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	05/22/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interview and record review, the facility failed to protect a resident right to be free from verbal abuse (R3) by another resident (R2) and failed to protect a resident right to be from physical abuse (R3) by another resident (R2). R2's Facility Census documents R2 was admitted to the facility on [DATE] and has the following medical diagnosis; Spastic Quadriplegic Cerebral Palsy, Seizures, Quadriplegia, Obstructive Sleep Apnea, Anxiety Disorder, Hyperlipidemia, Deficiency of Specified B Group Vitamins, Schizophrenia, Esophagitis without Bleeding, GERD, Insomnia, Functional Quadriplegia, HTN, Depression, Retention of Urine and Personal History of Malignant Neoplasm of Testis. R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview for Mental Status (BIMS) score 6, severe cognitive impairment and is dependent on staff's assistance with Activities of Daily Living. R2's Care Plan dated 6/21/23 documents R2 potential for abuse and neglect due to current cognition, medical condition and physical function. Interventions/ monitor R2 whereabouts, monitor for changes in behavior, notify Medical Doctor and family for any changes in condition, encourage R2 to verbalize any incidents of abuse and neglect and staff to monitor and intervene with any potential or actual acts of abuse and neglect. R2's Incident Note dated 4/23/25 at 4:12 pm documents assessment completed due to R2 to R3 altercation, no redness/bruising noted to right side of face/head. R2 denies any pain/discomfort at this time. 15-minute checks continue at this time. R3's Facility Census documents R3 was admitted to the facility on [DATE] and has the following medical diagnosis; Parkinson's Disease with Dyskinesia, Hemiplegia and Hemiparesis following Cerebral Infraction Affecting Right Dominant Side, Symptoms and Signs Involving Cognitive Functions Following Cerebral Infarction, COPD, Atrial Fibrillation, Shortness of Breath, Long Term Use of Anticoagulants, Chronic Kidney Disease Stage 2, Adult Failure to Thrive, Insomnia, Benign Prostatic Hyperplasia, Anemia, HTN, Paroxysmal Atrial Fibrillation, Rheumatoid Arthritis, Hyperlipidemia, and Chronic Diastolic Heart Failure. R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score 14, cognitively intact and is dependent on staff's assistance with Activities of Daily Living. (continued on next page)

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

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	05/22/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Incident Note dated 4/23/25 at 4:15 pm assessment completed, and no redness/bruising/injuries noted to right hand due to R3 to R2 altercation. R3 denies pain/discomfort at this time. 15-minute checks continue at this time. Facilities Abuse Prevention Policy Program dated February 2025 documents: Purpose: This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ individuals who have been convicted of abusing, neglecting, or mistreating individuals. Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. V7's Licensed Practical Nurse witness statement dated 4/23/25 at 5:00 pm documents V7 was standing at the nurse cart near the nurse's station, when V7 heard R2 yelling. V7 went to the room and just as V7 entered the door, V7 watched R3 quickly wheel up to R2 chair from behind and smack R2 on the right side of the head, open palm. V5 R3's Daughter/Power of Attorney was sitting with V5's hands folded on the side of R3's bed. As V7 pulled R3's chair back to separate them, V5 told V7 that R2 was saying the N-Word. V7 brought R2 to the TV room, which was vacant. There was no more yelling after that. On 5/22/25 at 1:15 pm R3 said, R2 was R3's roommate until last month. R3 said, R2 was yelling out last month while V5 R3's Daughter/POA was visiting. R3 said, R2 yelled out the N-word (slur) and R3 wheeled over to R2 and hit R3 in the head with R3's hand. On 5/22/25 at 1:47 pm V7 Licensed Practical Note said, on 4/23/25 at 2:52 pm V7 was standing at the nurse's medication cart near the nurse's station. V7 said, V7 heard R2 yelling and went to R2 and R3's room. V7 said, as V7 entered into R2's and R3's room, V7 observed R3 quickly wheel up to R2's wheelchair from behind and smack R2 on the right side of the head with an open palm. V7 said, V5 R3's Daughter/Power of Attorney was sitting with her hands folded on the side of R3's bed. V7 said, while V7 was separating R3 and R2, V5 told V7 that R2 was saying the N-word (derogatory).

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	05/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interview and record review the facility failed to report an injury of an unknown origin to the state survey agency for one (R6) of three residents reviewed for injuries in the sample list of 8. Findings include: Facilities Accidents and Incidents Policy dated November 2023 documents. Purpose: To provide staff with guidelines for investigating, reporting, and recording Accidents and Incidents. Policy: All accidents/incidents involving a resident, visitor or volunteer will be investigated, and then recorded in Risk Management of Electronic Health Record. Incident reports will be retained in accordance with State statue of limitations and record retention laws. Procedure: 1. Reporting an Accident and Incident: A. Accident and incidents, including injuries of an unknown origin, must be reported to the department supervisor, and an Accident/Incident Report Form must be completed on the shift the accident/incident occurred. 4. Investigate and follow/up Action: A. The charge nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties. H. The Director of Nursing/Designee will report and accident/incident of major injury to IDPH within 24 hours. R6's Facility Census documents R6 was admitted to the facility on [DATE] and has the following medical diagnosis; Atrial Fibrillation, Severe Protein-Calorie Malnutrition, Major Depressive Disorder, Dementia, Hyperlipidemia, Anemia, Depression, Osteoarthritis, Gastro-Esophageal Reflux Disease, Essential Hypertension and Personal History of Transient Ischemic Attack (TIA), and Infarction without Residual Deficits. R6's Minimum Data Set (MDS) dated [DATE] documents R6's Brief Interview for Mental Status (BIMS) score 6, severe cognitive impairment and is partial/moderate assistance with Activities of Daily Living. R6 Nursing Note dated 4/16/25 at 9:00 am documents R6 observed with significant discoloration at Right Upper Extremity (RUE); area of concern has been measured (11 centimeters x 7 centimeters) and reported to clinical management; awaiting response from Power of Attorney and assigned APRN. R6 denies pain, discomfort or acknowledgement on how area may have developed. V14 Licensed Practical Nurse observed R6's arms equal in alignment to arm rests on wheelchair. R6 received protective sleeves and personal sweater per request. The integrity of arm rests seem within normal limits -no ripping or increased concern for skin shearing. Will continue to monitor. R6's Weekly Skin assessment dated [DATE] documents Right Upper Extremity (RUE) 11.0 centimeters x 7.0 centimeters discoloration. No raised areas or opening skin. Skin intact. R6's Weekly Skin assessment dated [DATE] documents no skin issues. (continued on next page)

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	05/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 1:20pm V14 stated on 4/16/24 at 9:00 am V14 reported R6's bruise to V1 Administrator and V2 Director of Nursing (DON). V14 stated the bruise was noted to R6's Right Upper Extremity (RUE). V14 stated chart the measurements in R6's chart. On 5/22/25 at 1:58 pm, V16 Assistant Director of Nursing (ADON) stated they (facility) assumed R6's injury was based on history of bruising, taking an anticoagulant, and what the nurse (V14) noted in the report. V16 stated they did not consider the bruise to R6's right upper extremity to be an injury of unknown origin and did not report it to Illinois Department of Public Health.