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	09/14/2022

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

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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. 40385 Based on observation, interview, and record review the facility failed to promote residents' dignity by failing to ensure residents were served meals at the same time, ensure staff did not stand over residents while providing feeding assistance, ensure staff did not enter without knocking before entering a resident's bathroom, ensure staff provide assistance with dressing and shaving, and ensure staff removed institutional identification (hospital bracelets) and gait belts for 12 (R56, R42, R70, R92, R50, R86, R47, R104, R96, R91, R215, R14) of 24 residents reviewed for dignity in the sample list of 99. Findings include: The facility's undated Resident Rights, Privacy and Dignity policy documents: The resident has the right to be treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility may encourage and assist the residents to dress in their own clothes, rather than hospital type gown and appropriate footwear for the time of the day and individual preferences. Resident's appearance should be consistent with his or her choice. The facility must promote resident's independence and dignity while dining: c. Staff standing over residents while assisting them to eat. The facility's undated Quality of Life-Dignity policy documents: Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc. (etcetera). Resident's private space and property shall be respected at all times. a. Staff will knock and request permission before entering resident's rooms. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) On 8/29/22 the following occurred: At 11:33 AM R56, R42, R70, R92, R50, R86, R47, R104 and R96 were sitting in the lounge on the 2nd floor. Lunch meal trays were delivered to the 2nd floor. At this time R56 and R42 were served their meals and began eating. At 11:40 AM R70 stated I'm hungry, hungry, hungry. R70 did not have R70's meal, and was sitting directly beside R42. At 11:45 AM R92's meal was served. At 11:50 AM R42 finished R42's meal and left the lounge. R70 stated (R42) already finished eating and left. I'm hungry. I haven't ate yet. Why haven't I ate yet? At 11:54 AM V27 Certified Nursing Assistant (CNA) collected R42's and R56's meal trays. R70 asked V27 about R70's meal tray and R70 said R70 was hungry. V27 told R70 your (R70's) food is coming. At 12:02 PM a second meal tray cart was delivered to the 2nd floor and distributed down the [NAME] Hall. At this time R50's meal was served. V23 Licensed Practical Nurse (LPN) was standing and feeding R50. R70 stated sure would be nice to get something to eat. I (R70) haven't had anything to eat. V23 told R70 that V23 will check on R70's meal tray. At 12:07 PM R86's meal was served. R70 continued to repeatedly ask about R70's meal. At 12:11 PM (38 minutes after meal trays were served to R56 and R42) meal trays were delivered to R47, R104, R96 and R70. On 9/1/22 at 11:40 AM V3 Infection Preventionist stated: Staff should not be standing while feeding residents. Staff should serve meal trays for residents sitting in dining areas together and then distribute trays by hall. 2.) On 8/31/22 at 12:45 PM V42 Central Supply Clerk entered R91's bathroom, and did not knock before entering. R91 was sitting on the toilet in view of V42. V42 stated Oh my, I'm sorry. I didn't know you were in here. On 9/1/22 at 9:15 AM V3 Infection Preventionist confirmed staff are expected to knock before entering resident rooms and bathrooms. 35046 3.) On 8/30/22 at 10:00 AM, R215 was sitting in a wheelchair. R215 was wearing a hospital gown and had a fall risk bracelet and hospital band on his wrist. R215 stated, I don't know why they haven't taken it off and I am not sure why I'm not dressed. R215 was noted to have an overgrowth of facial hair and stated he doesn't usually wear a beard and is not sure why they don't shave him. R215 stated he would like to be shaved and dressed. 4.) On 8/29/22 at 11:11 AM, R14 was propelling self around the common area by the nurses' station. R14 had a bright yellow fall risk band on his wrist and bright yellow gait belt around waist. At that time, V35 Licensed Practical Nurse stated, I am not sure why (R14) is wearing a fall risk band. It was applied at the hospital and should be taken off.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35046 Based on observation, interview, and record review the facility failed to ensure medications were consumed during medication administration for one of one resident (R215) reviewed for self-administration of medication on the sample list of 99. Finding include: On 8/30/22 at 10:45 AM, a medication cup full of medications was sitting on R215's bed side table. R215 was sitting up at the table watching television. When asked if the medication in the cup were his morning medications, R215 stated, I guess, I don't know. R215 then picked up the medications and took them. At that time, V35 Licensed Practical Nurse was at the nurses' station and stated she sat a cup of medications on his bed side table earlier and that the medications in the cup were his morning medications. V35 stated she left them for him to take. V35 stated inside the cup was Baby Aspirin, Furosemide, Lisinopril, Magnesium, Metoprolol, Multivitamin, Pantoprazole, Senna, and Spironolactone. R215's Medication Administration Record dated 8/1/22 through 8/31/22 documents R215 is to receive the following medications at 9:00 AM: Aspirin 81 milligrams (MG), Lisinopril 2.5 mg, Multivitamin, Pantoprazole 40 mg, Spironolactone 25 mg, Metoprolol Succinate Extended Release, Magnesium Oxide 400 mg, Lasix 20 mg two tablets, and Senna-Docusate 8.6 - 50 milligrams. R215's Electronic Medical Record did not contain an assessment for self-administration of medications. The facility's undated Resident Rights, Privacy and Dignity policy documents, n. The resident has the right to self-administer medication, if the interdisciplinary care planning team determines it is safe.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 42702 Based on observation, interview and record review the facility failed to keep residents' emergency nurse call light devices within reach (R3, R36 and R371) and failed to provide a call light device that was appropriate for resident capability (R100), in four of 24 residents reviewed for call lights in a total sample list of 99. Findings include: The facility Use of Call Light policy dated October 2010 documents, The purpose of the call light procedure is to respond to the residents' request and needs. 3) Ask the resident to return the demonstration so that you will be sure that the resident can operate the system. 6) When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. 1) On 8/29/22 at 10:00 AM, R3's call light device was laying on the floor out of reach of R3. R3 stated, I don't know where it is. I hurt! 2) On 8/29/22 at 10:36 AM, R36 was lying in bed while R36's call light device was tied across the room. R36 could not access the call light across the room and stated, It's hers (roommate). 35046 3. On 8/29/22 at 11:00 AM, R100 was lying in bed. R100's call light was attached to the mattress. V36 (R100's Family Member) stated she cannot use the call light. V36 stated when she pushes it, it does not go off. At that time, R100 attempted to activate call light and it did not activate. The call light when pushed slowly did not activate. The call light did activate when pushed fast and hard. V36 was not able to push it fast and hard enough for it to activate. V36 stated R100 has had that type of call light since admission (7/27/22). On 9/7/22 at 12:09 PM, V16 Maintenance Director stated V16 went and checked R100's call light on 8/29/22. V16 stated R100 had the soft bulb call light that has to be squeezed and that she could not activate it when he asked her to activate it. V16 stated V16 switched it to the regular push button call light that she could easily activate. V16 stated nursing staff is responsible for ensuring that the residents are able to use the call light. 4.) On 8/29/22 at 10:45 AM, R371's was lying in bed. R371's call light device was lying on the floor and not within R317's reach. R371's care plan dated 8/10/22 documents to keep R371's call light within reach.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 35510 Based on interview and record review, the facility failed to address/provide response for concerns voiced during resident council meetings. These failures have the potential to affect all 122 residents residing in the facility. Findings include: The facility's Resident Council meeting minutes document resident concerns as follows: 1/18/22 10:30 AM Residents are concerned about food and consistently needing to discuss the food preparations. Residents would like more crunchy foods and more food choices at lunch and dinner. Residents are concerned with the internet and phone situations that were addressed over the holiday season. Residents concerned with shower times. 2/15/22 10:30 AM Residents concerned about the food, consistently. Food preparations needing revisited with the residents. Residents would like more variety in their foods for all meals. Residents concerned with medication pass and shower times. 3/8/22 at 10:30 AM Residents are concerned about the mealtimes and food preparations. Residents would like more variety in their foods for all meals. Residents are concerned about shower times and days. 4/26/22 10:30 AM Residents are concerned about sauces on their foods, like gravy. Residents would also like to know what is on their plate to be the same as on the meal tickets and would like more variety in their foods for all mealtimes. Residents are concerned about their showers/bed baths. 5/24/22 at 10:30 AM Residents are looking for new choices and variety in some of their side dishes when they don't like what is given for a choice. Residents would like more fresh fruits and summer treats. 7/26/22 un-timed - Would like more fresh fruit: bananas, oranges, apples and juices. There is no documentation in the facility's Resident Council Meeting minutes regarding addressing/following up on resident concerns from the previous Resident Council meetings as above. On 8/30/22 at 11:12 AM, Resident Council meeting was held with R32, R33, R48, R54, R88 and R109. During this meeting several concerns were presented including concerns with showers/bathing and dietary. At this time, R32 stated the facility does not provide details that concerns are being reviewed and addressed. R32 stated the resident council has concerns that do not get addressed. R32 stated there have been several dietary concerns and concerns related to showers/bathing that the facility has not addressed. The facility's Resident Census and Conditions of Residents dated 8/29/22 documents 122 residents reside in the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to notify the resident's physician and family of significant weight loss for three (R13, R70, R95) of twelve residents reviewed for nutrition in the sample list of 99. Findings include: The facility's Change in a Resident's Condition or Status policy with a revised date of December 2016, documents the facility will promptly notify the resident, resident's physician, and resident's representative of changes in a resident's physical, emotional, and mental condition. 1.) R13's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5. 56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 a 10% loss since 4/27/22. R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 Registered Dietitian documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI (Body Mass Index) of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. There is no documentation in R13's medical record that R13's family and physician were notified of R13's significant weight loss in May and August 2022. 2.) R70's MDS dated [DATE] documents R70 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22. R70's Nutrition Note dated 4/21/2022 at 1:19 PM by V47 RD documents R70 was reviewed for weight loss, R70 has history of fluid issues and receives a diuretic. This note documents a recommendation to add whole milk and juice with all meals. R70's Nutrition Note dated 8/11/2022 at 1:56 PM by V47 documents: R70 was reviewed for weight loss at 1, 3, and 6 months and R70 has a healing stage III wound. V47 recommended a frozen nutritional supplement once daily to provide an additional 290 kilocalories and 9 grams of protein. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is no documentation that R70's family and physician were notified of weight loss in June and July 2022. 3.) R95's MDS dated [DATE] documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10 % or more in 6 months. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 and recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs. There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21. 6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation in R95's medical record that R95's family and physician were notified of significant weight loss in July 2022. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated family and physician notification of significant weight loss should be documented in a nursing note. On 9/6/22 at 10:43 AM V3 stated V3 did not find documentation of family and physician notification for weight loss for R13, R70, and R95.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Identified failures require more than one deficient practice statement. A.) Based on interview and record review the facility failed to ensure R52, R64, and R88 were not to subjected mental, verbal, and physical abuse by R46. This failure puts these residents at risk for severe, life threatening, and potentially fatal injuries. R46, R52, R64 and R88 are four of seven residents reviewed for abuse in the sample list of 99. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 9/7/22, the facility remains out of compliance at severity level 2. While the facility continues to develop and implement measures for each identified resident to address tendencies and triggers that could lead to physical aggression towards others. Findings include: The facility's Abuse Prevention Program policy with an effective date of 11/28/17 documents, This 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. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. 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. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Pre-Admission Screening of Potential Residents. The facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendation Report into the identified offender's plan of care including the security measures listed. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of resident including, but not limited to, the separation of the residents. R46's Face Sheet dated 8/19/22 documents an admitted [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R46's Care Plan dated 6/20/22 documents R46 has a history of criminal behavior and documents a care plan updated 8/26/22 that since admission R46 has had some aggressive behaviors towards others with interventions to promote safety, intervene when inappropriate behavior is observed. This Care Plan documents R46 is a wanderer and (R46) goes in other resident's rooms and can be difficult to redirect with a revision date of 6/27/22. R46's Nurse's Notes in June 2022 documents R46 curses and yells at residents and staff and goes into other residents' rooms and gets agitated and does not want to leave easily. R46's Nurse's Notes in July 2022 documents R46 was physically and verbally abusive to staff. R46's Nurse's Notes in August 2022 continue to document verbal abuse and being combative with staff. R46's Nurse's Note dated 8/26/22 at 2:55 PM, documents R46 was sent to a Psychiatric hospital. R46's Nurse's Note dated 8/26/22 at 4:20 PM documents R46 was being issued a 30-day discharge notification due to recent incidents and behaviors which were affecting other residents. a.)1.) The facility's Preliminary Incident Investigation Report dated 8/19/22 at 12:20 PM, documents (R46) were ambulating in (R46's) wheelchair behind (R52) and (R64). (R46) said f*** you (expletive) and (R64) responded by saying the same to (R46). (R46) then propelled (R46's) wheelchair towards (R52) and (R64) and they fell to the ground. The residents were separated, and (R46) is being monitored 1:1 (one to one) pending orders received for (R46) to be sent out for evaluation. Following nurse assessments of the residents, no injuries were noted for any of the three residents. Residents will be monitored for signs and symptoms of distress. Physicians and POAs (Power of Attorneys) were notified. R46's Nurse's Note dated 8/19/22 at 12:20 PM, R46 became agitated with two other female residents (R52, R64). R46 was in a wheelchair on R46's way back from the dining room. (R52 and R64) were ambulating back from lunch. R46 was heard yelling F*** you to (R52 and R64). One of the female residents yelled F*** you back to R46. R46 sped up the wheelchair and hit (R52 and R64) directly knocking them to the ground. R46 stated that they deserved it, they shouldn't talk to R46 like that. R46 on 1:1 supervision from time of incident. On 9/1/22 at 9:42 AM, V14 LPN (Licensed Practical Nurse) stated V14 witnessed R46 run R46's wheelchair into R52 and R64 on 8/19/22 and knock them to the ground. V14 stated V14 heard bickering and cuss words being yelled and V14 saw R46 plow R46's wheelchair towards R52 and R64 and knock them to the ground. V14 stated when R52 and R64 were on the ground they were yelling cuss words at R46 and calling R46 a SOB (Son of a B****) (expletive). V14 stated V14 separated R46, R52 and R64. V14 stated V14 asked R46 why R46 knocked R52 and R64 down and R46 told V14 that they were making fun of R46 and R46 told V14 that R46 would do it again. V14 stated R46 stayed with V25 Social Services Director after the incident. R52's Order Summary Report dated 8/30/22 documents diagnoses including Major Depressive Disorder, Cerebral Infarction and Unspecified Dementia without Behavioral Disturbance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R52's Nurse's Note dated 8/19/22 at 12:20 PM, documents fall was witnessed and occurred in the hallway. R52 was ambulating back from the dining room and the reason for the fall was evident. Another resident knocked R52 over. R52 was ambulating down the hallway and a male resident (R46) yelled F*** you and R52 yelled it back. This prompted (R46) to speed toward R52 in R46's wheelchair knocking R52 to the ground. V14 LPN/writer witnessed the fall. No head trauma. Parties separated. Nursing Assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty. R52's BIMS Evaluation dated 8/19/22 documents a score of 9/15 indicating moderately impaired cognition. R64's Order Summary Report dated 8/30/22 documents diagnoses including Alzheimer's Disease, Unspecified Dementia with Behavior Disturbances and Anxiety Disorder. R64's Nurse's Note dated 8/19/22 at 2:05 PM, documents at 12:20 PM R64 was ambulating back to room from dining room, talking with roommate. Another male resident (R46) became agitated, yelled F*** you at R64, R64 yelled it back. This prompted R46 to speed toward R64 in R46's wheelchair knocking R64 to the ground. V14/writer witnessed fall. No head trauma. Parties separated. Nursing assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty. Primary Care Provider notified. POA notified. R64's BIMS Evaluation dated 8/19/22 documents a score of 3/15 indicating severely impaired cognition. a.)2.) The facility's Preliminary Incident Investigation Report dated 8/30/22 documents the incident happened on an unknown date. (R88) stated another resident (R46) called me a f***ing b**** (expletives) and double fist hit my nose so bad around a month ago. R88's Order Summary Report dated 8/31/22 documents diagnoses including Transient Cerebral Ischemic Attack and Repeated Falls. This Order Summary documents an order for Clopidogrel (Plavix/Anticoagulant) 75 mg (milligrams), one tablet by mouth once a day related to Cerebral Infarction with a start date of 5/18/21. R88's Nurse's Note dated 8/30/22 at 2:50 PM, documents (R88) reported to Administrator (V1) that a month or so ago, another resident called me F---in b---- and double fist hit my nose so bad. (R88) reported that (R88) still felt pain on (R88's) nose bridge every now and then from the alleged incident. R88's BIMS Evaluation dated 7/14/22 documents a score of 10/15 indicating moderately impaired cognition. On 8/30/22 at 11:12 AM, during resident council meeting, R32 reported there was a physical altercation R32 witnessed that occurred between two residents in R32's room but asked to identify the residents and details in private. (continued on next page)

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	09/14/2022

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/30/22 at 12:20 PM, (R32) requested the State Survey Agency come with R32 to R32's room after resident council meeting finished at this time. R32 stated R46 punched (R88) right in the face. R32 stated R32 witnessed this occur as it occurred right inside the doorway to R32's room. R32 stated R88 and R32 were in R32's room talking when R46 entered the doorway of R32's room. R32 stated R88 asked R46 to please move so R88 could leave R32's room and that is when R46 punched R88 with a closed fist. R32 stated R88's glasses went flying across the floor in R32's room and R88 started crying. R32 stated R46 got very hostile when this happened. On 8/30/22 at 1:25 PM, (R88) stated the picture the State Survey Agency showed R88 was R46. R88 stated R46 called R88 a fat f***ing b**** (expletives) a few different times. R88 stated around a month ago, R46 hit R88 so hard across the nose that R88 glasses fell off R88's face. R88 stated R88 hurt so bad and R88 was experiencing headaches and dizziness that R88 still gets from time to time since R46 hit R88. R88 stated R88 developed a little bruising to R88's nose. R88 stated R88 started crying and was afraid that R46 would come at R88 again. R88 stated, nothing would surprise (R88) with what (R46) could or would do to anyone in the facility. At this time R88 became tearful and began sobbing and crying again. R88 stated the facility would be stupid to ever let that f***ing a**hole (expletives) back in. R88 stated, (R88) just wants to feel safe. 8/30/22 at 1:41 PM, (R32) stated R32 is, very much so afraid of (R46) and that R46 has a bad temper. On 8/30/22 at 1:55 PM, (R88) began crying when discussing R46 hitting R88 across the nose. R88 stated R46 doubled up (R46) fist and hit R88 right across the nose. R88 stated, (R88) never hurt so bad as R88 did after R46 hit R88 with a closed fist. R88 stated it felt like R88's nose was split in half and R88's nose began bleeding after R46 hit R88. R88 stated R88 notified the staff nurses who R88 could not identify. R88 stated R88 nose still bleeds a little from time to time when R88 blows it. R88 stated staff had even taken stuff to clean R88's blood from R88's nose. R88 stated R88's nose still hurts. R88 agreed to go to the hospital for testing and/or radiology testing if the doctor says R88 needs to. On 8/30/22 the facility provided a list of interviewable residents on the second floor of the facility which also indicates all of the residents that could potentially be affected by R46's aggressive behavior. An Immediate Jeopardy situation was identified on 8/30/22. The Immediate Jeopardy was identified to have begun on 8/19/22 when the facility failed to ensure interventions were implemented related to R46's aggressive behaviors to prevent R46 from deliberately assaulting R52 and R64. On 9/2/22 at 11:23 AM, V1 Administrator was notified of the Immediate Jeopardy situation. On 9/6/22 at 1:05 PM, the surveyor confirmed through record review and interview that the facility took the following actions to remove the Immediate Jeopardy: 1.) R52 and R64 were interviewed. An initial abuse allegation report was completed on 8/19/22 by V24 Corporate Administrator and the final abuse investigation was completed on 8/26/22 by V1 Administrator for the incident of 8/19/22. R52 and R64 were assessed and monitored. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2.) R88 was interviewed. An initial abuse allegation report was completed on 8/30/22 by V1 and a final abuse investigation was completed on 9/2/22 for an allegation reported on 8/30/22. 3.) R46 was involuntarily discharged to a Psychiatric hospital on 8/26/22 with paperwork completed by V3 Nurse Manager and a 30-day Discharge was issued to R46 on 8/26/22 completed by V1 Administrator. 4.) On 9/7/22, V25 Social Services Director and V34 Social Services Assistant completed a review of residents and identified residents who were predisposed to physical violence and the identified residents were assessed and evaluated for their ability to safely co-exist with other residents. 5.) All facility staff, including contracted agency staff, to complete training on abuse prevention policy and how to recognize triggers to prevent resident to resident abuse. This action was initiated on 9/2/22 and completed by V1 Administrator and V24 Corporate Administrator. 40385 B.) Based on interview and record review the facility failed to prevent a resident-to-resident altercation for two (R89, R95) of seven residents reviewed for abuse in the sample list of 99. Findings include: b.)1.) The facility's Abuse Prevention Program dated November 28, 2017, documents: This 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. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The facility's Final Incident Investigation Report dated 9/2/22 documents the following: On 8/28/22 staff observed R95 attempt to inappropriately touch another resident R89. V12 Certified Nursing Assistant (CNA) initially reported that V12 witnessed R95 touch R89 on R89's private (genital) area. V12 intervened and separated R95 from R89. V12 later clarified to local police that R95 was attempting to grab and unbutton R89's pants, and R89 was shaking and pushing R95 away with both of R89's hands. R95's hands were touching and grabbing towards R89's private (genital) area. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R95's undated Diagnosis List documents R95 has diagnosis of Bipolar Disorder. R95's Minimum Data Set (MDS) dated [DATE] documents R95 has severe cognitive impairment, requires supervision of one staff person for locomotion on R95's unit. R95's Care Plan revised on 5/5/22 documents R95 has the potential to be physically aggressive towards other residents and has a history of a physical altercation with another resident. R95's Care Plan revised on 5/31/22 documents R95 has a behavior problem of exposing R95's self in R95's room and inappropriately touching female staff. This care plan includes an intervention Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. R95's Nursing Note dated 10/22/2021 at 11:51 PM documents R95 appeared in the common area wearing only an incontinence brief and shirt. R95 was asked what R95 was doing and replied that R95 wanted some. R95 was told that R95 was inappropriate and redirected back to R95's room. R95's Nursing Note dated 8/28/2022 at 2:24 PM documents R95 was touching a female resident (R89) and trying to unbutton her pants. R89's undated Diagnosis List documents R89 has a diagnosis of Alzheimer's Disease. R89's MDS dated [DATE] documents R89 is rarely/never understood, has short- and long-term memory impairment, R89's Care Plan dated 6/17/22 documents R89 is at risk for abuse and neglect per the facility's assessment tool. R89's Nursing Note dated 8/28/2022 at 2:39 PM documents R89 was sent to the hospital for evaluation after R89 was touched in groin area by another male resident (R95). On 8/29/22 at 3:56 PM V22 Licensed Practical Nurse (LPN) stated: R95 has made sexual comments to staff and residents while passing them in the hallway. R95 would say things such as you can come sit on my lap, or I'll help you undo your pants. This has been an ongoing behavior. We try to keep a close eye on R95 and have R95 near the nurse's station. R95 does wander at times. On 8/30/22 at 9:38 AM V12 CNA stated: On 8/28/22 around 1:50 PM, R95 was in the television room facing the window, and R89 was facing the television. R95 had R89's hands on R89 trying to unbutton R89's pants. R89 is nonverbal. R89 used R89's hands to try and push R95's hands off of R89, while R95 continued to attempt to unbutton R89's pants. V12 immediately separated R95 from R89. R95 is confused, and during incontinence care has made sexual comments in regards to female staff's breasts. On 8/31/22 at 3:30 PM V39 LPN stated: About a month ago during shift change, V39 saw R89 and R95 in the television room. R95's back was facing V39, and R95's arm was near R89. V39 was not able to see R95's hands. V39 approached R95, and R95 acted startled and said I'm not doing anything. It (the situation) didn't sit well with me (V39). R95 and R89 were immediately separated. V39 reported the incident to V13 Previous Administrator, and V13 told V39 it sounds like two residents with Dementia. After that incident, whenever V39 worked V39 had the female residents sit in the hallway for monitoring. R95 required close supervision.

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	145439	A. Building B. Wing	09/14/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to protect R52, R64, R89, and R99 from potential/further abuse pending investigation, following witnessed instances of physical, sexual, and mental/verbal abuse by R46 and V31. These failures impact six of seven residents (R46, R52, R64, R89, R95, R99) reviewed for abuse in the sample list of 99. Findings include: The facility's abuse policy documents, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. This will be done by: immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; VI. Protection of Residents. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. Accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of the investigation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. 1.) R46's Admission Record/Face Sheet documents R46 was admitted to the facility on [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. The facility's Preliminary Incident Investigation Report dated 8/19/22 at 12:20 PM, documents circumstances of the alleged incident: Resident (R46) was ambulating in (R46's) wheelchair behind (R52) and (R64). (R46) said 'f*** you' (expletive) and (R64) responded by saying the same to (R46). (R46) then propelled (R46's) wheelchair towards (R52) and (R64), and they fell to the ground. The residents were separated, and (R46) is being monitored 1:1 (one to one) pending orders received for (R46) to be sent out for evaluation. R46's Nurse's Note written by V14 Licensed Practical Nurse (LPN) dated 8/19/22 and written at 1:53 PM, documents the incident between R46, R52 and R64 and documents R46 was placed on 1:1 supervision at this time from time of incident. R46's Nurse's Note written by V43 Registered Nurse (RN) on 8/19/22 at 3:03 PM documents V45, R46's Physician, gave an order to send R46 to the hospital for evaluation. V43 wrote in R46's Nurse's Notes the same day, 8/19/22 at 8:29 PM that R46 returned from the hospital with no new orders. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V44 LPN wrote in R46's Nurse's Notes on 8/20/22 at 1:35 PM, writer did 1:1's with (R46) and documents that R46 came out of R46's room to mingle for a little. On 8/29/22 at 1:06 PM, V1 Administrator confirmed that when they document 1:1 monitoring they are meaning the resident is on 15 minutes checks. 40385 2.) The facility's abuse allegation investigative files from March 2022-August 2022 were reviewed. The only documented abuse allegation between R89 and R95 was for an incident that occurred on 8/28/22. The facility's Final Incident Investigation Report dated 9/2/22 documents the following: On 8/28/22 staff observed R95 attempt to inappropriately touch another resident R89. V12 Certified Nursing Assistant (CNA) initially reported that V12 witnessed R95 touch R89 on R89's private (genital) area. V12 intervened and separated R95 from R89. V12 later clarified to local police that R95 was attempting to grab and unbutton R89's pants, and R89 was shaking and pushing R95 away with both of R89's hands. R95's hands were touching and grabbing towards R89's private (genital) area. R95 was placed on 15-minute checks. R95's undated diagnosis list documents R95 has a diagnosis of Bipolar Disorder. R95's Minimum Data Set (MDS) dated [DATE] documents R95 has severe cognitive impairment, requires supervision of one staff person for locomotion on R95's unit. R95's Care Plan revised on 5/5/22 documents R95 has the potential to be physically aggressive towards other residents and has a history of a physical altercation with another resident. R95's Care Plan revised on 5/31/22 documents R95 has a behavior problem of exposing R95's self in R95's room and inappropriately touching female staff. R95's Nursing Note dated 10/22/2021 at 11:51 PM documents R95 appeared in the common area wearing only an incontinence brief and shirt. R95 was asked what R95 was doing and replied that R95 wanted some. R95 was told that R95 was inappropriate and redirected back to R95's room. R95's Nursing Note dated 8/28/2022 at 2:24 PM documents R95 was touching a female resident (R89) and trying to unbutton her pants. R95 was transferred to the local emergency room and returned to the facility on [DATE] at 8:48 PM. R95 was transferred to an inpatient psychiatric hospital on 8/29/22 at 2:00 PM. R95's 15 Minute Sign Off for 1:1 Supervision form documents R95 was checked on at 15-minute intervals from 8/28/22 at 8:00 PM until 2:00 PM on 8/29/22. R95's undated census report documents R95 resides on the 2nd floor of the facility. On 8/29/22 at 10:54 AM R95 was lying in bed, and there were no staff present in R95's room. On 8/29/22 at 3:56 PM V22 Licensed Practical Nurse (LPN) stated: R95 has made sexual comments to staff and residents while passing them in the hallway. R95 would say things such as you can come sit on my lap, or I'll help you undo your pants. This has been an ongoing behavior. We try to keep a close eye on R95 and have R95 near the nurse's station. R95 does wander at times. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/22 at 9:38 AM V12 CNA stated: On 8/28/22 around 1:50 PM, R95 was in the television room facing the window, and R89 was facing the television. R95 had R89's hands on R89 trying to unbutton R89's pants. R89 is nonverbal. R89 used R89's hands to try and push R95's hands off of R89, while R95 continued to attempt to unbutton R89's pants. V12 immediately separated R95 from R89. R95 is confused, and during incontinence care has made sexual comments in regard to female staff's breasts. On 8/31/22 at 3:30 PM V39 LPN stated: About a month ago during shift change, V39 saw R89 and R95 in the television room. R95's back was facing V39, and R95's arm was near R89. V39 was not able to see R95's hands. V39 approached R95, and R95 acted startled and said I'm not doing anything. It (the situation) didn't sit well with me (V39). R95 and R89 were immediately separated. V39 reported the incident to V13 Previous Administrator, and V13 told V39 it sounds like two residents with Dementia. V39 did not report the incident to anyone else. On 8/31/22 at 4:15 PM V1 Administrator confirmed there is no investigative file or report of an allegation of abuse between R95 and R89 prior to 8/28/22. V1 stated: After the incident on 8/28/22 R95 was placed on one-to-one supervision until R95 transferred to the psychiatric hospital on 8/29/22. We do not provide continuous one to one, our one to one is 15-minute checks. The Preliminary Incident Investigation Report dated 8/31/22 documents On 8/31/22 V39 verbalized an incident, a while ago, between residents (R95) and (R89) of what seems to be inappropriate interaction. V39 stated that R95's back was towards V39, and V39 observed R95's arm to be moving back and forth on what seemed like R89's lap. V39 immediately reported to V13 Previous Administrator, and V13 told V39 that the conclusion was two dementia residents having behaviors. This report documents an investigation was initiated. 35510 3.) The facility's verbal abuse allegation investigation for R99 and V31, Certified Nursing Assistant (CNA) documents the incident occurred on 8/18/22 at 8:00 AM. V31, CNA's Copy of Timecard Report dated 8/18/22 to 8/24/22 documents V31 worked as follows: 8/18/22 6:16 AM to 8:54 AM and 9:15 AM to 11:51 AM. 8/22/22 6:06 AM to 9:15 AM. On 9/6/22 at 10:35 AM, V32, Housekeeper stated V32 overheard V31, Certified Nursing Assistant (CNA) speaking in a negative tone to R99 on 8/18/22 between 6:30 AM and 8:00 AM. On 9/6/22 at 11:50 AM, V1, Administrator stated the facility should not have allowed V31, CNA to continue working on 8/18/22 after R99's alleged verbal abuse against V31. V1 Administrator stated V31 was to have been suspended pending the completion of the investigation and should not have worked on 8/22/22 either. V1 stated the investigation was completed 8/24/22. On 9/8/22 at 3:30 PM, V1, Administrator stated staff are not hired nor always scheduled to work the same unit and have the potential to work throughout the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level II was conducted after a resident was diagnosed with Bipolar Disorder for one (R95) of five residents reviewed for PASARR in the sample list of 99. Findings include: The facility's undated policy on PASRR & OBRA (Omnibus Budget Reconciliation Act) Screening documents The facility shall follow Illinois Department of Human Services requirements for PASRR and OBRA Screenings. All residents are required to go through this screening process and copy of the screening shall be maintained in the resident's record. Only those residents who screen as appropriate for long-term facility placement shall be admitted . Resident(s) who are appropriate for long-term care placement with special needs (e.g. (example) DD (Developmental Disability) and/or serious mental health issues shall be assessed for needs and an individualized plan of care shall be developed and implemented. R95's undated census list documents R95 admitted to the facility on [DATE]. R95's Illinois Department of Healthcare and Family Services Interagency Certification of Screening Results dated 10/16/20 documents Developmental Disability or Mental Illness were not suspected, and there for a Level II PASARR was not completed. R95's undated Diagnosis List documents a diagnosis of Bipolar Disorder was added on 10/7/21. There is no documentation in R95's medical record that a PASARR Level II was conducted after R95 was diagnosed with Bipolar Disorder. R95's Nursing Notes document the following: On 9/12/21 R95 was combative and involved in a physical altercation with another unidentified resident. V53 Psychiatrist evaluated R95 on 9/17/22 for mood swings and changes in behavior. V53 documents R95's is Bipolar, manic without psychosis, and has cognitive impairment. V53 ordered Depakote (mood stabilizer) 125 milligrams twice daily. On 9/23/22 V53 prescribed Seroquel (antipsychotic). R95 transferred to an inpatient psychiatric hospital on 8/29/22. On 9/26/22 at 10:23 AM V34 Social Services Assistant stated V34 does not assist with setting up PASARRs, and either V51 Guest Relations or V52 Business Office Manager is responsible for scheduling PASARRs. On 9/26/22 at 10:25 AM V51 stated V51 does not schedule PASARRs. On 9/26/22 at 10:27 AM V52 stated V52 only schedules PASARR screenings for residents upon admission and does not schedule PASARRs after a resident admits to the facility. V52 was asked who is responsible for scheduling PASARR Level II screenings after a resident is newly diagnosed with mental illness. V52 stated I'm not sure who does that, maybe (V34 Social Services Assistant). We have been behind in PASARRs. V52 confirmed a PASARR Level II was not completed for R95 after R95's Bipolar Diagnosis was added in October 2021.

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	145439	A. Building B. Wing	09/14/2022

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to develop an initial baseline care plan for one of 24 residents (R74) reviewed for care plans in the sample list of 99. Findings include: The facility's Care Plan Process policy dated 6/2015 documents, 2. The admitting nurse initiates the interim care plan, under Observations labeled initial Care plan. 3. The remainder of the interdisciplinary team will assess the resident within 72 hours of admission and add any issues to the initial care plan to address any immediate care needs. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). R74's MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. R74's Care Plan does not have any fall interventions until 8/6/22 when an actual fall took place. R74's initial Fall Risk assessment dated [DATE] documents R74 is at risk for falls and has had 1-2 falls in the last three months. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no initial baseline care plan initiated for R74's falls.

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	145439	A. Building B. Wing	09/14/2022

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to develop and implement a Comprehensive Care Plan for falls, bilateral hearing aide use, nutrition, weight loss and anticoagulant medication use for four of 24 residents (R74, R21, R101, R70) reviewed for Care Plans in the sample list of 99. Findings include: The facility's Care Plans-Comprehensive policy with a revised date of 1/2011 documents, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. A comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS (Minimum Data Set). 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. incorporate risk factors associated with identified problems; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; 4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem areas(s), rather than addressing only symptoms or triggers. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 1. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). This MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. This MDS's Care Area Assessment Summary documents the trigger for Falls and documents Falls should be carried over to R74's Care Plan. R74's Fall Risk Assessments dated 7/1/22, 7/14/22, 8/6/22 and 8/25/22 all document R74 is at risk for falls. R74's Care Plan documents the first mention of a fall risk is dated 8/6/22 with the first fall intervention dated 8/6/22. R74's Nurse's Notes dated 8/6/22 at 7:00 AM documents R74 was found on the floor in R74's room. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no comprehensive Care Plan developed for falls on admission or even after the admission MDS was completed for R74. V21 confirmed the first fall documentation on R74's Care Plan is after R74 fell at the facility on 8/6/22. Surveyor: [NAME], [NAME] (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R21's Order Summary Report dated 8/1/21-9/30/22 documents R21's medication orders including Xarelto (Anticoagulant) 20mg (milligrams) by mouth in the evenings for a diagnosis of Deep Vein Thrombosis. R21's Care Plans dated 2/16/22 does not document a Care Plan for R21's use of Anticoagulation medication and side effects to monitor for. R21's Progress Notes dated as follows documents: 7/17/22 at 7:48pm document R21 was actively bleeding from R21's right front tooth, pressure was applied and mouth rinsed with cool water and that bleeding continues. 7/17/22 at 8:37am documents to apply gauze and pressure until bleeding stops as needed to upper right tooth and monitor R21. On 9/6/22 at 11:50am, V1, Administrator confirmed V1 did not see a Care Plan for R21's Anticoagulation medication. The facility's Anticoagulation Clinical Protocol policy dated October 2015 documents the staff and physician will identify and address potential complications in individuals receiving anticoagulation. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and manage related problems. 3. On 08/29/22 10:55 AM R101 was in R101's bed. During attempt to talk with R101, it was noted R101's hearing aids were not in R101's ears. At this time there is a sign on R101's bedside table documenting R101 is fully blind and has hearing aids. R101 unable to see or communicate at this time. R101's Progress Notes dated 7/27/22 at 11:56pm document R101 has hearing aides. R101's Minimum Data Set (MDS) dated [DATE] does not document R101 requires hearing aids. R101's Care Plans dated 8/27/22 do not document a plan of care for R101's hearing aid use. On 9/6/22 at 11:50am, V1, Administrator confirmed R101 should have a plan of care for R101's hearing aid use. 40385 4. R70's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22. R70's Care Plan revised on 7/17/22 does not include a problem area, goals, and interventions for nutrition or weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/7/22 at 11:30 AM V21 MDS/Care Plan Coordinator stated V21 assists with updating care plans. V21 stated nutrition and weight loss should be addressed on the resident's care plan. V21 confirmed R70 does not have a nutrition or weight loss care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to update resident Care Plans with falls, nutrition and weight loss concerns. The facility failed to conduct a Care Plan meeting with a resident's family and failed to invite a resident to the resident's Care Plan meeting for four of 24 residents (R74, R100, R95, R13) reviewed for Care Plans in the sample list of 99. Findings include: The facility's Care Plans-Comprehensive policy with a revised date of 1/2011 documents, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The facility's Care Planning-Interdisciplinary Team policy with a revised date of 11/2010 documents, 3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. 1. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). This MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. This MDS's Care Area Assessment Summary documents the trigger for Falls and documents Falls should be carried over to R74's Care Plan. R74's Nurse's Notes document R74 was found on the floor in R74's room on 8/6/22 and on 8/25/22. R74's Care Plan provided by V1 Administrator on 8/29/22 documents one fall on 8/6/22 but does not document any other falls for R74. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) stated that V21 is aware that there is an issue with Care Plans being updated. V21 stated V21 has not had time to get to all of the Care Plans for the entire facility of 120 plus residents. 35046 2. On 8/29/22 at 11:56 AM, V36 (R100's Family Member) stated she has been here a month and he has not been to a care plan meeting. V36 stated he does not know the plan for his mom's (R100) discharge or the progress she has made. V36 stated he would like to know what is going on with her progress and plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 3:02 PM, V21 Care Plan Coordinator stated the facility hasn't been having care plan meetings. V21 stated they should have had R100's care plan after her 5 Day/Admission Minimum Data Set assessment (MDS). R100's Electronic Medical Record documents R100's Admission MDS was completed on 8/3/22. 40385 3. R13's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5. 56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 (a 10% loss since 4/27/22.) R13's Nutrition Note dated 4/28/22 at 12:48 PM recorded by V47 Registered Dietitian (RD) documents R13 was reviewed for recent admission, R13's BMI (Body Mass Index) was 21.6 and was adjusted for above knee amputation. This note, documents Will monitor for need to modify nutrition. R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. R13's Care Plan dated 6/21/22 documents R13 has a potential nutritional problem secondary to wound healing and includes interventions to provide diet as ordered and Registered Dietitian to evaluate and make dietary changes as needed. This care plan has not been updated to include R13's significant weight loss and nutritional interventions. On 9/7/22 at 11:20 AM V21 MDS/Care Plan Coordinator stated nutrition and weight loss should be addressed on the care plan. V21 confirmed R13's care plan has not been updated to reflect R13's weight loss. 4. R95's MDS dated [DATE] documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10 % or more in 6 months. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21. 6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation that R95 was evaluated by V47 after 3/7/22 until 7/21/22. R95's Care Plan dated as revised on 8/27/21 documents R95's diet is regular and R95 is at risk for altered nutrition due to new admission to the facility. This care plan includes interventions that R95 will be reviewed by the RD as needed, and this care plan has not been updated to reflect R95's significant weight loss and nutritional interventions to address weight loss. On 9/7/22 at 11:20 AM V21 MDS/Care Plan Coordinator confirmed R95's care plan has not been updated to address R95's weight loss.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide assistance with showers, nail care, shaving and dressing for two (R70, R215) of four residents reviewed for activities of daily living in a sample list of 99. Findings include: The facility's Shower Sheets policy dated February 2022, documents shower worksheets will be completed for resident showers and resident shower refusals, and the worksheets are signed by the nurse. The facility's Care of Fingernails/Toenails policy dated as revised January 2019 documents Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The facility's undated Quality of Life-Dignity policy documents: Residents shall be groomed as they wish to be groomed (hairy styles, nails, facial hair, etc. (etcetera). Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns. 1.) On 8/29/22 at 12:05 PM R70 was sitting in the lounge on the 2nd floor. R70's thumb nails were long and extended approximately 1/2 inch past R70's fingertips. R70 stated R70 would like R70's nails trimmed, and they (R70's thumb nails) look terrible. On 8/31/22 at 10:52 AM R70 was lying in bed, and R70's thumb nails were long past R70's fingertips. R70's hair appeared greasy. V12 Certified Nursing Assistant (CNA) confirmed R70's thumb nails were long, R70's other fingernails were short and did not extend past R70's fingertips. V12 stated the nurses are responsible for trimming resident's nails, and R70's fingernails are short because R70 bites R70's fingernails off. R70's Minimum Data Set, dated dated dated [DATE] documents R70 has severe cognitive impairment and requires extensive assistance of one staff person for personal hygiene and bathing. R70's Order Summary Report dated 8/31/22 documents R70's showers are scheduled for Mondays and Thursdays on the evening shift. R70's July and August 2022 Shower Sheets provided by V3 Infection Preventionist, do not document R70 received showers as scheduled between 7/2-7/7/22, 7/13-7/17/22, 7/19-7/30/22, 8/1-8/7/22, or after 8/18/22. On 8/31/22 at 11:19 AM V52 CNA stated showers are documented on paper shower sheets and given to the nurses to sign, and then turned into the nurse managers. On 8/31/22 at 11:26 AM V23 Licensed Practical Nurse stated residents are scheduled for showers/baths twice per week and as needed. If the resident refuses, the refusal should be documented, and the shower is rescheduled within 48 hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/22 at 9:15 AM V3 confirmed all of R70's July and August 2022 shower documentation was provided. V3 stated fingernails are to be trimmed by the CNAs or activity staff, unless the resident is Diabetic. V3 stated nail care should be done with showers. 35046 2. On 8/30/22 at 10:00 AM, R215 was sitting in a wheelchair in R215's room. R215's face was covered with unkempt scraggly facial hair and R215 was wearing a hospital gown. R215 stated he prefers to be clean shaven and dressed but he can't do it himself. R215's care plan includes an intervention dated 8/26/22 to assist R215 with his ADL's (activity of daily living) needs. R215's 8/27/22 Admission Minimum Data Set Assessment documents R215 requires extensive assistance of one person for dressing and personal hygiene.

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	145439	A. Building B. Wing	09/14/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to identify and document a wound, adjust wound treatments, implement physician ordered wound treatments and interventions, schedule follow up Orthopedic appointments, and monitor weights as ordered for four (R13, R34, R215, R372) of 24 residents reviewed for quality of care in the sample list of 99. Findings include: 1.) On 8/29/22 at 10:18 AM V38 (R13's Family) stated R13 had a toe amputation a few months ago due to Diabetic wounds. V38 had visited several times where R13's wound dressings weren't on, and R13's wounds were uncovered/exposed. V38 stated R13 is supposed to wear a surgical boot. V38 removed R13's sock and R13's right foot was wrapped with a dressing dated 8/28/22. On 8/31/22 at 1:02 PM V38 stated V38 had previously requested an order for R13 for Vitamin E oil and a petroleum-based ointment, but the facility never implemented the treatment. R13's Minimum Data Set (MDS) dated [DATE] documents: R13 has severe cognitive impairment and requires extensive assistance of one staff person for toileting and dressing. R13's Physician's Orders dated 8/31/22 documents an order with a start date of 6/14/22 to apply moisture barrier to perineal area and buttocks every shift, an order to cleanse the 5th toe arterial wound, pat dry, apply Santyl ointment to wound, apply gauze moistened with 1/4 strength Dakin's solution, cover with an abdominal pad, and wrap with gauze twice daily and as needed, apply Betadine twice daily to the right 3rd and 4th toe wounds, and an order dated 6/20/22 for a surgical boot to the right foot to be worn with ambulation. R13's Wound Evaluation & Management Summaries recorded by V46 Wound Physician document: On 5/12/22 R13's right 5th toe arterial wound measured 1.5 cm (centimeters) long x 1.2 cm wide x no measurable depth. The wound was 100 % covered with black, necrotic tissue, and had gangrene. V46 ordered Betadine applied topically twice daily. On 8/25/22 R13's right 5th toe wound measured 3.5 cm x 2 cm x 1.2 cm and contained 20% necrotic tissue. R13's right 4th toe arterial wound measured 2 cm x 1.5 cm x no measurable depth, was 100 % necrotic with gangrene. R13's right 3rd toe arterial wound measured 1.2 cm x 1 cm, was 100 % necrotic with gangrene. R13's Skin assessment dated [DATE] documents R13 has Moisture Associated Skin Damage (MASD) that is no blanchable, an initial treatment was administered, and R13's family and physician were notified. There is no documentation of R13's MASD prior to 8/31/22, or that treatments were altered to treat R13's MASD. R13's May 2022 Treatment Administration Record (TAR) documents the right 5th toe Betadine order was not implemented until the night shift on 5/16/22 (4 days after it was ordered.) This treatment is not signed out as administered on 5 days. R13's July 2022 TAR documents R13's right 3rd and 5th toe wound treatments are not signed out as administered on 7 days. R13's August 2022 TAR documents R13's right 3rd, 4th, and 5th toe wound treatments are not signed out as administered on 3 days. (continued on next page)

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	09/14/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 at 3:50 PM R13 was self-propelling R13's wheelchair in the hallway. R13 was not wearing a boot on the right foot. On 8/31/22 at 3:12 PM R13 was sitting on the side of the bed with R13's right foot on the floor. R13 was not wearing a boot on the right foot. On 8/31/22 at 12:57 PM V38 told V12 Certified Nursing Assistant (CNA) that R13 needed assistance and that R13 was incontinent of bowel movement. V38 pulled down R13's incontinence brief which contained a small amount of bowel movement. R13's buttocks were red and excoriated. V38 stated the area had looked better on Sunday (8/28/22), but it looks worse today. On 8/31/22 at 1:02 PM V38 applied Vitamin E oil and a petroleum-based ointment. On 8/31/22 at 1:14 PM V12 CNA stated: R13's buttock excoriation was showing improvement, and last week it was not as red. Today it looks worse. The nurse (unidentified) was aware. We don't have access to barrier cream, it is given to us by the nurses to apply, but the nurses have to get an order first. On 8/31/22 at 3:39 PM V39 Licensed Practical Nurse (LPN) stated nothing has been reported about R13's buttock excoriation, and this is the first time V39 has heard about the excoriation. V39 administered R13's wound treatments to the right 3rd and 4th toe wounds, and 5th toe amputation wound. R13's 3rd and 4th toes were black indicating necrotic/dead tissue. R13's 5th toe was amputated, and there was a large wound with yellow and red tissue. There was tan drainage on the dressing. V39 stated the 5th toe wound has gotten larger and contains more yellow tissue. V39 cleansed the 5th toe wound, applied Santyl and gauze sponges, and wrapped R13's foot with gauze. V39 did not apply Dakin's-soaked gauze to the 5th toe wound. On 8/31/22 at 4:08 PM V39 assessed R13's buttocks. V39 stated the area looks like it is moisture associated that has flared back up. V39 stated V39 will get an order and apply barrier cream. V39 confirmed V39 did not apply Dakin's-soaked gauze to R13's right 5th toe wound. V39 stated V39 must have overlooked the Dakin's-soaked gauze in the order. On 9/01/22 at 3:22 PM V3 Infection Preventionist stated skin assessments are completed weekly by the nurses. The nurses should document skin issues, obtain a treatment order, and notify the physician if the treatment is not improving. V3 stated R13's right 4th toe wound was identified on 5/11/22, and the Betadine treatment was initiated on 5/16/22. V3 stated nurses should document their initials on the TAR when treatments are administered, and document resident refusals. V3 stated R13's surgical boot has been missing since last week. V39 confirmed there is no documentation of when R13's surgical boot is applied/removed. The facility's Wound Prevention Program dated February 2022 documents Notify the physician for any changes in the ski condition and obtain wound care treatment orders. Apply wound treatment as ordered by the physician. 2.) R34's MDS dated [DATE] documents R34 has short- and long-term memory loss. R34's Hospital Discharge Summary dated 8/10/22 documents R34 was diagnosed with a left wrist fracture. R34's discharge instructions document: A follow up for Orthopedic has been ordered for you. You will be contacted by the scheduling center for an appointment. Please schedule an appointment as soon as possible, If you do not receive a call within 2 days from now, please call the number below for an appointment. R34's Nursing Note dated 8/13/22 at 3:30 PM recorded by V39 Licensed Practical Nurse (LPN) documents R34 was not wearing the soft cast to the right wrist. The Physician was notified and gave orders to schedule an Orthopedic follow up visit on Monday (8/15/22) for a possible hard cast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34's Physician Orders Summary Report dated 8/30/22 documents an active order dated 8/13/22 to schedule R34's follow up Orthopedic appointment, and to discontinue the order once the appointment has been made and family is notified. R34's Nursing Note dated 8/30/2022 at 10:58 AM documents V29 (R34's Power of Attorney) was notified and agreed with scheduling an Orthopedic follow up appointment. R34's Nursing Note dated 8/30/22 at 12:14 PM documents R34's Orthopedic follow up appointment is scheduled for 9/19/22 at 2:30 PM, V34 Social Services Assistant spoke with R34's family on 8/25/22, and the family preferred that R34 not have a hard cast placed. There is no documentation that R34 was scheduled for an Orthopedic follow up appointment prior to 8/30/22, or that R34's family declined for R34 to have an Orthopedic follow up appointment. On 8/30/22 at 10:15 AM R34 was self-propelling R34's wheelchair in the hallway, using both hands. R34 was not wearing a soft cast or splint to R34's left arm. On 8/31/22 at 3:30 PM V39 LPN stated: V39 spoke with R34's family about the order for a follow up Orthopedic appointment due to R34 removing the soft splint cast. R34's family was in agreement with the appointment. I (V39) was off for a few days, and I (V39) guess no one followed up with making (R34) the ortho (Orthopedic) appointment. On 8/30/22 R 10:29 AM V23 LPN stated V11 Physician recommended R34 have a follow up Orthopedic appointment for a hard cast due to R34's noncompliance with wearing the soft cast. R34's family refused R34's follow up appointment, and it should be documented in a progress note. On 8/30/22 AT 10:38 AM V23 stated V23 spoke with R34's family to confirm their refusal of the follow up Orthopedic appointment. R34's family was in agreement to schedule R34's follow up appointment, and R34's family wants everything the Orthopedist can do for R34. 35046 3.) R215's hospital summary dated 8/20/22 documents R215 has a history of Congestive Heart Failure. R215's physician order dated 8/24/22 documents to obtain daily weights. Notify physician if weight gain of more than 3 lbs per day or more than 5 lbs in one week. R215's medical record does not document weights were done daily. R215's medical record from 8/24/22 to 9/8/22 daily weights were only completed on 8/30/22, 9/2/22, and 9/6/22. R215's Wound Evaluation Form documented by V46 Wound Physician documents R215 has a Diabetic wound to the right ankle. This form includes a recommendation for a calf high heel protector while in bed. On 8/31/22 at 11:28 AM, R215 was lying in bed on his right side. R215's legs were curled up and R215's feet were crossed. R215 was not wearing a calf high heel protector or any other type of heel protector. At that time, a calf high heel protector was lying on a three-drawer cabinet on the other side of the room. (continued on next page)

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	09/14/2022

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 11:45 AM, V35 Licensed Practical Nurse stated she was unaware of the recommendation and is not sure when R215 is supposed to be wearing the heel protector. V35 stated is unsure why R215's weights aren't getting completed. 42702 4.) R372's Orthopedic after care notes document a post operative appointment on 5/18/22. The post operative visit notes dated 5/18/22 document that R372 is to follow up with another post operative appointment and Xray on 6/29/22. R372's medical record does not document R372 attending any appointments on 6/29/22, nor does it document the appointment being rescheduled. Additionally, R372's medical record does not document an Xray being done. On 9/13/22 at 9:27AM, V21 Minimum Data Set Coordinator/Care Plan Coordinator stated, After a surgery like R372 had, she should have been seen by Orthopedics as ordered and have gotten an Xray. On 9/13/22 at 11:00 AM, V34 Social Services Assistant/Appointment Scheduler stated that she did not know about this appointment. On 9/13/22 at 12:00 PM, V1 Administrator confirmed that R372 did not attend this appointment and that the facility could not explain why this error occurred.

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F 0689 Level of Harm - Minimal harm or potential for 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 investigate fall occurrences and implement fall interventions for three of four residents (R74, R21, R17) reviewed for falls in the sample list of 99. Findings include: The facility's Falls Prevention Program policy with a revised date of 11/2017 documents, Fall prevention program will be implemented to ensure all resident's safety in the facility whenever possible. This program should include a measure that determines each resident's needs by assessing the risks for falls and implementing appropriate interventions to provide the necessary supervision, and assistive devices are utilized as necessary. Post Fall Incidents: 4. Identify the root causes of the fall incident, which could be related to the resident's current or declining medical condition or worsening behavior. 5. The staff will evaluate, and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc. (etcetera). 6. For an individual who has fallen, staff will attempt to define possible root cause(s) of the fall. a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, multiple factors in varying degrees contribute to a falling problem. 10. Collect and evaluate any information until either the cause of the falling is identified or can be speculated as to what was the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Treatment/Management 1. Based on the preceding assessment, the staff and or physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2. If the underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment until falling reduces or stops or until a reason is identified for its continuation. Monitoring and Follow-Up If the individual continues to fall, the staff and physician will 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.) R74's Order Summary Report dated 8/30/22 documents diagnoses including Difficulty in Walking, Muscle Weakness and Cognitive Communication Deficit. R74's Minimum Data Set (MDS) dated [DATE] documents R74 requires extensive assistance of one staff for transfers and toileting and total dependence on one staff for walking in R74's room. R74's Census List dated 9/8/22 documents R74 was admitted to the facility on [DATE]. R74's Fall Risk Assessments dated 7/1/22, 7/14/22, 8/6/22 and 8/25/22 all document that R74 is at risk for falls. R74's MDS dated [DATE] documents R74 had one fall in the last month prior to admission and one fall with a fracture in the last six months prior to admission which triggered Falls on the CAAs (Care Area Assessments). The Assessment documents falls as a concern for R74 with instructions to proceed to care planning. R74's Care Plan does not document any fall interventions prior to 8/8/22. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no initial fall care plan for R74 with no fall interventions developed until 8/6/22. 35510 2. R21's Care Plans dated 1/31/22 document R21 can potentially have a fall. There is no documentation of R21 sustaining falls and/or post fall intervention updates for R21's fall on 8/29/22. On 08/29/22 at 11:53 AM R21 fell forward out of R21's wheelchair. At this time V28, Activities Director was walking behind R21. V28 stated He threw himself on the floor out of the chair. R21's leg dropped after R21 had lifted it and R21 fell to the floor on R21's knees. V41, Assistant Director of Nursing (ADON) asked V28 if there were any additional witnesses to R21's fall. V28 stated there were no additional witnesses to R21's fall out of R21's wheelchair. On 09/01/22 at 09:36 AM R21 stated R21's back of leg bothers R21. R21 stated R21's leg slipped off as R21 tried to move R21's upper leg and R21's leg got stuck dropped and R21 fell . On 9/1/22, after speaking with R21 at 9:36 AM, V1, Administrator was notified of R21's fall that had occurred on 8/29/22 and that this fall was not documented in R21's medical records. V1 stated staff should complete an investigation into a report of a fall and document in the resident's medical records. On 9/6/22 at 11:50 AM, V1, Administrator stated the facility should not just assume or consider a fall a behavior without investigating and that is what V1 feels the facility potentially did for R21's fall. 42702 3) R17's undated diagnosis list documents the following diagnoses including Neuromuscular Dysfunction of Bladder, Generalized Anxiety Disorder, Cognitive Communication Deficit, Unspecified Psychosis, Hypothyroidism, Major Depressive Disorder, Urinary Tract Infections and Retention, Syncope, Congenital Hydrocephalus, Spinal Stenosis, and Dysphagia. R17's brief interview for mental status dated 5/17/22 documents R17 as moderately cognitively impaired. R17's progress notes dated 7/4/22, 7/14/22, 7/25/22, 9/1/22 document resident falls from the bed, identified as behaviors of throwing self onto floor. R17's care plan dated 4/23/21, documents, Increase activities of his choice when resident is exhibiting behaviors and intentionally putting himself on the floor. On 8/29/22 and 8/30/22 from 9:00 AM to 4:00 PM no group activities with residents were observed. During this survey; no 1:1 activities were observed including R17. On 8/30/22 at 11:00 AM, R17 stated that no one provided activities for him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/22 at 10:00 AM and 2:00 PM, 8/30/22 at 9:30 AM and at 3:00 PM, 8/31/22 at10:30 AM and at 1:30 PM, 9/6/22 at 10:45 AM and at 3:30 PM and on 9/7/22 at 10:30 AM R17 was observed in his room, in bed. On 9/6/22 V22 Licensed Practical Nurse stated, They need to get him out of his bed. He is bored and that's why he keeps throwing himself out of bed. They used to do activities with everyone in the dining room but since COVID, (R17) and the others are just bored. They give them a paper and that's it. On 9/6/22 at 10:36 AM, V28 Activity Director stated, I haven't tried to get (R17) up for activities since March. I was told by V29 Administrator that I wasn't supposed to do group activities. I was doing 1:1 but (R17) is hard. I know that it is better for them to socialize. I was just doing what I was told.

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	145439	A. Building B. Wing	09/14/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35510 Based on observation, interview and record review, the facility failed to implement physician's orders for a urinary catheter, failed to develop and implement a plan of care related to the urinary catheter use. This failure affects one of four residents (R101) reviewed for urinary catheter use on the sample list of 99. Findings include: R101's Face Sheet documents R101 admitted to the facility on [DATE]. R101's Hospitalist Progress Note dated 7/26/22 documents R101 developed Acute Urinary Retention on 7/25/22 and a urinary catheter was placed. R101 is to follow-up with Urology as an outpatient. R101's urinary catheter was placed on 07/25/2022. (R101) will need Urology follow-up as an outpatient. This note also documents R101 is to follow-up with Urology for voiding study. R101's Post-Acute Care Transition Document dated 7/27/22 documents R101's urinary catheter as a Coude urinary catheter (slight curve near the insertion end of the urinary catheter tubing) size 14 french. This document also documents Discharge Instructions, Follow-up with Urology for voiding study. On 08/29/22 10:55 AM R101's urinary catheter tubing was red/brown. R101's Progress Notes dated 8/1/22 at 11:31 PM documents an order was received for a urinalysis to be obtained due to Hematuria. R101 to have f/u (follow-up) with Urology regarding Hematuria. R101's Order Summary Report dated 9/5/22 documents an order dated 8/1/22 to, Refer (R101) to Urology related to Hematuria. This report also documents to change R101's urinary catheter every four weeks but does not document R101's use of a Coude urinary catheter. There is no documentation R101 has had a follow-up appointment with a Urologist as ordered on admission as well as ordered on 8/1/22 by the facility. R101's Care Plans dated 8/27/27 document R101 has a urinary catheter due to Urinary Retention. These Care Plans do not document R101 has a Coude urinary catheter or size of R101's urinary catheter. These Care Plans also do not document R101's follow-up with a Urologist for voiding trials. On 9/8/22 at 1:00pm, V41, Assistant Director of Nursing (ADON) stated the facility did not call until 9/6/22 for an appointment for R101 at a local Urology clinic.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to timely identify and address significant weight loss, complete thorough nutritional assessments, and implement physician ordered nutritional recommendations for four (R13, R70, R95, R63) of 12 residents reviewed for nutrition in the sample list of 99. These failures resulted in R13 sustaining a severe weight loss of 6.11 % in 15 days. Findings include: The facility's Nutritional Assessment policy dated as revised December 2011 documents: Nutritional assessments will be completed upon admission and with changes in condition that put the resident at risk for impaired nutrition. Nutritional assessments will be conducted by the interdisciplinary team and the dietitian will include an estimate of the resident's calorie, protein, nutrient, and fluid needs. The facility's Weight Assessment and Intervention policy dated as revised June 2012 documents: Nursing staff are responsible for obtaining resident weights. An unplanned weight loss of 5% in one month, 7.5 % in 3 months, and 10 % in 6 months is considered significant, and greater than 5% in 1 month, 7.5 % in 3 months, and 10 % in 6 months is considered severe. The dietitian will be notified of weight changes in writing, and the dietitian should respond within 24 hours of receiving the notification. Interventions for undesirable weight loss include consideration of the use of supplements and nutrition/hydration needs. 1.) R13's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's Care Plan dated 6/21/22 documents R13 has a potential nutritional problem secondary to wound healing and includes interventions to prescribe diet as ordered and Registered Dietitian to evaluate and make dietary changes as needed. This care plan has not been updated to include R13's significant weight loss. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5. 56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 (a 10% loss since 4/27/22.) R13's Physician's Order Summary Report dated 8/31/22 documents R13's diet is regular with ice cream once daily, and a frozen nutritional supplement once daily, and orders dated 7/22/22 to give ice cream daily in the afternoon and a frozen nutritional supplement in the evening for low BMI (Body Mass Index) and weight loss. R13's August 2022 Medication Administration Record (MAR) documents R13's ice cream is scheduled to be given at 12:00 PM. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R13's Nutrition Note dated 4/28/22 at 12:48 PM recorded by V47 Registered Dietitian (RD) documents R13 was reviewed for recent admission, R13's BMI (Body Mass Index) was 21.6 and was adjusted for above knee amputation. This note documents, Will monitor for need to modify nutrition. R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. There is no documentation that R13's significant weight loss first noted on 5/9/22 was identified and reported to V47 until 5/26/22, and that nutritional interventions were implemented after 4/28/22 and prior to 5/26/22. There is no documentation that the frozen nutritional supplement was implemented prior to R13's hospital discharge on 6/1/22. On 8/29/22 at 10:18 AM V38 (R13's Family) stated R13 has lost weight recently but was unsure how much weight R13 has lost. On 8/31/22 at 12:23 PM V38 stated V38 was not sure what the facility was doing to help with R13's weight loss. On 8/29/22 at 12:39 PM R13 at all of the noodles with tomato sauce, mixed vegetables, and garlic bread. R13's meal tray did not contain whole milk or ice cream. On 8/31/22 at 12:17 PM R13's meal tray was delivered and contained ice cream but did not include whole milk. R13's meal ticket documented ice cream. On 8/31/22 at 12:22 PM V38 entered R13's room and requested V40 Certified Nursing Assistant get R13 a carton of milk. V40 returned with a carton of 2 % milk. On 8/31/22 at 12:25 PM V40 was passing drinks to residents. V40 stated: V40 knows what drinks to serve each resident based on knowing the residents. V40 usually works night shift, and V40 asks other staff as well. On 9/06/22 at 10:43 AM V3 Infection Preventionist confirmed R13's frozen nutritional supplement was not added to R13's orders/MAR until 7/21/22. On 9/06/22 at 3:26 PM V3 stated V47 assessed R13 on 4/28/22 and not again until 5/26/22, and there were no nutritional interventions implemented prior to 5/26/22. On 9/06/22 at 12:31 PM V47 RD stated: Often times residents will drink better than they eat, so V47 recommends juice and milk with meals. The facility notifies me of weight loss when V47 is in the facility, or by telephone and electronic mail. V47 expects V47's recommendations to be implemented within 1-2 days, and V47 provides the recommendations to the facility on the same day V47 completes the evaluations. V47 assessed R13 on 5/26/22 for R13's significant weight loss. V47 cannot recall when V47 was notified of R13's significant weight loss. V47 would have given V47's recommendations sooner (than 5/26/22) if V47 was notified. V47 was in the facility on 5/5, 5/12, 5/23, and 5/26/22. V47 recommended Ice cream, whole milk, and the frozen nutritional supplement to promote weight gain. 2.) R70's MDS dated [DATE] documents R70 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's Care Plan revised on 7/17/22 does not address nutrition/weight loss or interventions. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22. R70's Nutrition Note dated 4/21/2022 at 1:19 PM by V47 RD documents R70 was reviewed for weight loss, R70 has history of fluid issues and receives a diuretic. This note documents a recommendation to add whole milk and juice with all meals. R70's Nutrition Note dated 8/11/2022 at 1:56 PM by V47 documents: R70 was reviewed for weight loss at 1, 3, and 6 months and R70 has a healing stage III wound. V47 recommended a frozen nutritional supplement once daily to provide an additional 290 kilocalories and 9 grams of protein. R70's Physician Order Summary Report dated 8/31/22 documents R70's diet order includes whole milk and juice at meals, and a frozen nutritional supplement once daily. There is no identified time of when the frozen nutritional supplement is scheduled to be given or documentation that R70 receives the frozen nutritional supplement daily as ordered. On 8/29/22 at 12:14 PM R70's lunch tray included noodles with tomato sauce, mixed vegetables, garlic bread, mandarin oranges, and coffee. R70's meal ticket documents whole milk and juice with meals and does not document a frozen nutritional supplement. On 8/29/22 at 12:25 PM R70's meal tray did not include milk or juice. On 8/31/22 at 12:41 PM R70 ate 50 % of carrots, 75 % of mashed potatoes, all of the pears, and bites of roast beef. R70's meal tray did not include milk, juice, or a frozen nutritional supplement for the noon meals on 8/29 and 8/31/22. On 8/31/22 at 3:30 PM V39 Licensed Practical Nurse (LPN) stated: Frozen nutritional supplements and ice cream are delivered by dietary staff on the meal trays. The frozen nutritional supplement is documented on the MAR. R70 does not get a frozen nutritional supplement in the evening. On 9/06/22 at 12:31 PM V47 stated V47 recommended milk, juice, and a frozen nutritional supplement to promote weight gain for R70. 3.) R95's MDS dated [DATE] documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10% or more in 6 months. R95's Care Plan dated as revised on 8/27/21 documents R95's diet is regular and R95 is at risk for altered nutrition due to new admission to the facility. This care plan includes interventions that R95 will be reviewed by the RD as needed, and this care plan has not been updated to reflect R95's significant weight loss and nutritional interventions to address weight loss. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 and recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs . There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21. 6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation that R95 was evaluated by V47 after 3/7/22 until 7/21/22. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R95's Physician Order Summary Report dated 8/29/22 documents an order on hold dated 2/28/22 for a nutritional supplement 120 cc four times daily, and an order dated 8/5/22 for a nutritional shake three times a day. R95's August 2022 MAR documents R95's nutritional shake is scheduled three times daily at 9:00 AM, 12:00 PM, and 5:00 PM. This MAR does not document the amount of the shake that R95 consumes or that R95 received the nutritional supplement on 5 times and refers to R95's Nursing Notes. R95's August 2022 Nursing Notes do not document R95 received the nutritional supplement as ordered 5 scheduled times during the month. On 8/29/22 at 12:33 PM R95 was eating in R95's room. R95's meal contained noodles with tomato sauce, mixed vegetables, garlic bread, mandarin oranges, and an orange drink. R95's meal ticket listed a nutritional shake for the noon meal. R95's meal did not contain a nutritional shake. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated the facility was out of the (nutritional supplement) for a while and we replaced it with (nutritional shake). The nutritional shake is served by dietary staff on the meal trays. On 9/06/22 at 10:43 AM V3 provided R95's nutritional assessment dated [DATE] and stated that was the last full RD nutritional assessment V3 could locate for R95. On 9/06/22 at 12:31 PM V47 stated: R95's BMI was low. On 7/21/22 V47 recommended a frozen nutritional supplement. The nutritional supplement and shake are to promote weight gain and improve BMI. The goal is to have a BMI of at least 23 for age 65 and older. There was a shortage of the nutritional supplement, and we had switched to using the nutritional shake. V47 was off work during the first two weeks of July, and there was another RD who should have covered in V47's place. 32853 4.) R63's Order Summary Report dated 9/8/22 documents diagnoses including Unspecified Dementia, Unspecified Severity Without Behavioral Disturbances, Dysphagia and Psychotic Disturbance. This Order Summary documents an order for a regular diet, mechanical soft texture, regular/thin consistency, ground meat, whole milk and juice at all meals, add frozen nutritional supplement daily with a start date of 3/30/22. On 5/12/22 at 12:22 PM, V47 Dietician documented R63 was reviewed for weight loss at one and three months, BMI (Body Mass Index) 24.9, diet is regular/mechanical soft, and appetite has declined. Will request whole milk and juice at all meals and review as needed for need to further modify. R63's Weights and Vitals Summary report dated 9/8/22 documents R63's weight on 3/1/22 was 159.8 pounds and on 9/4/22 R63's weight was 135.8 pounds which was a 15.02% (percent) weight loss in six months. On 8/31/22 at 12:29 PM R63's meal tray only contained a 2% carton of milk. There was no whole milk on R63's tray as ordered. On 9/6/22 at 12:31 PM, V47 confirmed R63's recommendation for whole milk was for weight loss. V47 stated often times residents drink better than they eat, so V47 recommends milk and juice at meals.

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	145439	A. Building B. Wing	09/14/2022

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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. 35510 Based on observation, interview and record review, the facility failed to ensure a resident had physician's orders for use of a Continuous Positive Airway Pressure (CPAP) device. The facility also failed to ensure the resident had supplies for the device and failed to ensure the supplies were stored to prevent cross-contamination of the mask for the CPAP device, and to label Oxygen tubing and a humidification bottle. These failures affect two of two residents (R3, R21) reviewed for respiratory on the sample list of 99. Findings include: 1. R21's Order Summary Report dated 9/6/22 does not document a current physician's order for R21's Continuous Positive Airway Pressure (CPAP) device. On 08/29/22 at 12:30 PM, R21's CPAP device was observed dusty/unclean. R21's mask for R21's CPAP treatment was attached to the tubing which was attached to the machine and was in R21's dirty linen basket, uncovered. The CPAP device water reservoir compartment was dry. On 09/01/22 09:36 AM R21's Continuous Positive Airway Pressure (CPAP) device was on R21's night stand next to R21's bed. The device had appeared to have dust like debris/unclean on the surface. R21's CPAP tubing hanging down with R21's mask in R21's dirty linen basket and the water reservoir compartment was dry. The CPAP mask appears unclean with a film covering the inside of the mask and the cushion around the edges of the mask were unclean and yellowed in color. R21 stated R21 has told multiple staff R21 needed water for R21's CPAP machine and they have not brought/provided any for a while. R21 stated R21 would wear it if they would bring the water for the device. R21 stated R21's throat gets irritated and dried out and needs the water to be able to tolerate wearing the CPAP. R21's Care Plans dated 9/14/21 document R21 is at risk for respiratory failure due to noncompliance with respiratory management like oxygen therapy and the use of CPAP with interventions including to encourage R21 to wear CPAP at night. These care plans do not document R21's CPAP settings or maintenance/cleaning of CPAP machine. On 9/8/22 at 12:45 PM, V41, Assistant Director of Nursing (ADON) stated R21's CPAP mask should be placed in a plastic bag for storage when not in use. V41 stated R21's CPAP mask and CPAP machine should be cleaned every shift. The facility's CPAP-BIPAP (Bilevel Positive Airway Pressure) Support policy dated November 2015 documents to obtain a physician's order for the use of the device with details. Resident or staff should rinse and wipe down the mask on a daily basis to eliminate facial oil build up. If the headgear becomes soiled, wash with soap and water and rinse well and air dry. 2. R3's Order Summary Report dated 8/6/22 documents R3's physician's orders including Oxygen at 2L (liters)/nasal cannula (NC) to keep Oxygen Saturation above 90% as needed. On 08/29/22 2:15 PM and 8/30/22 at 9:50 AM, R3's Oxygen tubing and humidification bottle were not labeled/dated. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/22 V23 LPN stated, The oxygen tubing and water (humidification) bottles are supposed to be dated. The facility's undated Oxygen Administration policy documents the facility is to change the nasal cannula tubing weekly or as needed, change the humidifier prefilled bottle once the contents are consumed and if the oxygen tubing/facemask or nasal cannula is not being used, it is to be properly stored in a clean plastic bag. This policy does not document the facility is to document/label oxygen tubing or humidifier bottle.

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	145439	A. Building B. Wing	09/14/2022

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. 35510 Based on interview and record review, the facility failed to ensure a resident received orders for care of/maintenance for a resident's artificial eyes. This failure affects one of one resident (R101) reviewed for vision on the sample list of 99. Findings include: R101's Progress Notes dated 7/27/22 document R101 is legally blind with artificial eyes. R101's Progress Notes dated 7/27/22 at 11:56 PM document R101 is legally blind with artificial eyes. R101's Progress Notes dated 8/1/22 at 4:27 PM document R101 has artificial eyes and eye matting. R101's Baseline Care Plans are incomplete and do not include R101's bilateral artificial eye care needs. There is no documentation in R101's Care Plans dated 8/27/22 documenting a plan of care related to R101's bilateral artificial eyes and care of them. On 9/6/22 at 11:50 AM, V1, Administrator stated the facility should have contacted R101's physician to get orders/direction on how to care for R101's artificial eyes and should have a care plan in place for them.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42702 Based on observation, interview and record review the facility failed to provide residents with pain control and pain assessments. The facility also failed to provide timely treatment of pain for a resident post above knee amputation. This failure affects two of three residents (R3, R214) reviewed for pain in the sample of three from a total sample list of 99. These failures resulted in R3 experiencing unrelieved pain and the ability to receive physical therapy post above knee amputation. Findings include: 1. R3's progress notes dated 8/5/22 document that R3 returned to the facility after sustaining a right above knee amputation due to osteomyelitis and Methicillin Resistant Staphylococcus Aureus of the right leg. On 8/15/22 R3's Brief Interview Mental Status is documented as moderately impaired. R3's physician orders dated 8/5/22 document an order for Oxycodone 5 milligrams by mouth every 6 hours as needed for severe pain for the above the knee amputation. The last comprehensive pain assessment was completed on 5/5/22. R3's care plan dated 8/7/22 documents to give analgesics as ordered by the physician and monitor and document for side effects and effectiveness. R3's medical record first documented dose of pain medication (Oxycodone 5 milligrams) was on 8/6/22 at 3:40 PM. From 8/6/22 to 8/29/22, 29 of a possible 72 doses of Oxycodone were given to R3 for pain. On 8/14/22, R3's progress notes document R3's indicator of pain was vocal complaints of the right thigh generalized as sharp, stabbing and aching. On 8/14/22 Methocarbamol 750 Milligrams was ordered every six hours as needed for muscle aches and muscle spasms. From 8/14/22 to 8/29/22, 14 of a possible 52 doses of Methocarbamol was given for muscle aches and spasms. R3's 8/25/22 progress notes document verbal complaints of pain. On 8/29/22 10:00AM R3 was observed laying in bed while grimacing and yelling, Help! and holding his right stump. On 8/29/22 at 10:30AM, R3 continued to yell, Help, I hurt! V12 Certified Nursing Assistant stated, He yells a lot. On 8/29/22 at 3:45 PM, R3 was yelling at R5 Certified Nursing Assistant, My leg hurts! My right leg! On 8/31/22 at 8:25 AM V10 Certified Nursing Assistant stated, He had been yelling for months, I have pain, I have pain. I need medication! (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/29/22 at 4:05PM, V7 Licensed Practical Nurse stated, I called V11 Medical Doctor at 3:55PM for something for (R3's) pain. (R3) complains of pain a lot. Even before his amputation he yelled out in pain, but then he had Osteomyelitis, so who knows. (R3) recently told me that even air hitting the stump made him hurt. He needs something for breakthrough pain. On 8/29/22 at 4:15PM, V7 Licensed Practical Nurse stated that V11 Medical Doctor had called with an order for Tylenol 1000mg for breakthrough pain. R3's August 29, 2022, medication administration record does not document any Tylenol given for breakthrough pain. On 8/31/22 at 10:29 AM, V17 Physical Therapist stated, (R3) was in such pain that I couldn't even touch him to work on him. I told the staff, but he just couldn't tolerate therapy. Physical therapy discharge notes dated 8/16/22 documents, Poor tolerance to stretching due to severe pain. On 8/31/22 at 10:47 AM, V19 Nurse Practitioner stated that the last time she saw R3 was on 8/24/22 and the staff didn't tell her that R3 was having increased pain. The facility pain policy dated 2/23/22 documents, The purposes of this procedure are to help the staff identify pain in the resident and to develop intervention that are consistent with the resident goals and needs and that address the underlying causes of pain. 1. The pain management program is to provide comfort to the resident. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain b. Effectively recognizing the presence of pain. c. Identifying the characteristics of pain. d. Addressing the underlying causes of the pain. e. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain g. Monitoring to the effectiveness of interventions and h. modifying approaches as necessary. 35046 2. R214's Brief Interview for Mental Status dated 8/11/22 documents R214 is cognitively intact. On 8/29/22 at 10:50 AM, R214 stated she is in a lot of pain, but her pain medications are effective most of the time. R214 stated one day she had to wait 3.5 hours to get her call light answered. R214 stated she was needing pain medication. R214 stated she called her daughter (V20) because she was in so much pain and no one was coming to her room. R214 stated she was in so much pain that she couldn't breathe. R214 stated the nurse finally came in and gave her some pain medication but that soon after the paramedics showed up to get her because V20 called 911 to get her help. R214 stated it turns out my call light wasn't working correctly so no one knew I needed pain medicine. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/31/22 at 8:51 AM, V20 stated R214 called her the evening of 8/26/22. R214 stated, She called me and told me she was in so much pain she couldn't stand it. She was crying and told me she had to wait too long to get a pain pill and that the pain pill wasn't touching her pain. I called the ambulance because no one at the facility would answer the phone and I was scared because she was in so much pain and told me she had a bump behind her knee. I was afraid she had a blood clot. I drove to the facility right after I called 911. When I got there, she was leaving by ambulance and was still in pain. R214's nurse's note dated 8/26/2022 at 7:13 PM documents, Medical team came in stating (R214) called 911 and complains of severe leg pain and wanted to go to hospital. She took Norco about 30 min (minutes) ago. Upon leaving the facility daughter came in and (R214) will go to (hospital). On 8/31/22 at 2:30 PM, V43 stated on 8/26/22 at 6:30 PM, I was working down the other side of the hall. A kitchen aide (unknown) told me R214 was having pain and that she was wanting pain medication. I gave her a Norco (Hydrocodone Acetaminophen 5-325 milligrams). Then I heard people coming in and it was the paramedics. I didn't know they were coming. They arrived thirty minutes after I gave her pain medication. V43 stated she was in severe pain, and I am not sure how long she waited. V43 stated when the paramedics came her pain wasn't relieved and she was still in a lot of pain, so she went to the hospital. V43 stated V43 didn't know her call light wasn't working that night. On 8/30/22 at 9:52 AM, V50 Maintenance Assistant stated he fixed R214's call light on 8/26/22. V50 stated when he pushed her call light, he discovered her light above the door didn't light up. He had to replace the light bulb. V50 stated he doesn't remember the time but it was late in the day.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42702 Based on observation, interview and record review the facility failed to provide a full time Director of Nursing (DON) since January 1, 2022. These failures have the potential to affect all 122 residents in the facility. Findings include: On 8/29/22 there was no Director of Nursing at the facility. On 8/31/22 at 1:10 PM V3 Infection Control Nurse stated that there had not been a director of nursing in months. On 9/6/22 at 11:00 AM, V30 Wound Nurse stated, We haven't had a Director of Nursing in 8 months and that isn't helping us. On 9/8/22 at 10:00 AM, V21 Care Plan Coordinator stated that she did not work as a Director of Nursing forty hours per week at any time. The facility's August 2022 Nursing schedule does not document a Registered Nurse (RN) on the schedule at any time. The facility's Resident Census and Conditions of Residents form dated 8/29/22 documents 122 residents reside in the building.

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to comprehensively assess a resident's aggressive behaviors upon admission for one of one resident (R46) reviewed for behaviors in the sample list of 99. This failure has the potential to affect 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) residing on the second floor of the facility. Staff allowed R46 unsupervised access to residents who are unable to protect themselves from R46's behaviors. Findings include: The facility's Behavior Monitoring policy dated 10/2015 documents, Problematic behaviors will be identified and managed appropriately. The facility staff and Attending Physician will identify individuals with a history of impaired cognition (e.g., dementia, mental retardation), problematic behavior, or mental illness (e.g., bipolar disorder or schizophrenia). R46's Face Sheet dated 8/19/22 documents an admitted [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Progressive Neurological Conditions, Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. R46's MDS dated [DATE] documents R46 had behaviors that put others at significant risk for physical injury, significantly intruded on the privacy of others, significantly disrupted care or living environment and wandering significantly intrudes on the privacy or activities of others. R46's Baseline Care Plan dated 6/20/22 documents the only behavioral concern was wandering. R46's Social Services Behavior Conditions Review dated 8/26/22 (after R46 was discharged to the Psychiatric hospital) documents R46's new or worsening behavior as aggressive behaviors towards staff and other residents. This Review documents R46 had exhibited physically aggressive behaviors towards residents. R46's Nurse's Progress Note dated 6/20/22 at 1:54 PM documented by V22 Licensed Practical Nurse (LPN) documents, (R46) having behaviors noted on this shift/ refusing medication. and (cussing) at nursing staff. NP (Nurse Practitioner) notified. Will continue to monitor. On 6/20/22 at 8:37 PM, V22 documents, (R46) noted having behaviors on this shift. (R46) was cursing/ yelling while (R46) was in (R46's) room. When staff tried to redirect (R46) continued to curse and yell. (R46) is now calm in bed call light within reach. Will continue to monitor. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0740 Level of Harm - Actual harm Residents Affected - Some	R46's Nurse's Progress Note dated 6/24/22 at 11:17 AM by V44 Licensed Practical Nurse (LPN) documents, (R46) has been trying to go to other (resident's) room with redirection. After being informed to not go into other (people's) (rooms) (R46) continued to do so. (R46) unplugged (R12's) air mattress and spilled water all over the floor. (R46) refused to come out by staff. (R46) was finally able to be redirected to (R46's) room. (R46) is now in (R46's) room in bed. Facility management notified. R12's Diagnosis Report dated 9/8/22 documents diagnoses including Quadriplegia and Tracheostomy status. On 7/8/22 at 4:25 PM, V4 LPN documents, (R46) Behavior: E) Hallucinations/Delusions/Psychosis 1) Able to redirect and refocus 3) Medication given 2) Keep redirecting every shift. On 7/14/22 at 9:33 PM, V44 documents, (R46) having behaviors this evening. (R46) was being physically and verbally abusive to staff. (R46) stated I will punch you and give you two black eyes to the writer. (R46) was redirected and was unsuccessful. (R46) started to become a threat to staff, (residents), and self. (R46) started to push and shove furniture. MD (Medical Doctor) notified. (R46) is to be sent to (hospital) for altered mental status evaluation. When paramedics arrived (R46) became aggressive with EMT (Emergency Medical Technicians) by telling them Bet nobody touches me and screaming. Notified (POA) and facility (Administrator). Will continue to monitor. On 8/11/22 at 7:03 PM, V4 documents, (R46) Behavior: B) Combative/hitting/kicking staff/resists care C) Crying/restlessness/agitated E) Hallucinations/Delusions/Psychosis 1) Able to redirect and refocus 3) Medication given 2) Keep redirecting every shift. On 8/19/22 at 1:53 PM, V14 LPN documents, (R46) became agitated with 2 other female residents (R52, R64). (R46) was in wheelchair on (R46's) way back from dining room. Female patients ambulating back from lunch in the 2 south dining room. Writer heard (R46) yell F*** you to (R52, R64). Writer began going toward the commotion. (R52, R64) yelled back F*** you. (R46) sped up his wheelchair and hit (R52, R64) directly knocking them to ground. Writer interviewed and separated all parties. (R46) stated they deserved it and they shouldn't talk to (R46) like that. PCP (Primary Care Provider) notified states to continue monitoring. emergency contact notified. (Administrator) and nurse managers notified. (R46) on 1-1 supervision at this time from time of incident. On 8/26/22 at 1:04 AM, V4 documents, (R46) Behavior: C) Crying/restlessness/agitated 1) Able to redirect and refocus 2) Keep redirecting. On 8/26/22 at 2:58 PM, V14 documents, (R46) left with transport for (Psychiatric) hospital in (the north) at (2:40 PM). Med list (medication list) and face sheet sent with. Writer reached out to (hospital) to give report, they stated they do not need a report just send (R46). R74's Order Summary Report dated 8/30/22 documents diagnoses including Cognitive Communication Deficit and Difficulty Walking. R74's Minimum Data Set (MDS) dated [DATE] documents diagnoses including Fractures and Other Multiple Trauma and History of TIAs (Transient Ischemic Attacks). R74's BIMS Evaluation dated 7/3/22 documents a score of 7/15 indicating moderately impaired cognition. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	The facility's Preliminary Incident Investigation Report dated 8/25/22 at 6:22 PM, documents Employee reported suspicion of unusual event on 8/25/22 approximately 6:22 PM. (R74) was in (R74's) room with door blocked open by a wheelchair belonging to (R46). (R74's) wheelchair was between R74 and the other wheelchair. (R74) was lying on the floor and reported that (R74) had fallen. (R74) was undressed from waist down and soiled depend lying on (R74's) bed. No injury noted by nurse assessing the resident. Both residents (R46 and R74) were sent out for evaluation. Physicians and POA/emergency contacts notified. Police notified. (V15 Police Officer) arrived at facility to interview staff and residents. R74's Nurse's Note dated 8/25/22 at 5:00 PM, documents CNA (Certified Nursing Assistant) notified nurse that (R74) was on the ground, undressed from the waist down and (R46) was wrapped in (R74's) bed sheet. CNA told second nurse. Nurse notified administrator; statement given. Doctor contacted gave order to send out for assessment. POA notified. (R74) assessed. (R74) Vital Signs WNL (Within Normal Limits). No c/o (complaints of) pain. Sent (R74) to hospital to be assessed. On 8/29/22 at 3:55 PM, V5 Certified Nursing Assistant (CNA) stated on 8/25/22 around dinner time, 5:00 PM-6:30 PM, V5 noticed R46 standing at the nurse's station with no wheelchair with R46. V5 stated that V5 went to look for R46's wheelchair. V5 looked in a couple of rooms but then came to R74's room and the door would only open a small way.V5 stated that there were wheelchairs blocking the door and R74 was on the floor on the other side of the wheelchairs. V5 stated R74 had no clothes on from the waist down and R74's used incontinent brief was laying on the bed away from R74. V5 stated V5 could not fit through the opening without pushing the wheelchairs into R74 so V5 got the nurse (V6 Licensed Practical Nurse/LPN) and V6 was able to fit through the opening and climbed over the bed to get to the other side of the wheelchairs and rearranged things so V5 could come in and assist. V5 stated they got R74 up off the floor and dressed and during this time R46 returned to the room with R74's personal bed sheet wrapped around R46. V5 stated R46 was screaming at them to get out of R46's house. V5 stated after they got R74 up and R74's pants back on V5 left R74 with V6. V5 stated that R46 is a resident with high behaviors. V5 also stated that R46 is a highly disturbed man that is abusive, mean and nasty. On 9/8/22 at 10:30 AM, V25 confirmed that there was no behavior assessment completed for R46 upon admission. V25 stated that R46's behavior assessment was not completed until 8/26/22. The facility's Resident Room Roster provided on 8/30/22 documents 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) reside on the second floor.

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	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to complete psychological medication assessments, complete Abnormal Involuntary Movement Scales, and to provide rationale for gradual dose reduction (GDR) refusals for one (R81) of two residents reviewed for psychotropic medications from a total sample list of 99. Findings include: R81's undated diagnoses list documents R81's diagnoses include Alzheimer's Disease, Vascular Dementia with Behavioral Disturbances, and Unspecified Psychosis. R81's Minimum Data Set, dated dated dated [DATE] documents R81 has severe cognitive impairment, R81 receives an antipsychotic medication routinely, a GDR has not been attempted and a GDR has not been documented by a physician as clinically contraindicated. R81's Order Summary Report dated 8/31/22 documents orders dated 3/6/22 for Seroquel (antipsychotic) 25 mg (milligrams) one tablet by mouth daily and two tablets by mouth daily at bedtime. R81's February 2022 Medication Administration Record documents R81 received Seroquel 25 mg twice daily as of 5/18/21. R81's medical record documents a Psychotropic Medication Assessment for the use of Seroquel and Abnormal Involuntary Movement Scale (AIMS) were completed on 7/28/22. There are no other documented Psychotropic Medication Assessments or AIMS in R81's medical record. R81's Medication Regimen Review (MRR) dated 2/3/22 documents the pharmacy recommended to reduce Seroquel from 25 mg twice daily to 12.5 mg every morning and 25 mg every evening. V11 Physician approved the dose reduction. There is no documentation that this recommendation was implemented prior to 3/5/22. V11's Progress Note dated 3/5/22 documents R81 refuses care, bites, hits, and to continue all of R81's medications including Seroquel 25 mg twice daily. R81's Note to Attending Physician/Prescriber dated 8/2/22 documents a pharmacy recommendation to reduce R81's Seroquel to 25 mg twice daily. V11 signed this form on 8/14/22 and marked the box for Patient has had good response to treatment and requires the dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information.) V11 did not document a clinical rational or patient specific information for why the dose reduction was declined. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/22 at 1:18 PM V54 Registered Nurse stated R81 is on Seroquel for combative behaviors during care, yelling out, and resisting care. R81's Seroquel dosage was increased in March due to an increase in these behaviors. V54 stated the GDR in February was initially approved, but the provider and was informed that there was an increase in behaviors so the same dosage was continued. V54 confirmed V11 did not document a clinical rational for declining R81's Seroquel dose reductions in February and August 2022. V54 stated Psychotropic Medication Assessments and AIMS are completed upon admission, with increased dosages, and quarterly. On 9/06/22 at 1:35 PM V3 Infection Preventionist confirmed there are no other documented Psychotropic Medication Assessments or AIMS (besides 7/28/22) for R81. V3 stated R81 should have had a Psychotropic Medication Assessment completed for the increase in Seroquel in March 2022. The facility provided Psychotropic Medication Policy dated 2/15 documents GDR (Gradual Dose Reduction) consideration for residents with a diagnosis of dementia and on antipsychotic medications- within the first year in which the resident is admitted on antipsychotic therapy or after the facility has initiated an antipsychotic medication, the facility shall attempt a GDR (Gradual Dose Reduction) in two (2) separate quarters (with at least one month in between the attempts) unless contraindicated. After the first year, GDR (Gradual Dose Reduction) shall be attempted annually unless clinically contraindicated.

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	145439	A. Building B. Wing	09/14/2022

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35046 Based on interview and record review the facility failed to administer medications per physician's order for two of two residents (R215, R80) reviewed for significant medication errors on the sample list of 99. Findings include: 1) R215's hospital summary dated 8/20/22 documents R215 was hospitalized for Right Foot Gangrene with Cellulitis Osteomyelitis status post 4th and 5th digit amputation and followed by 2nd and 3rd metatarsal amputation with graft and Diabetes Mellitus type 2 Chronic with Neuropathy and Nephropathy. R215's Electronic Medical Record documents R215 was admitted to the facility on [DATE]. R215's physician orders documents orders dated 8/20/22 for Ertapenum Sodium 1 gram intravenously for right 4th and 5th toe amputation, Empagliflozin 20 milligrams every day for Diabetes Mellitus Type II, and Protonix (Gastric Acid Secretion Reducer) 40 milligrams every day for Gastrointestinal Reflux Disorder. R215's Medication Administration Record dated 8/1/2022 through 8/31/22 documents that R215 did not receive the physician ordered doses of Ertapenum Sodium (Antibiotic), Empagliflozin (Antihyperglycemic) 20 milligrams, or Protonix 40 milligrams on 8/21/22 and 8/22/22. R215's nurse's notes dated 8/21/22 and 8/22/22 documents, awaiting pharmacy. On 8/31/22 at 1:10 PM, V3 Registered Nurse Manager stated when R215 was admitted , R215's face sheet was not sent to the pharmacy as required so the pharmacy did not send R215's medications. V3 stated the nurse's on duty that weekend should have notified someone that R215 did not receive the medications from the pharmacy. 42702 2) R80's undated diagnosis sheet documents the following diagnoses including Metabolic Encephalopathy, Catatonic Schizophrenia, Stage four kidney disease, Chronic Atrial Fibrillation, Anxiety, Depression, Congestive Heart Failure, Atherosclerotic Heart Disease, Peripheral Vascular Disease, and History of Stroke. R80's hospital discharge/transfer notes dated 4/12/22 document R80 has a diagnoses of Paroxysmal Atrial Fibrillation (PAF) and takes Eliquis 5 milligrams twice a day for PAF. R80's care plan dated 8/27/22 documents that R80 is at risk for discolorations and bleeding due to anticoagulant medication for treatment of Atrial Fibrillation with Eliquis as the medication being used to treat. R80's August medication administration record documents Eliquis stopped on 8/7/22 and not resumed in the month of August. R80's September medication administration record documents no Eliquis given from September 1, 2022, through September 13, 2022. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/22 at 1:00 PM, V63 Medical Doctor stated, If (R80) was on Eliquis for Atrial Fibrillation, then she should be restarted on it. I was not the doctor who started her on this medication, nor did I stop it. On 9/13/22 at 2:54 PM, V61 Registered Nurse stated, (V62 Medical Doctor) wanted me to relay that the Eliquis should not have been stopped, should be restarted, and that the potential for harm is great with a moderate level of risk for Stroke recurrence. On 9/14/22 at 9:45AM, V1 Administrator stated that the facility could not determine why the Plavix had been stopped, but that they had received an order on 9/14/22 to restart the medication for R80.

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	145439	A. Building B. Wing	09/14/2022

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 35046 Based on observation, interview, and record review the facility failed to provide meals that met dietary needs and preferences for four (R14, R215, R106, and R214) of 24 residents reviewed for meals on the sample list of 99. Findings include: 1. On 8/29/22 at 11:11 AM, R14 stated he is supposed to get double portions but does not get his double portions. R14's lunch ticket on the tray documented R14 was to receive double portions. On 8/31/22 at 11:31 AM, R14 received a lunch tray. R14 stated, See, I didn't get double portions. R14's tray had one serving of roast beef, one scoop of potatoes, one scoop of cauliflower, one piece of bread and one bowl of fruit. On 8/31/22 at 11:40 AM, V35 Licensed Practical Nurse stated R14 is supposed to receive double portions, but the kitchen never sends him double portions. V35 stated it is a constant problem and that sometimes she will call and tell them they didn't send them, and they tell me they are out or will bring some but half the time they never show up with the double portions. 2. On 8/31/22 at 11:57 AM, R215 was served a piece of roast beef, cauliflower, and a bowl of fruit. R215's lunch ticket documented R215 is to receive a low carbohydrate diet with no starches, bread, or potatoes. R215 stated I don't want starches, so I hardly get any food. The facility's Daily Spreadsheet for Wednesday 8/31/22 documents the lunch menu as roast beef, baked potato, cauliflower, pears, and dinner roll. This Spreadsheet did not document an option for a low carbohydrate diet. 3. On 8/29/22 at 12:05 PM, R106 was sitting in her room eating lunch. R106 was observed just finishing her meal. R106 stated the facility served spaghetti with curly noodles mixed vegetables, mandarin oranges and bread. R106 stated the facility is aware R106 eats Gluten Free and R106 thinks the noodles and bread were not Gluten Free so she did not eat the bread. The facility's Daily Spreadsheet for Wednesday 8/31/22 documents the lunch menu as roast beef, baked potato, cauliflower, pears, and dinner roll. This Spreadsheet did not document an option for a Gluten Free diet. 4. On 8/29/22 at 10:30 AM, R214 stated there is no variety in the food and they serve too many starches. On 8/29/22 at 12:00 PM, R214 was sitting in her room eating lunch. R214 stated I don't want to eat all this starch. R214 was eating noodles with red sauce and chicken. R214's plate also contained mixed vegetables, mandarin oranges, and bread. R214's dietary ticket which was laying on the table documents R214 is receiving a regular diet. (continued on next page)

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	145439	A. Building B. Wing	09/14/2022

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/22 at 8:51 AM, V20 (R214's family member) stated the food in the facility is not good. V20 stated R214 is a Diabetic and her blood sugar isn't controlled very well and she is always getting too much starch. R214's diet order dated 8/9/22 documents a low concentrated sweet diet for Diabetes Type II. On 8/30/22 at 12:45 PM, V18 Certified Dietary Manager stated the facility does not have Gluten Free or low carbohydrate diets. V18 stated the facility has no concentrated sweets diet. V18 stated they do not have substitutions on the spreadsheet if a resident does not want carbohydrates.

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	145439	A. Building B. Wing	09/14/2022

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35046 Based on observation, interview, and record review the facility failed to prepare and serve meat that was easily cut and chewed for five (R214, R113, R67, R70, and R13) of 24 residents reviewed for meals on the sample list of 99. Findings include: 1. On 8/31/22 at 11:30 AM, R214 was eating lunch in her room. R214 stated her lunch had a good flavor but the roast beef was tough, and she could hardly chew it. R214 was picking at the roast beef, and it appeared dry and leathery. 2. On 8/31/22 at 12:14 PM, V12 Certified Nursing Assistant was assisting R113 with her meal in her room. V12 couldn't hardly cut the meat with the butter knife sawing back and forth R113's meat. On 8/31/22 at 12:17 PM, V12 Certified Nursing Assistant was picking up the lunch trays from the resident rooms. V12 stated it's all been hard to cut. V12 took a piece of meat off a tray that someone did not eat and had to pull hard to pull it apart. 3. On 8/3/22 at 12:15 PM, R67 was standing up at her bedside table eating her lunch. R67 stated the roast beef was tough and was ripping it apart to eat it. 4. On 8/31/22 at 12:41 PM, R70 was sitting in R70's room just finished eating. R70 had eaten 1/2 of the carrots, 3/4 of potatoes, all of pears, and only taken a couple bites of the roast beef. R70 stated, That meat is too tough for me to chew. 5. On 8/31/22 at 12:44 PM, R13 was observed in her room eating. R13 was having difficulty chewing the roast beef. At that time, V38 (R13's Family Member) stated the meat is kind of tough for her to chew. On 8/31/22 at 1:00 PM, V18 Certified Dietary Manager stated when V18 was getting ready to cook the roast beef he noticed he had an oven down, so he had to slice the meat prior to cooking it to save time and that was probably the reason it was dry and tough.

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	145439	A. Building B. Wing	09/14/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35046 Based on observation, interview, and record review, the facility failed to maintain sanitary food preparation and storage areas. These failures have the potential to affect all 122 residents in the facility. Findings include: On 8/29/22 at 10:00 AM, Four rolling storage bins were located under a counter in the kitchen. These bins contained oatmeal, sugar, flour, and breadcrumbs. The clear plastic openings on the top of the bins and the sides of these bins were covered with spots of various sticky residue and were streaked with dirt. At that time, V18 Certified Dietary Manager stated that they push these bins to the preparation and cooking areas and that is how they get soiled. V18 stated that these bins needed cleaned. On 8/29/22 at 10:10 AM, A drawer connected to the underneath of a small food preparation area containing potholders and loose papers had spilled dried puddles of liquids. A three-compartment container containing ladles and scoops had accumulated crumbs and dried spilled areas inside the container where the ladles and scoops were lying. Three clear plastic containers containing cooking utensils had accumulated crumbs and debris. At that time, V18 stated the drawer and containers needed to be cleaned. On 8/29/22 at 10:15 AM, The four-door refrigerator, the milk/juice cooler, and the two-door freezer were streaked with an unknown substance and the handles on the doors were sticky when grabbed. The clean dish cart containing plastic drinking tumblers, bowls, and plates had dried crumbs lying with the clean dishes. The inside of a microwave had areas of sticky residue on the sides, top, and on the top of the cooking surface. A warming cabinet containing five warming trays were covered with accumulated crumbs. V18 stated that all areas in the kitchen needed cleaned. The facility's Census and Conditions of Residents report dated 8/29/22 signed by V21 Registered Nurse documents there are 122 residents residing in the facility.

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	09/14/2022

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35046 Based on interview and record review the facility failed to designate and operationalize an effective governing body, impacting the operations of the facility. This failure had the potential to affect all 122 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] through 5/1/23 documents V13 (Former Administrator) as the Administrator and the Governing Body of the facility. This assessment does not document who the Administrator reports to concerning the management and operation of the facility. On 9/8/22 at 1:44 PM, V2 [NAME] President of Clinical and Reimbursement stated V2 is not sure who the governing body of the facility is and that she is over nursing only. V2 stated she does not oversee the Administrator or her duties in the facility. V2 stated the Administrator completed the facility's Facility Assessment. V2 stated the facility's Facility Assessment is not accurate as the Administrator cannot also be the governing body. The facility's Census and Condition report signed by V21 Registered Nurse documents there are 122 residents residing in the facility.

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	145439	A. Building B. Wing	09/14/2022

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 42702 Based on interview and record review the facility failed to implement a quality assurance program within the facility. This failure has the potential to affect all 122 residents residing in the facility. Findings include: On 9/1/22 at 11:06 AM V1 Administrator stated, I cannot say that (we) have quality projects or a quality assurance performance improvement program. On 9/7/22 at 2:30P M, V1 Administrator provided quality meeting sign in sheets for 3/25/22, 5/27/22 and 7/22/22. V1 Administrator confirmed that these were the only documented quality meeting sign in sheets that could be found. The facility Quality Assessment and Assurance Plan dated November 2017 documents, The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assessment and Assurance Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality and resolve identified problems. The resident census and condition report dated 8/29/22 documents 122 residents residing in the facility.

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	09/14/2022

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42702 Based on interview and record review the facility failed to hold quarterly quality meetings. This failure has the potential to affect all 122 residents residing in the facility. Findings include: On 9/1/22 at 11:06 AM V1 Administrator stated, (The facility) didn't have quarterly quality meetings. On 9/1/22 at 11:06 AM V1 Administrator stated, I cannot say that (we) have quality projects or a quality assurance performance improvement program. On 9/7/22 at 2:30PM, V1 Administrator provided quality meeting sign in sheets for 3/25/22, 5/27/22 and 7/22/22. V1 Administrator confirmed that these were the only documented quality meeting sign in sheets that could be found. The facility Quality Assessment and Assurance Plan dated November 2017 documents, This committee shall meet quarterly to review reports, evaluate the significance of data and monitor quality-related activities of all departments, services or committees. The resident census and condition report dated 8/29/22 documents 122 residents residing in the facility.

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	145439	A. Building B. Wing	09/14/2022

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42702 Based on interview and record review the facility failed to include the Director of Nursing in quality assurance meetings. This failure has the potential to affect all 122 residents residing in the facility. Findings include: On 9/1/22 at 11:06 AM V1 Administrator stated that the only meetings that could be found were in March, May and June of 2022 and there was no Director of Nursing at the time. On 9/7/22 at 2:30 PM, V1 Administrator provided quality meeting sign in sheets for 3/25/22, 5/27/22 and 7/22/22 none of the sign in sheets include a Director of Nursing in attendance. V1 Administrator confirmed that these were the only documented quality meeting sign in sheets that could be found. The resident census and condition report dated 8/29/22 documents 122 residents residing in the facility.

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	145439	A. Building B. Wing	09/14/2022

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40385 Based on observation, interview, and record review the facility failed to disinfect scissors after a wound treatment, change gloves, perform hand hygiene during incontinence care, implement isolation signage, isolation laundry, waste bins for transmission-based precautions, and ensure staff properly wear Personal Protective Equipment (PPE). These failures have the potential to affect for five (R13, R70, R82, R91, R103) of 24 residents reviewed for infection control in the sample list of 99. Findings include: 1.) R13's Right 5th Toe Wound Culture dated 7/24/22 documents a moderate colony count of Proteus Mirabilis (bacteria) and Methicillin Resistant Staphylococcus Aureus (MRSA, a multidrug resistant organism), indicating an active infection. R13's Order Summary Report dated 8/31/22 documents an order for contact isolation for six weeks that was initiated on 7/25/22. On 8/29/22 at 10:16 AM there was a sign posted on R13's door indicating R13 was on contact precautions. There was a cart containing PPE located outside of R13's doorway, and isolation bins for linen and waste were in R13's room. V38 (R13's Family) was in R13's room and was not wearing a gown or gloves. V38 stated R13 is not on isolation. On 8/29/22 at 10:14 AM V23 Licensed Practical Nurse (LPN) stated R13 is not on isolation, and staff must have forgotten to remove the isolation signage from R13's door. On 8/29/22 at 11:01 AM V23 stated V23 clarified R13's isolation status, and R13 is on contact isolation for a wound infection. On 8/31/22 at 11:58 AM and 3:12 PM R13 was in a different room than observed on 8/29/22. R13's door did not contain isolation signage and there was no cart containing PPE near R13's doorway. R13's room did not contain isolation linen and waste containers. On 8/31/22 at 3:16 PM V39 LPN prepared to enter R13's room to administer R13's wound treatment. V39 stated V39 needed to get an isolation gown, and that's not (R13's) regular room. At 3:18 PM V39 placed a cart containing PPE outside of R13's doorway. At 3:39 PM V39 used scissors to remove the dressing covering R13's right foot. R13 had necrotic, black tissue to R13's 3rd and 4th toes. R13 had a right 5th toe amputation. R13's right 5th toe wound had red and yellow tissue, and tan drainage on the gauze. V39 laid the scissors inside of the garbage bag used to hold the old dressing removed from R13's right foot wounds, contaminating V39's scissors. V39 cleansed R13's wounds and administered R13's wound treatments. V39 placed the contaminated scissors directly on the sink in the bathroom that adjoined with R91's room. V39 washed the scissors with soap and water, and then placed the scissors back onto the sink. V39 tied the plastic bag containing R13's soiled wound dressings and placed the bag into the waste receptacle on the treatment cart located in the hallway. V39 stated R13 does not have isolation waste and laundry containers in R13's room. V39 confirmed there is no isolation signage posted on R13's door. V39 took the scissors from the sink and placed the scissors into V39's pocket. At 4:08 PM V39 stated V39 is going to have to take the treatment cart and the waste bag to R13's previous room to place the waste into an isolation bag. V39 stated a bleach wipe should be used to disinfect scissors after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/01/22 at 10:50 AM V3 Infection Preventionist stated R13's wound culture on 7/24/22 showed MRSA infection. R13 is on contact isolation for the wound infection. Staff should wear a gown in R13's room if there is the potential to come into contact with drainage from R13's wound. Signage should be posted to alert staff and visitors of isolation. R13 should have had isolation signage posted and isolation bins for laundry and waste should have been moved with R13 to R13's temporary room. There should be a PPE cart outside of R13's door. Staff should disinfect scissors with a bleach wipe, and staff should have used a bleach wipe to wipe down R13's sink. 2.) On 8/31/22 at 10:52 AM R70 was laying in bed. V12 Certified Nursing Assistant (CNA) applied gloves, pulled down R70's incontinence brief, and wiped R70's buttocks with a disposable wipe. There was bowel movement visible on the wipe. Without changing gloves and performing hand hygiene, V12 applied R70's clean incontinence brief, pulled up R70's pants, opened R70's nightstand drawer, handed R70 a pen and paper, used R70's bed remote control to lower the bed, pushed back the privacy curtain, opened R70's door and left R70's room. V12 took the waste bag from R70's room and opened the door to the soiled utility room to dispose of the waste. V12 did not perform hand hygiene or remove V12's gloves until after V12 went to the soiled utility room. On 8/31/22 at 12:52 PM V12 stated V12 did not remove V12's gloves and perform hand hygiene until V12 was in the soiled utility room. V12 stated We don't change our gloves unless they are visibly soiled during care, such as with wound drainage. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated: Gloves should be changed, and hand hygiene performed when moving from soiled to clean areas during pericare and after pericare is completed. The CNA (V12) should have removed her gloves and not worn them in the hallway. 3.) The Updated Interim Guidance for Nursing Homes and Other Licensed Long-Term Care Facilities updated on 3/22/22 documents: For those residents not suspected to have COVID-19 (Human Coronavirus Infection), HCP (Health Care Professionals) should use community transmission levels to determine the appropriate PPE to wear. When community transmission levels are substantial or high at a minimum, HCP must wear a well-fitted mask at all times and eye protection while present in resident care areas. Facilities might consider having HCP wear N95 respirators at all times while in the facility. The Centers for Disease Control and Prevention COVID Data Tracker documents on 8/29/22 the facility's county transmission level was high. On 08/29/22 at 10:00 AM V49 CNA pushed R82 in a wheelchair down the hallway and into the lounge on the 2nd floor of the facility. V49's N95 mask was pulled down, exposing V49's nose and mouth. On 08/30/22 at 10:10 AM V50 Maintenance Assistant was walking down the East Hall of the 2nd floor, past residents and resident rooms. V50's eye protection was on top of V50's head, and not covering V50's eyes. The lower strap of V50's N95 mask was hanging loosely below V50's chin and was not positioned behind V50's head. At 10:43 AM V50 walked past the nurse's station and walked down the North Hall of the 2nd floor. The lower strap of V50's N95 mask was hanging below V50's chin. V50 stated V50 is assisting housekeeping staff today on the 2nd floor. On 8/31/22 at 11:14 AM V50 walked down the East and South Halls of the 2nd floor. V50 was not wearing eye protection, and V50's lower strap has hanging below V50's chin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/31/22 at 12:38 PM V56 CNA was standing at the nurse's station wearing an N95 mask positioned below V56's nose, exposing V56's nose. V56 was talking to R91 and R103, who were within six feet of V56 and were not wearing a mask. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated staff should be wearing eye protection and an N95 mask when in common areas, hallways, and during care of residents. V3 confirmed masks should be worn covering both the nose and the mouth. The facility's Transmission-Based Precautions policy with a revised date of 3/18/22 documents: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Infections with multidrug resistant organisms would be an example of an infection that requires Contact Precautions. Wear gloves and a gown when entering the Contact Precautions room. Adequately clean and disinfect resident care equipment before use for another resident. Signage Isolation, see the nurse will be posted to alert staff and visitors. The facility's Standard Precautions policy revised March 2022 documents Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one.) Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. The facility's policy Dressings, Soiled/Contaminated revised 3/18/22 documents Soiled dressings that are heavily soiled with exudate or drainage or from a resident with an infectious condition must be placed in specially designated BIOHAZARD containers for disposal. The facility's Personal Protective Equipment - Using Protective Eyewear revised 2/3/22 documents Masks and eye protection devices, such as goggles or glasses with solid side shields or chin-length face shields, shall be worn together whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be expected.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to offer COVID-19 (Human Coronavirus Infection) immunizations for three (R9, R99, and R31) of five residents reviewed for immunizations in the sample list of 99. Findings include: The facility's Prevention of Coronavirus (COVID-19) Infection Control Policy dated as reviewed 8/29/22 documents 4. Resident/patients will receive recommended immunization per CDC (Centers for Disease Control) recommendation. 5. Staff will obtain consent for COVID-19 vaccination from the resident or appropriate decision maker (POA (Power of Attorney)). Document the declination and approval of vaccines. 6. The physician will order the type of vaccination available. 7. Nursing staff will administer and document the COVID Vaccine as ordered when available. The facility's COVID Vaccination Log for residents dated 8/25/22 does not document that R94, R99, R31 have received any primary doses of the COVID-19 vaccine. The facility's Staff Testing Positive for COVID-19 logs dated 1/8/22-8/15/22 documents 11 staff have tested positive for COVID-19 since 7/25/22. The facility's Resident Testing Positive for COVID-19 logs dated 1/4/22-7/30/22 documents 1 resident has tested positive since 7/25/22. 1.) R94's undated diagnoses list documents R94's diagnoses include Type II Diabetes Mellitus, Hypertension, and History of Transient Ischemic Attack and Cerebral Infarction. R94's undated census report documents R94 admitted to the facility on [DATE]. There is no documentation in R94's medical record of R94's COVID-19 vaccination status, or that R94 was offered the vaccine and if R94 accepted or refused the vaccine. 2.) R99's undated diagnoses list documents R99's diagnoses include Type II Diabetes Mellitus, Chronic Kidney Disease Stage III, and Hypertension. R99's undated census report documents R99 admitted to the facility on [DATE]. There is no documentation in R99's medical record of R99's COVID-19 vaccination status, or that R99 was offered the vaccine and if R99 accepted or refused the vaccine. 3.) R31's undated diagnoses list documents R31's diagnoses include Parkinson's Disease, Type II Diabetes Mellitus, Chronic Kidney Disease Stage III, and Hypertension. R31's undated census report documents R31 admitted to the facility on [DATE]. There is no documentation in R31's medical record of R31's COVID-19 vaccination status, or that R31 was offered the vaccine and if R31 accepted or refused the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/22 at 1:50 PM V3 Infection Preventionist stated: COVID-19 vaccinations are administered by an outside pharmacy that comes to the facility monthly. R31 is on hospice and R31's family declined the COVID-19 vaccination. The COVID-19 consent/declination forms were used before V3 was hired, and V3 was unsure if a form is currently used. V3 does not have documentation that R94, R99, and R31 were offered the COVID-19 vaccine, and if they accepted or declined the vaccine. V3 was waiting for Veterans Affairs to provide R94's vaccination information.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to ensure a licensed nurse was vaccinated for COVID-19. This failure has the potential to affect all 122 residents residing in the facility. Findings include: The Vaccination of Facility Staff policy dated as revised 2/23/22 documents: If required, second dose administration shall be received per vaccination requirements, and evidence of this second vaccination shall be submitted for copy into the employee's personnel file and recorded on the Employee Vaccination Roster. Employees failing to obtain the required second vaccination dose per CDC (Centers for Disease Control and Prevention) guidelines shall be removed from the schedule and placed on unpaid administrative leave until meeting this requirement. Failure to meet this requirement within two weeks of this unpaid administrative leave shall be considered a voluntary resignation. The CDC's Stay Up to Date with COVID-19 Vaccines Including Boosters guidance dated 9/8/22 documents the 2nd primary dose of a twostep series should be given 3-8 weeks after the 1st dose for people aged [AGE] years and older. The facility's COVID-19 Staff Vaccination Status log documents V57 Licensed Practical Nurses first primary dose of a twostep series of the vaccine was given on 1/22/22. This log does not document that V57 received the 2nd primary dose of the vaccine. , or that V57 has a pending or approved medical or religious exemption. V57's COVID-19 Vaccination Record Card documents V57 received the 1st dose of a two-part series on 1/22/22, and does not document that V57 received the 2nd primary dose of the vaccine. The facility's Daily Schedules document V57 worked on all of the halls of the 1st floor on nine days between 8/17/22 and 8/31/22. On 9/1/22 at 9:26 AM V3 Infection Preventionist stated V3 does not track employee COVID-19 vaccinations and V48 Human Resources completes the tracking. On 9/01/22 at 10:50 AM V3 stated: V57 is the only employee who has not completed the primary doses of the COVID-19 vaccination. V57 received the first dose and had a panic attack. V3 had V57 scheduled to receive the 2nd dose two times, but V57 did not follow through. On 9/01/22 at 1:40 PM V48 stated before staff are allowed to work, they must show proof of COVID-19 vaccination or apply for a medical/religious exemption. V48 stated the exemptions have to be approved before the employee is allowed to work. At this time V57 LPN entered V48's office. V57 confirmed V57 has only received the 1st primary dose of a twostep series of the COVID-19 vaccination. V48 stated V57 does not have a qualifying medical or religious exemption. V57 stated V57 is waiting for V57's physician to provide a note. V48 told V57 that V57 has to get the 2nd dose of the vaccine by Monday (9/5/22). V57 stated the 2nd dose of the vaccine is administered 28-29 days after the 1st dose. V57 stated staff should be restricted from working if they are past due for the 2nd dose of the vaccine and they do not have an exemption. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/06/22 at 3:26 PM V3 Infection Preventionist stated V57 primarily works on the 1st floor of the facility, and V57 has also worked on the 2nd floor and the rehabilitation unit (all units of the facility). The Resident Census and Conditions of Residents dated 8/29/22 documents 122 residents reside in the facility.

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F 0919 Level of Harm - Actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 35046 Based on observation, interview, and record review the facility failed to ensure the emergency nurse call system had a functioning light for R214 and a properly functioning emergency nurse call device for R100. R214 and R100 are two of 24 residents reviewed for call lights on the sample list of 99. This failure resulted in R214 having excruciating pain for three hours and requiring R214 to be sent to the emergency room for evaluation. Findings include: 1.) R214's Brief Interview for Mental Status dated 8/11/22 documents R214 is cognitively intact. On 8/29/22 at 10:50 AM, R214 stated she is in a lot of pain, but her pain medications are effective most of the time. R214 stated one day she had to wait 3.5 hours to get her call light answered. R214 stated she was needing pain medication. R214 stated she called her daughter (V20) because she was in so much pain and no one was coming to her room. R214 stated she was in so much pain that she couldn't breathe. R214 stated the nurse finally came in and gave her some pain medication but that soon after the paramedics showed up to get her because V20 called 911 to get her help. R214 stated it turns out my call light wasn't working correctly so no one knew I needed pain medicine. On 8/31/22 at 8:51 AM, V20 stated R214 called her the evening of 8/26/22. R214 stated, she called me and told me she was in so much pain she couldn't stand it. She was crying and told me she had to wait too long to get a pain pill and that the pain pill wasn't touching her pain. I called the ambulance because no one at the facility would answer the phone and I was scared because she was in so much pain and told me she had a bump behind her knee. I was afraid she had a blood clot. I drove to the facility right after I called 911. When I got there, she was leaving by ambulance and was still in pain. R214's nurse's note dated 8/26/2022 at 7:13 PM documents, Medical team came in stating (R214) called 911, complains of severe leg pain and wanted to go to hospital. She took Norco about 30 min (minutes) ago. Upon leaving the facility daughter came in and (R214) will go to (hospital). On 8/31/22 at 2:30 PM, V43 stated on 8/26/22 at 6:30 PM, I was working down the other side of the hall. A kitchen aide (unknown) told me R214 was having pain and that she was wanting pain medication. I gave her a Norco (Hydrocodone Acetaminophen 5-325 milligrams). Then I heard people coming in and it was the paramedics. I didn't know they were coming. They arrived thirty minutes after I gave her pain medication. V43 stated she was in severe pain, and I am not sure how long she waited. V43 stated when the paramedics came her pain wasn't relieved and she was still in a lot of pain, so she went to the hospital. V43 stated V43 didn't know her call light wasn't working that night. On 8/30/22 at 9:52 AM, V50 Maintenance Assistant stated he fixed R214's call light on 8/26/22. V50 stated when he pushed her call light, he discovered her light above the door didn't light up. He had to replace the light bulb. V50 stated he doesn't remember the time, but it was late in the day. (continued on next page)

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F 0919 Level of Harm - Actual harm Residents Affected - Few	2.) On 8/29/22 at 11:00 AM, R100 was lying in bed. R100's call light was attached to the mattress. V36 stated when she pushes it, it does not go off (activate the nurse call system). At that time, R100 attempted to activate call light device and it did not activate the call system. The call light device button, when pushed slowly, did not activate the nurse call system. The call light system did activate only when the button on the device was pushed fast and hard.