STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145603	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of Paxton on Pells	1001 East Pells 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 40385 Based on interview and record review the facility failed to re-evaluate and coordinate discharge plans to address the needs of a resident (R1) being discharged home and notify the physician of changes in the discharge plan for one of three residents reviewed for discharge in the sample list of six. Findings include: R1's Physician Order dated 3/5/24 given by V16 Nurse Practitioner documents okay to discharge home with home health pt/ot (physical and occupational therapy). R1's Wound Evaluation & Management Summary dated 3/6/24 and recorded by V20 Wound Physician documents R1's right heel stage three pressure ulcer measured 0.4 centimeters (cm) long by 0.3 cm wide by 0.01 cm deep, had moderate serous drainage, and was 100% subcutaneous tissue. This note documents R1's left heel stage three pressure ulcer measured 1 cm by 3 cm by 0.2 cm, had moderate serous drainage, had 10% thick necrotic (dead) tissue, and 80% subcutaneous tissue. The treatment orders were calcium alginate covered with a foam dressing three times weekly and to wear pressure relieving boots when in bed. R1's Post Discharge Plan of Care dated 3/5/24 documents R1 will discharge home and under the section titled Wound Care, Treatments, Therapy (home health company) will evaluate and setup schedule/frequency, and pt/ot will continue for strengthening. This plan of care does not identify if wound care will be provided by home health and does not list any follow up appointments with a wound clinic. R1's Nursing Note dated 3/6/2024 at 11:32 AM recorded by V11 Post Acute Care Coordinator documents V11 spoke with V21 (R1's Family) regarding R1's discharge planned for 3/8/24 and (home health agency) was set up to be R1's home health provider. There is no documentation after this note of communication with V16 Nurse Practitioner, R1, V21 or V9 (R1's Family) that R1 was not accepted for home health services or to discuss scheduling a wound clinic appointment. R1's Nursing Note dated 3/8/24 at 4:00 PM documents R1 discharged home. On 4/30/24 at 10:33 AM R1 stated R1 admitted to the facility in February 2024 and discharged in March 2024 with facility acquired pressure ulcers to R1's heels. R1 stated the facility did not set up an appointment with a wound clinic or home health services for R1. R1 stated R1's family called V17 (R1's Physician) about R1's heel wounds in early April 2024, R1 was transferred to the hospital, and then a wound clinic appointment was scheduled. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 12:39 PM V20 Post Acute Care Coordinator stated V20 is responsible for setting up home health services and follow up appointments prior to a resident's discharge. V20 stated R1 had follow up appointments with V17 and a sleep study scheduled, and referrals had been sent to the three home health agencies that service the area. V20 stated R1 was declined by one home health agency due to R1's insurance, one agency was out of network for R1's insurance, and one agency was not accepting new patients. When asked if V20 reported R1's denial for home health to anyone, V20 replied that V20 reported this to R1 and R1's family and offered to set up a wound clinic appointment with transportation, but they declined. V20 stated V20 typically documents discharge information in a progress note, but sometimes V20 forgets to document. On 4/30/24 at 1:40 PM V16 Nurse Practitioner stated if the resident has wounds upon discharge, then the facility should set up home health services, and the primary physician determines the need for a wound clinic appointment during the resident's follow up appointment. V16 stated the staff probably should have notified V16 of R1's denial for home health services and V16 would have recommended for R1 to stay in the facility longer. On 4/30/24 at 3:00 PM V2 Director of Nursing stated R1 discharged home per family's wishes and (home health agency) is documented as R1's home health provider. V2 stated V2 was not aware that R1 was declined home health services. V2 stated if a resident is declined for home health, then we should follow up with the physician and schedule an appointment with an outpatient wound clinic. On 4/30/24 at 3:30 PM V2 stated V2 spoke with V20 and confirmed R1 discharged home without home health services. V2 stated V20 should have documented V20's follow up with R1 and R1's family. On 4/30/24 at 3:20 PM V13 Scheduler at (R1's assigned home health agency) confirmed R1 was not admitted for home health services. The facility's Discharge/Transfer policy dated August 2023 documents the facility will provide discharge planning that begins on admission and complete the Discharge Planning Assessment and Care Plan which includes expected outcomes and services. This policy documents the interdisciplinary team will review discharge planning to ensure appropriate discharge summary including outpatient services, discharge status, diet, and needed community services to be provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to conduct and thoroughly document weekly skin assessments, identify a newly reopened pressure ulcer, notify the physician, and obtain pressure ulcer treatment orders for one (R4) of three residents reviewed for pressure ulcers in the sample list of six. Findings include: On 4/30/24 at 9:25 AM R4 stated R4 has two buttock wounds that developed in the facility. R4's Minimum Data Set, dated dated dated [DATE] documents R4 is cognitively intact, R4 is at risk for pressure ulcers, has one stage two pressure ulcer and two stage three pressure ulcers that were facility acquired. There are no documented weekly skin assessments in R4's medical record after 2/25/24 until 3/22/24, and then not again until 4/5/24. R4's Nursing Note dated 04/17/2024 at 3:02 PM documents R4 was evaluated by V20 Wound Physician and R4's left buttock wound is healed. R4's Nurses Weekly Skin assessment dated [DATE] documents no new skin issues but does not identify if R4 has a wound or if skin is intact. There is no documentation in R4's medical record after 4/17/24 and prior to 4/24/24 that this wound reopened, the wound was assessed/measured, the physician was notified, or treatments were implemented. R4's Nursing Note dated 4/24/2024 at 4:19 PM documents R4 was evaluated by V20, R4's wound had reopened, and an order for calcium alginate and foam dressing was initiated. R4's Wound Evaluation & Management Summary recorded by V20 documents R4 has cluster of stage two pressure ulcers to the left buttock that measured 0.5 centimeters (cm) long by 0.4 cm wide by 0.1 cm deep. On 4/30/24 between 10:47 AM and 11:15 AM V10 Wound Nurse stated R4's left buttock wound reopened after recently being healed. There were two small, open, red wounds to R4's left buttock. V10 cleansed the wounds, applied Calcium Alginate and a foam dressing. On 4/30/24 at 11:18 AM V10 stated skin assessments are documented weekly by the nurses. On 4/30/24 at 3:26 PM V12 Licensed Practical Nurse stated R4 had a small open area to R4's left buttock when V12 completed R4's skin assessment on 4/19/24. V12 confirmed the physician should be notified and wounds measured when new wounds are identified. V12 stated V12 did not consider it to be a new wound since it was chronic and V12 did not realize the wound was closed prior. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 3:05 PM V2 Director of Nursing V2 confirmed skin assessments should be documented weekly in the assessments section of the resident's Electronic Medical Record. V2 viewed R4's skin assessments and confirmed there were none documented after 2/25/24 until 3/22/24, and then note again until 4/5/24. V2 stated V2 noticed that the weekly skin assessments do not identify if wounds are present or if skin is intact. On 4/30/24 at 3:30 PM V2 was asked about documentation for R4's wound assessments/measurements, wound treatments, and physician notification after 4/17/24 and prior to 4/24/24. V2 stated V2 will look, but if it's not in the record then it's not there. On 5/6/24 at 9:15 AM V2 was asked if V2 was able to locate R4's documentation that was requested on 4/30/24. V2 stated V2 was unable to locate the requested documentation. The facility's Skin Condition Monitoring policy dated June 2020 documents nurses weekly skin assessments will be initiated for all residents and when new wounds/skin abnormalities are found the area needs to be assessed and documented and notify the physician to obtain treatment orders.