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	07/01/2022

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on record review and interview, the facility failed to encode and transmit a Resident Assessment Instrument (MDS, Minimum Data Set) within the required time frames. This failure affects one resident (R1) on the sample list of seven. Findings include: On 6/30/22, R1's Minimum Data Set List documents an MDS dated [DATE] which is documented as In Progress. On 6/30/22, R1's MDS dated [DATE] did not have sections A, G, H, I, J, L, M, N, O, and P completed. On 6/30/22 at 2:36 pm, V14, Minimum Data Set Coordinator, began an interview by stating, I will tell you right now, I am behind on MDS's. I am the only one in the building doing MDS's and I am sharing the DON(Director of Nursing) responsibilities right now. (R1)'s MDS dated [DATE] is not completed, yes, that is behind. It is not completed or ready to transmit. I have to do a quarterly review whenever a resident gets COVID, so that one is from when (R1) had COVID.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34058 Based on observation, interview, and record review, the facility failed to sanitize scissors prior to a pressure ulcer dressing change, failed to document completion of pressure ulcer treatments, and failed to document weekly skin checks. These failures affect one resident (R1) on the sample of seven. Findings include: 1.) On 6/30/22 at 10:30 am, V5, Licensed Practical Nurse, conducted a pressure ulcer dressing change for R1. During this dressing change, V5 stated, I forgot my scissors, then requested for V18, Certified Nursing Assistant to go out to the treatment cart and retrieve the scissors. Upon receiving the scissors as requested from V18, V5 proceeded, without sanitizing the scissors, to cut a gauze roll which then was packed directly and firmly into the pressure ulcer on R1's sacrum. This pressure ulcer was approximately 5 centimeters (cm) long by 5 cm wide by 4 cm deep, had blackened areas of necrosis on the interior ulcer, devitalized slough tissue on the interior ulcer, and had a foul odor. At 10:40 am, V5 stated, Yes the scissors were here on top of the treatment cart. I am far from perfect. 2.) R1's current Physician Order Sheet (POS) dated 6/30/22 documents physician orders for pressure ulcer dressing treatments as, Stage 4 pressure wound of the sacrum, cleanse with NS/WC (normal saline/ wound cleanser), pat dry, pack wound with 1/4 strength Daikans (sp, Dakins) solution, cover with ABD (abdominal pad) twice daily and PRN (as needed), initiated 6/24/22 and Wound to the right heel, cleanse with NS/WC, pat dry, apply skin prep to peri-wound area, apply thera-honey to wound bed, then cover with silicone foam border, change 3 times per week and PRN, initiated 6/21/22. This same POS documents a physician order Weekly skin assessments to be done every week on evening shift on Tuesdays, initiated 5/21/22. R1's Treatment Administration Record (TAR) documents the sacrum ulcer did not receive a dressing change on 6/4/22, 6/9/22, 6/21/22, 6/25/22, and 6/29/22. This same TAR documents R1 did not receive the weekly skin check on Tuesday 6/21/22. On 6/30/22 at 3:47 pm, both V5, Licensed Practical Nurse/Wound Nurse, and V1, Administrator, stated they thought there needed to be some clarification and education among the nursing staff about the weekly skin check procedure because one nurse might only document a new open area, and one nurse might not document an open area if it is covered by a dressing, and some nurses don't necessarily disrobe a resident fully during the skin checks. V1 then stated, But in any event, they need to be documenting something rather than leave it blank.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34058 Based on observation, record review, and interview, the facility failed to manage a resident's pain in preparation for a skin ulcer dressing change, according to the resident's care plan. This failure affects one resident (R1) out of the sample of seven. Findings include: On 6/30/22 at 10:30 am, V5, Licensed Practical Nurse/Wound Care Nurse conducted an ulcer dressing change on the right heel for R1. During this dressing change, R1 was wincing, moaning, and withdrawing (R1's) leg away from the treatment procedure. On 6/30/22 at 10:40 am, V5 confirmed R1 was exhibiting expressions of pain, and stated, I will go talk with her nurse to give (R1) something. I do know her POA (Power of Attorney) doesn't want (R1) to have anything stronger than Tylenol. R1's current Care Plan (initiated 4/25/22, revised 6/10/22 documents a care plan focus area for, Stage 3 (deteriorated to stage 4 as of 6/24/22) pressure ulcer to sacrum, and (R1) has chronic pain related to diabetic neuropathy, and (R1) has a diabetic ulcer of the right heel. The nursing interventions for these focus areas is documented as, Administer analgesia (Bio-Freeze or Tylenol) as per orders, give 1/2 hour before treatment or care and turning or repositioning to ensure the resident's comfort. R1's Physician Order Sheet documents a physician order for, Tylenol 650 milligrams every 8 hours PRN (as needed) for pain. R1's Medication Administration Record for June 2022 documents R1 has not received a single dose of Tylenol during the month of June 2022. On 7/1/22 at 10:40 am, V1, Administrator stated, I agree that we need to be evaluating pain management for (R1) and give (R1) something before the treatments.