STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Savoy	302 West Burwash Savoy, IL 61874

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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to ensure R1 was free from misappropriation of personal belongings and information including R1's billfold, personal checkbook, and debit card information. R1 is one of three residents (R1) reviewed for misappropriation of property in the sample list of nine. This failure resulted in R1 having $1,752.69 stolen from R1's bank account, R1 being upset and frustrated with not having use of R1's checkbook and debit card and having to close and reopen accounts. Findings include: The facility's Abuse Prevention Program policy dated November 2017 documents, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Abuse: is defined at 483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent. R1's Order Summary Report dated 4/21/22 documents R1 was admitted to the facility on [DATE]. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. R1's Preliminary Incident Investigation Report documents the date of the alleged incident as reported on 4/11/22, time reported was 8:15 PM. This report documents, SSD (V3 Social Services Director) found that (R1) had called (V3's) work telephone and left a message that (R1's) billfold and checks were missing. (V3) then reached out to (R1) and confirmed the concern of missing items. A room search was performed with no findings. (V1 Administrator) was called immediately, and an investigation was implemented immediately. (R1's) medical provider and responsible party were notified. The local police department was notified. (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 0602 Level of Harm - Actual harm Residents Affected - Few	On 4/21/22 at 8:14 AM, R1 appeared grouchy and was short with responses. R1 stated that R1's billfold and checkbook were missing from R1's bedroom. R1 stated that R1's billfold and checkbook were stored and last seen on R1's bed side table. R1 stated that the police have been to the facility to talk to R1 regarding the missing billfold and checkbook. R1 stated there were several charges on R1's debit card that R1 did not make. R1 stated that V6 (R1's Power of Attorney) has had to close R1's accounts and is trying to get a new checking account open for R1. On 4/21/22 at 2:40 PM, R1 stated that R1 has R1's debit card numbers written down on a piece of paper at the facility. R1 stated that this makes R1 angry and is very frustrating that someone would take R1's things and steal R1's money. On 4/21/22 at 11:35 AM, V3 Social Services stated that R1 called V3 on 4/11/22 and stated that R1's checkbook and billfold were missing. V3 stated that V3 reported it to V1 Administrator, and they went to R1's room to look for the items. V3 stated that V6 confirmed R1's debit card had been used and turned that information over to the police. V6 stated there was a lot of activity on the card for smaller amounts and that there was a larger purchase of over $1,000 for a vacation rental dated 2/23/22. V3 confirmed R1's debit card information has been gone longer than just last week. On 4/21/22 at 12:13 PM, V6 R1's Power of Attorney (POA) stated that R1 told V6 that R1 couldn't find R1's checkbook. V6 stated that there were 10 or so suspicious charges in February and then double that in March. V6 stated that shortly after R1 was admitted to the nursing home that V6 took R1's credit cards home. V6 stated that to V6's knowledge, R1 had R1's checkbook at the facility and has the debit card numbers written down at the facility. V6 stated that V6 and V3 just went over the bank statements with R1 on 4/20/22 to determine what charges were R1's and what charges were not R1's. V6 stated V6 then sent that information to the police officer. On 4/22/22 at 3:08 PM, V1 Administrator stated that they were not getting anywhere with the investigation but then reached out to V6 to check bank statements. V1 stated V6 brought statements into the facility and there were several charges on the statements that R1 did not make. V1 stated that V1 called the police and gave the information to them. V1 stated that V1 had been reviewing video footage from the time frame R1 reported the checkbook and billfold missing but was not aware that they had been missing for much longer than originally thought. On 4/21/22 at 11:35 AM, V3 provided R1's bank statements which documents one purchase on 2/14/22 for $24.99 that was not made by R1, one purchase on 2/23/22 for $1,185.85 for a vacation rental that was not made by R1, seven small charges from 3/1/22 through 3/7/22 for a total of $52.93 that R1 did not make and several more charges from 3/9/22 to 4/8/22 for a total of $488.92 that R1 did not make. On 4/21/22 at 2:30 PM, V4 Human Resource Director provided copies of two checks that R1 had written to the facility dated 12/25/21 and 1/4/22 for R1's portion of R1's stay and V4 confirmed R1 had R1's checkbook at that time. R1's Nurse's Progress Notes document R1 was sent to the hospital on 2/11/22 for an infection and did not return to R1's room at the facility until 2/23/22. On 4/22/22 at 8:50 PM, V1 confirmed R1 had money stolen on R1's debit card and stated V1 has not completed the investigation at this time.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to secure a wheelchair to the wheelchair anchors in the transport van which resulted in R5's wheelchair toppling over and R5 striking R5's head on the floor of the transport van. R5 sustained a bleeding head injury (abrasion/laceration) requiring first aid treatment. The facility also failed to identify a root cause for falls and failed to develop and implement post fall interventions for two of three residents (R3,R5) reviewed for falls in the sample list of nine. Findings include: The facility's Falls Prevention Program policy with a revised date of July 2021 documents, Fall prevention program will be implemented to assure that safety of all residents in the facility whenever possible. This program should include measure which determines the individual needs of each resident by assessing the risks for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. 1. As part of the initial assessment, identify individuals with a history of falls and risk factors for subsequent falling.4. Identify the root causes of the fall incident which could be related to resident's current or declining medical condition or worsening behavior. This policy also documents, Treatment/Management 1. Based on the preceding assessment, identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Monitoring and Follow-Up 4. If the individual continues to fall, re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. 1. R5's Minimum Data Set (MDS) dated [DATE] documents R5 is cognitively intact and R5's speech is unclear and is only sometimes understood. This MDS documents R5 is totally dependent on two staff for transfers, R5 does not walk and R5 has impairment in both upper and both lower extremities. This assessment reflects that with seat to stand and surface to surface movement R5 is unsteady and not able to stabilize without staff assistance. This MDS documents R5 has the diagnosis of Cerebral Palsy. R5's current Physician Order Sheet and 4/21/21 Care Plan documents R5's diagnoses to include Quadriplegia, Spastic Quadriplegic Cerebral Palsy, Unspecified Lack of Coordination, Abnormal Posture, and Other Specified Disorders of Muscle. V7 facility van transport driver's statement dated 3/9/22 documents, Today at approximately 2:45 PM (V7) transportation driver for (the facility) with the assistance of (V8 student nurse) were taking (R5) to a medical appointment, about 3 minutes in to the trip we notice (R5) falling backwards with the chair, (V7) immediately stopped the van, (V8) and (V7) got (R5) up and (V7) realized that (V7) had forgot to fasten the front floor straps to the wheel chair, causing the chair to fall backwards. (V8) assessed the situation and we determined that since we were so close to our facility it would be best to get (R5) back so that a nurse could do a proper evaluation and determine the next step. (V7) all heartily hope that (R5) is ok, and (V7) I am terribly sorry for my gross negligence in what happen. signed by V7. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Occurrence Investigation 3/9/22 for R5 dated 3/10/22 documents, On 3/9/22 at approximately (2:00 PM) (R5's) wheelchair turn(ed) over resulting in a fall when being transported in the wheelchair van, from (R5's) wheelchair. (R5) hit (R5's) head on the floor of the van during the fall. The nurse assessed (R5) for any signs and symptoms of injury, pain, or changes in range of motion. Bleeding was noted on the posterior of (R5's) head. An abrasion was noted at the site of the bleeding. First aid was administered. (R5) was alert and could communicate by verbal gesture, and by turning (R5's) head side to side and up (and) down (normal for R5). (R5) denied any pain nor discomfort at this time. Vital signs were obtained. Neurochecks were initiated. (R5) was assisted upright into (R5's) wheelchair without event and returned to the facility. The Medical Provider and Responsible Party were notified. Upon completion of this investigation, it was identified that the root cause of this incident was related to the van strap. Education was provided. Immediate intervention was to initiate a checklist for van transports prior to transport. signed by V1 Administrator. The 3/9/22 Fall During Staff report for R5 documents under Injury Type as 'laceration.' On 4/21/22 at 2:10 PM, R5 was in R5's room in R5's wheelchair. When asked if R5 fell sideways in (R5's) wheelchair in the van, R5 motioned R5's head backwards over the back of the wheelchair indicating R5 fell backwards. On 4/22/22 at 3:08 PM, V1 Administrator stated that R5's wheelchair tipped over in the transport van because one of the straps was not secure. V1 stated that following the incident, they did training, and implemented a checklist that has to be completed prior to leaving with a resident in the van. On 4/22/22 at 6:35 PM, V7 confirmed V7's statement and V7 stated that R5 remained in the wheelchair when it tipped backwards because the rear wheelchair anchors and the lap and shoulder belt were fastened. V7 stated there was nothing broken regarding the wheelchair or the van itself, V7 stated V7 just forgot to fasten the front wheelchair anchors. 2. R3's MDS dated [DATE] documents R3 has moderately impaired cognition, inattention and disorganized thinking is present but fluctuates, R3 has other behavioral symptoms daily, R3 requires extensive assistance of one staff member for transfers and limited assistance of one staff member for toileting. This MDS documents R3's balance is not steady and only able to stabilize with staff assist. R3 is always incontinent of bowel and bladder. This MDS documents diagnoses including Alzheimer's Disease, non-Alzheimer's Dementia, Anxiety, Depression and Repeated Falls. R3's medical record documents falls on 3/27/22, 4/8/22 at 12:30 AM, 4/8/22 at 3:40 AM, 4/10/22 and 4/20/22. R3's Nurse's Progress Notes dated 3/27/22 documents R3 was found on the floor in R3's room and received a skin tear. R3's Fall Audit dated 4/4/22 documents, root cause related to (R3's) impulsive independent actions, impaired cognitive status, unsteady gait and poor balance. R3's Unwitnessed Injury Report dated 4/8/22 documents at 3:40 AM R3 was found on the floor in R3's room with a bump on R3's head over R3's eye and it was bleeding. The root cause was determined to be that R3 was attempting to get up and deals with impulsiveness. The intervention developed for this fall was to send R3 to the emergency room . R3's Nurse's Progress Notes dated 4/8/22 at 7:15 AM documents R3 was returning to the facility, all tests were negative, and they applied glue to a skin tear obtained in a previous fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Audit Report dated 4/12/22 documents on 4/10/22 at 8:20 PM, R3 was found on the floor by the nurse's station. R3 sustained a skin tear to R3's right forearm and right hand. The root cause determined for this fall was R3's Dementia, impaired cognition and impulsiveness. R3's Care Plan dated 4/10/22 documents an intervention implemented after the 4/10/22 fall to toilet R3 intermittently which will offer some diversion. On 4/22/22 at 3:57 PM, R3 was sitting in the television area across from the nurse's station in R3's wheelchair. On 4/22/22 at 5:00 PM, R3 was sitting in the same television area in R3's wheelchair. On 4/22/22 at 7:20 PM, R3 was sitting in the television area in R3's wheelchair rolling back and forth and crying that R3 was hurting. R3 was scooting R3's bottom around in the wheelchair and grabbing at R3's bottom and crotch area in the front. On 4/22/22 at 7:40 PM, V20 Certified Nursing Assistant wheeled R3 into R3's room and transferred R3 to the bed. R3 was whining that R3 hurt and grabbing at R3's bottom. When V20 pulled R3's slacks down there was stool everywhere in the incontinence brief from the front to the back. R3's slacks were wet out to the sides of the brief. R3's perineal area and bottom were fire red and had some open areas. V21 Licensed Practical Nurse applied some bandages to R3 and stated that R3 was obviously not repositioned or changed for quite some time like R3 is supposed to be. On 4/22/22 at 6:17 PM, V1 Administrator stated that they look at falls as a group and determine root cause and interventions. V1 confirmed there was no long-term intervention put into place for R3's fall on 4/8/22 at 3:40 AM. V1 confirmed that they determined the root cause for the above listed falls to be R3's impulsiveness and R3's cognitive status. V1 stated they could not determine any other root causes.