STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146010	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Pontiac	300 West Lowell Pontiac, IL 61764

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(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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to ensure residents' rights to dignity, respect, and timely assistance were maintained by failing to respond to call lights in a timely manner for three (R3, R4 and R8) of four residents reviewed for call light response time in the sample list of eight. Findings Include: The facility's grievance logs for April, May, and June 2026 document concerns related to delayed call light response times, including complaints that call lights were not monitored, and response times exceeded acceptable limits.The facility Resident Privacy and Dignity Policy revised 1/26, documents the facility is responsible for ensuring all residents are provided dignity and respect at all times. The policy further requires staff to respond appropriately to resident needs as part of maintaining a home-like environment that promotes dignity and respect.On 6/15/2026 at 10:45 a.m., R3 reported waiting over 45 minutes for R3's call light to be answered.On 6/15/2026 at 10:59 a.m., a call light was flashing at the nursing station with no Certified Nursing Assistants visible in the immediate area, while two additional call lights were observed activated.On 6/15/2026 at 11:07 a.m., R8's call light was actively sounding at the nurses station with a timer displaying approximately 29 minutes in duration.On 6/15/2026 at 11:10 a.m., V8 (Licensed Practical Nurse) confirmed that call lights should be answered within 5-10 minutes and acknowledged that the call light for R8's room had been active for approximately 29 minutes, which V8 stated should not have happened.On 6/15/2026 at 11:04 a.m., V10 (R4's Power of Attorney) stated that although R4's call light functions, staff response is frequently delayed beyond 30 minutes when assistance is needed for care.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to use foot pedals when transporting a resident in a wheelchair and failed to follow a care plan intervention to utilize a mechanical lift to transfer a resident for two (R2 and R7) of three residents reviewed for accidents in the sample of eight residents. These failures resulted in R2 falling from the wheelchair and suffering a head laceration requiring sutures and R7 suffering a fractured rib when staff transferred R7 without using the mechanical lift. Findings Include:1. According to the current Electronic Health Record (EHR), R2 has diagnoses including unspecified hydronephrosis, weakness, repeated falls, muscle wasting and atrophy of the bilateral thighs, lack of coordination, abnormal posture, cognitive communication deficit, chronic fatigue, osteoarthritis, obesity, anemia, lymphedema, and hypertension.The Care Plan Dated Revised on 5/14/2026 documents R2 as requiring assistance during transfers and being at high risk for falls related to weakness and non-compliance with transfer recommendations on the Minimum Data Set. Interventions include one-person assistance with transfers utilizing a gait belt and front-wheeled walker/grab bar.Emergency Department documentation dated 5/14/2026 documents R2 was evaluated after falling from her wheelchair and striking the left side of her head. The documentation states, Patient was in wheelchair and fell out of the wheelchair striking the left side of her head. The resident complained of head pain and required diagnostic evaluation including a CT (Computed Tomography) scan of the head, CT scan of the cervical spine, and right hip x-ray. The After Visit Summary dated 5/14/2026 documents R2 received sutures to the left side of her head.On 5/18/2026 at 10:58 a.m., the Interdisciplinary Team (IDT) Note documents R2 had requested to be wheeled to a prom event and did not have foot pedals attached to the wheelchair. The note states the resident normally self-propels using her feet and documents plans to obtain wheelchair bags to store foot pedals and educate staff to apply foot pedals before pushing residents in wheelchairs.5/18/2026 at 12:13 p.m., the IDT Note documents, IDT met to review fall. Root cause- resident fell out of wheelchair d/t (due to) foot pedals not being in place. Intervention- ensure foot pedals on wheelchair when staff is pushing resident.On 6/15/2026 at 10:05 a.m., V6 (Receptionist), stated V6 was wheeling R2 back to her room because the resident wanted to change clothes. V6 stated while transporting the resident, R2 stated her legs were dangling and getting tired. V6 stated she stopped and R2 fell forward, striking the left side of her head on a door frame in the hallway. V6 further stated she had not signed any education regarding wheelchair foot pedal requirements following the incident or before the incident.On 6/15/2026 at 11:30 a.m., V5 (Assistant Director of Nursing) confirmed R2 should have had foot pedals on the wheelchair due to R2's weakness. V5 stated not all staff have been in-serviced on foot pedals following the incident due to V5 believing only nursing staff should be pushing residents in wheelchairs. V5 confirmed auxiliary staff transported residents in wheelchairs and stated the facility had recently implemented a process to store wheelchair foot pedals in bags attached to the backs of wheelchairs.On 6/15/2026 at 11:45 a.m., approximately ten wheelchairs in the dining room did not have foot pedals in bags on the backs of the wheelchairs as intended by the facility's corrective action.On 6/15/2026 at 11:57 a.m., V1, (Administrator), stated foot pedals were required whenever staff push residents in wheelchairs and stated she could not guarantee all wheelchairs had foot pedals available in the designated storage bags. V1 also confirmed that R2's foot pedals should have been provided and the fall could have been prevented.2. According to the current EHR, R7 has diagnoses including Type II Diabetes Mellitus with skin ulcer, abnormal posture, dysphagia, abnormalities of gait and mobility, cognitive communication deficit, bilateral muscle wasting and atrophy, lack of coordination, repeated falls, chronic kidney disease stage IV, atrial fibrillation, hyperlipidemia, hypertension, unilateral osteoarthritis of the hip, unilateral osteoarthritis of the left knee, and presence of a right artificial knee joint.The Care Plan dated 4/7/26 documents R7 requires transfer assistance and documents, transfer with mechanical (full) lift x 2 (times two) staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident uses (geriatric) chair and is dependent on staff for propel.On 6/9/2026 at 2:38 p.m., Nursing Documentation on the electronic medical record documents R7 was noted to have bruising and swelling to the left arm and shoulder. V8 (Licensed Practical Nurse) documents R7 reported the injury occurred during a transfer. V8 notified Hospice and R7's Power of attorney (POA) was informed of the change in condition. The resident reported pain, and new orders were obtained for morphine sulfate concentrate 0.5 mL (milliliters) every 6 hours for 7 days, with 0.25 mL every 2 hours as needed for pain management.On 6/9/2026 at 7:08 p.m., Nursing Documentation from the EMR documents a physician order was received for a portable two-view x-ray of the left rib area due to bruising and pain, and the POA was notified. The POA requested additional imaging of the shoulder. Hospice was re-contacted regarding coverage for imaging, and response was pending.On 6/9/2026 at 7:18 p.m., Nursing Documentation from the EMR documents the Radiology Department was notified and a technician was scheduled to complete the ordered imaging.The X-ray Report dated 6/10/26 documents R7 has a left lateral seventh rib fracture.On 6/16/2026 at 5:05PM, V15 (Certified Nursing Assistant) confirmed while assisting R7 to bed, R7 was in her geriatric chair and V15 provided a pivot transfer by bear hugging the resident and turning to position R7 on the bed. V15 stated R7 requires a full mechanical lift and V15 should have received help. V15 stated, V15 was suspended regarding the incident and was told by V1 Administrator that V15 was getting a break from R7's hall.On 6/16/2026 at 2:38 p.m., V30 (Certified Nursing Assistant), stated she worked with V15, Certified Nursing Assistant, on 6/8/2026. V30 stated R7 required transfer assistance and reported V15 completed the transfer without the required assistance. V30 further stated that following the incident, V15 was no longer assigned to the hall where R7 resided.On 6/16/2026 at 1:56 p.m., V2, (Interim Director of Nursing), stated R7 requires a mechanical lift for transfers and staff were expected to use two staff members when transferring the resident. V2 stated she would not expect staff to improvise transfer methods or equipment. V2 stated radiological testing had been ordered following concerns regarding injury to R7.On 6/16/2026 at 11:30 p.m., V20, (Physician), stated he reviewed radiographs for R7 at the request of facility administration and referred back to the radiologist that R7 had a rib fracture.On 6/16/2026 at 3:03 p.m., V1, (Administrator), stated she requested physician review of the radiographs following concerns regarding injury to R7.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview and record review, the facility repeatedly failed to follow physician's orders to utilize a Bilevel Positive Airway Pressure (BiPAP) machine and failed to notify the physician when the BiPAP was not administered for one (R1) out of three residents reviewed for quality of care on a sample list of eight. R1's Administration Record dated April of 2026 documents an order, with a start date of 4/4/26, for R1 to wear a BIPAP every night.A Resident/Family Concern Grievance Form dated 4/6/26 at 9:00AM, documents R1 was concerned that his BiPAP was not at the facility when he admitted to the facility.An email exchange from V13 (Admissions/Marketing Coordinator) with the equipment company, dated 4/10/26, documents V13 notified the equipment company of an issue with R1's BiPAP tubing. The equipment company responded with information and V13 confirmed she would follow-up if the staff could not figure it out.R1's Orders-Administration Note, dated 4/10/26 at 7:07PM, documents that R1's BiPAP was not applied because it needs different equipment to function correctly.R1's Orders-Administration Note, dated 4/12/26 at 7:54PM, documents R1's BiPAP was not applied because it needs separate equipment to function properly.R1's Orders-Administration Note, dated 4/16/26 at 9:34PM, documents R1's BiPAP was not applied due to the BiPAP machine not having all of the correct parts to function correctly.R1's Orders-Administration Note, dated 4/23/26 at 8:15PM, documents the BiPAP is not working and a new one is being delivered.R1's Progress Notes do not contain documentation of physician notification that R1's BiPAP was not functioning.R1's Bed Hold Policy note, dated 4/27/26 at 8:15AM documents R1 was transferred to a local hospital for respiratory distress.R1's Nursing Note, dated 4/27/26 at 1:07PM, documents R1 was admitted to the hospital with a diagnosis of respiratory failure.On 6/15/26 at 10:24AM, V14 (R1's Power of Attorney) stated R1 was discharged from the hospital to the facility in early April of 2026. V14 stated the first week facility staff did not put R1's Bilevel Positive Airway Pressure (BiPAP) machine on him. V14 stated the facility kept telling V14 that they did not have the machine or couldn't find the machine. Once the facility did find the machine, then the staff did not know how to use the machine. V14 stated R1 only wore the BiPAP machine one or two nights during his stay at the facility. V14 stated the doctor ordered that R1 should wear it every night. V14 stated then R1 had to go to the local hospital because he was having breathing issues again. V14 stated R1 was very worried and scared about having to go back to the hospital. On 6/15/26 at 11:33AM, V11 (Registered Nurse) stated R1's BiPAP machine was having issues because the supply company did not send all the correct parts for it. V11 stated the machine tubing the supply company sent was for a Continuous Positive Airway Pressure (CPAP) machine, not a BiPAP. V11 stated V11 does not know when or if the part came in. V11 stated V11 called V5 (Assistant Director of Nursing) and V5 said she was calling the supply company to have them deliver the correct tubing.On 6/15/26 at 1:35PM, V13 (Admissions/ Marketing Coordinator) stated she ordered R1's BiPAP machine equipment and did not have to re-order any parts for it. V13 stated V5 (Assistant Director of Nursing) fixed the BiPAP machine and there were not any other issues with it.On 6/15/26 at 1:53PM, V5 (Assistant Director of Nursing) stated the box with the BiPAP for R1 was delivered on the day of admission, but staff did not know where it was delivered to in the facility. V5 stated the following morning, staff saw R1's BiPAP machine on North East hall and took it to R1. The machine was not working correctly, so V5 adapted the tubing. V5 stated other nurses may not be comfortable with the way V5 adapted the machine.On 6/15/26 at 3:23PM, V31 (Registered Nurse) stated R1's BiPAP has never worked. V31 stated there was a missing piece that R4's family was supposed to bring to the facility at some point. On 6/16/26 at 1:54PM, V5 (Assistant Director of Nursing) stated she is unsure if the physician was ever notified that R1's BiPAP was not functioning correctly. If the physician was notified then it would be documented in the Progress Notes. On 6/16/26 at 11:43AM, V2 (Interim Director of Nursing) stated R1's BiPAP could not be located upon admission. It was found a day or two later. V2 stated V2 is unaware of any further issues with R1's BiPAP. V2 stated If R1's BiPAP was not functioning, the nurses should document it (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and notify the physician, Power of Attorney, and management.On 6/16/26 at 1:56PM V2 (Interim Director of Nursing) stated the staff should not adapt any equipment or machines.On 6/15/26 at 1:46PM, V12 (Nurse Practitioner) stated R1's inconsistent use of BiPAP potentially lead to his hospitalization on 4/27/26.The facility's Physician Orders Policy, revised in September of 2023, documents any questions in regard to physician orders should be directed to the Director of Nursing.

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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 record review and interview the facility failed to ensure resident records were accurate for one of two residents (R7) reviewed for documentation accuracy on a sample list of eight.Findings Include:1. R7's Nursing Note dated 6/11/26 at 2:31 PM documents, (V21 Medical Director) also assessed resident, resident had no pain or discomfort in the rib area. No signs of fracture of the area. (V21) stated it looked like a noddle (sic) or legion. (Xray Company) called to re-review Xray and call back with findings.On 6/16/26 at 11:30AM, V5 (Assistant Director of Nursing) stated V21 (Medical Director) physically assessed R7 for a fracture.On 6/16/2026 at 11:16AM, V21, (Medical Director), stated he reviewed radiographs for R7 at the request of facility administration and referred to the radiologist. V21 stated he did not physically assess or see R7. V21 was stopped by V1 (Administrator) on his way out the door to have him review the radiographs.R7's Nurse's Note dated 6/12/26 at 9:56 AM authored by V1 (Administrator) documents, (V20 Physician) also assessed imaging and also did not see a fracture but a legion or nodes. He reviewed the other images that showed no findings from the same area the next day that had a misc. (miscellaneous) find of calcified LT hilar Lymph Nodes. He also assessed resident and she was at baseline for PROM (Passive Range of Motion) no pain at the time of assessment. The 2 sets of images were reviewed by 2 different techs with different findings. X-ray tech was called from the first imaging to re-review image and call administrator back with findings.On 6/16/26 at 3:03PM, V1 (Administrator) stated that she saw V20 (Physician) on Central Hall in the facility and V1 stopped him and asked him to look at R7's radiographs. V20 reported to V1 that he did not feel like R7 had a fracture rib. V20 told V1 that R7 was not his patient. V20 looked at R7's arm and pushed on it. V1 reviewed R7's Nurses Note, dated 6/12/26 at 9:56AM, authored by V1. V1 stated she just documented what she saw. V1 reports she told V20 that R7's passive range of motion was at her baseline. She did not have V20 enter his assessment himself on R7's chart because R7 was not his patient and he was just looking over the fractures for V1.On 6/16/26 at 2:53PM, V20 (Physician) stated that R7 is being followed by V21 (Medical Director). V1 (Administrator) did have V20 review radiographs for R7 on 6/12/26. V20 did not see a fracture. V20 stated he would refer to V21, as R7 is not V20's patient, so he is not familiar with R7. V20 stated he did not see and never physically assessed R7.