

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/15/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain the kitchen equipment in clean, sanitary, operable condition to prevent cross contamination, maintain freezer temperatures and ensure pureed food is a safe consistency. These failures have the potential to affect all 93 residents that reside in the facility. Findings include: 1. On 4/12/26 at 8:30 am during the initial kitchen tour, V6, Dietary Manager (DM) confirmed that the walk-in -freezer temperature log dated 4/01/26 through 4/12/26 documented temperatures measured between four and ten degrees Fahrenheit. The bottom of the same walk-in freezer temperature log documents the freezer temperature should be measured at minus two or below, Fahrenheit. The dial on the freezer thermometer gauge displayed the current freezer temperature measured as 15 degrees Fahrenheit. The walk-in freezer was filled with frozen food. V6, DM stated We did know the freezer temperatures were not right. It is supposed to be below zero. V6, DM also stated the facility had the maintenance department look at the freezer temperature several times over the past couple weeks and has ordered new parts and tried several other things to fix the thermostat. 2. On 4/13/26 at 9:50 am - 10:45 am on follow-up tour of the kitchen, V23, [NAME] was observed pureeing the meal for the day. V23, [NAME] pureed cooked chicken breast in a food processor. Due an abundance of [NAME]-like granules in chicken texture, (when sampled by this surveyor, V6 DM and V23 Cook), The chicken breast required extended periods of time (approximately 5 minutes, x 3 attempts) to process to a safe smooth texture to prevent the potential of resident aspiration. During the same observation V6, DM confirmed the foods required longer processing in order to become smooth. V6 stated We only have two blades for the food processor, one (blade) is at the hardware store being sharpened. This one (blade being used) will be sent to the hardware store next. It needs sharpened too. During the same observation V6, DM removed cooked pureed vegetables from the stove. V6, DM confirmed the vegetables were already pureed, and ready to serve. The pureed vegetables were then sampled by this surveyor, and V6, DM and V23, Cook. V6, DM confirmed the pureed vegetable had small chunks of vegetables and an overall sand-like textures present. V6 DM confirmed the vegetables were not pureed long enough, and posed a potential risk of aspiration to residents on the pureed diet. V6 DM directed V23, [NAME] to repeat processing the vegetables to smooth texture. During the same observation V23, [NAME] removed a tray from the refrigerator. The tray contained 15 bowls. The 15 bowls contained individual portions of presumed pureed servings. V23 confirmed that the pureed processing was complete, and the pears were ready to serve. V23 said these were pureed yesterday on evening shift. V23 Cook, and this surveyor sampled the pears to assess the consistency. V23 confirmed there were chunks of pears in resident's pureed pears. V23 confirmed the texture was not smooth enough to be served to the residents that require pureed food. V6, DM was present and directed V23 to repeat the puree processing to a smooth and safe consistency. During the same observation V6 DM stated the pasta on the menu for today, won't be smooth enough to serve the residents due to the dull blade in the food processor. V6, DM stated they will have to substitute mash potatoes. 3. During the same 4/13/26 at 9:50 am - 10:45 am follow-up tour of the kitchen V6, DM continued the tour of the kitchen and confirmed the tabletop can opener (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 6

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/15/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was rusty and had a grease buildup with food particle present in the gears, and the veneer of the blade was worn down to bare metal. V6, DM stated The facility needs a new table-top can opener because the current one is very old and no longer cleans up well.The CMS Long Term Care Application for Medicare and Medicaid documents 93 residents reside in the facility.The facility undated policy Equipment documents the following: Policy Statement: All food service equipment will be clean, sanitary, and in proper working order.		

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 04/15/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain residents right to dignified care, for two of two residents (R10 and R13) reviewed for activity of daily living assistance/dignity, on the sample list of 36. Findings include: 1. R10's current Diagnoses List documents the following: Unspecified Dementia, Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, Type II Diabetes Mellitus Without Complications, and Other, Lack of Coordination. R10's Minimum Data Set (MDS) dated [DATE] documents R10's Brief interview of Mental Status (BIMS) score as seven out of a possible 15, indicating severe cognitive impairment. The same MDS documents, R10, requires staff assistance with all activities of daily living. On 04/12/2026 12:10 pm R10 was seated in a low wheelchair, in the resident assistance dining room. R10's dining table was level with R10's neck. R10 had a dinner sized plate with mechanical soft turkey and gravy, rice with gravy, and cooked carrots. R10 also had a brownie on a separate plate. R10 raised her elbow out to her side at shoulder height, and stretch her arms forward to reach up to the dinner plate on the dining room table. R10 pulled the dinner plate off the table, part of the way and leaned forward to scoop turkey with a spoon and leaned back in her wheelchair to eat the scooped portion of food. R10 dropped small amounts of food in her lap several times. R10 then pushed the entree plate away and lifted the brownie plate off the table, holding the small plate with one hand while she ate the brownie with the fork in her other hand. R10 stated It would be very nice if I had a lower table. I am short and it is hard for me to eat. I can't reach it and I get messy. I don't like that. Maybe you could use your pull and get me a table that is a little lower. On 4/12/26 at 12:15 pm V10, Dietary Assistant confirmed R10's table height puts R10's food out of her reach, making it difficult for R10 to reach her food and dine with dignity. V10, Dietary Assistant bent down, looked under the table and said, this one (dining table) does not adjust. It is broken. R10 stated to V10, Dietary Assistant, Can you hand me my plate then, so I can eat. On 4/12/26 at 3:08 pm V2, Director of Nursing confirmed R10 dining at a low table was a dignity issue. V1 Administrator was present and stated R10 is petite and requires a shorter table to dine comfortably. 2. R13's current diagnoses list documents the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. R13's Minimum Data Set, dated [DATE] documents R13's Brief Interview of Mental Status score as 15 out of a possible 15 which indicates R13 has no cognitive impairment. R13's same MDS documents, R13, is totally dependent of staff assistance for toileting. On 4/13/26 at 12:25 pm R13 was propelling herself out of the dining room, in a wheelchair and down the hallway. R13 had a flaccid left side. R13 had one footrest that held her left foot. R13 was propelling her wheelchair with her right foot and using the handrail with her right hand to pull the wheelchair forward. R13 was hurried and stated to this surveyor, I am having a bad time. R13 stated I asked (V19, Certified Nursing Assistant) to help me to the bathroom. (V19, CNA) said she did not have time. She needed to take other people to the dining room and start feeding them. I (R13) can't sit in the dining room to eat, knowing I am going to go (evacuate bladder) in my (incontinence brief). I need to (urinate) on the toilet. I need to go bad. I can't unfasten my (incontinence brief). I just want to get out of here. I have to take myself now, I am afraid I won't make it. On 4/13/26 at 12:30 pm V19, Certified Nursing Assistant (CNA) stated Yes, I told (R13) I couldn't take her to the bathroom. I was in her room, changing her roommate (R53) and had to take her (R53) to the dining room. All of us CNA's were getting people out to the dining room. We had to feed people. I did not have time, and I did not ask anyone else to take her (R13). I told her she would have to wait. That was a while ago. I figured she took herself. On 4/13/26 at 2:05 pm V2, Director of Nursing (DON) stated she is aware that V19 told R13 that she could not take her to the bathroom. V2, DON confirmed Yes, this is a dignity issue. The facility Policy Resident Privacy and Dignity dated as revised January 2026 documents the following: PURPOSE: To provide all residents (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/15/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a home like environment that promotes dignity and respect to the residents of the facility.POLICY: To ensure that all residents are provided with dignity and privacy.RESPONSIBILITY: It is the responsibility of all staff to ensure that all residents have privacy and dignity.		

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 04/15/2026
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 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. V1 stated 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 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 (continued on next page)		

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 04/15/2026
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		