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	07/01/2024

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 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. 35046 Based on observation, interview, and record review the facility failed to prevent a fall by failing to explain cares and ensure safety while elevating a bed for one (R1) of three residents reviewed for falls on the sample list of three. This failure resulted in R1 falling from the bed to the floor and sustaining a skull fracture with a brain bleed. Finding include: R1's hospital records dated 6/15/24 document R1 was sent to the emergency room due to a fall. This record documents, (R1) was being repositioned and rolled out of bed at nursing home. (R1) has obvious signs of head trauma. R1's CT (computerized tomography) scan showed intracranial hemorrhage (brain bleed), acute C1 and C2 fractures (spinal fractures), and left frontal calvarium fracture (skull fracture). R1's Incident Note dated 6/15/2024 at 12:45 AM documents, (R1) was being bed checked by CNAs (V3 and V4 Certified Nurse's Assistants). While rolling (R1) to change (R1) rolled out of bed and fell to floor. CNA attempted to catch (R1) but was unable to. (R1) has laceration on (left) upper forehead. Also noted raised area on (left) top of head. This note also documents that R1 was sent to the emergency room . R1's undated Fall with Injury report documents an interview with V4 that states, We (V3, V4) were about to pass (R1's) room when we noticed she was laying fairly close to the edge of her bed. As we approached the room, (V3) was entering the room and I was still in the doorway. (R1) pulled the blanket off and immediately tumbled to the floor. It happened so fast; we were unable to catch her. This report also documents an interview with V3 that states, I asked (V4) to help me with my residents and we went in to reposition (R1). When I first saw her, she was laying in the edge of the bed, wrapped up in her cover, with it over her face. I think that's the only thing that kept her from falling from the bed before we got to her. As I was walking around the bed and raising it, (R1) started to move and pulled her blanket back, at that point she tumbled from the bed. It happened so quick that I couldn't get to her to catch her. On 7/1/24 at 9:51 AM, V3 stated in regard to R1's fall on 6/15/24 when V3 and V4 walked past R1's room she was lying to close to the side of the bed. V3 stated they entered the room and V3 was starting to raise the bed up when R1 pulled the cover back. V3 stated she attempted to run around to catch her, but she fell to the floor. (continued on next page)

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
	145603	A. Building B. Wing	07/01/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/1/24 at 12:42 PM, V4 stated in regard to R1's fall on 6/15/24 that V3 asked her to help her pull up her residents. V4 stated R1's bed was in a lower position, and she was at the edge of the bed. V4 stated, we stopped at her room and V3 went in and started to elevate the bed. V4 stated as she started to raise the bed, R1 noticed we were about to do care and this startled her and before we could do anything she flung her blanket back and rolled over her right arm, face first onto the floor. V4 stated R1 can be combative with cares. V4 stated when V3 hit the button it startled R1. V4 stated R1 was asleep and that they had not woke R1 up to explain cares. On 7/1/24 at 12:28 PM, V5 Licensed Practical Nurse stated when he started his shift on 6/15/24 he made rounds and noted that all the beds were in the low position. V5 stated that later in the shift V4 notified him that R1 had rolled out of the bed. V5 stated the bed in the room was then elevated. V5 stated R1 was lying on the floor, and he called emergency services due to R1 having a head injury. V5 stated there was blood coming from R1's forehead. V5 stated V3 and V4 told me they were rolling her, and she rolled too far, and they were unable to catch her. On 7/1/24 at 10:30 AM, V2 Director of Nursing walked into the room in which R1 resided. V2 stated the bed was in the same location as the day that R1 fell . V2 demonstrated where V3 was standing when R1 fell out of the bed. V2 was standing at the foot of the bed and stated V3 was standing here at the foot of the bed. V2 stated V4 was standing in the doorway which was nearest to the foot of the bed. V2 stated that V3 used the controls located on the outside of the footboard when she started to raise R1 in bed. V2 then lowered the bed to the floor using these controls. V2 then began to raise the bed and the bed shook and made a loud noise when it was starting to raise up. V2 stated that this sound could have startled R1. V2 stated that prior to raising the bed either V3 or V4 should have been standing on the side of the bed to prevent R1 from falling out of the bed. On 7/1/24 at 2:42 PM, V12 Nurse Practitioner stated R1 had graduated from hospice and then was put back on it after her 6/15/24 fall. V12 stated R1 had a fall with a fracture and a bleed. V12 stated R1 could be combative with cares. V12 stated the staff should attempt to explain cares to R1 prior to providing cares and if the bed is being raised then they should be on the side in case R1 were to roll out. R1's care plan dated with a reviewed dated of 5/20/24 documents R1 requires assistance with bed mobility and can be uncooperative with cares, have hallucinations and delusions related to a diagnosis of Dementia and Alzheimer's disease. This care plan documents and an intervention to give clear explanation of all care activities prior to and as they occur during each contact with R1. The facility's Resident Handling Policy Bed Positioning policy with a revision date of 9/18 documents the purpose of the policy is to ensure a safe working environment for resident's handlers. This policy documents to, 4. Explain the procedure to the resident prior to completing the procedure.