

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Accolade Hc of Paxton on Pells		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172</p> <p>Based on interview and record review the facility failed to immediately report an allegation of potential sexual abuse to the Abuse Coordinator and to the State Surveying Agency. This failure has the potential to affect two of three residents (R1, R2) reviewed for abuse in the sample of three.</p> <p>Findings Include:</p> <p>The untitled facility investigation dated 8/28/24 documents in the morning meeting on 8/28/24 at approximately 10:15 AM it was mentioned that R2 was found in R1's bed the night before. V1 Administrator had not been made aware of the incident until that moment. An investigation began and staff were interviewed. V4 Certified Nursing Assistant (CNA) stated she worked the evening before (8/27/24) and witnessed R2 on top of the covers in R1's bed kissing R1 on the cheek. V4 stated she called down the hall for V5 Licensed Practical Nurse (LPN) to come and assist. V5 LPN stated V4 called for her to come and help because R2 was in R1's bed. Neither V4 nor V5 reported the incident to V1 Administrator/Abuse Coordinator.</p> <p>R1's Medical Diagnoses list dated September 2024 documents R1 is diagnosed with Multi-System Degeneration of the Autonomic Nervous System, Encephalopathy, Epilepsy, Depression, Mood Disorder, Anxiety, Convulsions, Speech Disturbances, and Muscle Weakness.</p> <p>R1's Minimum Data Set, dated dated [DATE] documents R1 is severely cognitively impaired and dependent on staff for bed mobility and transfers.</p> <p>R2's Medical Diagnoses list dated September 2024 documents R2 is diagnosed with Schizophrenia and Disorders of the Brain.</p> <p>R2's Minimum Data Set, dated dated [DATE] documents R2 is moderately cognitively impaired, walks independently with a cane, and wanders. R2's wandering significantly intrudes on the privacy of others.</p> <p>(continued on next page)</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/4/24 at 3:50 PM V5 Licensed Practical Nurse stated on the evening of 8/27/24 at approximately 8:30 PM V4 CNA called her down to help get R2 out of R1's bed. V5 stated when she got down to R1's room, V4 had helped R2 off the bed and she was standing beside R1's bed. V5 stated R2 was removed from R1's room. V5 stated she asked V4 why she called her down there and V4 stated R2 was in R1's bed. V5 stated if that was the case, V4 needed to call V1 Administrator and report it. V4 confirmed she herself did not report the incident to V1 Administrator.</p> <p>On 9/4/24 at 11:25 AM V4 Certified Nurse Assistant (CNA) confirmed on the evening of 8/27/24 at approximately 8:30 PM she observed R2 laying in bed beside R1. R2 was on top of the covers cuddling with R1 and gave R1 a kiss on the cheek. V4 stated she yelled for the nurse on duty (V5 LPN) and went into R1's room and told R2 to get up, that R1 was not her husband, and she needed to go back to her own room. V4 stated she removed R2 from R1's room. V4 stated V1 Administrator should have been notified of the incident as potential abuse however V4 thought that V5 LPN was going to call and notify V1, and she apparently did not.</p> <p>On 9/5/24 at 11:45 AM V1 Administrator confirmed staff should always immediately report potential incidents of abuse to the Abuse Coordinator (V1). In this case, V4 CNA should have reported the incident to V1 Administrator when it occurred. V1 confirmed the incident was not reported to the Department of Public Health.</p>		