

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055004		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2025	
NAME OF PROVIDER OR SUPPLIER ACCOLADE HC OF PAXTON ON PELLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 EAST PELLIS STREET , PAXTON, Illinois, 60957			
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S0000	Initial Comments Compliant Investigations: 2567802/2592257 2567683/2591308 2567440/2585647		S0000			09/17/2025	
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210d)2)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.		S9999			09/17/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to thoroughly and accurately assess and measure pressure wounds at least weekly for two residents (R2, R3) of three residents in a sample list of nine residents. This failure caused (R2, R3) to experience worsening of facility acquired pressure ulcers. Findings Include: 1. R3's Current diagnoses list includes the following diagnoses: Hearing Loss, Anxiety, Muscle Wasting and Atrophy, Difficulty Walking, Depression, Pressure Ulcer Left Buttock, and History of Lumbar Spinal Fusion. R3's wound assessment dated 7/8/25 by V7, Licensed Practical Nurse (LPN) Wound nurse documents R3 has a Stage 3 Facility Acquired Pressure Ulcer first identified on 7/2/25. There are no wound assessments or measurements observed documented prior to 7/8/25. The 7/8/25 assessment documents the wound as measuring 5 CM (Centimeters) in length by 4 CM in width by 0.2 CM in depth. A photograph included in the wound assessment supports this assessment. On 8/25/25 at 11:00AM, V7 verified there was no wound assessment or measurements on this wound between 7/2/25 and 7/8/25. V7 stated "I was on vacation, and I became aware of (R3's) wound during my vacation, but I didn't get back to measure it until 7/8/25." R3's Care Plan problem list was updated by V2, Director of Nursing on 7/31/25 to include (R1) "has an unstageable pressure ulcer of the sacrum related to			S9999			

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S9999	Continued from page 2 Immobility and incontinence of bowels." This differs from the 7/8/25 Wound assessment and no wound related interventions are documented to have been added to R3's Care Plan since 4/30/25. R3's wound assessment dated 8/12/25 by V7, Licensed Practical Nurse (LPN) Wound nurse documents R3 has an "unstageable" Facility Acquired Pressure Ulcer first identified on 7/2/25. The 8/12/25 assessment documents the wound as measuring 9 CM in length by 10 CM in width by 2CM in depth. V7 documented the presence of undermining "at 7 O'clock to 9 O'clock measuring 2.0 CM and at 3 O'clock to 4 O'clock measuring 2.0 CM. A photograph included in the wound assessment documents an oval shaped wound over half covered by black leathery tissue with rolled edges and a narrow deep tract surrounding half the wound. On 8/25/25 at 7:40AM, V21 (R3's family member) stated "I was told by the facility (R3) had a Stage 3 pressure ulcer, but when I went to the hospital when (R3) was supposed to be having a suprapubic catheter put in I was shocked by what I saw. The odor was so bad it made me nauseated. The wound was deep and partly covered with black rotting flesh. The hospital couldn't do the catheter because of this horrible wound." 2. R2's current diagnoses list includes the following diagnoses: Macular Degeneration, Gout, Anxiety, Peripheral Vascular Disease, and History of Vertebral and Hip fractures. R1 was R2's roommate on 8/10/25. R1's progress note dated 8/10/25 at 9:55PM documents "Was told per CNA (Certified Nursing Assistant) that (R2) was doing care on her roommate. Went to (R1and R2's) room and (R1) was standing by (R2's) bed side rubbing (R2's) feet and telling nurse that there might be something wrong with (R2's) feet. Explained to (R1) that it is our job to take care of her roommate. (R1) acknowledged this and stated she would not do it again. Explained to (R1) about state laws and that this is not allowed." R2's progress note dated 8/13/25 at 2:13PM documents "Called to the shower room by CNA. Noted discolored areas to bilateral heels. Areas assessed. R2 denied pain. Wound nurse, (physician) and Power of Attorney notified. Foam dressings applied and heels floated." R2's Physician's orders document a treatment to cleanse wound, apply skin prep and a bordered foam dressing was initiated at that time. R2's Multi Wound Chart Details by V9, Wound Care Physician's Assistant dated 8/19/25 documents "Initial			S9999			

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S9999	Continued from page 3 Exam Stage 2 Pressure Ulcer Right, Distal, Plantar, Posterior, Inferior, heel measuring 1.0CM in length 0.5 CM in width 0.1 CM in depth and Left Distal, Plantar, Posterior, Inferior, heel measuring 3.0CM in length 1.5 CM in width 0.1 CM in depth." R2's Wound assessment dated 8/13/25 by V7 wound nurse documents the wounds are Deep Tissue Injuries as opposed to Stage 2 Pressure Ulcers. V9's documentation states the wounds were acquired 8/10/25 as opposed to 8/13/25. V9's wound care orders included in the 8/19/25 document state Cleanse wound with 0.125% Dakin's solution while the actual order being administered states to cleanse with wound cleanser. On 8/26/25 at 10:00AM, V7 stated "(R2's) heel wounds are closed unstageable pressure ulcers. You would not want to clean intact skin with Dakin's solution. The order in place is to clean with wound cleanser apply skin prep and cover with foam border dressing." V7 removed in place foam border dressings from R2's heel wounds. R2's left heel observed to have a half dollar sized purple intact Deep Tissue Injury. R2's right heel observed to have a dime sized purple Deep Tissue Injury. On 8/26/25 at 1:35PM V9 stated "(R2's) heel wounds are Deep Tissue Injuries." V9 verified Dakin's Solution would not be used for intact skin. When asked why his wound assessment indicated both wounds are Stage 2 Pressure injuries V9 stated "I believe I documented that by mistake." When asked what type of experience or certification V9 maintains in Wound Care V9 stated "I've been a Physician's Assistant for a long time." V9 did not indicate any specialized wound care experience or certification. (B) Statement of Licensure Violations 2 of 2: 300.610a) 300.1210a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee			S9999			

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S9999	Continued from page 4 consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to identify potential triggers for Post Traumatic Stress Disorder (PTSD) and failed to initiate		S9999				

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S9999	Continued from page 5 resident centered interventions to address PTSD for one resident (R1) admitted to the facility with a diagnosis of PTSD of three residents reviewed for admission transfer discharge rights in a sample list of nine residents. Consequently, R1 experienced an exacerbation of behavioral symptoms leading to emergent hospitalization. Findings include: R1's progress note documents R1 was admitted to the facility from home on 7/17/25 at 3:09PM. R1's physician's note dated 7/1/25 documents R1 "is a candidate for assisted living." R1's most recent diagnoses list includes the following diagnoses: Parkinson's Disease, Chronic Obstructive Pulmonary Disease, Lupus Erythematosus, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Major Depression, Osteoarthritis, and Sedative/Hypnotic/Anxiolytic Dependence. R1's Brief Trauma Questionnaire dated 7/28/25 fails to address R1's Diagnosis of PTSD and fails to identify possible triggers for behavior. R1's Care Plan updated 8/19/25 does not include interventions or possible triggers in relation to R1's PTSD. Surveyor attempted to reach R1 by phone on 8/25/25 at 8:13AM, 8/26/25 at 1:52PM and 8/27/25 at 10:00AM. The message mailbox was full. Unable to leave message. On 8/25/25 at 12:00PM V5, Social Service Director stated R1 was high functioning. V5 stated he had spoken with R1 in regard to whether or not R1 might be interested in assistance to find a less restrictive placement option. V1, Administrator and V5 both stated R1 was never going to be involuntarily discharged it was just an offer of assistance should that be R1's wishes. V5 stated after that conversation R1 became very suspicious of staff and seemed to believe she was being discharged which was not the case. On 8/11/25 at 11:49AM, V16 Licensed Clinical Social Worker (LCSW) contracted by the facility documented in R1's progress notes "Client presents in severe emotional distress on this date. Client appears to be in a manic episode and experiencing symptoms of posttraumatic stress disorder. Client is verbally stating she is getting kicked out of the nursing home and put on the streets to be homeless, which is not true confirmed by multiple administrators and staff at			S9999			

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S9999	Continued from page 6 this facility. Client is seen packing her bags and using her roommate's phone to make phone calls to leave. Client does not have anywhere to go. Client is making multiple accusations towards staff that they are kicking her out based on her age, race, and disabilities although staff is not making client leave. Through assessment, clinician identifies client is experiencing a manic, post-traumatic stress disorder trigger due to her challenges in interpersonal relationships and childhood/family trauma. Client does not feel welcome here and due to this personal belief, she is unable to be redirected or regulated emotionally at this time. Clinician utilized multiple interventions, including mindfulness of deep breathing, sorting through thoughts, and emotions, identifying emotions, encouragement of active listening, and removing client from the stressful environment without any success. Social services director and administration are involved in client's care. Client will be sent out for a psychiatric evaluation if she is agreeable or leaving AMA (Against Medical Advice)." V1 Administrator's Social Service Note dated 8/11/25 at 5:21PM stated "At approximately 5:00pm, (R1) was at front door demanding to be let out as she wanted to leave the facility. She had her belongings packed. When asked to sign AMA paperwork, (R1) stated she would not sign the papers as she did not see a doctor. (R1) was informed that if she left the facility the police would be called as the facility was looking out for her safety. (R1) stated to call the police as she was leaving. (R1) exited front door. The police were notified. V17, LPN, (Licensed Practical Nurse) stayed with (R1), until police arrived. (V19 local police officer) was informed of the incidents that occurred throughout the day, that lead resident to this point. (V19) stated that the conversation that was had with the resident in the parking lot, and writer was recorded on camera. (V19) stated even though she did not sign AMA paperwork, (R1) was alert and oriented and willing to make the decision to leave AMA without signing papers. (V19) stated (R1) would become the concern of the Police Department at this time. Staff continued to monitor (R1) and (V19). At 5:42pm, (V19) continued to remain with (R1) in the parking lot and an ambulance arrived on scene. EMT entered facility and received paperwork for transport to (hospital). (family member) was updated on the situation and was appreciative of the update. On 8/27/25 at 10:45AM V17, verified that V17 was observing R1 at all times from the time R1 went into the parking lot until R1 consensually left in the ambulance to be transferred to the hospital for		S9999				

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S9999	Continued from page 7 evaluation and treatment. V5 stated R1 then opted to be discharged from the hospital in the care of a family member. (B)			S9999			