

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 01/09/2025
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)
<p>F 0845</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Submit a timely, acceptable plan for facility closure, including notification of the appropriate entities and ensuring residents are transferred in a safe and orderly manner.</p> <p>31283</p> <p>Based on interview and record review, the facility failed to ensure their closure plan was approved by the State Agency prior to announcing impending closure and failed to provide a copy of their closure plan to facility residents when notice of closure was given. This failure has the potential to affect all 53 residents who were residing in the facility on 01/02/25, upon the facility's announcement of their intent to close.</p> <p>Findings include:</p> <p>The facility's Closure Plan (dated 12/30/24) documents the facility's intent to close with an anticipated closure date of 03/02/25.</p> <p>On 01/08/25 at 08:30 AM, V1 (Administrator) stated the following: The building is closing. The closure was announced on 01/02/25, and the anticipated date to close is 03/02/25. This is very sad for all involved. V1 stated letters for closure were provided to staff members, facility residents, family members and power of attorneys, CMS (Center for Medicare and Medicaid Services) Regional Office, V6 (Medical Director), all residents Primary Care Physicians, the State Medicaid Agency, and the Ombudsman's office. V1 stated the Closure Plan was submitted by V9 (Chief Operating Officer) to (State Agency) for approval on 12/30/24 and has yet to receive a response or notification of approval.</p> <p>On 01/09/25 at 8:30 AM, 8:55 AM, and 9:30 AM respectively, R1, R2 and R3 all confirmed they were given a letter detailing the facility's plan to close when the facility announced impending closure on 01/02/25. At these same times, R1, R2 and R3 stated they did not receive a copy of any type of detailed closure plan from the facility.</p> <p>On 01/08/25 at 11:20 AM, V1 (Administrator) confirmed that a copy of the facility's Closure Plan was not provided to residents when they were given written notice of closure. V1 stated, I was made aware of the facility's intent to close shortly before the residents and family members were informed on 01/02/25. I was then given instruction from the Corporate Office to proceed with resident placement and transfer to a new facility.</p> <p>On 01/09/25, V3 (Assistant Administrator) provided a copy of the facility's Daily Census form (dated 01/02/25), which documents 53 residents were residing in the facility at that time.</p>

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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