

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER Accolade Paxton Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		

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 - 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to appropriately label eye drops and inhalers with the date opened for three (R18, R42, R48) of eight residents reviewed for medication administration on a sample list of 43. Findings: On 4/8/26 at 10:53 a.m., the facility's Main Skilled Medication Cart was inspected in the presence of V20, Registered Nurse (RN). During the inspection, two open bottles of Latanoprost labeled for R18 were found without documented dates of opening. R42's Incruse Ellipta inhaler also lacked a documented date of opening and R48's Latanoprost and Timolol did not contain documented dates of opening. Review of R18's Medication Administration Record (MAR) dated April 2026 documents R18 has an active physician's order and is currently receiving Latanoprost 0.005 % Solution every evening. Review of R42's MAR dated April 2026 documents R42 has an active physician's order and is currently receiving Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 micrograms daily. Review of R48's MAR dated April 2026 documents R48 has an active physician's order and is currently receiving Latanoprost Ophthalmic Solution 0.005 % and Timolol Maleate Ophthalmic Solution 0.5 % daily. The Food and Drug Administration (FDA) approved package insert for Latanoprost Ophthalmic Solution states that once the bottle is opened, it may be stored at room temperature (up to 77 degrees Fahrenheit) for a maximum of six weeks before it must be discarded. The FDA approved package insert for Incruse Ellipta instructs staff to write the 'Tray opened' date on the inhaler's label at the time the tray is opened, and to write the 'Discard' date, which is 6 weeks after the tray opened date. On 4/8/26 at 10:53 a.m., V20, RN, stated that multi-dose containers must be labeled with the date of opening, and that the nurse who initially opens the container is responsible for documenting this information on the container. The facility's Labeling of Medications Policy dated August 2017 with a revision date of September 2023 documents that the facility will ensure that medications are properly labeled in accordance with current state and federal requirements. This policy also documents that it is the responsibility of the Charge Nurse to ensure that all medications are properly labeled.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Practitioner Orders for Life-Sustaining Treatment (POLST) status reflected resident wishes as desired throughout the Electronic Health Record for two (R8 and R51) of 17 residents reviewed for advanced directives in the sample of 43. Findings Include: 1. R51's admission Record documents an admission date of [DATE]. R51's Order Detail Report printed [DATE] documents on [DATE] an Advance Directive order for Full Code. R51's Resident Information Sheet printed on [DATE] documents R51's Advance Directive as FULL CODE. R51's IDPH (Illinois Department of Public Health) Uniform Practitioner Order For Life-Sustaining Treatment (POLST) Form documented an X marked on the box for Do Not Attempt Resuscitation. This form was signed by R51 and dated [DATE] and signed by the Authorized Practitioner. R51's Care Plan revised on [DATE] documents R51 chooses to have death with dignity, advanced directive established. Individual wishes include: DNR refer to POLST. On [DATE] at 12:02 PM V8 (Registered Nurse) verified she would refer to a resident's order listed on the Resident's Information Sheet in the facility's Electronic Healthcare Record (EHR) for their code status. 2. Review of R8's Electronic Health Record (EHR) shows a banner alert that documents Do Not Resuscitate (DNR): refer to POLST. The referenced POLST, dated [DATE], identified R8 as DNR but did not contain R8's signature or the resident representative's signature. This POLST form documents that it was signed only by an unknown hospital nurse indicating that verbal consent was received, however, the form did not identify who provided that consent. R8's Care Plan dated [DATE] documents R8 as a Full Code and documents R8 chooses to have death with dignity, with advance directives established. R8's EHR contains a progress note dated [DATE] at 5:37 p.m. by V18, Social Services Director (SSD) documenting that V18 made multiple unsuccessful attempts to clarify R8's preferences using R8's preferred communication method (white board). This note documents R8 had difficulty understanding Cardiopulmonary Resuscitation (CPR) despite explanation and was noted to have severe cognitive impairment during this interaction. On [DATE] at 9:56 a.m., V18, SSD stated R8's Care Plan should have been updated after R8 returned from the hospital with a reported change in code status to DNR. V18, SSD stated he was delaying the update until the next review and stated that when he contacted R8's POA, the POA did not recall agreeing to a DNR when R8 was hospitalized . On [DATE] at 3:10 p.m., V2, Director of Nursing (DON) stated that either R8 or his POA had given verbal consent at the hospital for R8 to be designated as DNR. V2 stated the POLST form returned from the hospital did not identify who provided the verbal consent. V2 stated the hospital had been returning POLST forms signed only by nursing staff indicating verbal consent, without identifying the consenting party, and the facility did not follow up with R8 or his POA to verify. V2 stated R8's code status change should have been addressed in the Care Plan at readmission. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directive(s)/Care Planning policy with a revision date of [DATE] documents that it is the policy of the facility to establish, implement and maintain written policies and procedures for advance directive. The resident has the right, and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide resident with a written description of the facility's policy to implement advance directives and comply with all applicable Illinois laws, including the Illinois Power of Attorney Act, the Health Care Surrogate Act and the Department of Public Health's Uniform POLST form. This includes the resident's right to formulate an advance directive, the facility's obligation to honor valid DNR/POLST orders, the process for revocation or modification of such directives, and the procedure followed in the event the facility or practitioner cannot comply with an advance directive due to reasons of conscience. Residents have the right to accept request refuse and/or discontinue medical or surgical treatment and to participate in or refuse to participate in experimental research. This Policy documents that the facility procedure is as follows: C. facility staff will provide the resident and/or resident representative with a written description of the facility's policies to implement an advance directive. The facility will identify the primary decision-maker (e.g. assess the resident's decision-making capacity and identify or arrange for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions.) i. if an individual is incapacitated at the time of admission and is unable to receive information or articulate whether he or she has executed an advance directive, the facility will give advance directive information to the individual's resident representative in accordance with State law. E. resident wishes will be communicated to the staff via the care plan/progress note documentation and to the resident physician. This policy documents the interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with the resident's goals wishes as the resident's medical condition changes.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to submit a discharge Minimum Data Sheet (MDS) resident assessment for two of 17 residents (R20, R54) reviewed for resident assessment on a sample list of 43. Findings Include: R20's census list documents an admission date of 11/12/25 and a discharge date of 12/27/25. R20's MDS list documents no discharge MDS completed. R54's census list documents an admission date of 11/06/25 and a discharge date of 12/11/25. R54's MDS list documents no discharge MDS completed. On 04/08/2026 at 11:22 AM V23 Minimum Data Set Registered Nurse stated she did in fact miss doing the discharge MDS for R20 and R54. V23 stated she usually completes the discharge MDS immediately.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to revise a care plan with falls and post fall interventions for one of three residents (R82) reviewed for falls in the sample list of 43. Findings include: On 4/6/26 at 9:37 AM R82 was lying in bed, bed was low to the floor, and a fall mat was beside the bed. R82 stated R82 recently admitted to the facility following shoulder surgery. R82 stated R82 slid out of her wheelchair two days ago. R82 stated R82 is using a different wheelchair than the one she was using that day. R82 stated R82 had a prior fall from her wheelchair while trying to stand up. R82 stated R82 was unsure what follow up actions the facility took to prevent further falls. R82's wheelchair contained an anti-tip device. The facility's Fall report dated 3/29/26 documents R82 fell at 10:30 PM after attempting to stand from her wheelchair to look for clothing in her closet. The interdisciplinary note dated 3/30/26 documents: R82's wheelchair brakes weren't locked at the time of the fall, and the root cause of the fall was R82 standing by herself in combination with unlocked wheelchair brakes. An anti-rollback device was implemented on the wheelchair to reduce movement in the event that R82 attempts to self-transfer without locking the brakes. A fall mat at the bedside was also initiated. The care plan was updated to reflect these changes. The facility's Fall report dated 4/4/26 documents R82 fell at 11:50 PM after attempting to self-transfer from the wheelchair. V26 Certified Nursing Assistant found R82 on the floor of her room. The interdisciplinary team note dated 4/5/26 documents interventions for frequent rounding and room move closer to nurse's station. The interdisciplinary note dated 4/7/26 documents therapy adjusted the wheelchair to lower the chair for better mobility and removed the anti-rollback device. This note documents a wheelchair anti-tip device was in place. R82's Care Plan dated 3/27/26 documents R82 is at risk for falls, R82 admitted to the facility on [DATE], and R82 has a right humerus fracture. This care plan has not been revised to include R82's falls after admission or post fall interventions after 3/27/26. On 4/6/26 at 2:34 PM V3 Assistant Director of Nursing stated V23 Care Plan/Minimum Data Set Coordinator is responsible for updating the care plans with post fall interventions. V3 reviewed R82's care plan and confirmed it had not been updated with R82's falls and post fall interventions. On 4/7/26 at 3:05 PM V1 Administrator stated R82's fall on 3/29/26 was unwitnessed, root cause was R82's attempt to self-transfer and post fall intervention was bed low to floor with fall mat and anti-rollback device added to wheelchair. V1 stated R82 had an unwitnessed fall on 4/4/26, root cause was R82's attempt to self-transfer from wheelchair and post fall interventions included room move closer to nurse's station, which R82 declined, and therapy lowered the wheelchair seat height which then discontinued the anti-rollback device. V1 confirmed these interventions had not been added to R82's care plan. V1 stated V1 will add the interventions today.		

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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.		