STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145449	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Paxton Senior Living	450 Fulton Street Paxton, IL 60957

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 - Some	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** Failures at this level required more than one deficient practice statement. A. Based on observation, interview and record review, the facility failed to ensure resident's call lights were answered in a reasonable time frame for seven of 17 residents (R50, R60, R81, R82, R74, R83, R43) reviewed for resident rights on a sample list of 43.B. Based on interview and record review the facility failed to ensure residents were treated with dignity and respect for three of 17 residents (R18, R74, R82) reviewed for resident rights in the sample list of 43. a.1) The facility policy Call Lights: Answering dated 8/2/17 documents call lights are to be answered in a reasonable time frame and all call lights should be answered courteously. Record review of Resident Council meeting minutes dated January, February, and March 2026 document ongoing concerns related to call lights not being answered timely. On 4/6/2026 at 12:15PM, V4 (R81's Power of Attorney) stated R81 had to wait an hour to get a Certified Nursing Assistant (CNA) to answer the call light to go to the bathroom. On 4/08/26 at 10:01 AM, V25 (Certified Nursing Assistant) stated it is difficult to see the call light alerts located at the end of the hallway, especially as they wear glasses. V25 further stated there is no audible alarm and expressed that a light system above resident room doors would improve visibility of alerts. a.2) On 4/07/26 at 10:32 AM R50 and R60 stated that at times they have to wait over an hour for someone to answer the call light. More at night but is a constant problem. Resident Council Minutes dated 2/18/26 document call light times are a problem. On 4/7/26 at 1:00PM the call light banner indicated R82 needed assistance. There was no audible alert and no light on above R82's door. R82 asked V27 Speech Therapist for help and V27 stated that she is not there to help her with that, she would have to wait for other staff. No call light banner was noted in 100 hallway. On 4/7/26 at 1:15PM V1 Administrator verified there is no sound or light above resident room doors indicating the call light has been activated. V1 stated the only alert is the scroll above the hall end doors. On 4/7/26 at 1:45 PM, V11 Nurse Manager, indicated where the call light panel was located at the nursing station. The panel is a computer screen showing a map of the facility and resident room call lights. The room on the map illuminates when the call light is pushed. A text alert also scrolls on the (continued on next page)

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 - Some	screen indicating which resident is alerting for help. V2 verified no sound is made when a call light is triggered. On 4/8/26 at 9:45AM the call light banner indicated assistance was needed and no staff member was at the desk monitoring the call light panel. On 4/8/26 at 10:38AM the call light banner indicated assistance was needed in resident rooms for R74, R82 and R83. No staff were observed monitoring the call light panel. On 4/8/26 at 10:46AM the call light banner continued to indicate assistance needed for R74, R82 and R83. On 4/8/26 at 11:25 AM V19 Maintenance Staff stated there is no sound component to the call light system. a.3) On 04/06/2026 at 10:00 AM R43 stated the facility does not have enough staff, it takes an hour at times for call lights to be answered often while waiting to use the bathroom. R43's Minimum Data Set (MDS) dated [DATE] documents R43 as cognitively intact and dependent on staff assistance for toileting hygiene and toilet transfers. a.4) On 4/6/26 at 11:47 AM R18 was in a wheelchair in his room. R18 stated R18 often calls for staff assistance to use the urinal around 4:00-5:00 AM, often waiting over an hour, causing R18 to wet his bed requiring a linen change. R18's MDS dated [DATE] documents R18 as cognitively intact, that R18 needs substantial/maximal staff assistance for toileting hygiene and R18 is always continent of bladder. The facility's Resident/Family Concern/Grievance Form dated 3/19/26 documents a reported concern from the resident council meeting that residents don't feel like they get enough support on nights. b.1) The facility policy Call Lights: Answering dated 8/2/17 documents be courteous when answering call lights. The facility's Resident Privacy and Dignity policy dated January 2026 documents All residents will be addressed and spoken to with dignity and respect at all times. On 4/6/26 at 11:47 AM R18 stated R18 calls for staff assistance during the night to use the urinal and has to wait for over an hour causing R18 to wet his bed, this often happens when the Certified Nursing Assistant (CNA) V13 is working R18's hallway. R18 stated a few weeks ago he turned his call light on around 4:00 - 5:00 AM and no staff answered it until 6:00 AM when R18 required bed linen change. R18 stated R18 complained to management about V13 and V13 wasn't supposed to take care of R18 anymore after that but V13 took care of him again recently. R18 questioned V13 who got smart with R18 and told R18 he should be going to the bathroom on his own. R18 stated he feels like V13 was being vindictive after R18 told V13 that R18 was going to report V13. R18 stated R18 has arthritis in his hands making it difficult to hold the urinal, requiring staff assistance so it doesn't spill. R18's Minimum Data Set (MDS) dated [DATE] documents R18 as cognitively intact and R18 needs substantial/maximal staff assistance for toileting hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Daily CNA Schedule dated 3/26/26 documents V13 was assigned to R18's hallway. The Resident/Family Concern/Grievance Form dated 11/12/25 documents concern reported from resident council regarding V13's tone of voice as coming off as rude. Action taken is listed as discussed tone and interaction with residents during care with V13 on 11/14/26. The Resident/Family Concern Grievance Form dated 3/27/26 documents R18 complained of V13 and waiting for help with his urinal requiring bed linen change. Action taken is listed as R18 was in agreement with having a different CNA provide care as R18 feels like V13 and R18 personalities just don't get along. This is documented as reviewed with the V7 CNA Supervisor regarding scheduling and education was given to V13. On 4/6/26 at 12:29 PM V7 stated a couple weeks ago R18 voiced concerns regarding V13 CNA and having personality conflict, which was reported to V1 Administrator. At 12:37 PM V1 stated about a week ago V7 reported R18's concern with personality conflict with V13. V1 and V2 Director of Nursing stated they followed up with R18 and R18 stated he just didn't care for V13. V1 and V2 stated V13 was instructed not to provide any further care for R18. On 4/6/26 at 3:08 PM V13 CNA stated V13 assisted R18 with using the urinal and R18 said that R18 wanted to talk to someone further and V13 told R18 that he could talk with V13's supervisor. V13 confirmed she received training on professionalism and tone on 3/28/26 regarding R18's concern. V13 stated V13 took care of R18 again sometime between 4/1/26-4/3/26. b.2) On 4/6/26 at 9:37 AM R82 stated one night a CNA was rude to R82, argued with R82, and R82 didn't like the way the CNA spoke to R82. On 4/06/2026 at 11:30 AM R74, R82's roommate, stated a night shift agency Certified Nursing Assistant (CNA) (identified as V17 based on R74's description) was really rude to R82 and talked down to R82 on the Saturday after R74 admitted to the facility (3/28/26). R74 stated R74 has not seen the CNA since that day. R74 stated the CNA rudely told R82 that R82 was going to have to wait for assistance since the CNA was there to answer R74's call light which caused R82 to get snippy with the CNA. R82's MDS dated [DATE] documents R82 as cognitively intact. The facility's Resident Council Minutes dated 2/18/26 document concerns with agency nursing staff, having attitudes and being mouthy. The Resident/Family Concern/Grievance Form dated 2/18/26 documents residents complained of agency staff not always identifying themselves and having mouthy attitudes. The action taken is listed as agency staff will be monitored related to expectations, reported concerns will be addressed and reported to the agency and with the staff member no longer being allowed to work in the facility. The facility's Daily Assignment Log dated 3/28/26 documents V17 CNA was assigned to R74's/R82's hallway on night shift. On 4/7/26 at 3:53 PM V17 CNA confirmed she last worked in the facility on night shift 3/28/26 and provided cares for R74/R82. V17 stated that night R74 kept turning on the call light for R82 saying R82 needed the bathroom or to be changed. V17 stated R82 denied needing to use the bathroom but then later called to report R82 had wet the bed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to accurately transcribe an order for pain medication for one of three residents (R18) reviewed for hospitalization in the sample list of 43. Findings include: On 04/06/2026 at 11:47 AM R18 stated he admitted to the facility from the hospital after being treated for severe pain in his left shoulder. R18 stated R18's pain returned and R18 was sent back to the hospital five days after R18 admitted to the facility. On 4/7/26 at 11:58 AM R18 showed a paper copy of R18's hospital discharge orders dated 3/9/26 which included Methocarbamol (muscle relaxant) 500 milligrams (mg) by mouth every six hours for 15 doses. R18 stated he did not recall taking this medication or requesting this order to be changed to as needed (PRN) instead of scheduled. R18's March 2026 Medication Administration Record (MAR) documents to administer Methocarbamol 500 mg by mouth every six hours as needed from 3/9/26-3/16/26, with only one dose administered. This MAR does not include the order to give Methocarbamol 500 mg every six hours for 15 doses. This MAR documents R18's pain was rated 3 on 3/11/26, 8 on 3/12/26 and 5 on 3/13/26. R18's medical record does not contain documentation as to why R18's Methocarbamol order was changed. R18's active care plan documents R18 has potential/actual pain with an intervention to give medication as ordered and document the effectiveness.On 4/8/26 at 11:10 AM V8 Registered Nurse stated V8 is the admissions nurse and reviews the orders with the Nurse Practitioner or Physician upon admission. V8 stated if there are ordered changes made then this is documented in a nursing note. V8 reviewed R18's 3/9/26 hospital discharge orders and confirmed the order for Methocarbamol 500 mg every six hours and V8 entered the order as PRN not scheduled. V8 stated V8 was unsure why. On 4/8/26 at 11: 50 AM V2 Director of Nursing stated R18's Methocarbamol order was a transcription error.