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	03/05/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Failures at this level required more than one deficient practice statement.A. Based on observation, interview, and record review the facility failed to maintain call lights accessible for resident use. This failure affects five of five residents (R1, R2, R11, R64, R97) reviewed for call lights on the sample list of 62.B. Based on observation, interview, and record review, the facility failed to ensure an electric bed remained consistently functional to maintain a resident's toileting independence. This failure affects one resident (R155) of ten reviewed for accommodation of needs in the sample list of 62. Findings Include: A. The facility's Call Lights policy dated January 2026 documents when a resident is in bed or in a chair, staff are to ensure the call light is within easy reach of the resident. On 3/1/26 between the hours of 11:00 AM and 12:00 PM R1, R2, R11, R64, and R97 were observed in their rooms without accessibility to their call light. Call lights were found on the floor or in areas not accessible to the residents. 1. On 3/1/26 at 11:42 AM R1 was in her room in her wheelchair. The room smelled of bowel movement and R1 stated she was soiled and needed to be changed. She had been waiting awhile for staff but did not have her call light. R1's call light was coiled up on the floor out of her reach. R1's Care Plan dated 1/28/26 documents R1 has a self care deficit related to Intellectual Disability, Impaired Mobility, Poor Safety Awareness, and Bowel and Bladder Incontinence. Staff are to encourage R1 to use the call light for assistance. R1 is also at risk for falls related to Deconditioning, Gait/Balance Problems, Syncope, Legally Blind in the Left Eye, Poor Safety Awareness and Impulsivity. Staff are to keep call light within R1's reach. 2. On 3/1/26 at 11:55 AM R2 was in her room in her wheelchair. R2 stated she needed some fresh ice water. R2 stated she would use her call light but couldn't reach it. R2's call light was hanging over a folded fall mat just out of her reach. R2's Care Plan dated 1/23/26 documents R2 is at risk for falls related to Impaired Cognition due to Dementia. Staff are to educate R2 to use her call light for assistance and keep call light within reach. 3. On 3/1/26 at 11:05 AM R11 was sitting on the side of her bed. R11's bed was soiled and the room smelled of urine. R11's call light was on the floor coiled by wall not within R11's reach. R11's Care Plan dated1/8/26 documents R11 is at risk for falls and requires staff assistance for Activities of Daily Living. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 3/1/26 at 11:52 AM R64 was in her room sitting on her bed. R64 stated she needed help. R64 did not know where her call light was. R64's call light was on the floor under her bed and out of R64's reach. R64's Care Plan dated 2/26/26 documents R64 is at risk for falls related to Weakness and Deconditioning, Incontinence, and Vision and Hearing problems. Staff are to ensure R64's call light is within reach and encourage R64 to use it to call for assistance. Staff should respond promptly to all requests for assistance. 5. On 3/1/26 at 11:40 AM R97 was sitting on her bed asking for help. R97 stated she was cold and needed a blanket. R97 stated she did not know where her call light was. R97's call light was coiled up on the floor out of reach. R97's Care Plan dated 2/20/26 documents R97 is at risk for falls related to Left Hemiplegia and Confusion. R97 requires staff assistance for Activities of Daily Living. Staff are to keep R97's call light within reach. On 3/2/26 at 4:50 PM V1 Admin confirmed call lights should be kept within resident's reach at all times. B. R155's diagnosis list (3/4/2026) documents diagnoses including Paraplegia, Muscle Wasting and Atrophy, Abnormality of Gait and Mobility, and Lack of Coordination. R155's Resident Assessment (12/8/2025) documents R155 is occasionally incontinent of bladder and frequently incontinent of bowel. The same record documents R155 has impaired lower extremity range of motion, is unable to walk, and uses a wheelchair for mobility. On 3/2/2026 at 9:10 AM, R155 was laying in an electric bed with a commode located beside R155's bed. R155 reported independent use of the commode for bowel and bladder toileting. On 3/3/2026 at 12:21PM, R155 reported raising and lowering the electric bed via a bed remote control to facilitate transfers on and off of the commode. R155 reported the remote has been intermittently malfunctioning for months disallowing R155 to position the bed at the same height as the commode to facilitate independent transfer on and off of the commode. R155 reported the remote will quit working and then the bed will be stuck at a higher position than the commode creating difficulty in transferring back into the bed. R155 reported the commode will then slide on the floor when R155 is fighting so hard to transfer back into bed after using the commode. R155 reported informing facility staff numerous times about the malfunctioning bed remote and staff not addressing the problem in a timely manner. R155 reported having to manipulate the wires to successfully use the remote to position the bed appropriately prior to transferring to the commode. R155 reported R155 shouldn't have to do that. R155 then retrieved the bed remote to attempt to lower or raise the bed height but the remote buttons did not work when depressed. The facility maintenance log (2025-2026) documents wires hanging from R155's bed remote on 1/8/2026, the bed remote not working on 1/29/2026, and not working again on 3/2/2026. On 3/4/2026 at 10:53AM, V20 (Licensed Practical Nurse) reported having a history of providing care to R155 and and denied R155 makes false statements related to staff and nursing care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide adequate supervision and implement interventions to prevent accidents. These failures affect three of eight residents (R124, R133, R148) reviewed for accidents and supervision on the sample list of 62. Findings Include: 1. R133's Medical Diagnoses Sheet date March 2026 documents R133 is diagnosed with Dysphagia, Hemiplegia, and Vascular Dementia. R133's Physician Order Sheet dated March 2026 documents a regular mechanical soft diet order. R133's Minimum Data Set, dated [DATE] documents R133 is cognitively intact and coughs or chokes during meals or when swallowing medications and has complaints of difficulty or pain with swallowing. R133's Care Plan dated 2/27/26 documents R133 has a swallowing problem related to a diagnosis of Dysphagia. R133 is at risk for Choking and Aspiration. R133 should eat only with supervision. R133's Nurse Progress note dated 2/6/26 documents R133 reported she had a choking episode that day during the noon meal. R133 had a short instance of labored breathing. R133's diet order was downgraded and a request for Speech Therapy to evaluate R133 was entered. On 3/1/26 at 12:10 PM R133 was eating her lunch in her room in bed with no staff supervision. On 3/3/26 at 12:37 PM R133 was eating her lunch in her room in bed with no staff supervision. On 3/3/26 at 12:55 PM V9 Director of Therapy stated R133 was referred for a speech evaluation regarding a diet upgrade. There was no mention of a choking or coughing episode. V9 stated if a resident is referred to speech therapy for a choking episode or difficulty swallowing, the therapy staff need to be notified of that in the referral so they can see the resident right away. V9 confirmed that a nurse's note was documented in R133's chart on 2/6/26 stating R133 reported a choking episode to the nurse and R133's diet was downgraded to mechanical soft until an evaluation was completed. V9 confirmed staff should have notified speech therapy right away of the choking episode so R133 could have gotten evaluated quickly. V9 stated the last time R133 was in speech therapy was in May 2024. Upon discharge from therapy at that time, recommendations to address aspiration risk included set up assistance and supervised dining room. Strategies to facilitate safety include an upright posture and supervised dining among other things. On 3/3/26 at 3:56 PM V2 Director of Nurses (DON) confirmed R133 reported to staff she had a choking episode while eating. V2 confirmed that a resident that has a potential choking episode should be evaluated by speech therapy and should have increased monitoring and supervision while eating until deemed safe to dine unsupervised. V2 confirmed therapy should have already assessed R133 as almost a month had passed. 2. R148's Medical Diagnoses sheet dated 1/26/26 documents diagnoses including wedge compression (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fracture of the fourth lumbar vertebra (subsequent encounter with routine healing), pneumonia, and acute respiratory failure with hypoxia. The MDS dated [DATE] documents R148 is moderately impaired cognitively, dependent on staff for all activities of daily living, displays behaviors of inattention and disorganized thinking, and is incontinent of bowel and bladder. The facility's incident report dated 2/22/26 documents that R148 ingested an unknown amount of (Name Brand) Shampoo and Body Wash. According to the report, V24, CNA (Certified Nurse Assistant) entered the room and observed R148 holding the bottle with the lid off and asking if V24 would like a drink, as it tastes good. V24, CNA stated she did not know how much was in the bottle prior to ingestion. V24, CNA removed the bottle, discarded it away from the resident, and notified V25, LPN (Licensed Practical Nurse). The facility's incident report dated 2/22/26 documents upon V25 LPN's initial assessment, R148 showed no impairment to her airway and was behaving at baseline. After paging the provider, R148 began vomiting. Vital signs were retaken and showed an oxygen saturation of 85%. Lung assessment revealed diminished breath sounds with additional abnormal noises. The provider ordered R148 to be transferred to the emergency room (ER). EMS (Emergency Medical Service) was contacted, and V25, LPN sent the bottle of shampoo/body wash with EMS for physician review. On 3/4/26 at 9:35 AM, V24 stated the bottle should not have been there and believed the night shift had left it out. She further stated that R148's breathing and speech became odd, prompting reassessment and notification of the nurse. V24 reported the resident vomited 30–60 minutes after ingestion, developed diarrhea, and required oxygen while awaiting EMS. On 3/4/26 at 9:42AM V25, LPN confirmed that she responded immediately when notified, assessed R148, notified the physician, and initiated transfer after observing vomiting, abnormal lung sounds, and low oxygen saturation. The undated manufacturer's Safety Data Sheet for (Name Brand) Shampoo and Body Wash documents the product is for external use only and instructs users to consult a physician if ingested. On 3/4/26 at 2:30 PM, V2, DON (Director of Nurses) acknowledged awareness of the incident and stated that the shampoo/body wash should not have been left out where R148 could reach it and drink the contents. 3. R124's diagnosis list (1/7/2026) documents diagnoses including Dementia, Osteoporosis, and Osteoarthritis. R124's Resident Assessment (12/5/2025) documents R124 has severely impaired cognition and a history of falls. R124's fall risk assessment (2/1/2026) documents R124 is at high risk for falls. The facility fall investigation (2/6/2026) documents R124 resides on the memory care unit of the facility and had an unwitnessed fall on 2/6/2026. The investigation documents R124 was found by staff on the ground at the doorway to the central bathroom and staff were subsequently educated to keep the central bathroom door closed and locked at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/2026 at 11:30AM, the above central bathroom doorway was observed closed and locked with a door handle keypad present on the door. V19 (Dementia Unit Director) was present and reported the door is supposed to remain shut and locked at all times and residents should only access the bathroom with staff supervision. V19 reported facility staff had propped the door open on 2/6/2026 when R124 accessed the bathroom independently and experienced a fall to the ground.