

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/28/2026
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement fall interventions and thoroughly investigate falls for two of three residents (R1, R2) reviewed for falls in the sample list of three. Findings include: The facility's Accidents and Incidents policy dated as revised January 2026 documents all accidents/incidents involving residents will be investigated and the charge nurse conducts an immediate investigation and implements immediate appropriate interventions. This policy documents the Risk Management and accompanying documentation will be reviewed by the Director of Nursing (DON)/designee, the DON will conduct an investigation of the accident/incident, and the interdisciplinary team will be notified of findings so that the care plan can be updated as needed. The facility's Transfers policy dated as revised June 2026 documents to follow the resident's care plan to ensure the use of proper transfer technique. 1.) R1's census documents R1 admitted to the facility on [DATE] and discharged [DATE]. R1's admission Minimum Data Set (MDS) dated [DATE] documents R1 was cognitively intact, R1 was frequently incontinent of urine, and required partial/moderate staff assistance with transfers, dressing, and toileting. This MDS documents R1 had a history of falls prior to admission. R1's Fall Risk assessment dated [DATE] documents R1 as a high fall risk, including risk factors of weakness and overestimates/forgets limits of R1's abilities. R1's Care Plan revised 7/1/26 documents R1 required one assist for transfers, R1 was at risk for falls with interventions including non-skid socks (4/4/26 and 4/27/26) and keeping items within reach (4/4/26). R1's care plan does not document R1 refuses to wear or removes the non-skid socks. R1's Fall Report dated 4/26/26 at 6:45 PM, completed by V12 Licensed Practical Nurse (LPN), documents R1 was found on the floor next to R1's bed and recliner, R1 had a skin tear to the back of right hand, and R1 was not wearing shoes. This report documents R1 reported R1 was laying down and slid out of bed onto the floor. The root cause of the fall is documented as resident (R1) slid out of bed and non-skid socks as the post fall intervention. V16's (Certified Nursing Assistant (CNA)) Employee Statement dated 4/26/26 documents V16 was coming back from the dining room and found R1 sitting on the floor near R1's bed and V16 had last seen R1 before dinner walking with family back to R1's room. This statement documents after the fall V16 cleaned up the urinal spill on R1's floor and applied R1's non-skid socks. R1's fall investigation does not include when R1 was last toileted or urinal emptied and does not include any documentation that R1 refused to wear non-skid socks or removed them. R1's Fall Report dated 5/13/26 at 8:20 AM documents CNA (V10) reported R1 was in the shower room turning to sit down to prepare for shower, lost balance and had a witnessed fall with skin tear to right elbow. R1 reported R1 thought his hand slipped off the railing while attempting to turn and sit down. V10's Employee Statement dated 5/13/26 documents R1 walked to the toilet and was in the process of sitting down as V10 grabbed a shower chair, V10 turned to see R1 lying on his side and R1's walker (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145603	If continuation sheet Page 1 of 5

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the floor. R1's Fall Report dated 6/12/26 at 6:30 AM, completed by V18 LPN, documents R1 reported R1 had fallen 30-45 minutes prior, had gotten himself up, and R1 had a 1.5 centimeter (cm) by 0.5 cm hematoma (bruising/swelling) to his left outer hand. R1 was unable to provide details about the fall. This report documents the root cause of the fall as R1 slipped while walking, R1 was encouraged to ask for assistance and signs were posted to ask for help and use the walker. There are no staff interviews regarding this fall besides V18's statement. The investigation of this fall does not identify who last saw R1 prior to the fall and R1's activity at that time, when R1 was last toileted, or R1's footwear when R1 fell. On 7/27/26 at 9:12 AM V4 LPN stated R1 was one assist for transfers and walking with use of gait belt and wheeled walker. V4 stated R1 was alert and oriented to person, place, and time but had intermittent confusion especially at night. V4 stated R1's fall interventions included non-skid socks, which R1 was compliant in wearing. On 7/27/26 at 9:28 AM V18 LPN stated on 6/12/26 around 6:00 AM R1 reported R1 had lost his balance, fell, and gotten himself back up, initially reported to V19 CNA. V18 stated R1 had a hematoma to the outer palm. V18 stated V18 had not seen R1 prior to the fall that morning since it was at the beginning of the shift. On 7/27/26 at 2:01 PM in regard to R1's fall on 5/13/26, V10 CNA stated R1 was in the shower room, as R1 went to sit down on the toilet V10 turned to grab the shower chair and R1 fell. V10 stated V10 had her back to R1 and was approximately a foot away. V10 stated V10 should have waited until R1 was fully seated on the toilet before getting the shower chair as R1 needed supervision for transfers. V10 stated V10 used a gait belt when R1 was walking in the hallway but did not use a gait belt or provide hands on assist during R1's toilet transfer/fall. On 7/27/26 at 4:04 PM V16 CNA confirmed V16 was R1's assigned CNA on 4/26/26. V16 stated prior to R1's fall that night, V16 last saw R1 walking with his family back to his room around 4:00 PM and V16 had emptied R1's urinal prior to that. V16 stated R1 used a urinal at the bedside, R1 would often spill the urinal or dribble urine on the floor, and V16 would frequently have to clean up R1's floor. V16 stated R1 was found on the floor near R1's bed, R1 had on regular socks that were wet from urine on the floor. V16 stated R1 did not have on non-skid socks due to refusing to wear them and removing them, and if R1 had on non-skid socks that would have prevented this fall. On 7/27/26 at 5:45 PM V12 LPN stated on 4/26/26 R1 was found on the floor between the bed and recliner, and it appeared as if R1 had slid out of bed. V12 stated R1 had a skin tear to the back of his hand and R1 had on regular socks without non-skid tread. V12 stated R1 was cooperative in wearing non-skid socks and didn't refuse them, and R1 was provided non-skid socks after the fall. V12 stated V12 believes non-skid socks would have prevented the fall. V12 stated V12 had not seen R1 prior to the fall that day as it was near the start of V18's shift. On 7/28/26 at 9:52 AM V2 DON reviewed R1's 6/12/26 fall investigation and confirmed there were no staff interviews/statements for the prior shift to identify when R1 was last seen or toileted prior to this fall. V2 stated R1 was getting out of bed and thought to have slid due to wearing regular socks for the 4/26/26 fall, and R1 would sometimes refuse to wear the non-skid socks or remove them, but there is no documentation of this. V2 confirmed R1's non-skid socks were care planned as a fall intervention when R1 admitted to the facility on [DATE], prior to the 4/26/26 fall. 2.) R2's MDS dated [DATE] documents R2 has severe cognitive impairment and is dependent on staff assistance for transfers and toileting. This MDS documents R2 has impaired range of motion to both legs and is always incontinent of bowel and bladder. R2's Fall Risk assessment dated [DATE] documents R2 is at high risk for falls. R2's Care Plan dated as revised 6/29/26 documents R2 has a diagnosis of Huntington's Disease and fall interventions include the use of a non-skid mat in the seat of R2's geriatric reclining back wheelchair (9/29/25), offer toileting before supper (6/21/25), and new style call light will be provided when it arrives (11/10/2025). This Care Plan also includes an intervention to keep call light within easy reach (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and encourage R2 to use it. R2's Fall Report dated 6/28/26 at 6:40 PM, completed by V12 LPN, documents R2 was found sitting on the floor on top of the leg rest of R1's wheelchair, the chair was tipped forward and R2's back was against the seat of the chair. R2 was incontinent of bladder and R2 had a small scratch to the top of R2's forehead. The fall investigation included three staff statements/interviews with V12, V24 CNA and V5 CNA, and did not identify when R2 was last toileted prior to the fall or if R2's chair had a non-skid mat. On 7/27/26 at 10:16 AM and 12:14 PM R2 was in bed. R2's touch sensor call light was on the fall mat on the floor beside R2's bed, and not within easy reach for R2. R2 did not respond to questions regarding R2's fall. At 12:14 PM V25 CNA stated V25 placed R2's call light on the fall mat due to R2 moving about in bed which would frequently trigger the call light. V25 confirmed the call light was not within R2's reach. On 7/28/26 at 8:25 AM R2 was asleep and sitting in a reclined geriatric wheelchair in the television room on the [NAME] wing. On 7/27/26 at 3:30 PM V24 CNA stated V24 found R2 sitting on the footrest of R2's geriatric reclining back wheelchair and the chair was tilted/upright in the air. V24 did not recall if there was a non-skid mat in R2's chair at that time. On 7/27/26 at 5:45 PM V12 LPN stated V12 had not seen R2 that night prior to his fall as it was the beginning of the shift. V12 stated R2 was found in the television lounge sitting on the footrest of his wheelchair which caused the chair to tip forward. V12 stated R2 was incontinent at the time of the fall and was assisted to bed. At 6:17 PM V12 did not recall if there was a non-skid mat in R2's chair during this fall. On 7/28/26 at 9:23 AM V23 Care Plan Coordinator stated R2 has a touch pad call light which should be kept near R2 within reach. V23 confirmed the care plan is where staff would look for documented fall interventions. On 7/28/26 at 9:52 AM V2 DON stated R2 fidgets and moves around a lot due to Huntington's Disease which causes R2 to slide down in R2's wheelchair. V2 stated V2 believes R2 slid to the foot of R2's wheelchair causing it to tip forward. V2 stated there should have been a non-skid mat in R2's wheelchair as that was a fall intervention prior to this fall. V2 confirmed R2's fall investigation did not include if a non-skid mat was in place or when R2 was last toileted or provided incontinence cares. V2 confirmed R2's call light should be within R2's reach and not on the fall mat. V2 stated V2 will need to do educate the CNAs regarding this.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to maintain documentation of neurological assessments for one of three residents reviewed (R1) for falls in the sample list of three. Findings include: The facility's undated Neurological Screenings Guidelines documents to use the guide for unwitnessed falls or when a resident has hit his/her head during a fall. This guide documents to complete and document neurological assessments on the Neurological Flow Sheet including monitoring for changes from baseline such as confusion, drowsiness, or deterioration and obtain vital signs every 15 minutes times four, then every four hours times four, then every eight hours times nine, equaling a minimum of 72 hours. The facility's Content of the Medical Record policy dated August 2017 documents the Medical Records Clerk is responsible for ensuring all required information is in the resident's medical record, and the Administrator should ensure all medical records are maintained according to regulations and guidelines. R1's Fall Report dated 6/12/26 at 6:30 AM, completed by V18 Licensed Practical Nurse (LPN), documents R1 reported R1 had fallen 30-45 minutes prior and had gotten himself up, and R1 had a 1.5 centimeter (cm) by 0.5 cm hematoma (bruising/swelling) to his left outer hand. R1 was unable to provide details about the fall and neurological assessments were initiated. R1's 72-Hour Fall Monitoring Assessments dated 6/12/26 at 4:07 PM and 6/13/26 at 2:54 PM document neurological assessments were completed, R1's neurological status was intact but does not include R1's level of consciousness, hand grasps, pupil response or vital signs as outlined on the corresponding 72-Hour Neurological Flow Sheet for this fall. R1's 72-Hour Neurological Flow Sheet initiated on 6/12/26 is incomplete and does not document assessment findings for level of consciousness/orientation, pupil response, hand grasps or vital signs for 15 minute and hourly checks on 6/12/26 or on the 6:00 AM-2:00 PM shift on 6/13/26. R1's Nursing Note dated 6/29/2026 at 10:40 PM documents R1 sustained a fall with noted head injury bleeding from laceration to right forehead. R1 was transferred to the local emergency room for evaluation. R1's Nursing Note dated 6/30/26 at 1:29 AM documents R1 returned to the facility with five sutures for right forehead laceration and neurological assessments continued per facility protocol with no noted changes. R1's Nursing Note dated 6/30/2026 at 9:45 PM documents R1's dressing was changed; sutures were intact and there was extensive bruising across R1's forehead and right eye appeared swollen consistent with recent trauma. Neurological status was assessed and remained in normal limits. There is no documentation in R1's medical record that a 72-Hour Neurological Flow Sheet was completed for R1's fall on 6/29/26. On 7/27/26 between 11:38 AM and 1:11 PM the following interviews were conducted: V6 Registered Nurse (RN) stated V6 completed neurological assessments for R1 on the evening shift on 6/30/26 and R1 had no noted changes. V21 RN stated R1 returned to the facility on V21's shift and neurological assessments continued, which were documented on a paper form for 72 hours post fall. V14 LPN confirmed V14 was R1's assigned nurse on dayshift on 6/30/26. V14 stated R1 was on 72 hour fall monitoring including neurological assessments, and R1 did not have any changes in his neurological status. On 7/28/26 at 8:53 AM V18 LPN confirmed V18 was R1's assigned nurse on dayshift on 6/12/26. V18 reviewed R1's post fall assessments and neurological assessments dated 6/12/26. V18 stated V18 completed neurological assessments that day and doesn't know why this information wasn't documented. V18 also verified R1's vital signs were not documented for the 15 minute and hourly checks as indicated on the Neurological Flow Sheet. On 7/27/26 at 11:28 AM V2 Director of Nursing (DON) confirmed R1's Neurological Flow Sheet dated 6/12/26 was incomplete. On 7/27/26 at 12:20 PM V3 Assistant DON stated when R1 returned (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the hospital R1 would have been due for neurological assessments every shift. V3 confirmed R1's post fall assessments document neurological status as intact but does not document findings of the assessment, and confirmed R1 did not have a 72-Hour Neurological Flow Sheet for the 6/29/26 fall. On 7/28/26 at 10:25 AM V1 Administrator stated V1 believes a 72-Hour Neurological Flow Sheet was completed for R1's 6/29/26 fall, the form was misplaced and was not uploaded into R1's electronic medical record.		