

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/20/2025
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received timely incontinence care for 3 of 3 (R4, R7, R13) residents reviewed for dignity in the sample of 21. Findings Include: 1. R13's admission Record with a print date of 11/18/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include spastic quadriplegic cerebral palsy and epilepsy. R13's MDS (Minimum Data Set) dated 8/24/25 documents R13 has a BIMS (Brief Interview for Mental Status) score of 15 which indicates he is cognitively intact. This same MDS documents R13 requires substantial/maximal assistance with toileting. R13's current Care Plan documents a Focus area of I have an ADL (activities of daily living) self-care performance deficit. Date Initiated: 01/31/2025. This Focus area includes the interventions of, Resident will put self in floor and urinate and defecate on a pad, resident refuses to use a bedpan or the toilet. Respect resident wishes, provide care as needed, ensure resident safety. Date Initiated: 01/31/2025. Toilet Use: The resident requires max assist staff for toileting. Date Initiated: 01/31/2025. R14's admission Record with a print date of 11/18/25 documents R14 was admitted to the facility on [DATE]. R14's MDS dated [DATE] documents a BIMS score of 15, indicating R14 is cognitively intact. On 11/17/25 at 12:48 PM, R14 stated they have two certified nursing assistants (CNAs) working on the hall she and her son (R13) reside on. R14 stated she and R13 share a room. R14 stated it takes them forever to answer the call lights when they need help. R14 stated on Friday night (11/14/25) it took the CNAs approximately one and a half hours to assist R13 after he had an incontinent episode, because they only had two CNAs working and they were busy providing care to other residents. On 11/17/25 at 1:15 PM, R13 stated on Friday (11/14/25) he sat in feces for almost 2 hours because they didn't have enough staff to help him timely. On 11/18/25 at 6:38 PM, V18 (Certified Nursing Assistant/CNA) stated she worked on Friday night 11/14/25 and provided care to R13. V18 stated R13 had a bowel movement between 6:30 and 7:00 PM and had to wait approximately 30 minutes for the CNAs to clean him up. When asked why he had to wait that long, V18 stated because there were only two CNAs for approximately 40 residents, and they had to put the residents who were at risk for falls to bed first so they wouldn't fall. On 11/18/25 at 7:12 PM, V17 (CNA) stated she worked 6 pm to 6 am beginning on the night of Friday, 11/14/25. V17 stated she provided care to R13 on that night and he had to wait approximately 30 minutes for them to clean him up after he had a bowel movement. V17 stated that is not typical for a resident to have to wait that long but the nurse was sending a resident out to the hospital. V17 stated thirty minutes is too long to wait. 2. R4's admission Record with a print date of 11/18/25 documents R4 was admitted to the facility on [DATE] with diagnoses that include peripheral vascular disease, anemia, and diverticulitis. R4's MDS dated [DATE] documents a BIMS score of 11, indicating R4 has a moderate cognitive deficit. This same MDS documents R4 is dependent on staff for toilet hygiene, requires substantial/maximal assistance for toilet transfer, and is occasionally incontinent of bowel and bladder. R4's current Care Plan documents a Focus area of, I have limited physical mobility. Date Initiated: 02/25/2025. This Focus area includes the following intervention. Urinal at bedside per resident request. This Care Plan does not address a Focus area, or interventions related to level of (continued on next page)		

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance required for incontinence care. On 11/16/25 at 7:27 AM, R4 stated sometimes it takes up to 45 minutes for the staff to answer the call lights. When asked if he had any negative outcome when it took the staff longer, R4 stated, I pi**ed and s**t. R4 stated when it happens, they say it is because they don't have enough staff. R4 stated he had been left soiled for up to three hours. When asked why it took that long for staff to assist him, R4 stated they say they will be right back and then never come back. R4 stated someone else eventually comes in and assist him. 3. R7's admission Record with a print date of 11/18/25 documents R7 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, diabetes, aortic aneurysm, hypertension, and heart failure. R7's MDS dated [DATE] documents a BIMS score of 15, indicating R7 is cognitively intact. This same MDS documents R7 is dependent on staff for toilet hygiene, frequently incontinent of bowel and occasionally incontinent of bladder. R7's current Care Plan documents a Focus area of Resident is usually able to perform ADL's with max assist from 2 staff. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Resident has requested to have urinal at bedside at all times for independence with voiding. Date Initiated: 12/18/2024. This same Care Plan documents a Focus area of, The resident has bowel incontinence. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Check resident every two hours and assist with toileting as needed. Date Initiated: 08/30/2023. Provide bedpan/bedside commode. Date Initiated: 08/30/2023. On 11/16/25 at 6:57 AM, R7 stated sometimes they are short staffed. R7 stated they use agency staff and sometimes that is not good. R7 stated the longest it had taken them to answer his call light was 45 minutes and that is when they are short staffed and slammed with call lights. R7 stated he had to lay in feces for 45 minutes on an unknown but recent day. On 11/18/25 at 10:32 PM, V16 (Agency Registered Nurse/RN) stated she worked on Friday, 11/14/25 night shift from 6 pm to 6 am. V16 stated she had never seen it take an hour or more for the staff to answer call lights and/or assist with incontinence care. V16 stated she wasn't aware of a specific incident with R13, but it was reasonable that with only two CNAs it could take up to 30 minutes to answer a call light. V16 stated if the two CNAs are providing assistance to a resident who needs more care they may be in that room for 20 minutes or more. V16 stated then it could take longer for other residents to get assistance and/or for call lights to be answered. V16 stated it takes longer to answer the call lights especially during the time frame of getting residents back to their rooms from the dining room after supper during the same time medications are being administered, and residents are needing to be assisted to bed. V16 stated she had never seen it take an hour but thirty minutes, I can see that. On 11/18/25 at 10:24 AM, V2 (Director of Nurses) stated they have enough staff to meet the needs of the residents timely. When asked if two CNAs could get residents from the dining room after the evening meal, cleaned up, in bed, and answer call lights timely, V2 stated, They do. V2 denied any complaints or concerns related to care being provided timely. On 11/19/25 at 2:00 PM, V1 (Administrator) stated she would expect call lights to be answered, and incontinence care provided in a timely manner. When asked what she considered timely, V1 stated it would depend on what the CNAs were doing when the call lights were going off. V1 stated she would expect them to be answered as quickly as possible. The facility Incontinence Care policy dated 11/28/12 documents, Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent residents will be checked periodically with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. The facility Call Light policy dated 11/28/12 documents, Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were assisted with showers and toileting for 4 of 4 (R4, R7, R11 and R13) residents reviewed for activities of daily living in the sample of 21. Findings include: 1. R13's admission Record with a print date of 11/18/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include spastic quadriplegic cerebral palsy and epilepsy. R13's MDS (Minimum Data Set) dated 8/24/25 documents R13 has a BIMS (Brief Interview for Mental Status) score of 15 which indicates he is cognitively intact. This same MDS documents R13 requires substantial/maximal assistance with bathing. R13's current Care Plan documents a Focus area of I have an ADL (activities of daily living) self-care performance deficit. Date Initiated: 01/31/2025. This Focus area includes the interventions. Bathing/Showering: The resident requires max assist twice a week and as necessary. Date Initiated: 01/31/2025. R14's admission Record with a print date of 11/18/25 documents R14 was admitted to the facility on [DATE]. R14's MDS dated [DATE] documents a BIMS score of 15, indicating R14 is cognitively intact. On 11/17/25 at 12:48 PM, R14 stated they have two certified nursing assistants (CNAs) working on the hall she and her son (R13) reside on. R14 stated she and R13 share a room. R14 stated R13's normal shower days are Tuesday and Friday. R14 stated R13 did not get a shower on Friday. R14 stated no one asked him if he wanted one. R14 stated he asked them if he could get one on Saturday and they told him they didn't have enough staff to give him one. R14 stated he did get a shower on Sunday when he asked again. On 11/17/25 at 1:15 PM, R13 stated he normally takes showers on Tuesday and Friday. R13 stated he didn't get offered a shower on Friday and when he asked if he could get one on Saturday, they told him they didn't have time. R13 stated he finally got one on Sunday. The facility Shower Schedule dated 10/7/2025 documents R13 is to get assistance with bathing on Tuesday and Friday nights. 2. R11's admission Record with a print date of 11/18/25 documents R11 was admitted to the facility on [DATE] with diagnoses that include displaced fracture, bipolar disorder, chronic kidney disease, major depressive disorder, and anxiety disorder. R11's MDS dated [DATE] documents a BIMS score of 12, indicating a moderate cognitive deficit. This same MDS documents R11 requires partial/moderate assist of staff for bathing. R11's current Care Plan does not document a Focus area related to activities of daily living and/or an intervention related to bathing. On 11/16/25 at 9:42 AM, R11 stated she is supposed to get showers on Wednesday and Saturday. R11 stated she normally gets them but last night she didn't because they didn't have enough staff. The facility Shower Schedule dated 10/07/25 documents R11 is scheduled for bathing on Wednesday and Saturday nights. The facility Daily Assignment Sheet dated 11/15/25 documents R11's name under night shift showers. This sheet does not indicate R11 was assisted with bathing. On 11/16/25 5:54 AM, V8 (Certified Nursing Assistant/CNA) stated they sometimes have four CNAs in the facility from 6 pm to 6 am and that is not enough to meet the needs of the residents timely. V8 stated they are sometimes able to do showers and other times they are not. V8 stated she worked 6 pm to 6 am beginning on 11/15/25 (Saturday) and ending on the morning of 11/16/25 (Sunday). V8 stated there was only one person who got their shower that night. 3. R4's admission Record with a print date of 11/18/25 documents R4 was admitted to the facility on [DATE] with diagnoses that include peripheral vascular disease, anemia, and diverticulitis. R4's MDS dated [DATE] documents a BIMS score of 11, indicating R4 has a moderate cognitive deficit. This same MDS documents R4 is dependent on staff for toilet hygiene, requires substantial/maximal assistance for toilet transfer, and is occasionally incontinent of bowel and bladder. R4's current Care Plan documents a Focus area of, I have limited physical mobility. Date Initiated: 02/25/2025. This Focus area includes the following intervention. Urinal at bedside per resident request. This Care Plan does not address a Focus area, or interventions related to level of assistance required for incontinence care. On 11/16/25 at 7:27 AM, R4 stated sometimes it takes up to 45 minutes for staff to answer the call lights. When (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked if he had any negative outcome when it took the staff longer, R4 stated, I pi**ed and s**t. R4 stated when it happens, they say it is because they don't have enough staff. R4 stated he had been left soiled for up to three hours. When asked why it took that long for staff to assist him, R4 stated they say they will be right back and then never come back. R4 stated someone else will eventually come in and assist him.4. R7's admission Record with a print date of 11/18/25 documents R7 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, diabetes, aortic aneurysm, hypertension, and heart failure.R7's MDS dated [DATE] documents a BIMS score of 15, indicating R7 is cognitively intact. This same MDS documents R7 is dependent for toilet hygiene, frequently incontinent of bowel and occasionally incontinent of bladder.R7's current Care Plan documents a Focus area of Resident is usually able to perform ADL's with max assist from 2 staff. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Resident has requested to have urinal at bedside at all times for independence with voiding. Date Initiated: 12/18/2024. This same Care Plan documents a Focus area of, The resident has bowel incontinence. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Check resident every two hours and assist with toileting as needed. Date Initiated: 08/30/2023.Provide bedpan/bedside commode. Date Initiated: 08/30/2023.On 11/16/25 at 6:57 AM, R7 stated sometimes they are short staffed. R7 stated they use agency staff and sometimes that is not good. R7 stated the longest it had taken them to answer his call light was 45 minutes and that is when they are short staffed and slammed with call lights. R7 stated he had to lay in feces for 45 minutes on an unknown but recent day.On 11/18/25 at 6:38 PM, V18 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V18 stated they aren't always able to answer call lights timely, provide incontinence care timely, and showers don't always get done as they should.On 11/18/25 at 7:12 PM, V17 (CNA) stated they have two CNAs on the units she works on and three would be better. V17 stated showers don't always get done as they should, and incontinence care is not always provided timely.On 11/18/25 at 10:32 PM, V16 (Agency Registered Nurse/RN) stated she had never seen it take an hour or more for the staff to answer call lights and/or assist with incontinence care. V16 stated it was reasonable that with only two CNAs it could take up to 30 minutes to answer a call light. V16 stated if the two CNAs are providing assistance to a resident who needs more care they may be in that room for 20 minutes or more. V16 stated then it could take longer for other residents to get assistance and/or for call lights to be answered. V16 stated it takes longer to answer the call lights especially during the time frame of getting residents back to their rooms from the dining room after supper during the same time medications are being administered, and residents are needing to be assisted to bed. V16 stated she had never seen it take an hour but thirty minutes, I can see that.On 11/18/25 at 10:24 AM, V2 (Director of Nurses) stated they have enough staff to meet the needs of the residents timely. V2 stated they have two CNAs on the southeast and southwest halls and two on the Alzheimer's unit and northeast halls on night shift. V2 stated they also have two nurses on night shift. V2 stated there are 43 residents on the southeast and southwest halls and 18 of them require assist of two staff for ADL's. V2 stated there is an 8 pm medication pass that goes from 7 pm to 9 pm. When asked if two CNAs could get residents from the dining room after the evening meal, cleaned up, in bed, and answer call lights timely, V2 stated, They do. V2 denied any complaints or concerns related to care being provided timely.On 11/19/25 at 2:00 PM, V1 (Administrator) stated she hadn't had any complaints/concerns brought to her related to showers not being done, incontinence care not being provided timely, and/or call lights not being answered timely. V1 stated it should all be done in a timely manner. When asked what she would consider timely, V1 stated it would depend on what the CNAs were doing when the call light went off. V1 stated she would expect it to be answered as quickly as possible.The facility Incontinence Care policy dated 11/28/12 documents, Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent residents will be checked periodically with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episode. The facility Call Light policy dated 11/28/12 documents, Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure they maintained sufficient staff to meet the needs of the residents timely for 4 of 4 residents (R4, R7, R11, and R13) reviewed for staffing in the sample of 21. This failure has the potential to affect all 70 residents who currently reside at the facility. Findings Include: The facility Resident List Report dated 11/16/25 documents 70 residents currently reside at the facility. 1. R13's admission Record with a print date of 11/18/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include spastic quadriplegic cerebral palsy and epilepsy. R13's MDS (Minimum Data Set) dated 8/24/25 documents R13 has a BIMS (Brief Interview for Mental Status) score of 15 which indicates he is cognitively intact. This same MDS documents R13 requires substantial/maximal assistance with toileting and bathing. R13's current Care Plan documents a Focus area of I have an ADL (activities of daily living) self-care performance deficit. Date Initiated: 01/31/2025. This Focus area includes the following interventions. Bathing/Showering: The resident requires max assist twice a week and as necessary. Date Initiated: 01/31/2025. Resident will put self in floor and urinate and defecate on a pad, resident refuses to use a bedpan or the toilet. Respect resident wishes, provide care as needed, ensure resident safety. Date Initiated: 01/31/2025. Toilet Use: The resident requires max assist staff for toileting. Date Initiated: 01/31/2025. R14's admission Record with a print date of 11/18/25 documents R14 was admitted to the facility on [DATE]. R14's MDS dated [DATE] documents a BIMS score of 15, indicating R14 is cognitively intact. On 11/17/25 at 12:48 PM, R14 stated they have two certified nursing assistants (CNAs) working on the hall she and her son (R13) reside on. R14 stated she and R13 share a room. R14 stated it takes them forever to answer the call lights when they need help. R14 stated on Friday night (11/14/25) it took the CNAs approximately one and a half hours to assist R13 after he had an incontinent episode, because they only had two CNAs working and they were busy providing care to other residents. R14 stated R13's normal shower days are Tuesday and Friday, and no one asked R13 if he wanted a shower on Friday, 11/14/24 so he didn't get one. R14 stated R13 asked for a shower on Saturday, 11/15/25 and unknown staff told R13 they didn't have enough staff to assist him with a shower. R14 stated R13 did get a shower on 11/16/25. On 11/17/25 at 1:15 PM, R13 stated he sat in feces for almost two hours on Friday (11/14/25) because they didn't have enough staff to help him timely. R13 stated he normally takes showers on Tuesday and Friday, and he wasn't offered a shower on Friday (11/14/25). R13 stated he asked if he could get one on Saturday (11/15/25) and staff told him they didn't have time. R13 stated he finally got one on Sunday (11/16/25). The facility Shower Schedule dated 10/7/2025 documents R13 is to get assistance with bathing on Tuesday and Friday nights. On 11/18/25 at 6:38 PM, V18 (Certified Nursing Assistant/CNA) stated she worked on Friday night 11/14/25 and provided care to R13. V18 stated R13 had a bowel movement between 6:30 and 7:00 PM and had to wait approximately 30 minutes for the CNAs to clean him up. When asked why he had to wait that long, V18 stated because there were only two CNAs for approximately 40 residents, and they had to put the residents who were at risk for falls to bed first so they wouldn't fall. V18 stated they usually have two CNA's covering two halls on night shift. When asked if that was enough to meet the needs of the residents timely, V18 stated, to be honest, no. V18 stated they try their best to answer call lights timely and prioritize the bathroom lights first. V18 stated showers are hard to get to with only two CNAs per hall, especially if they need more than set up or assistance so they don't always get done. On 11/18/25 at 7:12 PM, V17 (CNA) stated she worked 6 pm to 6 am beginning on the night of Friday, 11/14/25. V17 stated she provided care to R13 on that night and he had to wait approximately 30 minutes for them to clean him up after he had a bowel movement. V17 stated that is not typical for a resident to have to wait that long but the nurse was sending a resident out to the hospital. V17 stated thirty minutes is too long to wait. When asked if 2 CNAs could meet the needs of (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the residents, V17 stated, three would be better. V17 stated sometimes they don't get the showers done. On 11/18/25 at 10:32 PM, V16 (Agency Registered Nurse/RN) stated she worked on Friday, 11/14/25 night shift from 6 pm to 6 am. V16 stated she had never seen it take an hour or more for the staff to answer call lights and/or assist with incontinence care. V16 stated she wasn't aware of a specific incident with R13, but it was reasonable that with only two CNAs it could take up to 30 minutes to answer a call light. V16 stated if the two CNAs are providing assistance to a resident who needs more care they may be in that room for 20 minutes or more. V16 stated then it could take longer for other residents to get assistance and/or for call lights to be answered. V16 stated it takes longer to answer the call lights especially during the time frame of getting residents back to their rooms from the dining room after supper during the same time medications are being administered, and residents are needing to be assisted to bed. V16 stated she had never seen it take an hour but thirty minutes, I can see that. 2. R4's admission Record with a print date of 11/18/25 documents R4 was admitted to the facility on [DATE] with diagnoses that include peripheral vascular disease, anemia, and diverticulitis. R4's MDS dated [DATE] documents a BIMS score of 11, indicating R4 has a moderate cognitive deficit. This same MDS documents R4 is dependent on staff for toilet hygiene, requires substantial/maximal assistance for toilet transfer, and is occasionally incontinent of bowel and bladder. R4's current Care Plan documents a Focus area of, I have limited physical mobility. Date Initiated: 02/25/2025. This Focus area includes the following intervention. Urinal at bedside per resident request. This Care Plan does not address a Focus area, or interventions related to level of assistance required for incontinence care. On 11/16/25 at 7:27 AM, R4 stated sometimes it takes up to 45 minutes for the staff to answer the call lights. When asked if he had any negative outcome when it took the staff longer, R4 stated, I pi**ed and s**t. R4 stated when it happens, they say it is because they don't have enough staff. R4 stated he had been left soiled for up to three hours. When asked why it took that long for staff to assist him, R4 stated they say they will be right back and then never come back. R4 stated someone else eventually comes in and assist him. 3. R7's admission Record with a print date of 11/18/25 documents R7 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, diabetes, aortic aneurysm, hypertension, and heart failure. R7's MDS dated [DATE] documents a BIMS score of 15, indicating R7 is cognitively intact. This same MDS documents R7 is dependent on staff for toilet hygiene, frequently incontinent of bowel and occasionally incontinent of bladder. R7's current Care Plan documents a Focus area of Resident is usually able to perform ADL's with max assist from 2 staff. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Resident has requested to have urinal at bedside at all times for independence with voiding. Date Initiated: 12/18/2024. This same Care Plan documents a Focus area of, The resident has bowel incontinence. Date Initiated: 08/30/2023. This Focus area includes the following interventions. Check resident every two hours and assist with toileting as needed. Date Initiated: 08/30/2023. Provide bedpan/bedside commode. Date Initiated: 08/30/2023. On 11/16/25 at 6:57 AM, R7 stated sometimes they are short staffed. R7 stated they use agency staff and sometimes that is not good. R7 stated the longest it had taken them to answer his call light was 45 minutes and that is when they were short staffed and slammed with call lights. R7 stated he had to lay in feces for 45 minutes on an unknown but recent day. 4. R11's admission Record with a print date of 11/18/25 documents R11 was admitted to the facility on [DATE] with diagnoses that include displaced fracture, bipolar disorder, chronic kidney disease, major depressive disorder, and anxiety disorder. R11's MDS dated [DATE] documents a BIMS score of 12, indicating a moderate cognitive deficit. This same MDS documents R11 requires partial/moderate assist of staff for bathing. R11's current Care Plan does not document a Focus area related to activities of daily living and/or an intervention related to bathing. On 11/16/25 at 9:42 AM, R11 stated she is supposed to get showers on Wednesday and Saturday. R11 stated she normally gets them but last night she didn't because they didn't have enough staff. The facility Shower Schedule dated 10/07/25 documents R11 is scheduled for bathing on Wednesday and Saturday nights. The facility (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Axiom Gardens of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Shadwell Avenue Flora, IL 62839	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Daily Assignment Sheet dated 11/15/25 documents R11's name under night shift showers. This sheet does not indicate R11 was assisted with bathing. On 11/18/25 at 6:38 PM, V18 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V18 stated they aren't always able to answer call lights timely, provide incontinence care timely, and showers don't always get done as they should. On 11/16/25 at 5:54 AM, V8 (CNA) stated they sometimes have four CNAs in the facility from 6 pm to 6 am and that is not enough to meet the needs of the residents timely. V8 stated they are sometimes able to do showers and other times they are not. V8 stated she worked 6 pm to 6 am beginning on 11/15/25 and ending on the morning of 11/16/25. V8 stated she was responsible for the two halls R11 and R13 reside on. V8 stated they call those halls Southeast and Southwest. V8 stated there was a call in and when she got to work at 6 pm she was the only CNA working on those two halls. V8 stated she called another staff person in, but it took her awhile to get to the facility. V8 stated they had the staffing issue, then had to send a resident to the hospital. V8 stated she wasn't able to get people in bed when they wanted to and there was only one person who got their shower that night. V8 stated there are times residents are left soiled longer than they should be. V8 stated there are times call lights can't be answered timely because there isn't a staff member available to answer them. On 11/6/25 at 5:39 AM, V6 (CNA) stated they didn't have enough staff to meet the needs of the residents timely. V6 stated she works on the Alzheimer's unit and there are about 12 residents back there. V6 stated they typically have two CNAs but sometimes there is only one and they are responsible for the Alzheimer's unit and the independent unit. V6 stated there are residents who have behaviors, and it is very stressful. V6 stated sometimes they can't get the showers done. On 11/16/25 at 12:48 PM, V9 (Registered Nurse) stated they don't have enough staff to meet the needs of the residents timely. V9 stated call lights are answered as fast as they can be. On 11/18/25 at 9:38 AM, V19 (CNA) stated they are able to answer call lights timely if they have enough staff. When asked if they had enough staff to meet the needs of the residents timely V19 stated, Not all the time. V19 stated he works day shift and on 11/15/25 they only had three CNAs on the 100 halls. V19 stated on 11/16/25 (the day this surveyor entered the facility) they had six CNAs on the 100 halls. V19 stated they normally have four CNAs on those halls on day shift. V19 stated it is hard to answer call lights timely when there are less than four CNAs especially around mealtimes. On 11/18/25 at 10:24 AM, V2 (Director of Nurses) stated they have enough staff to meet the needs of the residents timely. V2 stated they have four CNAs and two nurses on night shift. V2 stated there are 43 residents on the 100 halls (southeast and southwest) and of those 43 residents 18 require assist of two staff for ADL's. V2 stated there is an 8 pm medication pass time that runs from 7 pm to 9 pm. When asked if two CNAs could get residents from the dining room after the evening meal, cleaned up, in bed, and answer call lights timely, V2 stated, They do. On 11/19/25 at 2:00 PM, V1 (Administrator) stated the facility runs 12-hour shifts and they try to have 5-6 CNAs on day shift and 4-5 on night shift. V1 stated she felt like they had the staff they needed based on their census. V1 stated based off the minimum staffing calculator they fall within those guidelines. V1 stated the calculator shows they should have 3.28 CNAs for night shift and 5.74 for evening shift. V1 clarified they don't run an evening shift, but the traditional evening shift would include the time frames of 6 pm to 10 pm, when the facility is running four CNA's and the calculator, she used to calculate they should be running 5.74 CNAs. V1 then stated the calculator is just a suggestion and they have the staffing numbers to meet the needs of the residents. The Facility Assessment Tool dated 9/5/24 documents under Staffing Plan, 3.2 Based on our resident population and their needs for care and support, the facility utilizes the minimum staffing calculator to determine staffing needs.		

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NAME OF PROVIDER OR SUPPLIER Axiom Gardens of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Shadwell Avenue Flora, IL 62839	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were available to be administered as ordered for 3 of 3 (R1, R7, and R9) residents reviewed for pharmacy services in the sample of 21. Findings Include: 1. R1's admission Record with a print date of 11/17/25 documents R1 was admitted to the facility on [DATE] with diagnoses that include epilepsy, schizophrenia, anxiety disorder, bipolar disorder, viral hepatitis, post-traumatic stress disorder, phantom limb syndrome with pain, hypertension, and absence of right and left fingers, and right and left lower legs. R1's MDS (Minimum Data Set) dated 10/22/25 documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact. R1's Order Summary Report dated 11/18/25 includes a physician order for dicyclomine 10 mg (milligrams) two capsules four times daily for bowel movement, with a start date of 3/27/25. R1's current Care Plan does not document a Focus area related to the dicyclomine and/or bowel movements/constipation. R1's MAR (Medication Administration Record) dated 10/01/25 to 10/31/25 documents a physician order for dicyclomine 10 mg administer two capsules four times daily. This same MAR documents a 9 in the signature spot on the following dates and times. 10/6- 5 pm and 8 pm, 10/07- 8 pm, 10/8- 9 am, 12 pm, and 8 pm, 10/9- 12 pm and 8 pm, 10/10- 9 am and 8 pm. This same MAR documents 2's on 10/7- 12 pm and 5 pm, 10/9- 9 am and 5 pm, and 10/10 - 12 pm and 5 pm. The Chart Codes documented on the MAR indicates a 2 means Drug Refused and the 9 means other/See Progress Notes. R1's Progress Notes document in the corresponding medication administration notes the dicyclomine was unavailable for administration from 10/06/25 until 10/10/25. R1 no longer resided at the facility and was unable to be reached via telephone for an interview during the survey. On 1/16/25 at 5:19 AM, V4 (Licensed Practical Nurse/LPN) stated they switched pharmacies in 10/2025, and it was a struggle getting medications filled at the time, but it was getting better. V4 stated R1 did miss medications during that time frame and him not getting his medications as ordered was a genuine concern and frustrating. On 11/18/25 at 10:24 AM, V2 (Director of Nurses/DON) stated R1 did not receive the dicyclomine as ordered from 10/06/25 through 10/10/25. V2 stated it wasn't available for R1 to take because they were waiting on the pharmacy to deliver it. 2. R8's admission Record with a print date of 11/18/25 documents R8 was admitted to the facility on [DATE] with diagnoses that include diffuse traumatic brain injury, traumatic hemorrhage of cerebrum, open wound of head, serotonin syndrome, delirium, and depression. R8's MDS dated [DATE] documents a BIMS score of 15, indicating R8 is cognitively intact. R8's current Care Plan documents a Focus area of I am on pain medication therapy r/t (related to) TBI (traumatic brain injury) .Date Initiated: 9/17/2025. This Focus area includes the intervention to administer analgesics as ordered by the physician. R8's Order Summary Report dated 11/19/25 includes a physician order for lidocaine external patch 5% apply to affected area topically one time daily with a start date of 9/5/25. R8's MAR dated 10/1/25 to 10/31/25 includes physician orders for lidocaine 5% patch administer to affected area one time daily and an order for Lyrica 150 mg twice daily. This same MAR documents a 9 for the administration of the lidocaine patch on 10/17, 10/18, 10/20, and 10/21 and a 9 for the administration of the Lyrica on 10/5 and 10/06/25. This indicates a corresponding progress note related to this medication administration date. R8's Progress Notes document on the corresponding medication administration notes the lidocaine patch was unavailable for administration on 10/17, 10/18, 10/20, and 10/21 and documents the Lyrica was unavailable for administration on 10/05 and 10/06/25. On 11/16/25 at 9:32 AM, R8 stated the facility has had some issues with getting his medications as ordered from the pharmacy. On 11/18/25 at 10:24 AM, V2 (DON) stated the physician ordered a 5 % patch instead of the 4% patch they normally use. V2 stated they had to order them from the pharmacy instead of the over-the-counter ones they normally use, and they weren't available in the emergency drug kit. This surveyor reviewed R8's MAR and progress (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Axiom Gardens of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Shadwell Avenue Flora, IL 62839	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes with V2 and asked if they weren't available on 10/17, 10/18, 10/20, and 10/21 how was it administered on 10/19/25. V2 stated she didn't know and would have to check with the nurse (V16 Agency Registered Nurse) who signed it out. V2 stated R8 was receiving the lidocaine patch for surgical after care/brain surgery. V2 stated R8 admitted to the facility on [DATE] with the order in place at the time of admission. When asked why over a month later the patch wasn't available, V2 stated, It had to be a pharmacy issue. V2 stated there was no documentation in R8's record why the medication was not available. V2 stated she didn't know what, if anything, was done to obtain the patches since there was no documentation. V2 stated R8's Lyrica was unavailable for administration on 10/05 and 10/06/25. V2 stated she thought R8 needed a new prescription before the pharmacy would fill it. When asked if it was acceptable practice for R8 to go without the Lyrica and the Lidocaine patch V2 stated, No, it is not. V2 stated she wasn't aware of any negative outcome related to R8 not getting his medications.3. R7's admission Record with a print date of 11/18/25 documents R7 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, diabetes, heart failure, and hypertension.R7's MDS dated [DATE] documents a BIMS score of 15, indicating R7 is cognitively intact.R7's Order Summary Report dated 11/19/25 documents a physician order for Sudafed 30 mg every 12 hours as needed with a start date of 11/05/25.R7's MAR dated 11/1/25 to 11/30/25 documents a physician order for Sudafed 30 mg every 12 hours as needed with a start date of 11/05/25. This same MAR does not document administration of the Sudafed from 11/05/25 to 11/10/25.On 11/16/25 at 6:57 AM, R7 stated he waited 3 to 4 weeks to get the insurance to approve his new sinus medication, but he was getting it now.On 11/18/25 at 10:24 AM, V2 (DON) stated when the physician first wrote the order for R7's Sudafed they didn't put a dosage on the prescription, so they had to get a new order with the dosage and resend it to the pharmacy. V2 stated once they got the new prescription to the pharmacy it came back as an over-the-counter prescription, so the facility had to pay for it. When asked if she knew why that took five days and if that was an acceptable length of time, V2 stated they were still getting used to the new pharmacy.On 11/16/25 at 12:48 PM, V9 (Registered Nurse) stated they had issues with medications not being available to administer when they switched pharmacies. V9 stated if a resident doesn't get their medication, it should be charted.On 11/18/25 at 10:24 AM, V2 (DON) was unable to locate documentation R1, R7, and/or R8's physicians were notified the medications were not available to see if they wanted to prescribe a different medication/dosage. V2 stated it was not acceptable practice for residents to not be administered medications as ordered. V2 stated she had in serviced the nursing staff what to do if a medication is unavailable.The Pharmacy policy dated 1/2018 documents under Policy-Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the menu met the resident's individual nutritional needs and preferences for 1 of 3 (R8) residents reviewed for dietary services in the sample of 21. Findings include: On 11/16/25 at 12:43 PM, R8 stated he didn't get a meal tray last night at the evening meal (11/15/25). R8 stated he normally eats in his room, and he wasn't sure why they didn't serve him supper. R8 stated at approximately 8:45 pm they made him three peanut butter and jelly sandwiches. R8 stated he would have rather had the chicken and French fries they served for the evening meal. R8's admission Record with a print date of 11/18/25 documents R8 was admitted to the facility on [DATE] with diagnoses that include diffuse traumatic brain injury, traumatic hemorrhage of cerebrum, open wound of head, serotonin syndrome, delirium, and depression. R8's MDS (Minimum Data Set) dated 9/16/25 documents a BIMS (Brief Interview for Mental Status) score of 15 indicating R8 is cognitively intact. R8's current Care Plan documents a Focus area of, I have a nutritional problem or potential problem r/t (related to) TBI (traumatic brain injury), depression Date Initiated: 09/01/2025. This Focus area includes the interventions of, Encourage PO (by mouth) intake of meals and snacks. Date Initiated: 09/17/2025. Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Date Initiated: 09/17/2025. R8's Order Summary Report dated 11/19/25 documents a physician order for a no added salt regular texture diet. The facility Diet Spreadsheet Dated Week 3 25-26 Saturday documents the menu for Dinner as, chicken tenders platter, French fries, ketchup, buttered peas, bread/margarine, banana's with whipped topping, milk/beverage. On 11/16/25 at 1:09 PM, V11 (Dietary Aid) stated she worked 11/15/25 and R8's tray was made and sent out the window but somehow didn't get to him. V11 stated they made him peanut butter and jelly sandwiches around 7 pm. When asked if this had ever happened before V11 stated they send the trays out and then the residents say they don't get them. V11 was unable to provide this surveyor with any specific dates and/or residents this had occurred with other than R8. On 11/16/25 at 1:12 PM, V12 (Cook) stated he worked 11/15/25 and wasn't sure what happened with R8's dinner meal tray. V12 stated two tickets may have gotten stuck together. V12 stated an unknown CNA told him R8 didn't get a meal tray, and he made him three peanut butter and jelly sandwiches around 7 pm. On 11/16/25 at 12:48 PM, V9 (Registered Nurse) stated R8's food is always messed up but was unable to provide this surveyor with specific details. On 11/17/25 at 2:39 PM, V10 (Dietary Manager) stated the nursing staff were aware R8's tray was served to the wrong person who was on the same diet as R8, but they didn't tell the dietary staff R8 needed another tray. On 11/19/25 at 2:20 PM, V10 (Dietary Manager) stated to his knowledge three peanut butter and jelly sandwiches were the only food R8 was served on the night of 11/15/25. V10 stated that was not an acceptable substitution for chicken tenders, French fries, buttered peas, and bananas. V10 stated R8 should have been offered a starch, vegetable, and a dessert. The facility policy titled Dining Options for Meal Service dated 2020 includes, Staff will monitor the resident's food and fluid intake for adequate consumption and offer appropriate meal substitutions to residents when needed.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to ensure food was served at a palatable temperature. This has the potential to affect 9 of 9 (R1, R10, R14-R20) residents served room trays on the long-term care units reviewed for dining in the sample of 21. Findings Include: On 11/19/25 at 2:55 PM, V1 (Administrator) provided this surveyor with the list of residents who are served meals in their room on the long-term care units. This list documents R1, R10, and R14-20 were served room trays. The facility Concern/Complaint Form dated 10/21/25 documents under Concern/Complaint: this resident (R21 who no longer resides at the facility) states that the vegetables are cold when being delivered on the hall. vegetables are not warm when reaching resident room. Dietary Manager in serviced with staff and educated them to prevent reoccurrence. There are no temperatures of the food documented on this form. On 11/16/25 at 7:27 AM, R4 stated he is served his meals in his room at times and the temperature of the food sucks. On 11/18/25 at 9:28 AM, V20 (CNA) stated the food is sometimes served cold. V20 was not able to recall a specific resident/time of the complaint but did say she sometimes eats at the facility and the food is cold at times. On 11/18/25 at 9:38 AM, V19 (CNA) stated the food is hot for the residents who eat in the dining room but the residents who eat in their rooms get colder food. On 11/16/25 at 12:39 PM, this surveyor and V10 (Dietary Manager/DM) followed the uninsulated cart carrying room trays including a test tray to the long-term care units. As the last room tray was being served to the residents, V10 (DM) used the facility thermometer to check the temperature of the food located on the test tray. The temperatures were as follows; pureed ham - 138 degrees Fahrenheit (F), mechanical soft ham 128 degrees F, pureed zucchini 115 degrees F, ham slice 112 degrees F, mashed potatoes 138 degrees F, and zucchini- 125 degrees F. On 11/16/25 at 1:04 PM, V10 (DM) stated the temperature of each of the foods on the food trays delivered to the residents should be 135 degrees F. On 11/17/25 at 2:39 PM, V10 (DM) stated they split the halls for hall trays up and that fixed the issue with the food not holding temperatures for the hall tray delivery times. The facility Monitoring Food Temperatures for Meal Service dated 2020 documents, Guideline: food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures. g. Meals that are served on room trays may be periodically checked at the point of service for palatable temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater to promote palatability for the resident. Any complaint regarding food temperatures by residents will be documented on the Food Temperature Log. Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120 degrees F. The investigation is recommended to be completed within 72 hours of the complaint.		