on her coccyx or buttocks, but had not seen her bare skin in those areas since before she went to the hospital. On 2/11/25 at 9:55AM, V7 C.N.A. stated that she did not know when the wounds occurred or what interventions were being put into place for R1's heels. On 2/11/25 at 10:20AM, V5 Nurse Manager removed the bilateral dressings from R1's feet/ankles. A quarter sized fuchsia colored deep tissue injury was noted on R1's right heel. V5 stated that it was boggy to the touch and that this dressing must have been left over from the hospital. V5 confirmed that there were two stage two wounds on R1's buttocks, and one deep tissue injury on R1's right heel. Additionally, V5 confirmed that there were no interventions put in place for the right heel, no orders for treatments for any of the wounds, nor was the treatment nurse, physician or family notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 6:51PM, V10 Licensed Practical Nurse who readmitted R1 from the hospital on 2/6/25 stated that she did not do a full and complete skin check upon R1's return from the hospital and that she was unaware of any wounds on R1's bottom or heels. On 2/11/25 at 10:40AM, V9 Wound Nurse stated that she was not made aware of R1 having any wounds on her bottom or feet and that staff are expected to do full and complete skin assessments upon return from the hospital including looking under dressings.