	OF DEFICIENCIES					
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.	· · · · · · · · · · · · · · · · · · ·		
		IL6001457	B. WING		12/	06/2024
AME OF PRO	OVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		
CCOLADI	E HEALTHCARE OF	SAVOY	ST BURWASH , IL 61874			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
S 000 Ir	nitial Comments		S 000			
Ir		nd Certification Survey ility Reported Incident of -No deficiency				
S9999 F	inal Observations		S9999			
	of 2 Statement of Licen	sure violation:				
3 3	00.610a) 00.1210b)4) 00.1210d)3) 00.3240a)					
S	Section 300.610 Re	esident Care Policies				
p fa C a n o p T tt b	rocedures governi acility. The written be formulated by a Committee consisti idministrator, the a nedical advisory co f nursing and othe policies shall compl he written policies ne facility and shall	dvisory physician or the ommittee, and representative r services in the facility. The ly with the Act and this Part. shall be followed in operating l be reviewed at least annual documented by written, signe	s g y			
	00.1210 Section G lursing and Persor	General Requirements for nal Care				
a p w e	nd services to atta racticable physical vell-being of the re- ach resident's con	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care				
	ent of Public Health IRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE		(X6) DATE
lectronica	ally Signed					12/19/24

IL6001457 NAME OF PROVIDER OR SUPPLIER STREET ADDF ACCOLADE HEALTHCARE OF SAVOY 302 WEST I SAVOY, IL SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	B. WING RESS, CITY, ST BURWASH	TATE, ZIP CODE PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE CO	(X5) MPLETI DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDR ACCOLADE HEALTHCARE OF SAVOY 302 WEST I (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	BURWASH 61874 ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR	TION ULD BE CO	(X5) MPLET
ACCOLADE HEALTHCARE OF SAVOY SAVOY, IL (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIENES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	61874 ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE CO	MPLET
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)S9999Continued From page 1plan. 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.4)All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE CO	MPLET
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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999			
nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,				
 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. 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 interview and record review, the facility				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6001457	B. WING		10/	06/2024
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		12/	00/2024
		302 WF	ST BURWASH			
ACCOLA		SAVOT SAVOY,	IL 61874			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	two residents (R89) monitor an at risk re to obtain weekly we resident's represen to develop a plan o weight loss for one failures affected thr R154) reviewed for	ghts per physician orders for , R96) and failed to adequately esident for weight loss, failed eights, failed to notify the tative of weight loss, and faile f care to address severe resident (R154). These ree of ten residents (R89, R96 nutrition on the sample list of resulted in continued severe 4.	d			
	Findings Include:					
	documents weekly significant change of declines for more the physician order. An significant weight for supplement until dia meeting. The family notified of significant care which will be of chart. The Director will forward dietary	at policy dated March 2023 weights will be done with a of condition, food intake han one week, or with a by resident with an unexplained oss will be ordered a scussed during weekly "RISK" y or Power of Attorney will be nt weight changes and plan of documented in the resident's of Nurses (DON) or designee recommendations to the Practitioner for approval.				
	December 2024 do with Dysphagia, Va Psychotic Disturbar	Diagnoses list dated cuments R154 is diagnosed scular Dementia with nce, Major Depressive r's Disease, and Anxiety				
	documents R154 is and requires super	ata Set dated 11/7/24 severely cognitively impaired vision or touching assistance er for eating. R154 has had a oss and is not on a				

STATEMEN	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		IL6001457	B. WING		12/	06/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ACCOLA	DE HEALTHCARE O	FSAVOY	T BURWASH				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From pa	ge 3	S9999				
	physician-prescribe	ed weight loss regimen.					
	December 2024 do severe weight loss December (162.5 p weight loss from 11 12/6/24 (162.5 pour are documented as 7/11/24- 200 pound 9/4/24- 188 pounds 11/13/24- 172.8 pour R154's Physician C December 2024 do regular diet with pu consistency liquids is no order for any to increased weekly w 12/6/24, after R154 discussed with V2 I Regional Registere Dietician, orders we weekly weights, blo foods with meals -r breakfast- and pud R154's Nutrition/Die (V7 Registered Die weight of 172.8 pour weeks, 10% in thre months. R154's die puree/honey-thick I be better-fair per fo include high-proteir	umentation from June 2024 to cuments R154 had a -22.80% from June (210.5 pounds) to oounds) and a -5.52% severe /13/24 (172.8 pounds) to nds). R154's monthly weights a 6/27/24- 210.5 pounds, (a, 8/2/24- 193.4 pounds, (a, 10/24/24- 188.3 pounds, unds, 12/6/24- 162.5 pounds.) Order Sheet (POS) dated cuments that R154 is on a reed texture and honey-thick with a bedtime snack. There nutritional supplements or veight monitoring for R154. On 's severe weight loss was Director of Nurses, V13 d Nurse, and V7 Registered ere added to R154's POS for bod draw for Albumin, fortified nutritionally fortified cereal at ding cups three times per day. etary Note dated 11/13/2024 tician) documents a Novembe unds, which is down 8% in two be months, and 18% in six it was recently changed to iquids, but intakes still need to ood logs. Recommendations in ice cream twice per day for protein and weekly weights for	r				
		weight is stable. e Plan does not address or provide any plan or					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6001457	B. WING		12/	06/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ACCOLA	DE HEALTHCARE OF	F SAVOY 302 WES SAVOY	T BURWASH L 61874			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 4	S9999			
	interventions to add loss.	dress R154's continued weight				
	order for the high-p entered into R154's card and provided f lunch. V19 stated h that would be the n are standing orders physician for any D to be followed. On 12/06/24 at 11:1 Nurse confirmed sh V23 confirmed that for residents unless or daily weights to b Assistant CNAs con their sheets to the r weights into the ele stated she does no weight loss, she be record system flags notifies the dietary of there was no order	onfirmed that although the rotein ice cream was not a POS, it was on her dietary for R154 at breakfast and e does not enter the orders; ursing's job. V19 stated there a from each resident's ietician (V7) recommendations 18 AM, V23 Licensed Practical he works with R154 regularly. staff obtain monthly weights a there is an order for weekly be done. Certified Nurses mplete the weights and give hurses. Nurses enter the ctronic medical record. V23 t verbally notify anyone about lieves the electronic medical a residents for weight loss and department. V23 confirmed in the electronic medical R154 to be weighed weekly.				
	Assistant confirmed December weight to stated R154 is not o	19 AM V21 Certified Nurses d she just obtained R154's oday at 162.5 pounds. V21 on weekly weights. R154 e with meals and her intakes				
	Registered Nurse c cream and weekly	37 AM V13 Regional confirmed the high protein ice weight recommendation from ician should have been				

	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6001457	B. WING		12/	06/2024
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		00/2024
ACCOLA	DE HEALTHCARE O	= SAVOY	ST BURWASH			
	SUMMARY STA	TEMENT OF DEFICIENCIES	, IL 61874	PROVIDER'S PLAN OF		(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 5	S9999			
	should have been of confirmed further wi identified sooner an have taken place su interventions or cha supplements. V13 s having unavoidable deteriorating medic unavoidable weight or documented on the On 12/06/24 at 12:0 Registered Nurse of should have been of loss continued them should have been r attempted to impler confirmed a resider representative should condition such as s	stated she believes R154 is weight loss due to her al condition. V13 confirmed loss has not been determine until today (12/6/24). 08 PM V13 Regional confirmed the weekly weights completed and if further weigh V7 Registered Dietician notified and could have at lease ment further interventions. V1 nt's physician and uld be notified with changes of	ed nt st 3			
	Dietician confirmed notified of continued increased the high pudding for R154. V loss is to be expect medical diagnoses addressed in her pl and family should a further weight loss of exhaust all of the ar (interventions).	if she would have been d weight loss, she could have protein ice cream or added /7 confirmed some weight ed due to R154's progressive however this should be an of care. R154's physician Il be involved and even if continues it wouldn't hurt to vailable options 58 PM V2 DON and V13				
	been addressed in should be documer	med weight loss should have R154's Care Plan and it nted in R154's record when th sident representatives are				

7RBF11

If continuation sheet 6 of 12

	Department of Public	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		IL6001457	B. WING		12/	06/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, S	TATE, ZIP CODE	, ZIP CODE		
ACCOLA	ADE HEALTHCARE OF	= SAVOY	ST BURWASH				
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
S9999	Continued From pa	ge 6	S9999				
	notified of a change weight loss).	e of condition (R154's severe					
	2. R89's Facility Census dated 12/5/24 documents R89 has the following medical diagnoses: Acute on Chronic Systolic (Congestive) Heart Failure, Ischemic, Cardiomyopathy, Chronic Systolic (Congestive) Heart Failure and Pleural Effusion.						
	has the potential for to Congestive Hear each morning befor	ited 11/17/23 documents R89 r fluid volume overload relaye t Failure. Interventions: Weig re breakfast. Contact provider 3 pounds in 24 hours or 5	d h				
	9/20/24 documents Doctor if weight gai hours or 5 pounds i	der Sheet (POS) dated daily weight-Notify Medical n of more than 3 pounds in 24 n 1 week, in the morning Systolic (Congestive) Heart	4				
	documents R89 had the last month or a last 6 months and a	ta Set (MDS) dated 10/25/24 d a 5% or more weight loss in 10% or more weight loss in a 5% or more weight gain in 10% or more weight gain in					
		mary documents from 9/20/24 sing 53 daily weights.	ŧ				
	documents R96 has diagnoses: Depend	Census dated 12/5/24 s the following medical lence on Renal Dialysis, End se and Congestive Heart					

	Pepartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6001457	B. WING		12/	06/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ACCOLA	DE HEALTHCARE OF	FSAVOY	T BURWASH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 7	S9999			
	nutritionally at risk of Mellitus and Hypert has potential for we dialysis. Interventio	ted 8/17/21 documents R96 is due to diagnosis of Diabetes tension related to dialysis. R96 eight fluctuations due to ns: R96 will be weighed as cy and notify dialysis of weight				
	11/21/24 document Medical Doctor if w pounds per day or {	der Sheet (POS) dated is obtain daily weights, notify eight gain of more than 2 5 pounds in one week, in the sday, Thursday, Saturday and tive Heart Failure.				
	documents R96 had the last month or a last 6 months and a	ta Set (MDS) dated 11/23/24 d a 5% or more weight loss in 10% or more weight loss in a 5% or more weight gain in 10% or more weight gain in				
		mary documents from R96 missing 9 weights.				
		5am R96 stated that the facility daily, they do it every so often.				
	that the facility is no physician orders as facility is going to a acknowledged that	Dam V1 Administrator stated of weighing the residents per they should be. V1 said the ddress this issue with staff. V1 R89 and R96's were not r physicians orders.				
	2 of 2 Statement of Licen	sure findings :				
	300.610a)					

STATE FORM

7RBF11

If continuation sheet 8 of 12

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		IL6001457	B. WING		12/	06/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
ACCOLA	DE HEALTHCARE O	= SAVOY	ST BURWASH , IL 61874			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ge 8	S9999			
	300.1010 h)					
	Section 300.610 Re	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shal	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating l be reviewed at least annual documented by written, signe	s g y			
	 h) The facility is physician of any ac change in a resider health, safety or we but not limited to, the manifest decubitus of five percent or me The facility shall ob plan of care for the 	Medical Care Policies shall notify the resident's cident, injury, or significant at's condition that threatens the effare of a resident, including, the presence of incipient or ulcers or a weight loss or gai ore within a period of 30 days tain and record the physician care or treatment of such thange in condition at the time	n s. 's			
	These regulations v	were not met as evidenced by	/:			
	facility failed to com dialysis center to co monitor a dialysis c site for one residen	ew and record review, the municate regularly with the pordinate care and failed to entral venous catheter acces t (R22). This failure resulted i n with a central venous				

	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6001457	B. WING		12/	06/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ACCOLA	DE HEALTHCARE OF	FSAVOY	ST BURWASH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 9	S9999			
		R22 is one of two residents s on the sample list of 82.				
	Findings include:					
	documents the follo nursing to provide of Nursing will also mo and symptoms of ir Communication wit by nursing, dietary, change of status in treatment. Dialysis facility any abnorma	Protocol (revised 9/23) owing: It is the responsibility of care for the dialysis resident. onitor the access site for sign offection or bleeding at the site h dialysis center will be done and/or social services with a the patient's care or will also communicate to the al lab work or change of tt's care plan will reflect their	IS Ə.			
	Agreement dated 9 will provide for the i	Home Dialysis Transfer /13/23 documents the facility interchange of information / for the care of the designate				
	following diagnoses	current) documents the s: End Stage Renal Disease, ease, Dependence on Renal itis of Chest Wall.				
	7/26/23- Check dai Monitor/document/r signs and/or sympto	ocuments the following: ly at the access site. report PRN (as needed) any oms of infection to the acces ng, warmth, or drainage.	s			
	following order: Dia	ders (current) document the lysis: May go to dialysis on days, Thursdays, and Fridays center.	3			

STATEMEN	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		IL6001457	B. WING		12/	06/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ACCOLA	DE HEALTHCARE O	FSAVOY	ST BURWASH			
(X4) ID	_	JMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	ge 10	S9999			
	R22 did not have orders to monitor R22's dialysis site in August, September, and October of 2024. R22 only had orders to monitor R22's dialysis site in November 2024 when R22 returned from the hospital on 11/8/24. This order was discontinued on 11/25/24. R22's EMR documents R22 was out of the facility at the hospital from 11/25/24 through 11/29/24.		3			
	at the hospital from	11/25/24 through 11/29/24.				
	R22 did not have of site from 11/29/24 t	rders to monitor R22's dialysis o 12/5/24.				
	document routine p	edical Record (EMR) does not are and post dialysis n the dialysis center.				
	documents R22's d upper chest satural reddened edema n same note further of sent a culture of dra and R22 states that	te dated 11/5/24 at 2:59pm lialysis port dressing to left ted with brown discharge and oted under port site. This documents R22 stated "dialysis ainage on Monday" [11/4/24] t it [dialysis site] "looks worse ent to Emergency department.	S			
	documents the follo emergency departm dialysis line (centra Patient [R22] states	rgency Department Report owing: [R22] presented to the nent with the concern of I venous catheter) infection. s has had increased drainage past week. [R22] states the				
	drainage is brown. site with surroundin redness of the skin	Physical Exam: Left chest por ig erythema (abnormal) and mild warm. Mild to g pus) drainage noted from the				
	port site. Suspected bloodstream infecti	d central line associated on. [R22] treated with Zosyn comycin (antibiotic). [R22]				
		s: Complication associated				

	epartment of Public	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CCOLA	DE HEALTHCARE O	F SAVOY 302 WES	T BURWASH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COM THE APPROPRIATE D	
S9999	Continued From pa	age 11	S9999			
	with dialysis cathete wall.	er and Cellulitis of the chest				
	and from dialysis. F it in a while." R22 s with a dialysis port	pm, R22 stated a ebook used to go with R22 to R22 stated R22 "has not seen tated R22 was hospitalized infection in November, and ot monitoring R22's dialysis				
	Nurse stated R22 h that contains a note between the facility stated R22 keeps t V14 stated R22 has (CVC) in R22's left that the dialysis cer to CVC. V14 stated clear occlusive drea see if there is any s	pm, V14 Licensed Practical has a bag R22 takes to dialysis book for communication and the dialysis center. V14 hat bag in R22's possession. s a central venous catheter chest for dialysis. V14 stated hter handles everything related I R22's CVC is covered with a ssing and nursing staff can signs and/or symptoms of ed the monitoring of R22's CVC nted.				
	stated that nurses signs and/or sympt the status of the sit daily. V24 also stat occur between the to inform the reside	3 pm, V24's Nurse Practitioner should assess the CVC site for oms of infection and documen e and the dressing at least ed that communication should facility and the dialysis center ent of any changes in condition y other pertinent information.	t			