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	09/03/2025

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 Interview, Observation and Record Review the facility failed to notify the physician and power of attorney for an incident of elopement for one (R7) of three residents reviewed for elopement on a sample list of nine. On 9/2/2025 at 12:37PM, V10 Licensed Practical Nurse (LPN) stated V10 did not complete an assessment, notify R7's physician or family, and didn't follow the Facilities Missing Resident Policy for R7's elopement from the facility on 8/31/25. On 9/2/2025 at 1:10PM, V1 Administrator stated he was unaware of the situation that had occurred with R7 as it wasn't reported to V1 and V1 just initiated an investigation into the incident. Video surveillance was viewed with V1 at this time. On 8/31/25 between 8:55 AM and 9:07 AM, R7 left the facility through the southwest alarmed door of the memory care unit walking across the parking lot and grass lot, towards a church located next to the facility. R7 was found by V18 (R9's Family) at the church, which is located approximately a football distance away from the facility door. At 9:10 AM, V10 Licensed Practical Nurse was alerted by V18 and was observed going to get R7 in the parking lot of the church. V1 stated that no notification to the medical director, power of attorney, and green code was completed, as V1 is still investigating the failure. On 9/2/2025 at 2:35pm, V2 (Director of Nursing), stated V2 received a call around 9:15AM on 8/31/25 from V10 stating that R7 had left of the memory care unit of the facility and was next door in the church parking lot, and V2 informed V10 to chart that R7 was exit seeking. On 9/3/2025 at 9:15AM, V21 Nurse Practitioner stated that there was no communication provided from the facility about R7's elopement. The Facilities Missing residents Policy Revised on 1/23 is to provide facility staff with guidelines for ensuring the health, safety and welfare of all residents, and protocol to be followed when a resident is noted to be missing. This policy also documents that should an employee discover that a resident is missing from the facility, he/she should: Determine if the resident is out on an authorized leave or pass, Announce a Code green three times consecutively. Make a thorough search of the building and premises. If the resident is not located within 15 minutes the charge nurse will report the incident to the shift supervisor who will direct additional staff to search the premises outside of the facility. The residents attending physician will be notified. This policy also documents that upon return of the resident the facility, should announce a code [NAME] is all clear, examine the resident for injuries, contact the attending physician and report what happened, take orders pertaining to the resident condition and follow through as indicated. Contact the resident's legal representative and inform him/her of the incident. Complete and file an incident report, make appropriate notations in the medical record, reflecting all facts induing specific times, time discover, time of notification, local police, administrator.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor and report changes in condition, including monitoring and reporting blood pressures, daily weights, and urination for two of five residents (R1, R2) reviewed for changes in condition in the sample list of nine. These failures resulted in a delay in treatment for R1's changes in condition, R1 was hospitalized with congestive hyponatremia (low sodium), acute kidney injury (AKI), renal failure, urinary tract infection (UTI), and required dialysis. The facility's Physician Notification of Resident Change of Condition policy dated [DATE] documents the Director of Nursing (DON) is responsible for monitoring the 24-hour report to ensure physicians are notified of changes in condition. This policy documents when there is a change in resident condition, the nurse must assess the resident, document the change in the resident's medical record, notify the resident's physician, and place the resident on the 24-hour report to ensure close monitoring of the condition on each shift.1.) R1's hospital Discharge summary dated [DATE] documents R1 was hospitalized for cystitis with hematuria, AKI, Acute on chronic respiratory failure, Pneumonia, Myocardial Infarction, Severe Sepsis, Pulmonary Edema, elevated B-Type Natriuretic Peptide, UTI and Acute Heart Failure. R1's Blood Urea Nitrogen (BUN) was 47 and Creatinine (Cr) was 1.8 on [DATE]. R1's Minimum Data Set, dated [DATE] documents R1 as cognitively intact and required supervision/touch assistance from staff for toileting hygiene and partial/moderate staff assistance for toilet transfers. R1's Care Plan dated [DATE] documents R1 receives diuretic therapy, monitor for side effects and effectiveness, observe/document/report adverse reactions including postural hypotension, report lab results to the physician, especially Sodium and Potassium. R1's [DATE] Medication Administration Record (MAR) documents R1's daily weight (pounds) as 144.9 on [DATE], 145 on [DATE], 148.8 on [DATE], 150.2 on [DATE], 149 on [DATE] and 149.6 on [DATE]; and to notify of three-pound gain in 24 hours or five-pound gain in one week. This MAR documents R1 received the following medications: Amlodipine 10 milligrams (mg) one tablet by mouth (PO) daily 8/13-[DATE] when changed to half a tablet daily. Lasix 20 mg PO daily, Isosorbide Mononitrate Extended Release (ER) 120 mg PO daily, Lisinopril 20 mg PO daily and Metoprolol Succinate ER 50 mg twice daily [DATE]-[DATE]. R1's Physician Orders dated [DATE] document to notify if no urinary output for eight hours, and reporting parameters for systolic blood pressure less than 100.R1's Urinary Continence report dated [DATE]-[DATE] documents R1 as continent/incontinent once on [DATE], [DATE], [DATE], [DATE], and twice on [DATE], [DATE], and [DATE]. This report does not document the number of times R1 urinated or the amount. R1's blood pressure log documents R1's blood pressures as follows:[DATE] at 4:02 PM 90/43 [DATE] at 5:21 PM 90 / 42 [DATE] at 4:24 PM 79 / 29 [DATE] at 2:52 PM 95 / 47 [DATE] at 7:36 AM 89 / 34 [DATE] at 11:04 PM 91 / 35 [DATE] at 11:10 PM [DATE]/2025 at 8:34 PM 91 / 39 [DATE] at 1:25 AM 149 / 49 [DATE] at 7:31 PM 138 / 71R1's Progress Note dated [DATE], recorded by V21 Nurse Practitioner, documents to continue daily weight and will recheck Basic Metabolic Panel (BMP). There is no documentation that a BMP was collected prior to [DATE]. The Coverage On-Call Note dated [DATE] at 10:29 PM documents nurse contacted V20 Nurse Practitioner to report that R1 reports she had not urinated for two days, and R1 had been eating/drinking well with fluids encouraged. This note documents V21 ordered Urinalysis with culture and sensitivity this morning, but the nurse did not think this was completed. This note documents to straight catheterize to obtain urine sample and if greater than 300 cubic centimeter of urine return then leave the catheter inserted. R1's Progress Note dated [DATE], recorded by V21, documents R1 reported having minimal urine output for the last couple of days, R1's BUN was 76 and Cr was 6.2 on [DATE], will send R1 to the emergency room for further evaluation and treatment. R1's Nursing Notes document the following: -[DATE] at 7:36 AM R1 reported scanty urine overnight and was concerned she may be developing UTI. A request for straight catheterization and urinalysis was sent via electronic facsimile to V28 Physician. -[DATE] at 6:47 AM R1's urinalysis/culture and sensitivity order note, will collect on Sunday shift for lab to pick up Monday morning. [DATE] at 7:39 PM due to lab schedule, will collect tomorrow. [DATE] at 12:24 AM due to lab schedule, collect tomorrow.- [DATE] at 1:40 PM R1 urinated twice this shift and had removed the collection hat from the toilet, and the second time urine sample obtained by clean catch, but was contaminated with bowel movement. Urine sample to be collected and picked up on Monday. - [DATE] at 10:05 PM R1 voided in collection hat, but urine was contaminated with bowel movement. R1 also voided in the shower, but was unable to collect sample. R1 was unable to void again at this time. -[DATE] at 5:20 AM R1 had minimal urine in collection hat, missed hat. -[DATE] at 1:13 PM Unable

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to use foot pedals during wheelchair transportation for two of four residents (R3, R4) reviewed for accidents in the sample list of nine residents. This failure resulted in R3's right leg contacting the floor causing ankle fractures. The facility also failed to supervise a cognitively impaired resident (R7) at risk for elopement, which resulted in R7 leaving the facility's property unnoticed. R7 was one of three residents reviewed for elopement in a sample list of nine. 1.) On 8/27/25 at 9:30 AM, R3 was sitting in her wheelchair in her room. R3's right leg was in a splint and elevated on the wheelchair leg rest. R3 stated that V3 Physical Therapy Assistant was pushing R3 in a wheelchair down to the therapy gym, R3's feet were sticking out and the wheelchair did not have foot pedals. R3 stated R3 had difficulty holding her legs up, R3's right foot went underneath of R3 causing R3's ankle to roll or twist and R3 screamed out in pain. R3 stated R3 has two broken ankle bones because of that incident. R3 stated R3 had right knee replacement surgery on 7/23/25, V29 (Podiatrist) applied R3's leg splint yesterday and told R3 that she could either choose to have surgery or go four to six weeks non-weight bearing without surgery. R3 stated R3 has a follow up orthopedic appointment next week to determine if there was any damage to R3's right knee. R3 stated R3 has not had any other falls or incidents that could have caused the injury. R3 stated R3 admitted to the facility for rehab and planned to return home, but now R3's recovery will take longer. R3's Minimum Data Set, dated [DATE] documents R3 as cognitively intact and has impaired range of motion to one lower extremity. R3's Care Plan active care plan documents R3 admitted to the facility following right knee arthroplasty (knee replacement), R3 has decreased functional ability and fatigue, and requires wheelchair for long distance transportation. R3's Incident Report dated 8/22/25 at 9:30 AM documents the following: R3 was assisted in wheelchair by staff while R3 was holding leg up with immobilizer in place. As R3 went over the threshold, R3 dropped her leg causing her foot to drop to the ground and R3 complained of pain after therapy. R3 reported that R3 thought she could make it to the therapy gym without wheelchair foot pedals, but by the time R3 made it to the threshold of the gym, R3 was too weak to hold her leg up causing her leg to drop. R3's right ankle portable x-ray dated 8/22/25 documents acute nondisplaced medial malleolus fracture of right ankle. R3's emergency room right ankle x-ray dated 8/23/25 documents R3 has severe osteopenia (low bone mineral density), R3 had Subtle linear lucencies noted through the medial and lateral malleoli suspicious for acute nondisplaced fractures and soft tissue swelling. R3's emergency room Note dated 8/22/25 at 11:09 PM documents R3 presented for ankle pain after being pushed in a wheelchair to therapy while R3's right knee was in immobilizer and without wheelchair foot pedals. R3 reported R3 was unable to hold her right leg up, her leg dropped and her foot/ankle bent underneath the wheelchair causing significant pain, [NAME], and bruising. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Progress Note dated 8/26/25, recorded by V29 Podiatrist, documents R3 was evaluated for right nondisplaced medial and lateral malleoli fractures. Treatment options were discussed and included fracture fragments are in anatomical alignment, given R3's age and limited ambulatory status related to knee replacement, conservative therapy would be an option, which would consist of four to six weeks of non-weight bearing followed by 4 weeks of weight-bearing in a boot prior to transitioning to ankle brace. Risk associated with this include continued instability of the ankle joint requiring of surgical intervention in the future and with R3's osteopenia, healing may take longer. Surgical intervention option would include fixation of the fractures to the right lower extremity, with weight-bearing pivot status approximately two weeks post-surgery, and full weight-bearing with boot for 4 weeks to transition back into an ankle brace. Associated risks include infection, pain, and need for additional surgery. R3 wanted to think about the treatment options before making a decision at this time. On 8/27/25 at 10:14 AM, V3 stated V3 was pushing R3 in a wheelchair down to the therapy gym, R3's right leg dropped as they crossed the threshold causing R3's ankle to turn. R3's right leg was in an immobilizer and there were no foot pedals on the wheelchair. V3 stated there were foot pedals in R3's room, but V3 did not apply them prior to transporting R3 to the gym. V3 confirmed the use of foot pedals would have prevented R3's leg from dropping. V3 stated the facility did an in-service and now everyone should have footrests on when being transported in a wheelchair by staff, and if they don't have footrests on, we are to ask the resident to self-propel their wheelchair rather than transporting them. On 8/27/25 at 2:05 PM, V2 Director or Nursing stated osteopenia is an underlying contributing factor, and V3 pushing R3 in a wheelchair without foot pedals, causing R3 to hold her legs up, caused R3's ankle fractures. V2 stated the facility does not have a policy regarding wheelchair transportation or use of foot pedals. V2 stated V2 expects foot pedals to be used whenever staff are pushing residents in a wheelchair long distances, otherwise the staff should have the resident self-propel their wheelchair. On 9/3/25 at 8:45 AM, V21 Nurse Practitioner stated on 8/22/25 R3 had ice on her ankle when V21 evaluated R3. R3 told V21 that her foot got caught underneath the wheelchair while staff transported her to therapy. V21 stated R3 did not have any complaints of ankle pain prior and had admitted post right knee replacement. V21 stated an x-ray was ordered and confirmed R3's ankle fractures. V21 stated it depends on the angle R3's foot/ankle got caught on whether this incident caused R3's fractures. V21 stated R3's right leg is weak due to post knee replacement, and staff should have used the footrests, which could have prevented R3's injury. 2.) On 8/27/25 at 9:23 AM, V13 Certified Occupational Therapy Assistant transported R4 in a wheelchair without foot pedals, down the hallway, past the nurses' station and into R4's room which was near the end of the hall. R4's feet were approximately two inches off of the floor. On 8/27/25 at 9:27 AM V13 stated R4 broke her clavicle from a fall prior to admitting to the facility and R4 is receiving physical and occupational therapy. V13 confirmed there were no foot pedals on R4's wheelchair and there should be. V28 stated V28 is going to have to get R4 foot pedals, and foot pedals should be used when transporting a resident in a wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/27/25 at 9:49 AM R4 was lying in bed with a sling to her right arm. R4 stated R4 had fallen prior to admitting to the facility due to low blood sugar and broke her collar bone. R4 stated R4 doesn't have foot pedals on her wheelchair and R4 has to hold her feet up during transportation. There were no foot pedals in R4's room or on R4's wheelchair at this time. 3.) The Facilities Missing residents Policy Revised on 1/23 is to provide facility staff with guidelines for ensuring the health, safety and welfare of all residents, and protocol to be followed when a resident is noted to be missing. Each Unit Charge Nurse, during their respective tour of duty will be aware and responsible for always knowing the location of their residents. Nursing must report and investigate all reports of missing residents. This policy also documents that should an employee discover that a resident is missing from the facility, he/she should: Determine if the resident is out on an authorized leave or pass, Announce a Code “green” three times consecutively. Make a thorough search of the building and premises. If the resident is not located within 15 minutes the charge nurse will report the incident to the shift supervisor who will direct additional staff to search the premises outside of the facility. The residents attending physician will be notified. This policy also documents that upon return of the resident the facility, should announce a code [NAME] is all clear, examine the resident for injuries, contact the attending physician and report what happened, take orders pertaining to the resident condition and follow through as indicated. Contact the resident's legal representative and inform him/her of the incident. Complete and file an incident report, make appropriate notations in the medical record, reflecting all facts induing specific times, time discover, time of notification, local police, administrator. On 9/2/25 at 11:08AM, R7 was wandering around the memory care unit walking up to the doors and windows and looking outside. On 9/2/2025 at 12:37PM, V10 Licensed Practical Nurse reenacted how R7 left the building through the door in the memory care unit. V10 stated that she had left to go to break around 8:55AM and when she returned around 9:08AM, V18 (R9's Family) had come into the facility and told V10 that V18 thought a resident was in the church parking lot. V10 stated V10 ran outside, R7 was in the church parking lot and V10 called V2 Director of Nursing to report the situation. V10 did not complete an assessment, notify the Medical Director or the Power Attorney and didn't follow the Facilities Missing Resident Policy regarding R7's elopement from the facility on 8/31/25. On 9/2/2025 at 1:10PM, V1 Administrator stated he was unaware of the situation that had occurred with R7 as it wasn't reported to V1 and V1 just initiated an investigation into the incident. Video surveillance was viewed with V1 at this time. On 8/31/25 at between 8:55 AM and 9:07 AM R7 left the facility through the southwest alarmed door of the memory care unit walking across the parking lot and grass lot, towards a church located next to the facility. R7 was found by V18 (R9's Family) at the church, which is located approximately a football distance away from the facility door. At 9:10 AM V10 Licensed Practical Nurse was alerted by V18 and was observed going to get R7 in the parking lot of the church. V1 stated that no notification to the medical director, power of attorney, and green code was completed, as V1 is still investigating the failure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's minimum data set documented on 7/1/25 documents R7 is cognitively impaired. There is no documentation in R7's medical record that R7's elopement risk was reassessed after this incident or that new interventions were developed and implemented to address R7's elopement and exit seeking behavior. The last recorded Elopement Risk Assessment in R7's medical record is dated 7/6/25 and documents R7 as low risk. R7's active care plan documents the problem area elopement/risk wandering related to Dementia was not revised after R7's elopement until 9/3/25. On 9/2/2024 at 2:35pm, V2 Director of Nursing stated she received a call around 9:15am on 8/31/25 from V10 stating R7 had got out of the building and was next door in the church parking lot. On 9/3/2025 at 9:10AM, V21 (Nurse Practitioner) stated that there was no communication provided to any of the Physician On Call encounters from the facility about R7's elopement. V21 stated R7 has a history of Asthma, has a shuffled gait, and is at high risk for falling. V21 stated if V21 had been notified, she would have put in an intervention for increased monitoring or one to one supervision.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to transcribe physician's orders for one of four residents (R3) reviewed for accidents in the sample list of nine. On 8/27/25 at 9:30 AM, R3 was sitting in her wheelchair in her room. R3's right leg was in a splint and elevated on the wheelchair leg rest. R3 stated that V3 Physical Therapy Assistant was pushing R3 in a wheelchair down to the therapy gym, R3's feet were sticking out and the wheelchair did not have foot pedals. R3 stated R3 had difficulty holding her legs up, R3's right foot went underneath of R3 causing R3's ankle to roll or twist and R3 screamed out in pain. R3 stated R3 has two broken ankle bones because of that incident. R3's right ankle x-ray dated 8/23/25 documents R3 has severe osteopenia (low bone mineral density), R3 had Subtle linear lucencies noted through the medial and lateral malleoli suspicious for acute nondisplaced fractures and soft tissue swelling. R3's emergency room Note dated 8/22/25 at 11:09 PM documents R3 presented for ankle pain after being pushed in a wheelchair to therapy while R3's right knee was in immobilizer and without wheelchair foot pedals. R3 reported R3 was unable to hold her right leg up, her leg dropped, and her foot/ankle bent underneath the wheelchair causing significant pain, swelling, and bruising. R3's Progress Note dated 8/26/25, recorded by V29 Podiatrist, documents R3 was evaluated for right nondisplaced medial and lateral malleoli fractures, treatment options were discussed, including R3's osteopenia which may delay healing. This note documents an order for Vitamin D3 2000 units daily. R3's August and September 2025 Medication Administration Records document as of 8/6/25 R3 receives Os-Cal Calcium plus D3 500 milligrams (mg) - 5 micrograms (200 units of vitamin D3) one tablet by mouth daily and PreserVision multivitamin with minerals two tablets by mouth twice daily. As of 9/3/25, the order for Vitamin D3 2000 units had not been transcribed or implemented. On 9/3/25 at 10:00 AM, V2 Director of Nursing stated the facility does not receive any communication of new orders or progress notes after R3's orthopedic/podiatry appointments. V2 stated these progress notes have to be obtained from (electronic health records software). V2 confirmed R3's order for Vitamin D3 2000 units ordered on 8/26/25 by V29. V2 stated R3 receives a multivitamin and Os-cal, which provides less than 2000 units of Vitamin D3 daily. V2 stated V2 will implement the order today.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to administer medications as ordered resulting in significant medication errors for one of five residents (R2) reviewed for changes in condition in the sample list of nine. R2's hospital discharge orders dated 7/22/24 include orders for Metoprolol Succinate (cardiac medication) Extended Release 12.5 milligrams (mg) by mouth (PO) daily, Midodrine (treats low blood pressure)10 mg PO three times daily, and Novolog insulin per blood glucose-based sliding scale three times daily before meals. R2's July 2025 Medication Administration Record documents R2's Metoprolol, Midodrine, and Novolog insulin were stopped on 7/23/25 and R2 did not receive any doses of these medications after the morning dose on 7/23/25 prior to being hospitalized on the evening of 7/24/25. There is no documentation in R2's medical record as to why these medications were stopped or that the physician was notified of the missed doses. On 9/3/25 at 10:00 AM, V25 Assistant Director of Nursing stated on 7/23/25, V25 thought R2 was still in the hospital and did a batch order discontinuing R2's medications. V25 stated later that day V25 resumed R2's orders, but with batch orders not all of the orders pop up if they are too close to the next scheduled dose, so not all of R2's medication orders were resumed. V25 confirmed R2's missed doses of Midodrine, Metoprolol and Novolog insulin between 7/23/25 and 7/24/25. V25 stated these medications would be considered significant with missed doses as medication errors, but there was no negative impact on R2.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure medical records are complete and accurate for four of seven residents (R1, R2, R3, R7) reviewed for changes in condition and elopement in the sample list of nine. The facility's Content of the Medical Record policy dated August 2017 documents the Administrator is responsible for ensuring medical records are maintained according to regulations and guidelines. This policy documents medical records should include documentation of resident care, observations, assessments and changes in condition. This policy documents physician and consultant visits should be recorded at the time of each visit. 1.) R1's 8/13/25 and 8/19/25 Provider Progress Notes with print date 9/2/25 were provided by V2 Director of Nursing (DON) on 9/2/25. These visit notes were not uploaded into R1's Electronic Medical Record (EMR). On 9/3/25 at 10:00 AM, V2 and V25 both confirmed provider progress notes are not consistently uploaded into each resident's EMR, including R1, R2, and R3. V2 stated these notes have to be pulled off of (electronic health record system), which the floor nurses do not have access to, only the nurse managers have access. 2.) R2's 7/11/25, 7/22/25 and 7/23/25 Provider Progress Notes with print date of 9/2/25 were provided by V2 on 9/2/25. These visit notes were not uploaded into R2's EMR. On 9/2/25 at 2:07 PM, V25 stated the providers enter notes in (electronic health record system) which the floor nurses do not have access to. V25 confirmed R2's Provider Progress Notes were obtained from (electronic health record system) and not included in R2's EMR. 3.) R3's 8/22/25 Provider Progress Note with print date 8/27/25, recorded by V21 Nurse Practitioner, documents at the time of visit R3 was sitting in a wheelchair with ice on her right ankle, and her ankle had mild swelling. This note documents R3 reported that R3's right leg was caught on the doorway causing R3 pain after this incident. V21 ordered an x-ray. This note was provided by V2 on 8/27/25 and was not uploaded into R3's EMR. R3's Incident Report dated 8/22/25 documents R3 was in a wheelchair propelled by staff. There were no foot pedals on R3's wheelchair. R3 was holding R3's leg up, which was in an immobilizer as R3's wheelchair crossed the threshold R3's leg dropped, and foot contacted the ground. This incident is not documented in R3's EMR. On 8/27/25 at 2:05 PM, V2 stated incidents are documented on an incident report which links to a nursing note in the resident's medical record. V2 confirmed R3's incident was not documented in R3's EMR. (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	09/03/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) On 9/2/2025 at 1:10PM, V1 Administrator stated he was unaware of the situation that had occurred with R7 as it wasn't reported to V1 and V1 just initiated an investigation into the incident. Video surveillance was viewed with V1 at this time. On 8/31/25 between 8:55 AM and 9:07 AM, R7 left the facility through the southwest alarmed door of the memory care unit walking across the parking lot and grass lot, towards a church located next to the facility. R7 was found by V18 (R9's Family) at the church, which is located approximately a football distance away from the facility door. At 9:10 AM, V10 Licensed Practical Nurse was alerted by V18 and was observed going to get R7 in the parking lot of the church. V1 stated that no notification to the medical director, power of attorney, and no green code was completed, as V1 is still investigating the failure. R7's 8/31/25 Nursing Progress notes documents R7 was exit seeking. There is no documentation in R7's medical record that R7 eloped from the facility on 8/31/25 or what steps were taken after R7's elopement and return to the facility. On 9/2/2025 at 12:37PM, V10 confirmed V10 did not follow the facility's missing resident policy and did not document R7's elopement incident in R7's medical record. On 9/2/2024 at 2:35pm, V2 (Director of Nursing) stated V2 received a call around 9:15AM on 8/31/25 from V10 stating R7 had left the building and was found next door in the church parking lot. V2 stated V2 told V10 to chart that R7 was exit seeking. The Facilities Missing residents Policy Revised on 1/23 is to provide facility staff with guidelines for ensuring the health, safety and welfare of all residents, and protocol to be followed when a resident is noted to be missing. Each Unit Charge Nurse, during their respective tour of duty will be aware and responsible for always knowing the location of their residents. Nursing must report and investigate all reports of missing residents. This policy also documents that should an employee discover that a resident is missing from the facility, he/she should: Determine if the resident is out on an authorized leave or pass, Announce a Code “green” three times consecutively. Make a thorough search of the building and premises. If the resident is not located within 15 minutes the charge nurse will report the incident to the shift supervisor who will direct additional staff to search the premises outside of the facility. The residents attending physician will be notified. This policy also documents that upon return of the resident the facility, should announce a code [NAME] is all clear, examine the resident for injuries, contact the attending physician and report what happened, take orders pertaining to the resident condition and follow through as indicated. Contact the resident's legal representative and inform him/her of the incident. Complete and file an incident report, make appropriate notations in the medical record, reflecting all facts induing specific times, time discover, time of notification, local police, administrator.