

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare of Pontiac		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Lowell Pontiac, IL 61764	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure an incident resulting in a fracture was reported to the State Agency within the required timeframe for one (R1) of three residents reviewed for Accidents. Findings IncludeThe Facilities Accidents and Incidents policy revised on 1/26 documents that reporting accidents and incidents, including injuries of an unknown origin, must be reported to the department supervisor and an Accident/Incident Report form must be completed on the shift that the accident or incident occurred. This document also states that the Director of Nursing (DON)/Designee will report any accident/incident of major injury to the State Agency within 24 hours.On 11/29/26 at 3:04AM, R1's Nursing Progress note documents R1 was sent to the hospital after complaining of pain in the area above R1's left knee. R1 received Norco for pain management just before leaving for the hospital. The Hospital gave R1 Tylenol, Fentanyl and Ketorolac for pain management. R1 returned from the hospital at 6:00AM. The hospital diagnosis after review of the left knee Xray shows Sprain of medial collateral ligament of left knee.On 12/11/26 at 1:30PM, R1 went and saw the orthopedic doctor and completed a computed tomography scan (CT scan) of the left knee. The CT scan showed a Left Knee Fracture.R1's Minimum Data Set, dated [DATE] documents that R1 is Dependent with all transfers and is cognitively intact.On 2/9/26 at 11:05AM, V2 Director of Nursing confirmed that a reportable incident was not sent to the State Agency.On 2/9/26 at 1:15PM, V1 Administrator confirmed that R3's fracture that was received on 12/11/25 was not reported to the State Agency.</p>

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation of the required transfer/discharge process for one (R3) of three residents reviewed for transfer/discharge. The facility discharged R3 without documentation of the required discharge notice and required elements in the medical record. The Facility Discharge/Transfer Policy revised 1/25 documents the facility is to provide guidelines for appropriate discharge and transfer procedures. The facility also documents that the facility will have a written or telephone order from the attending physician for the transfer or discharge of a resident. R3 was admitted to the facility on [DATE] per R3's nursing progress notes. Per R3's Hospital notes dated 2/23/26, R3 was dropped off at the Emergency Department (ED) from the facility with complaints of social concern. Per the facility, it was discovered during R3's background check that R3 had a sexual offense and could not be admitted to the facility. The Facility attempted to find different placement but could not. The Facility brought R3 back to the Emergency Department for nursing home placement. On 3/10/26 at 10:36AM, V7 (R3's) Power of Attorney stated the facility told V7 that R3 was being sent back to the hospital due to R3's background check results. On 3/10/26 at 11:00AM, V8 Social Service Director (SSD) stated R3's CHIRP (Criminal History Information Response Process) dated 2/23/26 was received and V8 SSD tried to find placement for R3. R3 was sent back to the hospital due to the CHIRP results showing R3 is listed as a Sexual Offender. On 3/10/26 at 9:35AM, V1 Administrator confirmed no discharge documentation or discharge orders were found in the chart for R3.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure safe transfer techniques were implemented for one (R1) of three residents reviewed for accidents. The resident sustained a fracture of the left knee when a mechanical lift transfer requiring two staff members was performed by only one staff member. Findings Include The Facilities Hydraulic Lift (Hoyer) Policy revised on 1/26 documents all nursing staff will be trained on the proper use of the hydraulic (hoier) lifts that are used within the facility, to ensure safe transfer for residents. This Policy also documents that the staff is to obtain assistance from a second staff member. On 11/29/26 at 3:04AM, the Nursing Progress notes documents: R1 was sent to the hospital after complaining of pain in the area above her left knee. R1 received Norco (pain medication) just before leaving for the hospital. The hospital gave R1 Tylenol, Fentanyl and Ketorolac for pain management. R1 returned from hospital at 6:00AM. The Hospital diagnosis after the left knee Xray showed a Sprain of Medial Collateral Ligament of Left Knee. On 11/29/26 at 5:28AM, R1's Nursing Progress note documents: call received from the Emergency Department (ED) nurse. R1 was being discharged. Left knee x-ray was negative. R1 said R1 heard a pop when being transferred with a total body mechanical lift. R1 was given fentanyl 50mcg (microgram) given IM (Intramuscular) for pain management. No other concerns currently. On 11/29/25 through 12/3/25, R1 complained of pain in R1's left knee. R1 was given HYDROcodone-Acetaminophen Oral Tablet 7.5/325mg (Milligrams) for pain management. On 12/3/2025 the Nurse Practitioner's (NP) note documents R1 was assessed in R1's room lying in bed. NP reviewed R1's urine culture which showed mixed growth with possible contamination. R1 stated R1 still doesn't feel well. R1 was sent to the ED in the past week and stated that the Certified Nursing Assistant (CNA) hurt R1. The x-ray was performed of R1's left knee which was negative for a fracture. R1 stated R1 knows something is wrong and wants an MRI (Magnetic Resonance Imaging). The NP explained that R1 can be referred to ortho for further diagnostic testing and patient began yelling that she wants something done now and that she's tired of this place. The NP will refer R1 to ortho and instructed the nursing staff to get another UA (urinalysis). On 12/11/25 at 1:30PM, R1 had an appointment with the orthopedic doctor and completed a CT (computed tomography) scan of the left knee. The CT scan showed a Left Knee Fracture. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is Dependent with all transfers and is cognitively intact. On 2/9/26 at 10:40AM, R1 was lying in bed and stated that V9 CNA (Certified Nursing Assistant) was transferring R1 via a total body mechanical lift without the assistance of a second CNA. V9 was pushing on me, then suddenly R1 heard a pop and a crack. R1 stated that V9 told R1 look your standing up. R1 stated I haven't stood up in years. R1 stated that R1's feet were touching the floor and R1's left knee hit the side of the bed. On 2/9/26 at 11:05AM, V9 CNA confirmed that V9 did complete a total body mechanical lift transfer for R1 without the assistance of a second staff member. On 2/9/26 at 11:05AM, V2 DON (Director of Nursing) stated that R1 was sent to the hospital, and the x-ray from the Emergency Department stated it was only a sprain. V2 confirmed two nursing staff should have been performing the transfer and not just one. V2 stated V9 CNA had disciplinary action taken against him as a result of this incident. On 2/9/26 at 11:15AM, V3 ADON (Assist Director of Nursing) stated a two-person transfer is required for all staff when using a total body mechanical lift.</p>		