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Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6000210 B. WING 08/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 NORTH LOGAN AVENUE** ACCOLADE HEALTHCARE DANVILLE DANVILLE, IL 61832 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 2366502/IL162880 Facility Reported Incident of 7/22/23/IL162839 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies The facility shall have written policies and a) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 Attachment A each resident's comprehensive resident care Statement of Licensure Violations plan. Adequate and properly supervised nursing care and personal care shall be provided to each Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

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Illinois L	Department of Public				FOR	M APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000210				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			C 08/16/2023		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET AD			DDRESS, CITY, STATE, ZIP CODE			
ACCOLA	ADE HEALTHCARE DA	ANVILLE 801 NOR	TH'LOGAN A' E, IL 61832				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	59999	DETIDIENCE)		Li ta di para	
d die en experience	resident to meet the care needs of the re	e total nursing and personal esident.				NEW YORK OF THE PROPERTY AND THE PROPERT	
enenig-eldismeseupe-g-dis	c) Each direct of and be knowledgeal respective resident of	care-giving staff shall review ble about his or her residents' care plan.				former entrephilateir est spracephilateir est est spracephilateir est spracephilateir est spracephilateir est est spracephilateir est est est est est est spracephilateir est	
mergeneral and designation of the second	nursing care shall in	subsection (a), general clude, at a minimum, the practiced on a 24-hour, asis:					
	to assure that the re: as free of accident h nursing personnel st	y precautions shall be taken sidents' environment remains azards as possible. All hall evaluate residents to see ceives adequate supervision event accidents.				epis addantalists	
T E	These requirements by:	were not met as evidenced					
Ti Fi	ailed to safely transfo esidents reviewed fo	r transfers from a total This failure resulted in R1			The matters and query represent to account to the control of the c		
F	indings include:						
de nu te pr	ursing staff to ensure chniques when trans omote the safe trans	ne responsibility of all the use of safe transfer sferring a resident. To sfer for the residents, as pelts and mechanical lifts		U E	Transaction of the continuous state of the continuous		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		T		
AND CENTUR CORRECTION		DENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		IL6000210	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	STOLET 10	STREET ADDRESS, CITY, STATE, ZIP CODE		08/	16/2023	
					*3		
ACCOL	ADE HEALTHCARE DA		TH LOGAN A' E, IL 61832	VENUE			
(X4) ID	SUMMARY STATEMENT OF DECICIENCIES		ID	PROVIDER'S PLAN OF CO			
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	LEACH CORRECTIVE ACTION	N SHOULD DE	(X5) COMPLET	
			TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
S999 9	Continued From page	ge 2	S9999				
		•	00000				
	7/2020 documents t	Belts/Gait Belts policy dated that if two staff are required					
	for a transfer and a	mechanical lift is not required,					
	a gait belt should us	ed. Do not attempt to	1				
	transfer/lift/ambulate	a resident who requires	1				
Annie alla Adecida	assist, without a gait	belt.					
	D44 #	1				100	
	R1's diagnosis shee	t documents diagnoses					
and the second	Including; Right Abov	ve Knee Amputation,					
The delication of the state of	Congestive Obstruct	ive Pulmonary Disease, Type					
	Disease Chronic Vi-	Gastroesophageal Reflux					
and the factors	Disease, Chronic Kidney Disease Stage IV requiring Hemodialysis, Fracture of the Left						
7	Fibula, and Morbid O	hesity					
		-					
di di	R1's Minimum Data S	Set dated 5/17/23 documents					
	R1 is cognitively intac	ct and a two person assist for					
	transfer.						
	On 8/15/23 at 1:50PA	fl, V4 Certified Nursing					
	Assistant (CNA) said	that on the day of R1's	1				
i	ncident, V4 and V6 C	NA were taking residents					
C	outside to an activity i	near the front driveway VA					
! \$	iaid, "vve jumped into	the van because the van					
i C	river said that (R1) n	eeded to have her	1				
(1	mechanical lift) sling	adjusted before she could	1				
19	io nack to lighe digitie	SIS." V4 said they placed	1				
T/	neir arms under R1's	under arms and lifted R1	1	75 84			
W	mile she was suppos	ed to put her weight on her	1				
IE O	nt leg. v4 said, "We \	were trying to fix her sling					
a fi	HO HER KNEE DUCKIED	and she dropped to the					
10	oor. We didn't use a g	yan ben."					
0	n 8/16/23 at 9:45AM	, V6 CNA confirmed a gait					
be	elt was not used durin	ng R1's transfer.				-	
			1				
0	11 0/10/23 at 2:34PM,	V7 Dialysis Registered					
11/1	ni 24 29i0 MUOU K1 Le	turned to the facility on the				10	
ha	uring ber stand on 5-	sis, (R1) said they were					
110	nt of Public Health	r left leg while they (V4,				- 1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	Torrest and the second	
		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DA	(X3) DATE SURVEY COMPLETED
IL6000210		B. WING		08/16/2023		
AME OF	PROVIDER OR SUPPLIE	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	1 00	710/2023
CCOL	ADE HEALTHCARE [DANVILLE 801 NOR	TH LOGAN A			
(X4) ID	SIMMADVO	DANVILL	E, IL 61832	<u> </u>		
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR	ECTION (X5)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE PPROPRIATE	COMPLETE
S9999	Continued From a			DEFICIENCY)		
20000	portunada i Toni pa	_	S9999	31535 3232 XXXX - 1005		1
	V6) adjusted the s	ling and R1 can't stand very				
	foll onto be large	ally stands and pivots, so she				
	knew it was going	R1 said it hurt and that she				
	doctor know what i	to swell. V7 stated, "We let our nappened before we went				
1	ahead with her tres	itment. She was completely				
	alert and oriented".	was completely				
	R1's fall investigation	on dated 7/22/23 documents				
1	IT I Was assisted in the transport van by 1/4 and					
	An Carrilled MilkiUi	Assistants (CNAs) to adjust				
	a mechanical intelli	10 underneath of R1 so				
- 1	R1 could not eletair	er R1 using a mechanical lift.				
	she went to the floo	n standing on her left foot and r. V5 Medical Doctor	1			
	recommended pain	medication as needed with				
	continued monitorin	g.				
- 0	On 8/16/23 at 1:10P	M, V12 CNA stated, "After				
	one tell, she said tha	It She couldn't stand and	1			
11.19	DIVOT, SO WE used the	e (mechanical lift) After that				
S	ine just complained	of occasional pain."				
C	On 8/16/23 at 1·20P	M, V13 Registered Nurse				
S	tated while waiting	for the dialysis bus on				9
11	/28/23, R1 mention	ed to someone in the lobby				
u	ial site thought she	Might need an y-ray, 1/12				
3	alu, Trey let me kr	ow that she said that and I	- L			
O	rdered it that day."					
R	1's facility provided	x-ray dated 7/28/23,				
de	Ocuments an acute	x-ray dated 7/28/23, proximal fibular fracture of				
th	e left leg.	k. Avundi unrigi itscinte of				- 1
R	1's emergency room	notes dated 7/29/23				
QC	xcument, "I he patie	Ot is a 65-vear-old female				- 1
30	itir tiete itom füe Un	ISING home after an varay				
Uli	at was cone vesterd	av showed a provimoi				1
IID	ular fracture from a	fall one week ago. Patient				
316	ares' tueh atobbed	me'."				- 1
epartmer	nt of Public Health			2000		- 1

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	IL6000210			B. WING		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		16/2023
ACCOLA	NDE HEALTHCARE DA		TH LOGAN A	VENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	E, IL 61832			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	OFO BY FULL			
S9999	Continued From page 4		S9999			
	8/10/23 documents days ago. (R1) was department and was complaining of knees side with a 4/10 throanon-weight-bearin shortness of breath, is improved with (no medications) and results of the first of the facility with not the facility with not departments.	M, V2 Director of Nursing as should have brought R1 nore people to help them se a gait belt for leverage, V2				
Distribution or spage						- 1
		, I			. management	
						1
					320	
						1
					The Annual or State of State o	
					Million Indiana.	
	ont of Public Health				990	