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	04/07/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure dependent residents were provided dignified care, this failure affected two (R1 and R8) of eight residents reviewed for hygiene/dignity on the sample list of nine residents.Findings include:1. R8's current Diagnoses List includes the following: Essential (Primary) Hypertension, Acute Respiratory Failure with Hypoxia, Pneumonitis due to Inhalation of Food and Vomit, Encounter for Surgical Aftercare Following Surgery of the Digestive System, Repeated Falls, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Age-Related Osteoporosis Without Current Pathological Fracture, and Other Specified Disorders of Cone Density and Structure, Site Unspecified.R8 Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status score as 11 out of a possible 15, which indicates moderate cognitive impairment. The same MDS documents R8 has had no episodes of rejecting care and required partial/moderate assistance or substantial/maximal assistance with activities of daily living, except eating. R8 required Setup or clean-up assistance.R8's current Care Plan documents the following: R8 has ADL (Activities of Daily Living), self-care performance deficit: Dressing: The resident requires one assistance of staff to dress. Personal Hygiene/Oral Care: The resident requires one assistance from staff. Toileting: The resident requires two staff assistance for toileting.R8's same care plan documents the following: R8 is at risk for falls, has Osteoporosis and Osteopenia which could contribute to falls/ severity of illness. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.On 4/1/26 at 2:40 pm, V33 (R8's) Family Member was in R8's room. R8 sat in a wheelchair at bedside. R8's pants had copious amounts of dried food on the upper legs/ lap of his pants and the abdomen area of his shirt. R8 stated This does not look good (points to his upper pant legs), I am supposed to have therapy. I am hoping I don't have to go like this. I asked the nurses to change my pants after finishing my breakfast (breakfast scheduled at 7:30 am). I am guessing, they are just busy. They are all very nice and I don't want to get anyone in trouble. I feed myself and my hands shake. I need to go to the bathroom. I better call someone to help me. R8 turns on R8's call light and V35 Certified Nursing Assistant (CNA) instantly entered R8's room and pushed R8's wheelchair into R8's bathroom. V33 (R8's) Family member stated I'm very happy with the room itself, it is the nursing care I am troubled with, and the (V1) Administrator knows this. I have been here, turned on the call light myself and waited fifteen minutes to get staff to R8's room for care. (R8) can't wait 15 minutes to use the bathroom. Yes, call lights are an issue. Approximately 20 minutes had passed since V35 CNA assisted R8 to the bathroom, as noted above. V3 voiced concerns that R8 was still in the bathroom with V35 CNA. This surveyor knocked on R8's bathroom door. R8 and V35 were no longer in the bathroom. R8's shared a bathroom with an adjoining empty room. V33 (R8's) Family Member stated Perhaps (V35) the CNA has taken (R8) to therapy. V33 (R8's) Family Member and this surveyor walked down the long facility entrance hallway, of which R8 would have traveled to get to the therapy room. R33 and this surveyor walked past several residents in the hall and visible in their (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, past numerous staff, and visitors to get to the facilities therapy room. R8 was receiving therapy by an unidentified therapist. R8's pants and shirt remained soiled with copious amounts of dried food on R8's upper pants and lower shirt. As R8's therapy continued, V33 (R8's) family member stated the (V34) Home Care Provider does (R8's) laundry. There should be plenty of clothes for (R8) here.On 4/1/26 at 3:25 pm, V35 CNA confirmed V35 noticed all the food on R8's clothes when V35 took R8 to the bathroom, before therapy. V35 CNA stated I should have changed R8's clothes when I had R8 in the bathroom. I know R8 has clean clothes in R8's closet. I was going to come back later and change them. I never thought about it, until now, R8 probably was embarrassed when he went to therapy like that. I had to go help the woman (unidentified resident) across the hall, or I would have changed R8's clothes right away.2. R1's Minimum Data Set (MDS) dated [DATE] documents the following: R1's Brief Interview of Mental Status score of eight out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R1s Primary Medical Condition is Progressive Neurological Condition. The same MDS documents: R1 required the following assistance with dressing, toileting, and to transfer from R1'swheelchair chair to bed: Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk limbs, but provides less than half the effort, during personal hygiene, On 4/07/26 at 8:05 am, breakfast trays were not delivered to residents in the rooms, yet. Therefore, R1 had not eaten. There was a kitchen tray cart parked at the end of the hall, filled with residents' meal trays. R1 was lying in bed with the bed sheet and blanket covering the lower half of R1's body. R1 did not have on night clothes. R1 was wearing a long sleeve, red shirt that was soiled with light colored food-like particles stuck to R1's chest area. R1 also had dried, long lines of liquid-like substance streaked down the front of R1's shirt. R1 stated R1 has not had breakfast this morning. R1 stated R1 was put to bed in R1's soiled day clothes, last night after supper. R1 stated I would prefer to sleep in clean pajamas. I would be more comfortable. R1 exercised R1's right to stay in bed, sleep and delay R1's morning care.On 4/7/25 at 10:25 am, R1 was awake lying in bed. V56 Certified Nursing Assistant (CNA) entered R1's room to complete morning care. V56 CNA confirmed R1 was in soiled day clothes and had to have slept in the soiled clothes overnight.The facility Policy Resident Privacy and Dignity dated January 2026 documents the following:PURPOSE:To provide all residents with a home-like environment that promotes dignity and respect to the residents of the facility.POLICY:To ensure that all residents are provided with dignity and privacy.RESPONSIBILITY:It is the responsibility of all staff to ensure that all residents have privacy and dignity.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observations, interviews and record review, the facility repeatedly failed to maintain a safe environment for residents at risk of falls. These failures affected four residents (R2, R3, R8 and R9) of six residents, which were reviewed for falls/environment, on the sample list of nine residents. R3's fall from an elevated bed with a slick surfaced air mattress, resulted in a Right Humerus, Acute Moderately Displaced Spiral Fracture of the Mid Humeral Diaphysis (main shaft of the bone) that required hospitalization.Findings include:1. R3's current Diagnoses Sheet documents the following: Secondary Malignant Neoplasm of Liver, and Intrahepatic Bile Duct, Secondary Malignant Neoplasm of Right Lung, Secondary Neoplasm of the Bone, Neoplasm Related Pain ?(Acute)' Chronic, Chronic Obstructive Pulmonary Disease, Unspecified, and Anxiety, Unspecified.R3's Minimum Data Set (MDS) dated [DATE] (prior to R3's fall with fracture on 3/8/26) documents the following: R3's Brief Interview of Mental Status (BIMS) score of 11, which indicates R3 has moderate cognitive impairment and has Behavior present, fluctuates (comes and goes, changes in severity) of Inattention - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said.R3's MDS also documented the following Activities of Daily Living (ADL's) prior to R3's fall 3/8/26 as follows: Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunks or limbs, but provides less than half the effort. This assistance is needed to roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer.The same MDS prior to a fall with fracture document:R3 is Dependent - Helper does ALL the effort. Residents do none of the effort to complete the activity, or the assistance of 2 (two) or more helpers is required for the resident to complete the activity for ambulation and uses a manual wheelchair and walker for mobility.R3's same MDS documents R3 is Frequently incontinent (of) bladder and always incontinent of bowel.R3's Fall Risk assessment dated [DATE] document's R3 was at moderate risk for falls (prior to R3's fall 3/8/26).R3's current Care Plan documents the following: R3 is at risk for falls related to Deconditioning, Gait/balance problemsDate Initiated: 09/30/2025. Interventions include: Non-skid socks- when resident will allow Date Initiated: 02/27/2026. Resident observed with bed in the air, bed remote in hand after trying to lower bed, resident declined and continued with remote in hand; education provided. (The above MDS documents R3 was cognitively impaired and had Initiation in tracking information). Date Initiated: 02/09/2025 (Before R3's fall with fracture)Anticipate and meet the residents' needs. Date Initiated. 9/30/25. Be sure the resident's call light is within reach and encourage the resident to use it as assistance as needed. The residents' needs, prompt response to all requests. Date Initiated: 09/30/2025. R3's same Care Plan documents on 3/8/26- remove LAL (Low Air Loss Mattress). Date Initiated: 03/08/2026 (post fall). 3/8/26- sent to the ER for evaluation 3/9/26- education (after fall 3/08/26, per MDS above, R3 has moderate cognitive impairment and has Inattention behaviors) on lowering the bed while in the bed; resident request to keep bed remote in reach and adjust as he prefers including the height of the bed. education on risks of dangers and injury risk. Date Initiated: 03/09/2026 3/9/26- sign placed to encourage use of call light. Date Initiated: 03/09/2026. Appropriate footwear. Date Initiated: 02/27/2026 Call light within reach. Date Initiated: 02/27/2026 Keep items within reach. Date Initiated: 02/27/2026R3's Fall with Major Injury Investigation report and witness statements, dated 3/8/26 at 4:25 pm documents the following:R3's Transfer Status: (R3) requires substantial assistance with one staff member to get out of bed, along with assistance of one for bed mobility. (R3) requires assistance from one staff member for incontinence of care and personal hygiene and can use the urinal independently with some incontinence of bowel and bladder.R3's same Fall with Major Injury Investigation report documents the following witness statements:Timeline of Events:It was documented on 3/08/26 at 3:10 pm that: V42 Certified Nursing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assistant/CNA stated that V42 arrived at 2:00 pm for V42's shift. V42 CNA reported observing R3 in bed at that time, call light in reach with R3's bed at a reasonable height. While rounding at approximately 3:10 pm, V42 CNA stated, V42 completed incontinence care and lowered R3's bed back down, giving R3 the call light attached to R3's gown and bed remote (though R3 has moderate cognitive impairment and inattention according to the 2/14/26 MDS above) was in R3's left hand. V42 CNA stated R3 moves R3's bed freely. V42 CNA stated that R3's urinal was at R3's bedside when V42 was leaving the room and the table was to the right side for all frequent use items in reach. V42 CNA stated that during incontinence care that nonskid footwear was on. V42 CNA stated while leaving the room V42 shut the door per resident request.It was documented on 3/08/26 at 4:20 pm that V53 CNA reported that V53 saw resident (R3) within 5 (five) minutes prior to fall. V53 CNA reports that (R3) was observed sitting on the side of the bed, and R3 was assisted back into bed. V53 CNA noted that R3's bed was raised to about waist level, bed control was beside R3, with call light at this time on R3's left side. The bedside table was on the right of R3. At that time V53 CNA attempted to meet the needs and see what R3 needed, R3 stated R3 was just sitting there, it was explained the lack of safety, R3 agreed. R3 is moderately cognitively impaired and has a behavior of Inattention making it difficult to keep track of what is being said as noted above on R3's 2/14/26 MDS). R3 was positioned in a manner of comfort with call light across resident with bed remote to R3's left side, bedside table on the right side, urinal present in room. V53 CNA reported that R3 was not often wanting to get out of bed. V53 CNA reported that V53 was attempting to find a staff member on that hall to report that R3 was more active and was sitting on the side of the bed.It was documented on 3/08/26 at 4:25 pm by V17 Registered Nurse (RN): V17 RN reported hearing a call for help at which time V17 RN went to inquire about the calling. A visitor (unidentified) was observed pointing into the room of R3. V17 RN reported that upon entry to the room, R3 was observed laying on the right side of R3's bed, head toward the head of R3's bed, feet toward the foot of bed, lateral (laterally) to R3's bed on R3's right side. The floor was clear of debris and dry. The recliner was placed to the right of the bed; a wheelchair was closest to the bed (per family interviews and surveyor observation R3's wheelchair was consistently positioned across the room, on the opposite side of R3's recliner, approximately eight feet away) beside the recliner. Call light was observed on the resident, not engaged. The resident was clothed with a brief on, and non-skid socks were not on. V17 RN reported that R3 stated that R3 was attempting to get up and go to the wheelchair. V17 RN reported that V17 assessed R3 without an immediate sign of injury, R3 reported minimal pain while lying on the ground, no shortening or oration, or deformity to bilateral lower extremities. R3 stated that R3 did not hit R3's head; mention was at baseline, aox3 (alert and oriented to person, place and time). V53 CNA and V57 CNA were attempting to assist R3 with the full body mechanical lift at which time R3 appeared to have increased pain. V17 RN returned to the room and observed a noted deformity to R3's right upper arm. V17 RN reported it appeared that R3's arm was dislocated. V17 RN reported that an assessment of the right arm resulted in a positive radial pulse, with good temperature and pallor. V17 RN informed the CNA's not to move resident any further at which time V17 RN and V57 CNA made R3 as comfortable as possible with a pillow under R3's head and V57 CNA remained with R3 while the nurse started to call providers and EMS (Emergency Medical System). The ambulance arrived and administered pain medication and assisted R3 off the ground following their protocols.R3's same Fall with Major Injury Investigation report documents the following: During the investigation it was determined that general decline in health contributed to this fall in conjunction with mild cognitive decline. R3 was observed on the ground laterally to the bed. R3 exclaimed that R3 wanted to get in the wheelchair and to another staff member wanted to walk. While R3 requires one staff assist to transfer, it was determined that R3 did not ask for help. While the call light was pinned to R3, it was found that R3 does not use R3's light often (see MDS cognitive on 2/14/26). A reminder sign was placed in eye view and return articulation observed with call light engagement.R3's same Fall with Major Injury Investigation report documents the following: During the investigation it was discovered (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	that R3 adjusts R3's bed independently without insight (above MDS 2/14/26, Moderate cognitive impairment and inattention to track conversations) of risk relating to injury. While R3 has a prior intervention to wear nonskid socks, it was noted that R3 had socks on prior to the fall that they were not on at the time of fall. This was reviewed as contribution to the fall. R3 was interviewed and R3 stated that at times R3 does not want socks on and at times they just come off. Socks were reviewed with proper sizes observed. All frequently used items are placed in reach.R3's same Fall with Major Injury Investigation report documents the following: The interdisciplinary team reviewed the use of R3's low air loss mattress (LAL) supplied by Hospice. Due to the improvement of wound impairment with end-of-life care, it was determined that the removal of the low air loss mattress is appropriate. Due to the slick material and unsteadiness while sitting at the bedside, it was determined that while this was not the root cause it was a contribution.R3's same Fall with Major Injury Investigation report documents the following: Due to all the factors that increase the risks for major injury, it is determined that the interventions placed will aid in the reduction of major injury. While some factors such as metastatic bone cancer raise risks for the resident (R3). The use of bed control alone did contribute to the risks; education used to reduce the risks. Due to the overall decline, resident (R3) is on hospice with a greater risk for further decline and risks. While there are risks, it is determined that encouragement of nonskid footwear and offering regularly to get up as residents have shown is lack of call light use. Along with the use of the reminder, it is anticipated to aid in reduced risks. (R3) continued to want comfort over all other treatment this includes reducing the risk for further injury.R3's Hospital records dated 3/8/26 document the following: HPI (History of Present Illness): (R3) is a (specified age) old male with significant PMH (Past Medical History) of poorly differentiated metastatic adenocarcinoma, who presented with a chief complaint of arm pain. Patient (R3) was recently admitted [DATE] through 02/26/2026 for pleuritic chest pain requiring pain medication titration. Decision was made during hospitalization to discharge to ECF (Extended Care Facility) on Hospice. Patient was brought in via EMS (Emergency Medical Service) from the ECF today, after a fall. Patient was seen and examined at bedside; (V55, Family Member) present as well. Patient states he (R3) has been doing well at the ECF and had gained some energy back after discharge. (V55) notes the first day he took Norco (narcotic pain medication) post-discharge he (R3) was extremely tired but otherwise has been doing well with his pain medications. Patient (R3) was reportedly groggy today (3/8/26) and attempted to get out of bed and into his wheelchair. Patient (R3) typically knows that he cannot walk and should not be transferring by himself. Patient fell and landed on his arms. In the ED (Emergency Department), XR (X-Ray) right humerus shows acute, moderately displaced spiral fracture of the mid humeral diaphysis (upper arm). Patient (R3) required IV (intravenous) ketorolac (anti-inflammatory medication used for moderate to severe pain) and morphine (narcotic medication treatment used for severe pain) due to intractable (difficult to control) arm pain. He (R3) is admitted (to the hospital) for further management. On 4/3/26 at 2:25 pm, V39 Wound / Registered Nurse (RN), V42 and V43 Certified Nursing Assistants (CNAs) washed their hands and donned gowns and gloves before entering R3's room. R3 was lying in bed on R3's back. R3 had a brace on his right upper arm/shoulder. V39 RN stated R3 had been administered pain medication in anticipation of completing the wound dressing change. R3 stated R3's shoulder was fractured when R3 was trying to sit up on the side of R3's bed. R3 also stated I (R3) had a different mattress at the time. Before, I (R3) could get to a seated position in bed, the air in the other mattress pushed me off the bed. R3 stated The bed was too high and thrust me forward. My wheelchair was over there (points to the opposite side of the room) in the corner. I tried to stay on my feet but couldn't, so I reached towards my wheelchair and fell. I was tossed off the bed. That is all I remember. I can't say how long I was on the floor. My concept of time was skewed. My arm was hurting pretty bad.On 4/3/26 at 4:25 pm, V2 Director of Nursing (DON) reviewed details of R3's fall with the humerus fracture on 3/8/26. V2 DON confirmed R3 is moderately cognitively impaired, has had a change in conditions and is currently on (end of life care services) Hospice. V2 DON also stated (R3) had a low air loss mattress which was a contributing (continued on next page)

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V54 was seated in a straight back chair across from the foot of R3's bed. V55 was seated in R3's wheelchair next to R3's bed. R3 was asleep in bed. V54 stated V54, V55, and several other family members were visiting R3 the afternoon of R3's, 3/8/26 fall. We (R3's Family Members) were all here, from a little before 1:00 pm, until a little after 2:00 pm. We decided to go to lunch. When we all left. (R3) was in bed, asleep. (V55, Power of Attorney/Family Member) got a call about an hour or so later, saying (R3) fell. We came back to find (R3) on the floor and in a lot of pain. V55, then stated When I got the call from one of the nurses (unidentified) at the nursing home, I was told (R3) was lifted off his bed by the air mattress when he (R3) went to stand up to go to the bathroom. When we arrived (R3) was on the floor and had severe arm pain. The Paramedics showed up just before 4:00 pm. They took one look at (R3's) arm and said they were sure (R3's) arm was broken. While (R3) was on the floor (R3) told me he was up, sitting on the side of the bed, and felt a push from his mattress. (R3) told me the air mattress thrust him to stand up, next to his bed. He (R3) said the bed was too high for him to stand up, so he attempted to go towards his wheelchair and fell. V55 also stated His (R3) recollection at that time, lying in pain was very clear. Though, he does have confusion at times. He was clear as a bell while waiting for the ambulance. V55 (R3's) POA and V54 (R3's) Family Member both stated, R3's wheelchair is not ever next to his bed. V55 also stated The CNAs (Certified Nursing Assistants) put it out of the way, across the room, next to (R3's) recliner in the corner. It was there every day, when we came in. That is where it was when we left, the day he fell. V55 then stated I sit in it (wheelchair), next to (R3's) bed when I come in (seated in R3's wheelchair at the time of the interview). I get it (wheelchair) from up against the wall, next to recliner every time. I put it back there, so it is not in the CNA's way. (V55 points across R3's room approximately eight feet from R3's bed) That is where they say they want it. (V54 confirmed the area, eight feet from R3's bed is where R3's wheelchair is placed routinely). He (R3) would never have made it that far on his own. He has gotten very weak since getting on Hospice. V54 and V55 both confirmed R3 does not use his call light, and they have not seen him change the level of the bed but believe it is possible when he gets confused. V55 stated He may confuse that remote (bed device) with the TV (television) remote. He probably shouldn't have it (bed remote control device) in his bed. V54 and V55 both agreed they have seen CNA's raise his bed to change his incontinence brief and leave the room with R3's bed still elevated too high. V55 also stated she has lowered R3's bed several times before she leaves the facility.On 4/07/26 at 10:15 am, V51 Hospice Nurse was standing at the side of R3's bed. V51 stated I (V51) was notified the night he (R3) fell. They had contacted the on-call Hospice service. I (V51) talked to several staff in the facility the next day. I (V51) heard he (R3) tried to get out of bed. The facility said they felt like the air mattress was the reason for his (R3) fall. I (V51) asked for bedrails and (V2 Director of Nursing) said he (R3) would not pass the assessment. I have come into the facility several times and seen his (R3's) bed elevated to about this height (approximately four feet). I (V51) have let several staff know this should not happen. This is a big safety risk. His (R3's) bed mattress is new and has bolsters, which makes sense since bed rails are not an option for him.2. R3 had a second safety event after the above fall with fracture which is documented below.R3's current Diagnoses Sheet documents the following: Subluxation of Other Parts of Right Shoulder Girdle, Subsequent Encounter, and Non-Surgical Orthopedic/Musculoskeletal.R3's Minimum Data Set (MDS) dated [DATE] (after the fall with fracture (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3/8/26) documents R3's Brief Interview for Mental Status (BIMS) score of 11, that indicated R3 had moderate cognitive impairment. The same MDS documents R3's Activities of Daily Living (ADL's) decline as follows: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. for the following: Roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer.The same MDS documents the following:R3 is Dependent - Helper does ALL the effort, residents do none of the effort to complete the activity. Or the assistance of 2 (two) or more helpers is required for the resident to complete the activity for ambulation and requires a manual wheelchair for mobility.R3's Fall with Major Injury Investigation report dated 3/8/26 at 4:25 pm documents R3 had a fall from an elevated bed with a low air loss mattress.R3's Hospital Records dated 3/8/26 document R3 was admitted via the emergency room to the local hospital, after a fall in the long-term care facility. The same hospital records documents R3 sustained a Right Humerus, Moderately Displaced Spiral Fracture of the Mid- Humeral Diaphysis (upper arm bone).On 4/1/26 at 12:10 pm, R3 was found lying in an elevated bed. The surface of R3's foam bed mattress was approximately three and a half feet above the floor. R3's wheelchair was across the room, sitting next to a recliner chair at the far corner (approximately eight feet) from R3's bed. There is a sign on the bathroom door directing R3 to use his call light for help. The bathroom door is approximately eight feet from R3's bed, on the opposite side of the room from R3's wheelchair. R3's call light cord was out of reach, and was dangling off the bed frame, at the head of R3's bed. R3's bed remote control device was also out of R3's reach. R3's bed remote control device was laying on top of the blanket, approximately six inches from the foot of R3's bed. R3 was pleasantly confused. R3 stated R3 did not understand why his bed was elevated and does not know how it got that way. R3 also stated R3 does not know if R3 had any falls, You would have to ask the lady. I just woke up when the lady was in here checking to see if I was wet.On 4/1/26 at 12:15 pm, V30 Certified Nursing Assistant (CNA) confirmed R3's bed was elevated, call light out of R3's reach and R3's bed control at the foot of R3's bed. V30 CNA stated to R3 Your bed is way too high. We have got to make you safe. V30 CNA removed the bed control device from the foot of R3's bed. V30 CNA stated to R3, Well it is obvious you did not put the bed up by yourself. You can't reach this (shows R3 the bed control device). V30 CNA lowered R3's bed by approximately one foot. V30 CNA then removed the dangling call light cord and attached it to the upper right side of R3's shirt, close to R3's shoulder. V30 CNA then directed R3 to push the call light button if R3 needs anything, and V30 would come back to help R3. R3 stated I can't see that thing. I don't see well at all. If I can't see it, I can't push it. V30 then clipped the call light button lower and centered on R3's chest. R3 pushed the call light immediately. V30 CNA then stated to R3 That was good practice. Do that if you need me. I will move your wheelchair closer to your bed, but I don't want you to get up without calling us for help.3. R2's current Diagnoses List documents the following: Diabetes Mellitus Type II, With Hyperglycemia, Diabetes Mellitus Type II, With Polyneuropathy (damage nerves, causing numbness, tingling and weakness), Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified.R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental status (BIMS) score as 12 out of a possible 15, indicating moderate cognitive impairment.The same MDS documents R2 has had one fall with no injury (during the lookback period of this assessment) and is dependent on staff for substantial maximum assistance, with all Activities of Daily Living, except eating.R2's current Care Plan documents the following: (R2) is at risk for falls r/t (related to) weakness, requires assistance with transfers, nonAmbulatory. Encourage the resident to use bell to call for assistance.R2's three progress notes below, each document recent unwitnessed falls without injury.R2's Fall/Incident Note (Unwitnessed) dated 3/24/26 at 10:20 am documents: R2 leaned over to pick up tennis shoes and fell out of R2's wheelchair.R2's Fall/Incident note dated 3/10/2026 at 8:31 pm documents: An unidentified Certified Nursing Assistant went in and found resident was lying on the floor on R2's back, against the wheelchair behind him, sitting in front of the toilet.R2's Fall/Incident note dated 3/6/2026 at 03:48 am (continued on next page)

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	145439	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Savoy	302 West Burwash Savoy, IL 61874

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	documents: Resident was trying to reach for his bag and slipped off R2's bed.On 4/3/26 at 8:55 am, R2 was lying in an elevated bed. R2's bed was elevated with the mattress approximately three and a half feet off the floor bed. The head of R3's bed was positioned at approximately 45 degrees. R2's bed control device was behind the elevated head of the bed. R2's bed control device was attached to R2's headboard, behind the mattress, centered behind R2's head. R2 did not have R2's call light within reach. R2's call light cord was coiled on the floor under the head of R2's bed. R2 stated I have no way of asking staff for help, when my call light is not up on my bed. I cannot reach the bed control for my bed, and I sure don't like my bed off the floor, this far. I woke up like this when the dietary people brought my food. I am thinking, this probably is how the night shift left me when they changed me in the middle of the night.On 4/3/26 at 9:03 am, V40 Certified Nursing Assistant (CNA) entered R2's room and confirmed R2's bed was not at a safe height, call light was on the floor and R2's bed control was out of reach. V40 CNA lowered R2's bed to approximately two and a half feet off the floor and handed R2 the bed control and attached R2's call light to R2's clean bed linen within R2's reach.4. R8's current Diagnoses List includes the following: Essential (Primary) Hypertension, Repeated Falls, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Age-Related Osteoporosis Without Current Pathological Fracture, and Other Specified Disorders of Cone Density and Structure, Site Unspecified.R8's Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status (BIMS) score as 11 out of a possible 15, which indicates moderate cognitive impairment. The same MDS documents R8 has had two falls, without major injury while residing in the facility.R8's current Care Plan documents the following: (R8) is at risk for falls, has Osteoporosis and Osteopenia which could contribute to falls/ severity of illness. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.R8's (most recent fall) Nursing Note dated 3/25/2026 at 10:22 pm, documents the following: Note Text: 2030 (8:30 PM)- patient fell after standing up from recliner in room. CNA (Certified Nursing Assistant) entering room when patient fell. Right side of (R8's) head hit bedside table causing laceration. Large skin tear to right elbow. Bleeding controlled with pressure to both sites.On 4/3/26 at 8:10 am, R8 was seated in a wheelchair three feet from R8's bed. R8's call light cord was attached to R8's pillowcase on R8's bed. R8 stated I can't reach that call light (stretching his right arm out falling short approximately 18 inches from the call light). I can't call those girls if I need something.On 4/3/26 at 8:15 am, V37 Certified Occupational Therapy Assistant (COTA) confirmed R8's call light was out of R8's reach. V37 COTA stated to R8 Let me fix that. You should always have your call light within reach. I am sorry about that.5. R9's current Diagnoses List documents the following: Repeated Falls, Encephalopathy, Unspecified, Cerebral Aneurysm, Non-ruptured, Muscle Wasting and Atrophy Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified, Other Abnormalities of Gait and Mobility, Other Lack of Coordination, and Cognitive Communication Deficit.R9's current Physician Order Sheet documents the following: LAL (Low Air Loss) mattress- Dial must be set at resident's weight. Loose sheet only or bed pad only under resident to not disturb pressure relieving device.R9's Minimum Data Set (MDS) dated [DATE] documents R9's Brief Interview of Mental Status (BIMS) score as nine out of a possible 15 indicating moderate cognitive impairment and has a pressure reducing device for the bed.R9's Fall risk assessment dated [DATE] documents R9 is at high risk for falls.On 4/07/26 at 8:45 am, V48 Certified Occupational Therapy Assistant (COTA) came out of resident R9's bedroom. V7 Licensed Practical Nurse (LPN) was standing at V7's medication cart in the hallway outside R9's room. V48 COTA told V47 LPN that R9's low air loss mattress had deflated. V48 stated V48 found it almost flat while R9 was lying in the bed.On 4/07/26 at 8:48 am, V48 COTA re- entered R9's bedroom with this surveyor. R9 laid in bed, on V48's left side, asleep. V48 COTA stated V48 had found R9's air mattress had deflated again this morning. V48 COTA stated V48 did not initially know why. I let (V49 Certified Nursing Assistant/CNA) know it was deflated. (V49 CNA) came in and found the plug (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(beach-ball-like) had come out. (R9's) bed (low air loss mattress) had deflated maybe, halfway flat. I completed a stopwatch (maintenance request form) report, so it will be fixed. I know it happened this weekend too. It needs to be fixed. V48 then lifted an orange piece of material that flapped over the air mattress plug. The plug was off, and the air mattress was losing air. V48 stated It is not functioning right. It (beach ball type plug) has popped out, again. V48 used force to push the air mattress plug back in.On 4/07/26 at 9:20 am, V49 Certified Nursing Assistant (CNA) explained when V49 identified the problem with R9's low air loss mattress not holding air. V49 stated The night Supervisor V32 Registered Nurse / Supervisor) showed me one evening, when I worked over (past her day shift schedule), about a week ago. (R9's) air mattress had gone flat. I was going to get her (R9) up from the bed. She (R9) has had pressure ulcers previously and that is why she (R9) is supposed to be on one (low air loss mattress). (V32 RN Supervisor) showed me (V49) why it went flat. The plug had popped open. We did not have to get her (R9) out of bed. We stayed with her (R9) until it (air mattress) was filled back up.The facility policy FALL MANAGEMENT PROGRAM dated as revised January 2026 documents the following: POLICY - To provide guidelines on preventing resident falls or injury. PROCEDURE: Complete the fall assessment initially on admission, and then quarterly. Initial Plan of Care:1. Initiate risk reducing interventions.2. Verify and obtain orders if needed.3. Develop admission fall care plan. Action Steps:1. Provide ongoing risk reducing interventions.2. Initiate physician orders as needed.3. Identify and implement related care link interventions.4. Provide ongoing evaluation of resident response to intervention.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide incontinence care in a timely manner for one (R2) of eight residents reviewed for incontinence care/activities of daily living on the sample list of nine residents.Findings include:R2's current Diagnoses List documents the following: Diabetes Mellitus Type II, with Hyperglycemia, Diabetes Mellitus Type II, with Polyneuropathy (damage nerves, causing numbness, tingling and weakness), Diabetes Mellitus Type II, with Chronic Kidney Disease, Dependent on Renal Dialysis, Low Back Pain, Unspecified, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Difficulty Walking, Not Elsewhere Classified and Depression.R2's Current Physician Order Sheet documents the following diuretic (stimulates the kidneys to excrete excess fluid from the body) medication order: Spironolactone Oral tablet 50 milligrams, give one tablet by mouth in the morning, related to Essential Hypertension.R2's Minimum Data Set (MDS) dated [DATE] documents R2's Brief Interview of Mental Status (BIMS) score as 12 out of a possible 15, indicating moderate cognitive impairment.The same MDS documents, R2 is dependent on staff for substantial/maximum assistance, with all Activities of Daily Living (ADL), except eating.The same MDS documents R2 is frequently incontinent of bladder and always incontinent of bowel.R2's current Care Plan documents the following: (R2) has an ADL self-care performance deficit r/t (related to) Fatigue and recentsurgery, Hemiplegia, weakness, SOB (Shortness of Breath) on exertiondue to CHF (Congestive Heart Failure). Transfers (R2) requires sit to stand lift. Encourage the resident to use bell to call for assistance.R2's same Care Plan documents: (R2) has MASD (Moisture Associated Skin Damage) to the scrotum/ bilateral buttocks. MASD to bilateral buttock/scrotum will show signs of healing within 5-7 (five to seven) days Date Initiated: 03/30/2026.Administer treatment as ordered.Educate resident/family/caregivers of causative factors and measures to prevent skin injury.Encourage good nutrition and hydration to promote healthier skin. Follow facility protocols for tx (treatment) of injury.Keep skin clean and dry. Use lotion on dry skin. Do not apply in open areas.Avoid scratching and keep hands/body parts from excessive moisture.Keep fingernails short.Observe/document location, size, and treatment of skin injury.Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration, etc. to MD (Medical Doctor).Weekly tx (treatment) documentation to include measurement of each area of skin breakdowns, width, length, depth, type of tissue and exudate, and any other notable changes/observations.Wound MD/wound nurse (V58 Wound Physician / V8 Wound Licensed Practical Nurse and V39 Wound Registered Nurse), round weekly as indicated by wound needs.R2's Wound Assessment -Detail Report dated 4/1/26 documents the following: Left Buttock, MASD due to incontinence, and present on admission 3/26/26.On 4/3/26 at 8:55 am, R2 was lying in bed. R2's bed was elevated with the mattress approximately three and a half feet above the floor. R2 had a strong feces odor permeating R2's room. R2's call light was out of reach, on the floor. R2 stated R2 has no way to call staff for assistance. R2 then stated R2 was thinking, A night shift Certified Nursing Assistants (CNA)(unidentified), probably left me with my bed elevated and my call light out of reach, when they changed me in the middle of the night. R2 also stated I am not sure if I am wet now. I know I had some wet gas overnight. I think I might have leaked then. I need to be checked. Could you let one of the nursing aides know?On 4/3/26 at 9:03 am, V40 Certified Nursing Assistant entered R2's room, adjusted R2's bed, provided call light and stated V40 CNA will tell R2's CNA (V16 CNA) that R2 needed incontinence care.On 4/3/26 at 9:10 am, V16 CNA stated I have not changed (R2) yet today. I came in at 6:00 am. Night shift told me in report they did (R2's) care around 5:00 am, on rounds. I was just going to check on him.On 4/3/26 at 9:30 am (approximately four hours and thirty minutes from last incontinence care, per V16 CNAs above interview), V39 Registered Nurse/Wound Nurse, V41 CNA and V16 CNA entered R2's room, after they put on Personal Protective Equipment (PPE). V16 and V42 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs completed R2's incontinence care. R2 was incontinent of feces that had dried on R2's bilateral buttocks. R2 had visible, bilateral buttocks Moisture Associated Skin Damage (MASD) with pencil eraser shearing in two areas on the left buttocks, and one area of R2's right buttock. V39 Wound Registered Nurse recleaned R2's bilateral buttocks with wound cleaner and applied Triad medicated wound paste, as the physician ordered. V39 Wound Registered Nurse confirmed R2's MASD was likely caused by delays in incontinence care.The facility policy Subject: TOILETING AND INCONTINENT CARE dated as revised January 2026 documents the following: PURPOSE:To provide guidelines to all nursing staff for providing proper assistance with toileting and incontinence care to clean skin so it remains clean, dry, free of irritation and odor.POLICY:All will receive assistance with toileting needs according to their plan of care guidelines. Incontinence care will be provided to keep skin clean, dry, free of irritation and odor. Incontinence care will be provided after each incontinent episode.RESPONSIBILITY:It is the responsibility of the C.N.A. to provide toileting assistance and incontinence care after each incontinent episode.It is the responsibility of the Charge Nurse to ensure that residents are provided toileting assistance and incontinent residents receive appropriate incontinence care.