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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145439 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/28/2022 |
| NAME OF PROVIDER OR SUPPLIER Accolade Healthcare of Savoy | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <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** 32172</p> <p>Based on interview and record review the facility failed to implement increased supervision after a fall resulting in a second and third fall and subsequent injuries for one cognitively impaired resident (R1). This failure resulted in R1 being sent to the emergency room , diagnosed , and treated for multiple right side rib fractures, a Cervical-5 (C5) fracture, Lumbar-4 (L4) compression fracture, forehead laceration, and skin tears. R1 is one of three residents reviewed for falls in the sample of three.</p> <p>Findings include:</p> <p>R1's Minimum Data Set, dated dated dated [DATE] documents R1 is severely cognitively impaired and requires limited assistance of one staff person for transfers.</p> <p>R1's Fall Risk Evaluation dated 9/16/22 documents R1 is at high risk for falls related to intermittent confusion, 1-2 recent falls, ambulatory, balance problems while standing and walking, requires assistive device (walker), has medical diagnoses and takes medications that also put him at risk.</p> <p>R1's Incident Report dated 9/21/22 documents at 1:50 AM, R1 was heard yelling that he was falling and was found on the floor by his bed. R1 stated he was getting dressed to go home. At the time of the fall, R1 was orientated to person and had impaired memory, confusion, gait imbalance, recent illness, and had poor safety awareness related to Dementia. R1 was assessed for injuries and helped back to his bed. Neurological checks were started. The last neurological check was documented at 3:35 AM.</p> <p>R1's Incident Report dated 9/21/22 documents at 4:20 AM, R1 was yelling that he had fallen and was found in his room on the floor by his nightstand. R1 had a laceration to the right forehead and skin tears to his right arm and right knee. R1 was transported to the emergency room (ER).</p> <p>R1's Computed Tomography (CT) results dated 9/21/22 document R1 fell from a standing position and sustained a large laceration to his forehead, multiple acute right lower rib fractures, acute-subacute appearing L4 compression fracture, and an acute non-displaced fracture of the left C5 posterior transverse process.</p> <p>R1's Nurses Note dated 9/21/22 documents R1 returned from the ER with 11 staples to his forehead laceration and a cervical collar in place.</p> <p>(continued on next page)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>R1's Incident Report dated 9/23/22 documents at 3:10 AM, R1 was walking in the hallway outside of his room with his walker and fell sideways to his right onto the floor. R1 reopened his forehead laceration from 9/21/22 and skin tears to his right arm. R1 was transported to the emergency room (ER).</p> <p>R1's Hospital History and Physical Note dated 9/23/22 documents R1 presented in the ER after recurrent falls. R1 was seen in the ER two days ago after a fall in which he suffered a left C5 fracture, right rib fractures, and lumbar fracture of indeterminate age. R1 also had a forehead laceration which was re-opened with this current fall.</p> <p>On 9/27/22 at 1:15 PM V16 Registered Nurse stated she was R1's assigned nurse during all three falls on 9/21/22 and 9/23/22. V16 stated R1 had been moved to first floor on 9/16/22 due to testing positive for Covid-19. He was on isolation in a room that was at the end of the hall furthest from the nurses' station. R1 was a high fall risk, had poor safety awareness, and was confused. On 9/21/22 at 1:50 AM, V16 found R1 on the floor in his room. V16 stated R1 didn't appear to have any injuries so they started neurological checks. R1 was last checked at 3:35 AM. He was in bed with no neurological changes noted. At 4:20 AM, V16 heard R1 call out and went down to his room. R1 had fallen again and hit his head on the bedside table. There was blood all over his head and the table. R1 was transported to the ER.</p> <p>On 9/23/22 V16 was again R1's nurse and at about 3:10 AM V16 noticed R1 walking in the hall with his walker. V16 stated she yelled for someone to get him, but they couldn't get to him before he fell over and hit his head on the floor and reopened his forehead laceration and skin tears. V16 stated there wasn't any new fall interventions put in place between the first fall, second fall, and third fall that she was aware of. V16 stated she was monitoring R1 more frequently during his neurological checks after his first fall on 9/21 but when the time frame moved to every hour, that is when he fell . V16 confirmed that visual monitoring should have been more frequent in order to prevent further falls.</p> <p>On 9/28/22 at 10:00 AM V4 Minimum Date Set Registered Nurse confirmed R1 was a confused resident with dementia, high fall risk, balance issues, and low safety awareness. He had previous falls and with his newly diagnosed Covid infection, he was even a higher fall risk than normal. He was also at higher risk because he was on isolation and at the end of the hall furthest away from the nurses' station. V4 confirmed R1 should have had more fall interventions in place and should have been supervised more closely, especially after his first fall on 9/21/22. These things could've potentially prevented the falls and subsequent injuries.</p> <p>On 9/28/22 at 1:52 PM V3 Medical Doctor confirmed R1 was a confused resident with Dementia, high fall risk, balance issues, and low safety awareness. He had previous falls and with his newly diagnosed Covid infection, he was even a higher fall risk than normal. R1 was on isolation and at the end of the hall furthest away from the nurses' station which would also make his fall risk higher. V3 confirmed R1's falls with injuries might have been prevented if staff had supervised him more frequently and had more fall prevention interventions in place.</p> <p>The facility's Fall Prevention Program dated January 2022 documents the fall prevention program will be implemented to ensure all residents' safety in the facility. Each resident's risk for falls will be assessed and appropriate interventions in order to provide the necessary supervision and assistive devices will be implemented.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172</p> <p>Based on interview and record review the facility failed to administer ordered and available respiratory nebulizer treatments for a resident (R2) who requested treatment while experiencing a Chronic Obstructive Pulmonary Disease (COPD) exacerbation. This failure resulted in R2 being transferred to the emergency room (ER) to receive treatment. R2 is one of three residents reviewed for a delay in care in the sample of three.</p> <p>Findings include:</p> <p>R2's Minimum Data Set, dated [DATE] documents R2 is cognitively intact.</p> <p>R2's Physician Order Sheet, dated September 2022, documents an order for Albuterol Sulfate Nebulization Solution 0.083% (2.5 milligram/3 milliliters) 2.5 milligrams inhale orally via nebulizer every four hours as needed for wheezing.</p> <p>On 9/26/22 at 10:59 AM R2 stated on the early morning hours of 9/20/22, she was short of breath. She knew she was having a COPD exacerbation. She asked for a nebulizer treatment at about 7:30 AM. She had one she could have as needed per the doctor orders. However, the nurse, V13 Licensed Practical Nurse/LPN wouldn't give her the nebulizer treatment. V13 stated she couldn't because it was against the facility's Covid policy. V13 told R2 to take her other medications and inhalers and rest and see if that helped. R2 told V13 it wouldn't help enough but V13 didn't listen. At 9:00 AM R2 went to the nurse's station and V13 was just sitting there. R2 told V13 if she didn't call the ambulance R2 was going to call them herself. R2 stated she was tired of waiting for V13 to do something to help her. Finally, V13 got on the phone and called Emergency Medical Services and they took R2 to the ER. R2 was given oxygen and nebulizer treatments and stated she felt better. R2 stated she felt helpless and the fact that V13 LPN, the nurse in charge of her care, wasn't willing to give R2 a nebulizer treatment made her feel very anxious and scared that V13 would just let R2 get worse and worse. R2 stated she felt neglected and like no one cared.</p> <p>R2's Nurses Note dated 9/20/22, written by V13 Licensed Practical Nurse documents R2 was complaining of shortness of breath and requesting a nebulizer treatment. V13 told R2 that due to Covid the facility doesn't administer nebulizer treatments. R2 requested to go to the emergency room . Emergency Medical Services were called and R2 was transported to the emergency room for evaluation.</p> <p>R2's Emergency Medicine Record dated 9/20/22 documents R2 arrived in the ER with shortness of breath. R2 has a history of COPD. R2 stated facility V13 LPN would not give R2 her prescribed nebulizer treatment and R2 feels she was being neglected. ER pulmonary assessment showed expiratory wheezing and shortness of breath.</p> <p>On 9/27/22 at 2:58 PM V9 Infection Preventionist Registered Nurse confirmed R2 had an order for a nebulizer treatment PRN (as needed) for wheezing and if R2 stated she was short of breath and needed the medication, V13 LPN should have given it to R2. V13 did not follow physician orders and did not provide treatment to R2 when needed/requested. V13 was terminated for this reason.</p> <p>(continued on next page)</p> | | |

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| F 0695 Level of Harm - Actual harm Residents Affected - Few | V13's LPN Termination/Resignation record dated 9/21/22 documents V13 was terminated by the facility for a violation of policy. On 9/28/22 at 1:52 PM V3 Medical Doctor confirmed R2 had a PRN (as needed) nebulizer treatment ordered, and the nurse (V13 LPN) should have given it to R1 if she requested it due to respiratory symptoms from a COPD exacerbation. The nurse should have not withheld the treatment. | | |