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	01/16/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 51951 Based on observation, interview and record review, the facility failed to perform hand hygiene before and after catheter care to prevent potential contamination and failed to ensure a urinary drainage bag was covered with a dignity bag for one of one resident (R39) reviewed for catheters on the sample list of 38. Findings Include: On 1/13/25 at 8:40 am and 3:12 PM, R39 was lying in bed and had an uncovered urinary catheter drainage bag hanging on the bed frame, which was visible from the hallway. On 1/14/25 at 8:40 am, R39 was lying in bed and had an uncovered urinary catheter drainage bag hanging on the bed frame, which was visible from the hallway. On 1/15/25 at 11:25 AM, R39 was lying in bed and the urinary catheter drainage bag was hanging on the bed frame, covered in a dignity bag. At this time, V33 and V34 CNAs (Certified Nursing Assistants) both stated that catheter drainage bags should be in a dignity bag at all times. V33 and V34 donned gloves to provide catheter care using disposable wash rags but did not wash their hands before donning gloves. After catheter care was completed, with the same gloved hands, V33 and V34 proceeded to place an incontinence brief onto R39, adjust R39's sheets and blankets, and reposition R39's call light. V33 and V34 then removed their gloves and exited the room without performing hand hygiene. V33 and V34 both confirmed they did not perform hand hygiene before or after catheter care. The facility Catheter Care and Maintenance Policy dated March 2024 documents a resident's catheter drainage bag will be concealed with a privacy covering. The facility Hand Washing Policy dated March 2024 documents the facility considers hand hygiene the primary means to prevent the spread of infections. All staff will properly wash hands after direct contact with any contaminated substances, after direct resident care, and as instructed. Employees must wash their hands for 15 to 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents, when hands are visibly dirty or soiled with blood or other bodily fluids, after contact with blood, body fluids, secretions, mucous membranes, and after removing gloves.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to obtain a re-admission weight, notify the physician and resident representative of significant weight loss, and develop a plan of care to address significant weight loss for one of three residents (R77) reviewed for weight loss on the sample list of 38. Findings Include: The facility's Weight Management policy dated August 2017 documents all residents will be weighed on admission, re-admission, and weekly for the first four weeks, then monthly thereafter. Weekly weights will also be done with a significant change of condition. Any significant weight loss will be reviewed with the physician to obtain an order for a nutritional supplement until the resident's condition is discussed during weekly risk meetings. The resident's care plan will be updated to include interventions promoting weight gain or loss. The family or Power of Attorney will be notified of significant weight changes and plan of care which will be documented in the resident's medical record. R77's Medical Diagnoses List dated January 2025 documents R77 is diagnosed with Severe Protein Calorie Malnutrition, Muscle Wasting and Atrophy, Dysphagia, and Adult Body Mass Index of 19.9 or less. R77's Clinical Census list dated January 2025 documents R77 was discharged to the hospital on 8/18/24 and was readmitted to the facility on [DATE]. R77's Progress Note dated 8/15/24 documents R77 was positive for Covid-19 and R77's Progress Note dated 8/18/24 documents R77 had a change of condition was sent to the emergency room for evaluations. R77's progress note dated 8/28/24 documents R77 returned to the facility on [DATE] and had been diagnosed with Pneumonia. R77's Weight Log documents on 8/6/24 R77's weight was 131 pounds. The same Weight Log documents on 9/4/24 R77's weight was 112 pounds. This is a 14.5% weight loss in one month. R77's Electronic Medical Record does not have documentation of a re-admission weight within 24 hours of admission, physician notification or family notification regarding R77's significant weight loss, or a weight specific care plan addressing R77's risk for or actual weight loss with related interventions. On 1/15/25 at 1:23 PM V2 Director of Nurses confirmed a re-admission weight should be taken within 24 hours. V2 also confirmed if a resident has lost a significant amount of weight, the resident's physician and family should be notified of the weight loss. V2 also confirmed residents at risk for weight loss or with actual unplanned weight loss should have a documented plan of care with interventions in place to prevent further weight loss. V2 confirmed there was no documentation that any of these things were done for R77.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 40385 Based on observation, interview, and record review the facility failed to track culture results and organisms as part of the resident infection control logs. This failure has the potential to affect all 92 residents in the facility. The facility also failed to implement enhanced barrier precautions (EBP), provide hygienic wound care, and identify and report changes in urine for four of 24 residents (R24, R70, R45, R39) reviewed for infection control in the sample list of 38. Findings include: 1.) The facility's August 2024 - January 2025 resident infection control logs do not document culture results for wound or urinary tract infections or tracking of bacterial organisms as part of the surveillance monitoring used to identify any trends. On 1/16/25 at 9:24 AM V1 Administrator confirmed the facility's infection control logs do not document if cultures were completed or tracking of organisms. V1 stated that is something we are doing, but it just isn't logged. The facility's Long Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents a census of 92 residents. The facility's Surveillance and Baseline Calculations for Nosocomial Infections policy dated April 2024 documents the Infection Control Nurse or Designee is responsible for monitoring infections to determine incidences of infections, outbreaks, probably cause, and prevention. This policy documents an infection incidence report will be completed monthly, quarterly, and annually and information will be obtained including laboratory records and infection control rounds. 2.) On 1/13/25 at 2:08 PM V12 and V13 CNAs entered R70's room with a full mechanical lift and transferred R70 into bed. V12 and V13 did not apply a gown prior to entering R70's room. There was a sign on R70's door indicating EBP and to wear a gown and gloves during high contact care including transfers. V13 stated the EBP sign on R70's door was for R70's roommate. V12 and V13 stated EBP is followed only for when they are providing urinary catheter or wound care. On 1/14/25 between 12:10 PM and 12:52 PM V9 Wound Nurse, V18 Wound Nurse Practitioner, and V40 CNA entered R70's room to assess R70's wounds and administer wound treatments. These staff were not wearing gowns during R70's wound care. V9 brought the treatment cart into R70's room and placed supplies on top of the cart including R70's wound supplies and the cellular phone used to photograph wounds. V9 cleansed and applied R70's wound treatments to the left buttock wound, right ischium wound, and right heel wound. During R70's wound treatments V9 did not consistently perform hand hygiene and glove changes prior to and during each wound treatment, after handling the cellular phone, after removal of soiled dressings, after cleansing wounds, and after applying the treatment. V9 tore a piece of calcium alginate that was applied to R70's right heel and right ischium wounds while wearing the same gloves used when handling the cellular phone. V9 did not disinfect the cellular phone or treatment cart prior to or after R70's wound care. V9 left R70's room and continued rounding with V18 down the hallway with the treatment cart and cellular phone. The EBP sign remained posted on R70's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/14/25 between 4:15 PM and 4:28 PM V2 Director of Nursing stated V9 should not have taken the treatment cart into R70's room since R70 is on EBP. V2 confirmed EBP is implemented for residents with pressure ulcers and urinary catheters and gowns/gloves should be worn for all high contact cares. V2 stated V2 will need to do more education with staff on EBP. On 1/15/25 at 9:05 AM V9 stated V9 was not aware that a treatment cart should not be brought into a resident's room during wound treatments. V9 stated V9 uses a bleach wipe to disinfect scissors after use and the cellular phone used to photograph wounds. V9 confirmed V9 did not disinfect the cellular phone and treatment cart after R70's wound treatments on 1/14/25. V9 stated hand hygiene should be performed during wound care when moving from soiled to clean and when changing gloves. V9 stated V9 changes gloves and performs hand hygiene after removing soiled dressings and then V9 cleans the wound and applies the clean dressing. V9 confirmed V9 was inconsistent with glove changes and hand hygiene during R70's wound care. V9 stated V9 was not aware of EBP until after V2 spoke with V9 yesterday. V9 confirmed gowns were not worn during R70's wound care. The facility's Infection Control Enhanced Barrier Precautions policy dated 10/21/22 documents EBP expands the use of gown and gloves to be worn during high contact resident care activities that provide opportunities to transfer multidrug resistant organisms (MDROs) to staff hands and clothing that may be indirectly transferred to other residents. This policy documents that residents with indwelling medical devices and wounds are at high risk of acquiring MDROs. The facility's Hand Washing policy dated March 2024 documents hand hygiene is used to prevent the spread of infections and staff should wash their hands before/after direct contact with residents; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; after removing gloves; and after handling items potentially contaminated with blood, body fluids or intact skin. This policy documents to use hand sanitizer if hands are not visibly soiled before/after direct resident contact; before performing non-surgical invasive procedures; before handling clean or soiled dressings; before moving from contaminated body site to a clean site during cares; after contact with a resident's skin; after handling soiled dressings and contaminated equipment; and after removing gloves. The facility's Treatment Administration policy dated April 2023 documents to place all necessary supplies in the treatment cart, complete the treatment as ordered using stringent infection prevention and control measures and discard disposable dressings and return reusable items to the proper location. 3.) On 1/14/25 at 1:35 PM V12 Certified Nursing Assistant (CNA) was in R24's room using a sit to stand mechanical lift to transfer R24. R24 was not wearing a gown or gloves during R24's transfer. There was a sign on R24's door indicating EBP and to wear gown and gloves for high contact care including transfers. There was no personal protective equipment cart in or near R24's room. R24's Physician Order dated 2/21/24 documents R24 uses a urinary catheter. R24's Physician Order dated 3/12/24 documents R24 is on EBP. 50322 4.) R45's current care plan documents R45 has an ostomy and buttock wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/14/25 at 3:15 PM Wound care observed for R45 with wound nurse practitioner V18 and wound nurse V9. There was an EBP sign on the door and there was no personal protective equipment available outside R45's room or visualized in R45's room. No gowns or masks were worn by either V18 or V9 while assessing R45's wounds and hand hygiene was not performed before or after R45's treatment. V18 donned one glove only while touching R45 and assessing the wound. V9 brought in the treatment cart with wound care into R45's room and placed next to R45's bed. V9 did not change gloves or perform disinfection at any time prior, during, and after R45's treatment. V9 placed used instruments on top of the treatment cart, then opened drawers and grabbed items with the same dirty gloves on. On 1/14/25 between 4:15 PM and 4:28 PM V2 Director of Nursing confirmed EBP is implemented for residents with pressure ulcers and urinary catheters and gowns/gloves should be worn for all high contact cares. V2 stated V2 will need to do more education with staff on EBP. 51951 5. On 01/13/25 at 09:20 AM, R39 had an EBP (Enhanced Barrier Precautions) sign posted outside of R39's room but there was no PPE (Personal Protective Equipment) cart at R39's door. At this time, R39 stated staff wear gloves but not gowns when providing cares to R39. On 1/14/25 at 08:40 AM, R39 was lying in bed with a urinary catheter in place. The EBP sign remained posted outside of R39's room. At this time, R39 stated R39 had been told by V30 LPN (Licensed Practical Nurse) that his urine was cloudy but then a couple weeks later, R39 ended up being hospitalized with a UTI (Urinary Tract Infection). On 1/15/25 at 9:08 AM, V30 LPN stated R39 has a history of UTI's and confirmed that V30 had noticed R39's urine was cloudy, prior to R39 being hospitalized with a UTI. V30 stated V30 had written that update on a communication sheet for V28 NP (Nurse Practitioner) but that V28 never responded or replied to the update. V30 stated V28 is in the facility two days one week and three days the next. V30 provided a copy of the undated/untitled communication form that documents on 12/15/24, R39's urine is starting to get cloudy-do you want a UA (Urinalysis)? This communication form did not have a response from V28. R39's Hospital Discharge Note dated 1/2/25 documents R39 was hospitalized from 12/30/24 - 1/2/25 for a UTI. On 1/15/25 at 9:30 AM, V2 DON (Director of Nursing) stated that nursing staff are to notify the provider on call when a change of condition is observed. On 01/15/25 at 11:25 AM, an EBP sign remained posted at R39's door but there was no PPE cart in sight. V33 and V34 CNAs entered R39's room to provide catheter care and donned gloves but did not don a gown. V33 and V34 completed catheter care and exited R39's room. At this time, both V33 and V34 stated they have received EBP training but normally do not wear gowns when performing catheter cares for R39. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Catheter Care and Maintenance Policy dated March 2024 documents, residents with indwelling catheters will receive the appropriate care and monitoring as indicated in the procedures. The facility will monitor the resident's urine for unusual appearance (i.e., blood, color, consistency, odor, etc.) and will report any changes in condition such as pain or the resident experiencing fullness in the bladder, to the health care provider. The facility will monitor the resident for signs and symptoms of urinary tract infection and urinary retention which can include abdominal distention and pain, changes in volume and appearance of urinary output, fever, altered mental status or increased confusion, nausea, or vomiting, etc. Negative findings will be reported to the health care provider. The facilities Physician Notification of Resident Change of Condition Policy dated August 2023 documents, the resident's attending physician will be notified of changes that occur in the resident's condition by Licensed Personnel as warranted.