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	11/24/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely report daily weight changes for congestive heart failure to the physician for one of three residents (R3) reviewed for changes in condition in the sample list of nine. This failure resulted in R3 admitting to the intensive care unit for acute on chronic respiratory and heart failure requiring intravenous diuresis related to fluid retention. Findings include:R3's Minimum Data Set, dated [DATE] documents R3 as cognitively intact. R3's active care plan revised 11/6/25, documents R3 has congestive heart failure (CHF) and includes an intervention for daily weight monitoring and to notify the physician with weight fluctuations as ordered. R3's November 2025 Medication Administration Record documents the following: R3 receives Torsemide (diuretic) 20 milligrams (mg) by mouth daily. No additional doses were given prior to a one time dose of 40 mg on 11/11/25. Obtain daily weight before breakfast and report gain of 3 pounds (lb) in 24 hours or 5 lbs in one week related to Congestive Heart Failure. R3 weighed 355 lbs on 11/1, 11/2, and 11/8. R3 weighed 394.6 lbs (39.6 lb gain) and 393.5 lbs. There is no documentation in R3's medical record that a provider was notified of R3's weight gain until 11/11/25 or that R3 was assessed/monitored for CHF symptoms such as edema after 11/9/25, besides routine vital signs and pulse oximetry (SPO2). R3's Situation Background Assessment and Recommendation (SBAR) Communication Form dated 11/11/25 at 3:36 PM documents R3 was lethargic (sluggish), pale, and sleeping on and off throughout the shift. R3 had edema (swelling) to both arms and left leg. R3 also had low Hemoglobin contributing to lethargy. These symptoms were reported to V15 Nurse Practitioner at 11:00 AM and new orders were given for an additional one time dose of Torsemide 40 mg for fluid retention. R3's Change in Condition note dated 11/11/25 at 3:26 PM documents V15 also gave orders to monitor vital signs every hour for the next four hours and apply R3's continuous positive airway pressure (CPAP) for oxygen therapy while resting in bed. R3's vitals were monitored and CPAP applied with no significant changes noted. R3's Nursing Note dated 11/11/25 at 5:38 PM documents V15 was updated on R3's change in condition and ordered for R3 to transfer to the hospital. R3's Intensive Care Unit (ICU) History & Physical Note dated 11/11/25 at 8:32 PM documents R3 presented to the emergency room for evaluation of progressive shortness of breath and over 35 lb weight gain over the past several days. R3 was found to be hypoxic with oxygen at 3 liters per nasal cannula and was placed on bilevel PAP. R3's chest x-ray showed pulmonary vascular congestion and R3 was given intravenous (IV) furosemide 40 mg in the emergency room and was admitted to the ICU for ongoing need for noninvasive ventilation and close monitoring and management of acute on chronic hypercapnic, hypoxemic respiratory failure. R3's assessment includes acute on chronic respiratory failure with diuresis treatment; and acute heart failure exacerbation with IV furosemide 40 mg three times daily, strict intake/output monitoring, and daily weights. On 11/21/25 at 9:27 AM R3 stated R3 just got back from the hospital and she was hospitalized due to retaining fluid. On 11/24/25 at 12:10 PM V3 Director of Nursing (DON) stated V3 thought the provider was notified of R3's weight gain before 11/11/25 since R3 had such a significant weight gain we obtained reweights to ensure the weight was accurate. V3 stated physician notification would be documented in a progress note. At 1:50 PM V3 provided a copy of a facsimile (fax) letter dated 11/10/25 notifying V15 of R3's weight (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	gain. This letter did not document receipt of confirmation or that it was reviewed by V15, confirmed with V3. V3 stated this was the only documentation V3 could locate for R3's weight gain notification. V3 stated V3 also spoke with V15 who said that V15 never received the facsimile notification. At 3:15 PM V3 stated CHF symptom monitoring would be documented on the Medication/Treatment Administration Records and sp02 monitored, if spo2 was abnormal this would prompt for a full respiratory assessment documented in nursing note. V3 confirmed this does not include monitoring for edema. V3 stated the Nurse Practitioners gave the facility a list of things they want to be called about and a list of things to fax, and weight gain is not something they want to be called about. V3 stated the Nurse Practitioners have someone that reviews the faxes, but we don't always receive anything back to confirm they reviewed the information that was sent. On 11/24/25 at 1:00 PM V18 Registered Nurse stated V18 had compared R3's weight on 11/10/25 to the day prior and it was the same, so V18 did not notify the provider. V18 stated V3 DON had staff obtain R3's reweights and V18 was unsure if the provider was aware of R3's weight gain. V18 thought someone had sent a message to V15's office. On 11/24/25 at 1:41 PM V15 stated no one notified V15 of R3's weight gain until 11/11/25, staff should have been following the daily weight CHF protocol and should have notified V15 sooner. V15 stated V15 would have doubled R3's Torsemide dosage for a few days then had Basic Metabolic Panel drawn after the last dose was given. V15 stated on 11/11/25 R3 was lethargic, R3's left arm was swollen and abdomen was distended/stretched, and R3 was not wearing her CPAP. V15 gave orders for a one time dose of Torsemide 40 mg and to reweigh R3 because V15 suspected an error with the weight, but it was confirmed with V17 Assistant at 5:00 PM that R3's weight was accurate. V15 stated R3 was hospitalized for fluid retention and required intravenous diuretics. V15 stated R3's hospitalization could have been prevented if staff had reported R3's weight gain sooner. The facility's Acute Condition Changes Clinical Protocol dated October 2025 documents prior to notifying the physician of acute changes in condition, the nurse will make observations and gather information to report to the physician, and will utilize the SBAR assessment when appropriate. This protocol documents for emergencies staff will call or page the physician and request a prompt response and the physician/practitioner will respond in a timely manner to notifications of changes in condition. This protocol documents many acute changes in condition can be effectively managed at the facility with outcomes comparable to hospitalization.