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	07/01/2025

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 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. Based on observation, interview, and record review, the facility failed to report a resident fall to the licensed nurse, directly resulting in a lack notification of the residents physician and family member. This failure affects one resident (R1) out of one reviewed for notifications on the sample list of six. This past compliance occurred from 6/20/25 and 7/1/25. Findings include: On 7/1/25 at 10:39 AM, V3, Family Member and legal Power of Attorney for R1, stated that the facility had not notified her of R1's most recent fall. V3 stated she had found out about R1's fall during a conversation with a friend (unidentified) who worked at the facility. R1's comprehensive Electronic Medical Record did not document any actual recent fall event experienced by R1. R1's Nurses Notes dated 6/20/25 documented facility staff held a care plan conference for R1 attended by V3. R1's Nurses Notes dated 6/21/25 document one post fall neurological check conducted by V15, Licensed Practical Nurse. R1's Assessment record documented further neurological checks beginning with the documented one on 6/21/25 and continuing through 6/25/25, with one additional check on 6/27/25 (date of survey entrance). On 7/1/25 at 2:40 PM, V10, Registered Nurse Manager, stated that V3 had attended the care plan conference on 6/20/25 and questioned why she (V3) had not been notified about R1's fall the day prior to the care plan conference. V10 stated she had questioned the nurse who was on duty (unidentified) at the time of the alleged fall who told V10 that there had been no reported falls from the day referenced (6/19/25). V10 further stated she had checked with the Certified Nursing Assistants (CNA) and did find that V16 CNA had found R1 on the floor and, with assistance form V17 CNA, did pick R1 up from the floor without reporting the fall to the nurse on duty. V10 confirmed there was no documentation in R1's medical record about the actual fall event, only a note in the risk management portion of R1's record (inaccessible to state survey staff). V10 stated she had then reported the incident to the Administrator (V1), and Director of Nursing (V2), who had given a written disciplinary notice to V16, and conducted an investigation into the fall experienced by R1. (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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(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	On 7/1/25 at 2:50 PM, V16, Certified Nursing Assistant, stated she was delivering meal trays to resident rooms and had gone into R1's room to find R1 on the floor by the bed. V16 stated she could not locate the nurse on duty, assumed the nurse was on lunch break, and did seek assistance to pick R1 up from the floor and back into bed. V16 further stated she was busy during the resident supper time into the evening shift and by the time she saw the nurse, had forgotten about R1's fall. During the survey period on 6/27/25 and 7/1/25 first and second shifts, there was a minimum of two licensed nurses on duty on the second floor of the facility, as well as a nurse manager. The facility policy for Accidents and Incidents dated 11/2023 documents accidents and incidents must be reported to the department manager. Employees must report accidents and incidents to their immediate supervisor. The charge nurse must be informed of all accidents and incidents so medical attention can be provided. Employees must summon help by reporting to the nurses station that help is needed, asking someone else to report to the nurses station, or by using the resident call light. On 7/1/25 at 3:27 PM, V1, Administrator, confirmed there is an expectation for staff to report falls to the licensed nurse. V1 stated there has to be a problem before we can identify and correct the problem. V1 then provided a notebook with a plan of correction implemented by the facility prior to the initiation of this survey. Surveyor was able to determine that the facility initiated a plan of correction on 6/20/25 with the following corrective actions: Assembled an Interdisciplinary Team and Quality Assurance plan of action. The plan of action included identification of the problem, an unreported fall. Initiated audits of all resident falls to determine of the fall was reported and documented timely. Implemented an all staff inservice education regarding the facility policies for fall reporting and definitions of a fall. Established a Quality Assurance monitoring system of the conducted audits. Initiated an investigation into the fall circumstances for R1. Assessed R1 for injury, finding none. Monitored R1 for neurological changes, finding none. Administered a written disciplinary warning for V16. The facility continued with their auditing of resident falls from 6/20/25 through 7/1/25 (date of survey exit).

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility staff failed to report a resident fall to the licensed nurse, directly resulting in a lack of a licensed nurse completing a nursing assessment and a neurological assessment prior to picking the resident up from the floor. This failure affects one resident (R1) out of one reviewed for fall reporting on the sample list of six. This past compliance occurred from 6/20/25 and 7/1/25. Findings include: On 7/1/25 at 2:40 PM, V10, Registered Nurse Manager, stated R1 did experience a fall on 6/19/25. V10 stated she had only found out about the fall because V3, Family Member of R1, had attended a care plan conference on 6/20/25 and made an inquiry as to why she (V3) was not notified of R1's fall the day prior to the care plan conference. V10 stated she had found that V16, Certified Nursing Assistant, had picked R1 up from the floor without notifying the licensed nurse. On 7/1/25 at 2:50 PM, V16 stated she had gone into R1's room to deliver a meal tray and found R1 on the floor by the bed. V16 stated she could not locate the licensed nurse on duty and, assuming the nurse was on meal break, had sought the assistance of V17, Certified Nursing Assistant, to pick up R1 from the floor and back to the bed. During the survey period on 6/27/25 and 7/1/25 first and second shifts, there was a minimum of two licensed nurses on duty on the second floor of the facility, as well as a nurse manager. The facility policy for Accidents and Incidents, dated 11/2023, documents the charge nurse must be notified of all accidents and incidents so medical attention can be provided. Summon assistance from the nurses station or use the call light for assistance. Do not move the victim until he/ she has been examined for injuries. The charge nurse shall examine all accident or incident victims. On 7/1/25 at 3:27 PM, V1, Administrator, confirmed there is an expectation for staff to report falls to the licensed nurse and to not pick residents up from the floor until a licensed nurse assesses the resident. V1 stated there has to be a problem before we can identify and correct the problem. V1 then provided a notebook with a plan of correction implemented by the facility prior to the initiation of this survey. Surveyor was able to determine that the facility initiated a plan of correction on 6/20/25 with the following corrective actions: Assembled an Interdisciplinary Team and Quality Assurance plan of action. The plan of action included identification of the problem, an unreported fall. Initiated audits of all resident falls to determine of the fall was reported and documented timely. Implemented an all staff inservice education regarding the facility policies for fall reporting and definitions of a fall. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Established a Quality Assurance monitoring system of the conducted audits. Initiated an investigation into the fall circumstances for R1. Assessed R1 for injury, finding none. Monitored R1 for neurological changes, finding none. Administered a written disciplinary warning for V16. The facility continued with their auditing of resident falls from 6/20/25 through 7/1/25 (date of survey exit).