STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of East Peoria	500 Centennial Drive East Peoria, IL 61611

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50430 Based on observation, interview and record review the facility failed to ensure the resident rooms were organized, clean, free of debris and odor and walls were in good repair and failed to provide enough housekeeping staff consistently to clean facility. These failures have the potential to affect all 57 residents residing in facility. Findings include: The facility's Midnight Census Report dated 6/11/24 documents 57 residents are currently residing in facility. The undated Employee Job description titled Housekeeping and Laundry Aide Job Description documents under Essential Duties and responsibilities to clean floors daily: to include sweeping, dusting, damp/wet mopping, stripping, waxing buffing, disinfecting etc. The policy further documents Clean, wash, sanitize, and/or polish fixtures, ledges, room heating and cooling units, bathroom fixtures etc. The undated Employee Job description titled Housekeeping and Laundry Supervisor documents The primary purpose of Housekeeping Supervisor is to perform day-to day operations of the housekeeping and laundry department in accordance with current Federal, state and local standards, guidelines and regulations governing our facility, and as directed by the Executive Director, Administrator or the Director of Environmental Services, to ensure that our facility is maintained in a clean, safe and comfortable manner. Facility job description Maintenance Director signed on 1/24/2024 documents the Maintenance Director will ensure all aspects of the facility are in good repair. Job description further documents performs routine inspections of interior and exterior of building. On 6/11/24 at 9:17 AM (R7's) room had towels and wash cloths lying on floor of shower in resident's bathroom. Floor in room had visible food and debris. On 6/11/24 at 9:21 AM (R8 and R9's) in room bathroom had dry feces smeared on toilet seat. In shower was a trash can, two wash basins and a blow-up device were on shower floor. Floor in room had visible dried food and debris. On 6/11/24 at 9:24 AM (R10 and R11's) room had large scuff marks on wall with missing paint. There are two fall mats in the room leaned against wall that are visibly dirty. The room was very cluttered with items around the permeameter of room and against beds. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of East Peoria	500 Centennial Drive East Peoria, IL 61611

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/24 at 9:27 AM (R1's) room was very cluttered with items all over floor. Floor had chocolate milk that was dry. Chocolate milk container still on R1's bedside table. R1's Adult Brief soiled with urine laying in Wheelchair. An unused oxygen concentrator was in corner of room along with a large inflatable air mattress lying on floor rolled up in plastic bag. On 6/11/24 at 9:30 AM (R2 and R6's) room had debris on floor and dried urine next to bed two. Empty urinal on bedside table above the urine on floor. On 6/11/24 at 10:15 AM R5's husband stated that he brings his own cleaning supplies into facility and keeps them in bathroom because R5's room is not being cleaned. On 6/11/24 at 1:45 PM observations of resident rooms were made and remained unchanged. On 6/13/24 at 10:00 AM V8 (Maintenance/Housekeeping Director) confirmed he was aware that on 6/11/24 rooms were not cleaned according to the cleaning checklist. V8 stated, Both of those housekeepers quit today. V8 confirmed the resident rooms have paint chipping off walls and scuff marks. V8 stated the facility is going to start working on remodeling and going to take some time as they can only do one room a month. V8 confirmed the resident rooms are cluttered and they plan to work on them. V8 confirmed that no cleaning audits of facility have been done in over three months. V8 stated he is new to the job three months ago and is still trying to learn about housekeeping. On 6/13/24 at 11:02 AM V1 (Administrator) confirmed V11 (Housekeeper) and V12 (Housekeeper) quit this morning. V1 stated, (V11) and (V12) wanted to work together on the same hall and were upset when I told them they were expected to work separate halls. (V11) and (V12) did not like that so they quit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Accolade Hc of East Peoria		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Centennial Drive East Peoria, IL 61611	

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** 49187 Based on interview, observation and record review, the facility failed to ensure a resident was properly positioned on a bed pan in bed to prevent a fall for one (R1) of three residents reviewed for falls in the sample of 5. This failure resulted in R1 sustaining a fall out of bed resulting in R1 suffering a painful left cheek laceration requiring stiches to the laceration, a closed head injury, and an abrasion to (R1's) left second toe requiring hospital treatment. Findings include: The facility's Fall Prevention Program policy dated 10/2023 documents, Policy: To provide guidelines on preventing resident falls or injury. Procedure: Individualized Care Plan- 1. Identify problem or need. The facility's Positioning the Resident policy dated 7/2023 documents, Purpose: To provide guidelines to staff for properly positioning residents while maintaining good body alignments and using proper body mechanics. Policy: Residents who are unable to reposition themselves assistance will be repositioned by staff to relieve pressure, prevent skin breakdown, relieve pain, and promote proper body alignment. Responsibility: It is the responsibility for all nursing staff to ensure that residents are frequently and properly repositioned. R1's current Admission Record documents R1 was admitted on [DATE]. This same form documents R1 has the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Type Two Diabetes Mellitus with other specified complications, Rheumatoid Arthritis, Major Depressive Disorder, Post-Traumatic Stress Disorder, State Two Chronic Kidney Disease, Unspecified Osteoarthritis, Barrett's Esophagus without dysplasia, and Morbid (severe) Obesity with alveolar hypoventilation. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact and was not coded for exhibiting any behaviors. This same form documents R1 is receiving Hospice services. R1'S Care Plan dated 5/10/2024 documents, (R1) has an ADL (activities of daily living)/mobility self-care performance related to weakness, pain, exertional dyspnea, and morbid obesity. Interventions: Bed mobility- (R1) can turn and reposition herself in bed every two hours and as necessary. Provide more assistance as needed due to anticipated decline with terminal prognosis. Toilet use- (R1) requires moderate assist 1-2 staff for toileting. Provide assistance as needed to due to anticipated decline with terminal prognosis. This same care plan documents R1 is at risk for falls related to weakness, unsteady balance, pain, and morbid obesity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of East Peoria	500 Centennial Drive East Peoria, IL 61611

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 0689 Level of Harm - Actual harm Residents Affected - Few	R1's ED (Emergency Department) Notes dated 5/19/2024 document, Chief Complaint: Fall- (R1) a [AGE] year-old female with a history of chronic respiratory failure on four liters nasal cannula, Diabetes, Chronic Obstructive Pulmonary Disease, paroxysmal atrial fibrillation not on anticoagulation, presenting to the ED after fall out of bed. (R1) rolled out of bed and cut her left cheek on a nightstand, and then fell to the floor, landing on her face. Denied landing on her back or neck. No loss of consciousness. (R1) additionally hit her left second toe during the fall. Physical Exam: Skin- 5cm (centimeter) superficial linear laceration of the left cheek the maxilla. Hemostatic. 1cm superficial hemostatic skin tear on the dorsum of the left second toe. Clinical Impressions: Facial laceration, toe abrasion, ground-level fall, and closed head injury. This same note documents R1 received 7 sutures to R1's left cheek. R1's Incident Report dated 5/18/2024 and signed by V3 (Former Registered Nurse) documents, Nursing Description: This nurse was notified by the nurse assistant that (R1) was on the floor. Upon arrival in the (R1's) room, I observed (R1) laying on the floor next to her bed while bleeding from her left cheek. Call light was within reach. (R1) stated that she was in the process of using a bed pan and she ended up falling to the floor. (R1) is reporting hitting her head on the floor. (R1) has a 5.5cm deep skin cut to left of her cheek, around cut measuring 0.5cm on her left great toe. R1's Progress Note dated 5/19/24 and signed by V9 (RN/Registered Nurse) documents, R1 was observed on the floor approximately 11:00 PM, (R1) was lying on her left side with her head between the oxygen concentrator and the table beside her HOB (head of bed), bed pan lying on the floor somewhat under (R1's) buttock, large amount of bright red blood noted on the floor. (R1) stated she was bleeding from her face, small amount of bright red blood noted on the floor by (R1's) left foot. R1's IDPH (Illinois Department of Public Health) Reportable (undated) documents, Original Incident: On 5/18/2024 at 11:00 PM, (R1) was using the bed pan when she rolled out of bed resulting in a fall with a laceration to left cheek. Conclusion: (R1) has a complex and terminal medical condition which at times requires additional assistance of staff to position self in the middle of the bed. Continued staff education provided on safe bed positioning. On 6/11/2024 at 10:41 AM R1 was in her room sitting in her wheelchair. A small scar was noted to R1's left cheek. R1 was dressed and groomed appropriately. R1's nasal cannula was in place. R1 was visibly upset and stated, The night I fell out of bed (V4/Certified Nursing Assistant) and (V5/Certified Nursing Assistant) were just in my room prior to that and placed me on the bedpan. When (V4) was done positioning me on the bed pan, I told (V4) that I was too close to the side of the bed and that I felt like I was going to fall out and didn't feel safe. (V4) told me that I was not close to the edge of the bed and that I was fine. (V4) did not assist in repositioning me and I was unable to re-position myself. (V5) was brand new so she was just following everything (V4) said. When (V4) left the room, a few minutes later I felt myself sliding off the bed. I rolled off hitting my face on my bedside table and hurting my toe. I was in horrible pain and had to go to the ED. My left cheek still causes me pain. On 6/11/2024 at 12:30 PM V2 (DON/Director of Nursing) stated, If a resident requests for assistance the staff should provide it. If a resident is unable to reposition themselves in bed and requests for help, the staff should provide the assistance and ensure the resident feels safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of East Peoria	500 Centennial Drive East Peoria, IL 61611

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/13/2024 at 11:36 AM V10 (Hospice Registered Nurse) stated, I have only worked with (R1) one time. I am not (R1's) main nurse, her main nurse is off for the week. When I worked with (R1), (R1) stated she was becoming weaker that's one of the reason's she was picked up for therapy because of her decline in her ADL (activities of daily living) status. On 6/13/2024 at 2:48 PM V9/RN stated, I have been (R1's) main nurse on night shift since (R1) admitted to (the facility). I have not known (R1) to make any false accusations. I do know that (R1) says that she has become weaker since she has received Hospice services and has been asking for more assistance. (R1) is a bigger lady so she has to be positioned just right in her bariatric bed.