

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 09/12/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent elopement of a resident when staff did not verify that the exit door was properly secured after use. This failure effected one (R1) of three residents reviewed for elopement. Findings include:R1's Facility Census documents R1 was admitted to the facility on [DATE] and has the following medical diagnoses; Dementia, Metabolic Encephalopathy, Type 2 Diabetes, Muscle Wasting and Atrophy, Lack of Coordination, Abnormal Posture, Abnormalities of Gait and Mobility, Difficulty in Walking, Intervertebral Disc Degeneration, Alzheimer's Disease, Heart Failure, Anxiety Disorder, Colostomy, Fall on Same Level, Depression, Cognitive Communication Deficit, Repeated Falls, Weakness and Age-related Cognitive Decline.On 9/12/25 at 10:10 AM, V3 Licensed Practical Nurse stated on 8/27/25 at 6:15 PM V3 and V4 Certified Nursing Assistant went outside to smoke, exiting the employee service door which has a key code lock. V3 stated that sometimes the door does not lock if it doesn't close all the way, and V3 is unsure if it locked that day. V3 stated that shortly after returning into the facility V4 informed V3 that R1 was outside of R1's room tapping on the window. V3 stated V4 went and pushed R1 in R1's wheelchair back into the facility and to R1's room. On 9/12/25 at 10:56 AM, V4 Certified Nursing Assistant stated that on 8/27/25 at 6:15pm V4 and V3 Licensed Practical Nurse went outside to smoke. V4 stated that while walking to the employee service door V4 observed R1 in the hallway. V4 stated that V4 and V3 used the employee service door to go outside, and this door does have a keypad lock. V4 stated that sometimes the door doesn't latch, and you have to pull it closed to lock. V4 stated V4 does not recall if V4 or V3 pulled the door closed to make sure was locked. V4 stated that at 6:20 PM V4 and V3 returned back into the facility. V4 was gathering supplies to change a resident, and upon walking past R1's room, V4 heard a knocking noise. V4 stated V4 went into the room and observed R1 knocking on the window from outside. V4 stated V4 and another CNA went outside and got R1 and brought R1 to R1's room. On 9/12/25 at 1:01 PM, R1 stated that a couple of weeks ago R1 followed the girls out the door, and when R1 got out the door it locked and R1 could not get back in. R1 stated that R1 went over to a room window and knocked on the window until staff seen R1 and came and got R1 back inside the facility.On 9/12/25 V1 Administrator stated that on 8/27/25 at 6:25 PM V8 Certified Nursing Assistant called V1 and informed V1 that R1 was outside of R1's window knocking on R1's window from outside. V1 stated V4 further stated to V1 that this was around 6:15 PM and V4 and V3 Licensed Practical Nurse were going outside for a smoke, and R1 appeared to be propelling back towards the dining room. V1 stated that V4 informed V1 that V4 returned back into the facility about 5 minutes later, and while passing R1's room heard knocking on the window, and upon going into R1's room, observed R1 outside R1's window. V1 stated that V1 interviewed V3 Licensed Practical Nurse who stated to V1 that V3 and V4 went outside to smoke, exiting the employees service door. V1 stated V3 returned back into the facility at 6:20pm and V4 informed V3 that R1 was outside knocking on R1's window. V1 stated V3 brought R1 back into the facility. V1 stated that neither V3 nor V4 were able to confirm if the door locked when they exited the facility. The Facilities Missing Person's Policy revised 1/23 documents: Purpose: to provide facility staff with the guidance for ensuring the health, safety and welfare of all the residents, and protocol to be followed when a resident is noted to be missing. Policy: Each unit charge nurse, during their respective tour of duty will be aware and responsible for knowing the location of their residents at all times. When residents are participating in various programs such as physical therapy, recreational activities, dining, etc., the staff at these program areas will exercise sound judgement and be aware and responsible for the health, safety and welfare of their participants. Nursing personnel must report and investigate all reports of missing residents.</p>		