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	09/26/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish clear communication regarding notification to a funeral home to remove a resident R1 remains for 1 of 3 residents reviewed for death.This past non-compliance occurred from [DATE] to [DATE].Findings include: R1's Facility Census documents show that R1 was admitted to the facility on [DATE] and was discharged on [DATE]. R1 had the following medical diagnoses: Traumatic Subdural Hemorrhage with Loss of Consciousness, Dementia, COPD, Heart Disease, Chronic Kidney Disease Stage 4, Anxiety Disorder, Scoliosis, GERD, and Repeated Falls.R1's Nursing Note dated [DATE] at 11:58 AM documented that R1 expired at 11:52 AM. A hospice nurse and family were at the bedside, and V2, Director of Nursing, was notified.R1's Nursing Note dated [DATE] at 10:33 AM documented that the funeral home arrived and removed R1's body from the facility.On [DATE] at 10:00 AM, V6, Licensed Practical Nurse (LPN), stated that on [DATE] V6 was working the 6:00 AM to 2:00 PM shift and that R1 was in V6's group. V6 stated that R1 passed away at 11:52 AM, which was confirmed by V12, Hospice Registered Nurse. V6 stated that at shift change, V6 informed V7, Licensed Practical Nurse, that R1 had expired and that the funeral home had not picked up R1's remains. V6 stated that V6 did not call the funeral home to inform them that R1 had expired, assuming that V12 had made the call. V6 stated that V6 should have confirmed with V12 that the funeral home had been notified.On [DATE] at 10:15 AM, V7, Licensed Practical Nurse (LPN), stated that on [DATE] V7 worked from 2:00 PM to 6:00 PM and, upon receiving report, was notified by V6 that R1 had expired and was still in R1's room. V7 stated that at the end of V7's shift, R1 had still not been picked up by the funeral home, and V7 informed V8, Licensed Practical Nurse (LPN), that R1 remained in the room. V7 stated that V7 did not call the funeral home.On [DATE] at 10:30 AM, V10, Licensed Practical Nurse (LPN), stated that on [DATE] V10 worked the 6:00 AM to 6:00 PM shift and was informed during report that R1 had expired on [DATE] at 11:52 AM, but was not informed that R1 was still present in the facility. V10 stated that at 10:00 AM, V11, Housekeeper, informed V10 that upon entering R1's room to clean it, V11 observed R1 in bed. V10 stated that notifications were made to V13, the duty manager, and that the funeral home was called and picked up R1's remains at 10:33 AM.On [DATE] at 10:48 AM, V9, [NAME] President of Hospice Operations, stated that on [DATE] V12's hospice nursing notes documented that R1 was pronounced expired at 11:52 AM. V9 stated that V12 notified the Ford County Coroner, and the coroner released R1's body to the funeral home in [NAME] City at 12:21 PM. V12 stated that V12 informed V6 that the family wanted some time with R1, and that after the family left, the facility would provide postmortem care and that the facility was responsible for calling the funeral home.On [DATE] at 10:58 AM, V11, Housekeeping, stated that on [DATE] V11 worked the 6:30 AM to 3:00 PM shift. V11 stated that V11 was informed that R1 had passed away and that V11 would need to clean R1's room. V11 stated that at 10:00 AM V11 went to clean R1's room and, upon opening the door, observed R1's body still in bed. V11 stated that V11 informed V6, Licensed Practical Nurse, that R1's body was still in the room.On [DATE] at 11:10 AM, V2, Director of Nursing, confirmed that R1 had expired on [DATE] at 11:52 AM and that the funeral home was not notified until [DATE] at 10:05 AM to remove R1's remains. V2 stated that the facility should have communicated with V12, Hospice Registered Nurse, to ensure that hospice had notified the funeral home. V2 stated that there was no documentation in R1's chart indicating that R1's remains were removed from the facility until [DATE].Prior to the survey date of [DATE], the facility took the following actions to correct the non-compliance:On [DATE], R1 expired at the facility under hospice care at 11:52 AM.On [DATE], the Quality Assurance Committee developed a Plan of Correction for the [DATE] incident and a Performance Improvement Plan.On [DATE], the Director of Nursing and Administrator provided in-service education to nursing staff on documentation and communication requirements for end-of-life care, after-death care, the death checklist, midnight census procedures, and shift-to-shift reporting following a death.On [DATE], the facility standardized communication pathways with hospice, the funeral home, and the coroner.Starting on [DATE], the Director of Nursing and/or designee began auditing resident end-of-life documentation, the funeral home/coroner notification log, shift-to-shift handoff reports, and after-death care after every resident death for one month.The facility QAPI Committee will continue to monitor performance to ensure corrective actions related to the [DATE] incident are effective.Completion date of substantial compliance: [DATE].