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	IL6004675	A. BUILDING: _____ B. WING _____	C 08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of 7/27/22/IL149998 Investigation of Facility Reported Incident of 7/28/22/IL149883	S 000		
S9999	Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1220b)2) 300.1220c) 300.3100d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999		

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S9999	Continued From page 2 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to supervise R1, a resident with a known history of wandering and diagnoses of Dementia and Alzheimer's Disease	S9999		

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S9999	Continued From page 3 with moderate cognitive impairment, which resulted in R1 leaving the facility alone and unsupervised. R1 was found by a member of the community, "a couple blocks" away from the facility, unattended, seated in her wheelchair. R1 was self-propelling the wheelchair in the street of a residential neighborhood. The facility was not aware of R1's elopement. R1 is one of three residents reviewed for wandering. Findings include: The facility's investigation dated 8/2/22 documents the following: On 7/28/22 at 6:26 PM V1 Administrator was notified that R1 was assisted to the facility by a community member at 6:25 PM. It was identified that R1 had left the facility through the front door at 6:00 PM. V3 Receptionist told V1 that V3 had opened the door for R1. V3's employment was terminated. V3's Notice of Termination of Employment dated 8/1/22 documents the following: (V3) pushed a resident (R1) in a wheelchair outside and left her unattended. The resident (R1) was found "blocks away" by a community member who returned R1 to the facility. V3 admitted that V3 took R1 outside and left R1. The facility's video surveillance footage confirmed this as well. A local web based weather application documents on 7/28/22 at the time R1 eloped from the facility the temperature ranged from 78 and 79 degrees Fahrenheit with humidity ranging from 68-69%. R1's Minimum Data Set dated 7/2/22 documents R1 has moderate cognitive impairment, requires setup and supervision of one staff person for locomotion on the unit and limited assistance for	S9999		

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locomotion off the unit. R1's Care Plan revised 10/30/20 documents "(R1) is at risk for elopement and is a high risk for wandering related to impaired cognition secondary to diagnosis Alzheimer's disease, Dementia." The goal for this problem area documents "(R1) will not leave the facility unattended through the review date." Interventions include: "Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate." Observe location at regular and frequent intervals. Document wandering behavior and attempted diversion interventions. Orient (R1) to environment. Redirect (R1) away from the door and explain to her the reason she can't leave."

R1's Behavior Tracking documents wandering on 7/17/22 at 10:33 AM and on 7/28/22 at 10:57 AM.

R1's Nurse Practitioner (V9) Note dated 7/27/22 at 3:25 PM documents: Staff reported that R1's family was concerned about R1 being more tired than usual. R1 is a poor historian and has cognitive deficits. R1 was started on antibiotic treatment for a Urinary Tract Infection (UTI).

On 8/10/22 at 3:35 PM R1 was interviewed. R1 could state R1's name and the town R1 was in. R1 could not recall the name of the facility, room number, or month/day/time. R1 was unable to recall any details of the incident that occurred on 7/28/22, or that R1 had left the facility unattended. R1 was asked questions to determine safety awareness while outside of the facility, but verbalized incoherently, and fell asleep.

On 8/10/22 at 8:42 AM V4 Registered Nurse (RN) stated: V4 received a phone call from a

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community member (V7) between 5:15 PM and 5:30 PM on 7/28/22. V7 told V4 that V7 thought R1 was one of the residents of the facility. V4 was not aware that any residents were missing, and asked V7 to elaborate. V7 reported R1's name was labeled on the back of R1's wheelchair. V7 was driving by and saw R1 self propelling R1's wheelchair in the street that is East of the facility (Washington Street) and North about a block or two, which caused V7 to stop and assist R1. V8 CNA returned R1 to the facility at approximately 5:30 PM. R1 could not tell V4 how R1 got out of the facility, and R1 was not aware that R1 had left the facility.

On 8/10/22 at 11:50 AM V4 stated: R1 is more confused in the evening. R1 had a UTI when R1 eloped, which caused increased confusion. It is hard to say what R1's safety awareness was at that time that R1 was outside of the facility. V4 was not sure that at that time R1 would be able to safely navigate traffic while attempting to cross the street.
On 8/10/22 at 10:04 AM V5 Certified Nursing Assistant (CNA) stated: V5 worked until 5:00 PM on 7/28/22. As V5 was leaving the facility through the front entrance, R1 was sitting near the double doors leading to the receptionist area at the front entrance of the facility. R1 caused the door alarm to sound. V5 reset the alarm, and the door alarm sounded again as V5 left the facility. V3 Receptionist responded to the door alarm.

On 8/10/22 at 10:12 AM V8 CNA stated: R1 has a history of wandering in the facility and into other resident rooms. R1 gets more anxious after R1's Family (V11) leaves, and V11 visited R1 the day R1 eloped from the facility. V7 notified the facility that V7 found R1 a couple blocks away from the facility between 4:30 PM and 5:30 PM on 7/28/22.

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S9999	Continued From page 6 V8 assisted R1 back to the facility at approximately 5:30 PM. On 8/10/22 at 10:30 AM V1 Administrator stated: V2 Director of Nursing (DON) notified V1 on 7/28/22 at 6:26 PM that V7 Community Member called the facility to report R1 was outside of the facility on Washington Street. V1 interviewed V3 Receptionist. V3 reported that prior to the incident, R1 was trying to go through the double doors at the front entrance of the facility, and set off the door alarms. V3 reported R1 wanted to go outside, so V3 let R1 go outside and left R1 outside unsupervised. V3's employment was terminated based on this incident. Following the incident, a binder was placed at the receptionist desk that includes a list of residents who wander. Prior to the incident this binder/list was only kept at the nurse's station. On 8/10/22 at 12:11 PM V6 Administrator of (Sister Facility) stated: V6 reviewed the video surveillance footage for the time frame identified for R1's incident as part of the investigation. V6 saw R1 come through the double doors to the front receptionist area. There was no one else observed with R1. R1 pushed on the doors to the front entrance of the facility and sounded the door alarm. V3 redirected R1 and deactivated the alarm. V5 CNA waved at R1 and walked outside through the front door of the facility. R1 sounded the front door alarm, and V3 pushed R1 in a wheelchair outside through the front entrance of the facility. V3 came back into the facility without R1. R1 had to have turned right after leaving the facility, heading up the hill incline towards Washington Street. If R1 would have turned left, R1 would have rolled down the incline in R1's wheelchair.	S9999		

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S9999	Continued From page 7 On 8/11/22 at 9:36 AM V10 (R1's Physician) stated: V10 was notified that R1 was found outside of the facility self propelling R1's wheelchair in the street. V10 was told by the facility that a staff member had let R1 outside of the facility when R1 had attempted to get out of the facility, and the employee left R1 unsupervised. R1 should not have been left outside of the facility unsupervised. In that setting R1 would have very little to no safety awareness. R1's Urinary Tract Infection certainly could have caused increased confusion. Potential consequences of the incident would include dehydration and risk for serious injury if R1 was struck by a car. Staff should not have let R1 out of the facility and the facility staff need to be educated." On 8/10/22 at 5:10 PM Washington Street was located to the East of the facility's main entrance, up an incline/hill. Fulton Street (the street the facility's main entrance is located on) inclines East to Washington Street and declines West to Union Street. There were no sidewalks located on Fulton Street in front of the facility. There were no sidewalks observed on the West side of Washington Street between Summer Street (the block South of the facility) and Ottawa Road (the block North of the facility). Vehicles were parked on the streets. The facility's Missing Residents policy dated as revised on May 2021 documents the following: 1. Should an employee observe a resident leaving the premises, he/she should: A. Attempt to prevent the departure; B. Obtain assistance from other staff m embers in the immediate vicinity, if necessary; C. Instruct another staff member to inform the charge nurse or director of nursing services that a resident has left the premises; and	S9999		

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S9999	Continued From page 8 D. Be courteous in preventing the departure and in returning the resident to the facility." (A) #2 Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to transfer residents in

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accordance with the resident assessment and plan of care, and failed to thoroughly investigate a fall to accurately identify the root cause. This affected two (R4, R5) residents reviewed for transfer assistance. This failure resulted in R4 falling and sustaining an acute right femur fracture.

Findings include:

1.) R4's Minimum Data Set (MDS) dated 7/22/22 documents: R4 requires extensive assistance of staff for transfers, and has severe cognitive impairment. R4 has impaired balance, and is only able to stabilize self with staff assistance for toileting transfers.

R4's Care Plan documents interventions dated 2/21/21 R4 requires limited assistance for transfers and toileting.

R4's Nursing Note dated 7/27/22 at 3:17 PM documents: R4's fall was witnessed by Certified Nursing Assistant (CNA) (V12), who was transferring R4 to the toilet in R4's bathroom. V12 stated that R4 suddenly started to fall, V12 attempted to break R4's fall, and R4 fell onto R4's right side. V12 thought R4 may have "passed out." R4 was transferred back to bed by V12, who was then educated to leave the resident where the fall occurs until after a nurse completes an assessment. R4 screamed out in pain when R4 was turned, and passive range of motion was unable to be performed to the right leg due to pain.

R4's Fall Investigation dated 7/27/22 at 1:15 PM documents the following: A CNA (V12) notified V4 Registered Nurse (RN) that R4 had fallen in the bathroom while transferring to the toilet. R4 was

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found lying in R4's bed with signs of right hip pain rated a 10 on a 1-10 scale. R4 was unable to perform right hip active range of motion. V12's Interview dated 7/27/22 documents V12 was transferring R4 to the toilet. V12 was unable to break R4's fall, and R4 fell onto R4's right side. The root cause of R4's fall was that R4 lost balance during the transfer. The post fall intervention was physical and occupational therapy evaluation and treatment when R4 returns from the hospital.

There is no documentation that V12 used a gait belt during R4's transfer, or what V12 was doing at the time of R4's fall. There is no documentation that education on how to transfer residents was provided to V12 following R4's fall.

R4's Hospital History & Physical dated 7/27/22 at 8:16 PM documents R4 was brought to the emergency room following a fall at the long term care facility with obvious right hip deformity. R4's Right Femur X-ray dated 7/27/22 documents: The indication for the x-ray is listed as a fall, and additional history lists hip deformity and pain. "Findings: Comminuted displaced fracture involving the proximal right femur with fracture involvement of the right femoral neck and intertrochanteric region." "Impression: 1. Acute fracture of the proximal right femur. 2. Osteopenia."

On 8/10/22 at 1:52 PM R4 was lying in bed. R4 stated R4 had a recent fall and hurt R4's leg, but was unable to give details of the fall.

On 8/10/22 at 12:48 PM V4 RN stated: V4 was on break at the time R4 fell. V4 was notified of the fall and went into R4's room to assess R4. At this time R4 was lying in bed, yelling out in pain. V12

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told V4 that V12 had transferred R4 in the bathroom, and R4 "went limp" when V12 moved R4's wheelchair. V12 had transferred R4 from the floor to the bed before notifying anyone. "That was a big error." Prior to R4's fall, R4 transferred with one assist and a gait belt. V4 was not sure if a gait belt was used during R4's transfer/fall.

On 8/10/22 at 12:53 PM V12 stated the day R4 fell, V12 was transferring R4 to the toilet. V12 stated R4 used the grab bar in the bathroom to pull R4's self to a standing position from the wheelchair. V12 stated V12 attempted to move R4's wheelchair, which was difficult to move due to automatic locking brakes. V12 stated V12 had to use both hands to move the wheelchair, R4 lost R4's balance, and R4 fell to the floor. V12 stated V12 prevented R4 from hitting R4's head, but could not stop R4 from falling. V12 confirmed a gait belt was not used during R4's transfer. V12 stated V12 then transferred R4 off of the floor, into the wheelchair, and into bed by placing V12's arms underneath of R4's shoulders. V12 stated R4 yelled out in pain and was unable to bear weight. V12 confirmed V12 did not notify a nurse prior to transferring R4 off of the floor. On 8/10/22 at 1:49 PM V12 stated after R4's fall, V12 learned that the wheelchair seat can be folded to be easily moved, and this would have allowed V12 to move the wheelchair more quickly and be able to provide hands on support of R4. V12 was not sure what R4's post fall intervention was.

On 8/10/22 at 3:46 PM V2 Director of Nursing (DON) stated CNAs can see the resident's transfer status through the electronic charting system that pulls information from the resident's care plan. V2 stated the standard practice in the facility is that staff are expected to use gait belts for 1 and 2 assist transfers. V2 stated R4's post

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	IL6004675	A. BUILDING: _____ B. WING _____	C 08/16/2022

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ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

fall intervention for the 7/27/22 fall was physical and occupational therapy, and V12 was educated to notify a nurse prior to moving a resident following a fall. On 8/11/22 at 11:00 AM stated V2 was not sure that a gait belt was used during the transfer. V2 stated V12 had to let go of R4 to fold up the wheelchair. V2 confirmed V12 was not provided education to maintain contact with the resident or use of a gait belt during transfers.

b2.) R5's MDS dated 8/6/22 documents R5 requires extensive assistance of one staff person for transfers and toileting assistance. R5 has impaired balance that requires staff assistance to stabilize when moving on and off of the toilet.

R5's Baseline Care Plan dated 7/30/22 documents R5 uses two or more staff for transfers and toileting assistance.

On 8/10/22 at 2:25 PM V16 Physical Therapist was providing therapy services for R5 in R5's room. V16 stated R5's transfer status is moderate assistance of one person with the use of a gait belt.

On 8/10/22 at 3:08 PM R5 grabbed the bathroom assist bar and stood from the wheelchair. V13 (CNA) grabbed the back of R5's pants during the transfer. R5 had difficulty pivoting to the toilet, and sat partially sideways onto the toilet. V13 transferred R5 back to a standing position while R5 held onto the assist bar. V13 cleansed R5's buttocks, and was not holding onto R5. R5's knees were bent, and V13 instructed R5 to stand up straight. R5 became shaky. V13 held onto the waistband of R5's pants with one hand, and used the other hand to grab R5's wheelchair that was sitting in the doorway of the bathroom. V13 transported R5 in the wheelchair to the bed. V13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004675	A. BUILDING: _____ B. WING _____	C 08/16/2022

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ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

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S9999	Continued From page 14 instructed R5 to hold onto V13 and place R5's hands on V13's shoulders. R5 stood and pivoted to the bed. V13 did not use a gait belt for R5's transfers. The facility's Incident and Accident Prevention policy dated July 2022 documents: "Following a fall, determine root cause of the fall." "Put interventions in place to address root cause of fall." The facility's Transfers policy dated as revised January 2020 documents: "To promote safe transfer for the residents, as well as the staff, gait belts, (full mechanical lifts), and/or sit to stand will be used, unless otherwise specified." "Follow Plan of Care to ensure the use of proper transfer technique." The facility's Transfer Belts/Gait Belts policy dates as revised July 2020 documents: "It is the responsibility of the Restorative staff/Nursing Staff to determine when the need for the use of Transfer Belts/Gait Belts for each resident. It is the responsibility of the CNA's/Restorative Aide to utilize the Gait Belt/(full mechanical lift) when transferring or ambulating resident." "The resident is transferred by grasping the secured gait belt to provide stability and balance during movement. Grasp belt from behind if one person transfer, bringing hand from bottom up." "Do not attempt to transfer/lift/ambulate a resident who requires assist, without a gait belt." (A)	S9999		