

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2025
NAME OF PROVIDER OR SUPPLIER  Axiom Gardens of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Shadwell Avenue Flora, IL 62839	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to ensure residents are free from neglect for one (R15) of 15 residents reviewed for neglect in the sample of 15.</p> <p>Findings include:</p> <p>R15's Face Sheet documented an original admitted [DATE] and readmitted [DATE] and included diagnoses of morbid obesity, diabetes type 2, and congestive heart failure. R15's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R15 has no deficits in cognition. This MDS also documented R15 has limited range of motion in both lower extremities and is totally dependent on staff for transfers.</p> <p>R15's Care Plan documented a Focus Area of Resident is usually able to perform ADLs (Activities of Daily Living) with maximum assist from 2 staff initiated on 8/30/23, with a corresponding intervention also initiated on 8/30/23 of Assist to transfer resident using mechanical (lift) and 2 staff members. Explain all procedures prior to starting. Advise resident what is expected of him/her during the transfer. Reassure Resident of safety as needed. Keep hand on Resident to reassure of safety if needed. Ensure lift sheet is intact and correct size for resident. May leave lift sheet under Resident if comfort in placing/removing sheet is problematic. There were no problem areas in the Care Plan to indicate R15 reports falsehoods about staff or displays manipulative behavior.</p> <p>There was no documentation in R15's Nursing Progress Notes about issues with R15's 3/26/25 mechanical lift transfer as documented below.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/3/25 at 2:55pm, R15 was alert and oriented to person, place, and time. R15 stated on Wednesday 3/26/25 on the 6pm to 6am shift, V19 (Agency Certified Nursing Assistant/CNA) was transferring him from his wheelchair to the shower chair using a mechanical lift. R15 stated there were no other staff members present. R15 stated as the mechanical lift sling was moving, he was experiencing back pain and was complaining to V19 that R15 didn't feel V19 was doing the transfer correctly. R15 stated V19 was mad, threw up his hands, yelled, That's it, I quit, and walked out of the room shutting the door, leaving R15 elevated several inches away from the shower chair. R15 stated he could not reach the call light and yelled for help for about 10 minutes, until two other staff members responded and lowered him into the shower chair. R15 stated he was not injured nor emotionally traumatized by the event, as several years ago at a different facility he was dropped during a mechanical lift transfer, so nothing phases him anymore. R15 stated the following day in the afternoon, V1 (Administrator) asked him about the event, and asked him if he would be willing to work with V19 again, to which R15 stated no he would not as he didn't feel safe in his care after what happened. R15 stated he has not seen V19 since then.</p> <p>On 4/3/25 at 3:15pm, V23 (Registered Nurse/RN), stated when she came in on 3/27/25at 6:00am, R15 had reported to her that the previous evening, V19 left R15 hanging in a mechanical lift sling during a transfer because V19 was mad at R15. V23 stated she reported the incident to V1 that morning when V1 arrived.</p> <p>On 4/3/25 at 3:50pm, V1 stated she found out about the incident when she arrived for work the morning of 3/27/25. V1 stated she talked to R15 and staff about what had happened, but there was no incident report about the event as R15 told V1 he did not feel V19 had neglected or abused him. V1 stated R15 was verbally abusive to V19 and V19 left the room to de-escalate R15. V1 stated V19 has not been back to the facility as he got in an argument with another employee and V1 told him he is not welcome back.</p> <p>On 4/3/25 at 4:05pm, V20 (Agency RN) stated, on 3/26/25 during the 6pm to 6am shift, unsure of the time, she and V21 (CNA) were standing at the nurses' station when V19 approached, stated that R15 was, Being nitpicky about his (Mechanical lift) transfer and that he didn't want to further escalate him so V19 left the room. V20 stated within seconds, she and V21 entered the room and saw that R15 was in the mechanical lift sling, positioned several inches above the shower chair. V20 stated R15 was not injured, nor did he seem upset. V20 stated she and V21 lowered R15 into the shower chair and proceeded with his care. V20 stated V19 worked the remainder of his shift but did not go back into R15's room. V20 stated she did not notify management about what happened.</p> <p>On 4/3/25 at 6:00pm, V21 corroborated V20's account of the incident. V21 stated she did not notify management about the incident. V21 stated after the event, staff were re-educated on safe mechanical lift transfers.</p> <p>On 4/4/25 at 7:45am, V19 stated he was performing the transfer without other staff present as, That's just the way he always does it. V19 stated he had worked with R15 previously with no issues. V19 stated R15 was becoming verbally aggressive during the transfer, saying V19 wasn't doing it right, so V19 decided to calm the situation down and he would leave and get other staff to continue care. V19 stated when he left the room, R15 was already sitting in the shower chair but was still in the sling. V19 stated less than a minute elapsed between him leaving the room and other staff relieving him. V19 stated V1 later told him he could not return to the facility because, They didn't want me to get in trouble because of (R15) lying on me. He makes stuff up about staff.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to immediately report to the Administrator an instance of staff to resident neglect for one (R15) of 15 residents reviewed for neglect in the sample of 15.</p> <p>Findings include:</p> <p>R15's Face Sheet documented an original admitted [DATE] and readmitted [DATE] and included diagnoses of morbid obesity, diabetes type 2, and congestive heart failure. R15's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R15 has no deficits in cognition. This MDS also documented R15 has limited range of motion in both lower extremities and is totally dependent on staff for transfers.</p> <p>R15's Care Plan documented a Focus Area of Resident is usually able to perform ADLs (Activities of Daily Living) with maximum assist from 2 staff initiated on 8/30/23, with a corresponding intervention also initiated on 8/30/23 of Assist to transfer resident using mechanical (lift) and 2 staff members. Explain all procedures prior to starting. Advise resident what is expected of him/her during the transfer. Reassure Resident of safety as needed. Keep hand on Resident to reassure of safety if needed. Ensure lift sheet is intact and correct size for resident. May leave lift sheet under Resident if comfort in placing/removing sheet is problematic. There were no problem areas in the Care Plan to indicate R15 reports falsehoods about staff or displays manipulative behavior.</p> <p>There was no documentation in R15's Nursing Progress Notes about issues with R15's 3/26/25 mechanical lift transfer as documented below.</p> <p>On 4/3/25 at 2:55pm, R15 was alert and oriented to person, place, and time. R15 stated on Wednesday 3/26/25 on the 6pm to 6am shift, V19 (Agency Certified Nursing Assistant/CNA) was transferring him from his wheelchair to the shower chair using a mechanical lift. R15 stated there were no other staff members present. R15 stated as the mechanical sling was moving, he was experiencing back pain and was complaining to V19 that R15 didn't feel V19 was doing the transfer correctly. R15 stated V19 was mad, threw up his hands, yelled, That's it, I quit, and walked out of the room shutting the door, leaving R15 elevated several inches away from the shower chair. R15 stated he could not reach the call light and yelled for help for about 10 minutes, until two other staff members responded and lowered him into the shower chair. R15 stated he was not injured nor emotionally traumatized by the event, as several years ago at a different facility he was dropped during a mechanical lift transfer, so nothing phases him anymore. R15 stated the following day in the afternoon, V1 (Administrator) asked him about the event, and asked him if he would be willing to work with V19 again, to which R15 stated no he would not as he didn't feel safe in his care after what happened. R15 stated he has not seen V19 since then.</p> <p>On 4/3/25 at 3:15pm, V23 (Registered Nurse/RN) stated when she came in on 3/27/25at 6:00am, R15 had reported to her that the previous evening, V19 left R15 hanging in a mechanical lift sling during a transfer because V19 was mad at R15. V23 stated she reported the incident to V1 that morning when V1 arrived.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to investigate an allegation of staff to resident neglect for one (R15) of 15 residents reviewed for neglect in the sample of 15.</p> <p>Findings include:</p> <p>R15's Face Sheet documented an original admitted [DATE] and readmitted [DATE] and included diagnoses of morbid obesity, diabetes type 2, and congestive heart failure. R15's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R15 has no deficits in cognition. This MDS also documented R15 has limited range of motion in both lower extremities and is totally dependent on staff for transfers.</p> <p>R15's Care Plan documented a Focus Area of Resident is usually able to perform ADLs (Activities of Daily Living) with maximum assist from 2 staff initiated on 8/30/23, with a corresponding intervention also initiated on 8/30/23 of Assist to transfer resident using mechanical (lift) and 2 staff members. Explain all procedures prior to starting. Advise resident what is expected of him/her during the transfer. Reassure Resident of safety as needed. Keep hand on Resident to reassure of safety if needed. Ensure lift sheet is intact and correct size for resident. May leave lift sheet under Resident if comfort in placing/removing sheet is problematic. There were no problem areas in the Care Plan to indicate R15 reports falsehoods about staff or displays manipulative behavior.</p> <p>There was no documentation in R15's Nursing Progress Notes about issues with R15's 3/26/25 mechanical lift transfer as documented below.</p> <p>On 4/3/25 at 2:55pm, R15 was alert and oriented to person, place, and time. R15 stated on Wednesday 3/26/25 on the 6pm to 6am shift, V19 (Agency Certified Nursing Assistant/CNA) was transferring him from his wheelchair to the shower chair using a mechanical lift. R15 stated there were no other staff members present. R15 stated as the mechanical sling was moving, he was experiencing back pain and was complaining to V19 that R15 didn't feel V19 was doing the transfer correctly. R15 stated V19 was mad, threw up his hands, yelled, That's it, I quit, and walked out of the room shutting the door, leaving R15 elevated several inches away from the shower chair. R15 stated he could not reach the call light and yelled for help for about 10 minutes, until two other staff members responded and lowered him into the shower chair. R15 stated he was not injured nor emotionally traumatized by the event, as several years ago at a different facility he was dropped during a mechanical lift transfer, so nothing phases him anymore. R15 stated the following day in the afternoon, V1 (Administrator) asked him about the event, and asked him if he would be willing to work with V19 again, to which R15 stated no he would not as he didn't feel safe in his care after what happened. R15 stated he has not seen V19 since then.</p> <p>On 4/3/25 at 3:15pm, V23 (Registered Nurse/RN) stated when she came in on 3/27/25at 6:00am, R15 had reported to her that the previous evening, V19 left R15 hanging in a mechanical lift sling during a transfer because V19 was mad at R15. V23 stated she reported the incident to V1 that morning when V1 arrived.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on record review and interview, the facility failed to provide a safe mechanical lift transfer for one (R15) of two residents reviewed for mechanical lift transfers in the sample of 15.</p> <p>Findings include:</p> <p>R15's Face Sheet documented an original admitted [DATE] and readmitted [DATE] and included diagnoses of morbid obesity, diabetes type 2, and congestive heart failure. R15's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R15 has no deficits in cognition. This MDS also documented R15 has limited range of motion in both lower extremities and is totally dependent on staff for transfers.</p> <p>R15's Care Plan documented a Focus Area of Resident is usually able to perform ADLs (Activities of Daily Living) with maximum assist from 2 staff initiated on 8/30/23, with a corresponding intervention also initiated on 8/30/23 of Assist to transfer resident using mechanical (lift) and 2 staff members. Explain all procedures prior to starting. Advise resident what is expected of him/her during the transfer. Reassure Resident of safety as needed. Keep hand on Resident to reassure of safety if needed. Ensure lift sheet is intact and correct size for resident. May leave lift sheet under Resident if comfort in placing/removing sheet is problematic. There were no problem areas in the Care Plan to indicate R15 reports falsehoods about staff or displays manipulative behavior.</p> <p>There was no documentation in R15's Nursing Progress Notes about issues with R15's 3/26/25 mechanical lift transfer as documented below.</p> <p>On 4/3/25 at 2:55pm, R15 was alert and oriented to person, place, and time. R15 stated on Wednesday 3/26/25 on the 6pm to 6am shift, V19 (Agency Certified Nursing Assistant) was transferring him from his wheelchair to the shower chair using a mechanical lift. R15 stated there were no other staff members present. R15 stated as the mechanical sling was moving, he was experiencing back pain and was complaining to V19 that R15 didn't feel V19 was doing the transfer correctly. R15 stated V19 was mad, threw up his hands, yelled, That's it, I quit, and walked out of the room shutting the door, leaving R15 elevated several inches away from the shower chair. R15 stated he could not reach the call light and yelled for help for about 10 minutes, until two other staff members responded and lowered him into the shower chair. R15 stated he was not injured nor emotionally traumatized by the event, as several years ago at a different facility he was dropped during a mechanical lift transfer, so nothing phases him anymore. R15 stated the following day in the afternoon, V1 (Administrator) asked him about the event, and asked him if he would be willing to work with V19 again, to which R15 stated no he would not as he didn't feel safe in his care after what happened. R15 stated he has not seen V19 since then.</p> <p>On 4/3/25 at 3:15pm, V23 (Registered Nurse/RN) stated when she came in on 3/27/25at 6:00am, R15 had reported to her that the previous evening, V19 left R15 hanging in a mechanical lift sling during a transfer because V19 was mad at R15. V23 stated she reported the incident to V1 that morning when V1 arrived.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2025
NAME OF PROVIDER OR SUPPLIER  Axiom Gardens of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Shadwell Avenue Flora, IL 62839	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/3/25 at 3:50pm, V1 stated she found out about the incident when she arrived for work the morning of 3/27/25. V1 stated she talked to R15 and staff about what had happened, but there was no incident report about the event as R15 told V1 he did not feel V19 had neglected or abused him. V1 stated R15 was verbally abusive to V19 and V19 left the room to de-escalate R15. V1 stated V19 has not been back to the facility as he got in an argument with another employee and V1 told him he is not welcome back.</p> <p>On 4/3/25 at 3:55pm, V2 (Director of Nurses/DON) stated mechanical lift transfers are to always be done with 2 staff members present.</p> <p>On 4/3/25 at 4:05pm, V20 (Agency RN) stated, on 3/26/25 during the 6pm to 6am shift, she was unsure of the time, but she and V21 (CNA) were standing at the nurses' station when V19 approached, stated that R15 was, Being nitpicky about his (Mechanical lift) transfer and that he didn't want to further escalate him so V19 left the room. V20 stated within seconds, she and V21 entered the room and saw that R15 was in the mechanical lift sling, positioned several inches above the shower chair. V20 stated R15 was not injured, nor did he seem upset. V20 stated she and V21 lowered R15 into the shower chair and proceeded with his care. V20 stated V19 worked the remainder of his shift but did not go back into R15's room. V20 stated she did not notify management about what happened.</p> <p>On 4/3/25 at 6:00pm, V21 corroborated V20's account of the incident. V21 stated she did not notify management about the incident. V21 stated after the event, staff were re-educated on safe mechanical lift transfers.</p> <p>On 4/4/25 at 7:45am, V19 stated he was performing the transfer without other staff present as, That's just the way he always does it. V19 stated he had worked with R15 previously with no issues. V19 stated R15 was becoming verbally aggressive during the transfer, saying V19 wasn't doing it right, so V19 decided to calm the situation down by leaving to get other staff to continue care. V19 stated when he left the room, R15 was already sitting in the shower chair but was still in the sling. V19 stated less than a minute elapsed between him leaving the room and other staff relieving him. V19 stated V1 later told him he could not return to the facility because, They didn't want me to get in trouble because of (R15) lying on me. He makes stuff up about staff.</p> <p>A Transfers-Manual Gait Belt and Mechanical Lifts Policy dated 1/19/18 documented, In order to protect the safety and wellbeing of the staff and residents, and to promote quality care, this facility will use mechanical lifting devices for the lifting and movement of residents. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories: H) Mechanical lift (trade name mechanical lift) with 2 caregivers.</p>		