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	04/15/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the residents' right to be free from verbal abuse by another resident for two of four residents (R75 and R84) reviewed for abuse on the sample list of 36. Findings include:R75's Minimum Data Set (MDS) dated [DATE] documents R75's Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15 indicating no cognitive impairment. This same MDS documents R75 has no delusions or hallucinations, and no behaviors directed towards self or others.On 4/12/26 at 2:50 pm R75 and V26, R75's Family Member were seated in R75's room. R75 stated that R84 came past her room in the hallway one day and scream into R75's room. (R84) called me an (F expletive B expletive). I kept it to myself. I did not say anything to any staff. We (R84 and R75) were friends. This had come out of nowhere. I was really just worried about my roommate (R9). She (R9) doesn't get out of bed very often. She likes to sleep. I worried about her and figured he (R84) could come into our room, though, he (R84) hadn't. The next day, it happened again. This time he exploded with very bad nasty, curse words. Some I did not even know. His (R84) tone was so angry, I knew they (the words she didn't know) were bad words also. I was crying. He just kept it up for what seemed like several minutes. I (got up my courage) then and told him to go away. I told him to leave the building. He stayed outside in the hall looking through the window of the assisted dining room. He was watching me, and I was really uncomfortable and still crying. V26, R75's Family Member stated My Mom (R75) was really upset. She was tearful, each time I talked to her for the next couple days. R75 stated You can talk to (V29 Certified Nursing Assistant) CNA she can tell you all about it. I am not afraid of anyone else, staff or residents. I have no fear here, since he (R84) was ejected (discharged)from the facility.On 4/13/26 at 7:15 am V1, Administrator/Abuse Prevention Coordinator stated the facility did not conclude in their verbal abuse investigation between R84 and R75 that abuse occurred. V1 stated the conclusion she arrived at was because she thought it had to be a willful intent to harm. She reviewed the facility abuse prevention policy to clarify her understanding. V1stated she can see now that it only had to be an intentional act. V1 confirmed R84 intentionally cursed at R75.On 4/14/26 at 10:00am V28, Registered Nurse (RN) stated I reported the resident to resident incident between (R75) and (R84) to the (V1, Abuse Prevention Coordinator) Administrator. That is our protocol after we make sure the residents are separated. (V29, Certified Nursing Assistant/CNA) was pushing (R75's) wheelchair down the hall. (R29, CNA) asked me if I heard what (R75) had just said. I said no and (R75) was tearful and told me that (R84) had just screamed profanities at her (R75) in the dining room. V28, RN also stated V28, RN stated (R75) became more upset when she started telling me what he said. (R75) said he called her an (F expletive B expletive), and was saying all kinds of other harsh, foul words. My heart broke for (R75). I took her to the nurses station and asked (V29, CNA) to stay with her. I went to find (R84) because I did not want him around other residents. (R84) was in his room. Of course, I asked him what he (R84) said to (R75). He denied anything inappropriate was said between him and (R75). He looked angry when I talked to him, but he did not say anything in his agitated state. I went immediately and reported it to (V1, Administrator/Abuse Prevention Coordinator). All staff on the unit knew to watch his room, to make (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure he stayed there until the ambulance came to transport to the hospital for evaluation.R84's current diagnoses list documents: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, and Depression.R84's MDS dated [DATE] documents the following: R84's BIMS score of ten out of a possible 15, indicating moderate cognitive impairment. R84's Physician Order Sheet dated March 2026 documents the following Psychotropic Medications: Sertraline HCl Oral Tablet 50 MG (milligrams), Give 50 mg by mouth in the morning, Divalproex Sodium Oral Capsule, Delayed Release Sprinkle 125 MG, (Divalproex Sodium), Give 250 mg by mouth two times a day and Trazodone HCl Oral Tablet 50 MG, Give 0.5 tablet by mouth at bedtime.R84's corresponding Medication Administration Sheet dated March 2026, documents R84 refused to take R84's above psychotropic medications for 16 days out of 24 days, (prior to verbally abusing R75 on 3/25/26).R84's current Care Plan documents: (R84) receives antidepressant medication related to Depression and behaviors of wearing non-appropriate clothing in hallways, anger. The same care plan documents: (R84) refuses taking his medications.R84's Behavior Note Narrative dated 3/24/2026 at 7:40 pm documents the following: Note Text: Resident was having pleasant conversation with another resident, when he suddenly became angry and started cussing at her. Staff immediately separated residents, (R84 and R75) and (R84) went to his room. Other resident (R75) remained with staff, and was calm, just confused as to why he (R84) suddenly became angry with her. Resident has not been taking medications per his refusals; EMS (Emergency Medical Service) was called resident sent to local ER (Emergency Room).The facility Illinois Department of Public Health Final Report dated 3/2726, documents: Resident (R84) to (R75) Resident Verbal Abuse on 3/25/26. Conclusion: Abuse FINAL Investigation (R75) is no longer scared and has maintained distance. (R84) is now able to get to the level of psychiatric care that he needs and should not be returning to the facility. The facility policy Abuse and Retaliation Prevention Program dated January 2026 documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.The same policy documents: Abuse: Abuse means any physical or mental injury; retaliation; or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means; the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.