STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Gardens of Flora	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent the verbal, physical and sexual abuse of residents from another resident with a known history of abuse for 4 of 6 residents (R1, R6, R8 and R9) reviewed for abuse in the sample of 11. This failure would cause a reasonable person to experience feelings of fear, anxiety and anger while residing in their home. Findings include:1. R7's admission Records documents R7 was admitted on [DATE] with diagnoses to include: Dementia with agitation, lack of coordination, anxiety, depression. R7's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 01, indicating R7 has severe cognitive impairment.R7's current Care Plan documents a focus area: I have behavior problems related to verbally/physically aggressive with staff during care, wander/elopement risk with an initiation date of 11/18/25. The only mention in R7's care plan about any resident to resident altercation is listed on 12/11/25 under intervention for this focus area: resident involved in altercation with another resident, intervention for this event is refer this resident to behavioral health.R8's admission Record documents an admission date of 1/14/25 with diagnoses including in part Alzheimer's disease, bipolar disorder, Parkinson's disease, and depression.R8's MDS dated [DATE] documents a BIMS of 00, indicating severe cognitive impairment.A final report sent to the state surveying agency on 12/17/25 documents on 12/11/25 at 2:55pm, R7 went up to R8 and hit her in the face and then called her a stupid b**ch. Residents were immediately separated. No injuries were noted. R7 was referred for medication review and a referral was sent to a local behavioral health center. Final report summary documented, During investigation, (V13) CNA (Certified Nursing Assistant) stated that (R7) walked into the Dining Room on the Dementia Unit where (R8) was sitting. She stated (R8) had been yelling when (R7) walked up to her and slapped her across the face and then yelled stupid b**ch. (V13) stated she immediately separated the residents. (R7) stated he was annoyed with her yelling. (R8) could not recall what happened.A facility document titled #782 Res/Res Altercation for R7 dated 12/11/25, prepared by V11 (Registered Nurse/RN) documents under Incident Description, Nursing Description: This RN was called into dining room by CNA who witnessed resident (R7) slap another resident (R8) on the left side of the face. Per CNA she was in the dining room talking with another resident and R8 was sitting close by talking out loud to herself. Resident (R7) walked up the hallway to the dining room to sit in his usual spot at the dining room table. (R8) was sitting at the same table. CNA thought resident (R7) was going to sit down. Instead, he took a step drew back and slapped resident (R8) across the left side of her face. Resident (R8) jumped up yelling he hit me. During the alteratio (sic) resident (R7) was calling the other resident a stupid b**ch and was attempting to slap her again. The CNA immediately intervened by stepping in the middle of the altercation. Under Resident Description it documents Resident (R7) stated he was annoyed with all the screaming and yelling resident (R8) was doing so he had to slap her to shut her up. Resident (R7) stated if the CNA had not stepped in between them, he would (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	have slapped her again.A facility document titled #783 Res/Res Altercation for R8 dated 12/11/25 prepared by V11 documents under incident Description, Nursing Description: This RN Was called into dining room by CNA who witnessed resident (R7) slap resident (R8) on the left side of the face. Per CNA she was in the dining room talking with another resident and (R8) was sitting close by talking out loud to herself. Resident (R7) walked up the hallway to the dining room to sit in his usual spot at the dining room table. (R8) was sitting at the same table. CNA thought resident (R7) was going to sit down. Instead, he took a step drew back and slapped resident (R8) across the left side of her face. Resident (R8) jumped up yelling he hit me. During the alteration resident (R7) was calling resident (R8) a stupid b**ch and was attempting to slap her again. The CNA Immediately intervened by stepping in the middle of the altercation. Resident Description: Resident (R8) stated he was annoyed with all the screaming and yelling resident (R8) was doing so he had to slap her to shut her up. Resident (R8) stated if the CNA had not stepped in between them, he would have slapped her again. Under Resident Description it documents Resident Unable to give Description. Under Immediate Action Taken, Description it documents CNA intervened by standing in between the residents to prevent resident (R7) from hitting resident (R8) again. This RN immediately intervened by tending to resident (R8). This RN escorted resident (R8) to her room to deescalate the tension between the two residents. The resident (R8) was not harmed during the altercation. Administrator (V1) notified of alteration. Per direction from management either resident does not have to go to the hospital at this time. (Local Police Department) Police were called at this time by administrator (V1). Police decided to not visit facility at this time. In the same document under Statements, it documents a statement by an unnamed staff Per CNA (V13) 'I was in D.R. (dining room) talking to (name) and listening to (R8) carry on. (R7) came up the hall into the D.R. moved a chair in his usual spot and I thought he was going to sit down, and he took a step drew back and slapped (R8) across the left side of her face. (R8) jumped up yelling he hit me. As soon as (R7) slapped her I ran over and got in the middle of them because he was calling her a stupid b**ch and was gonna slap her again. (R8) then was taken back to her room and I stayed in the D.R. to watch (R7).On 1/13/26 at 11:23 AM, V13 (CNA) stated she was in the dining room with a different resident when R8 was in the dining room yelling out. V13 stated then R7 was walked into the dining room, and she thought he was just going to sit down like he usually does but the next thing she knew, R8 stood up and yelled and then R7 her in the face. V13 stated she went over and got in between R7 and R8. V13 stated R8 stated again that R7 hit her and R7 stated he hit her, and he will do it again because she won't shut up. V13 stated after she got them separated, she got another staff member to get the nurse for her, but she can't remember who the other staff member was. V13 stated the nurse handled it from there.2. R1's admission Record documents an admission date of 5/22/24 with diagnoses including in part major depressive disorder, generalized anxiety, dementia in other diseases classified elsewhere moderate with other behavioral disturbance, and unsteadiness on feet.R1's MDS dated [DATE] documents a BIMS of 11, indicating moderate cognitive impairment.A final report sent to the state surveying agency documents that on 12/16/25 at 5:45pm, R7 attempted to flip R1 out of her wheelchair and then began yelling and cussing at her. No injuries were noted. Staff immediately intervened and separated residents. R7 was provided sensory activities during signs of agitation. Final summary documents, During investigation, (V11) RN (Registered Nurse) stated that she was called to (R1's) room by (V12) CNA. (V12) stated that when she arrived to the room (R7) had been attempting to tip (R1) out of her wheelchair, staff was able to intervene and (R7) let go of (R1's) wheelchair but then proceeded to yell and cuss at (R1). (R7) was able to be redirected by (V11) RN. A facility document titled #790 Res/Res Altercation for R7 dated 12/16/25 documents under Incident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Description, Nursing Description: This RN was notified by CNA that resident (R7) was in another resident's (R1) room trying to [NAME] the other resident (R1) out of her wheelchair. CNA immediately intervened by standing in between resident (R7) and the other resident's (R1) wheelchair. Resident (R7) yelling and cussing at this time at CNA, and other resident (R1). As RN walked in resident (F7) walked out of the resident's (R1) room cussing and yelling 'next time I will hurt her'. In the same document it documents under Statements, 12/16/25 - Resident (R7) very agitated throughout the day. Around 3pm he was banging doors stating, I got to get out of this damn place, swinging. Had try (sic) to go out the north door going outside banging on the door handle, hit the window let me out of here. Also was verbally distressed yelling in dining room at other residents and staff. Resident was directed back to his room.On 1/12/26 at 11:06 AM, V12 (CNA) stated R1's call light was on and when she went into the room to answer it R7 was in her room and had a hold of her wheelchair by the handles trying to tip it over. V12 stated she reached out for R7's hand and asked him to come with her and she walked him out of the room. V12 stated she took R7 back to his room and turned on football for him. V12 stated after R7 was calmed down she got the nurse, but she can't remember who the nurse was that day.3. R9's admission Record documents R9 was admitted on [DATE] with diagnoses including in part Parkinson's disease with dyskinesia, Alzheimer's disease, chronic pain syndrome, and depression.R9's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 06, indicating severe cognitive impairment.A final abuse report sent to the state surveying agency dated 1/2/26 documents on 12/28/25 around 5:45pm, R7 allegedly grabbed R9 by the neck. No injuries were noted. The final summary documents, (V9 Certified Nursing Assistant/CNA) reports she was feeding residents in the dining room of the Dementia Unit when (R7) got up and went towards (R9) and her then grabbed (R9's) neck. (V9) was able to immediately separate residents. It is believed that (R7) was overstimulated by the noise in the dining room. (R7) was immediately sent to the emergency room for evaluation of physical behavior. (R9) resumed activities with no ill effects.A facility document titled #799 Res/Res Altercation for R7 dated 12/28/25 documents under incident description: R7 was eating in the dining room, stood up and went to R9 and grabbed him by the throat. In the same document under immediate Action Taken it documents Staff able to separate residents. The resident (R7) still visibly agitated. Notified admin (administration), ADON (Assistant Director of Nursing), and local police department. Administered IM (intramuscular) Ativan per MAR (Medication Administration Record). Unable to redirect resident. Sending the ER (Emergency Room) for evaluation/treatment. Under Statements it documents, statement by V9 (CNA) on 12/28/25 I was feeding residents and Resident (R7) got up and went towards another resident (R9) and grabbed him by the neck. Went towards residents and yelled for other CNA to assist. Was able to separate residents. Other CNA was able to redirect this resident and a statement by V32 (CNA) Other CNA yelled for me for help stated that resident (R7) had put his hands around another residents (R9) neck. Resident (R7) flailing arms around trying to hit anyone. Was able to get resident (R7) away from situation and notified nurse.A facility document titled #800 Res/Res Altercation for R9 dated 12/28/25 documents under Incident Description, Nursing Description: Another resident (R7) grabbed this resident (R9) by the throat. This resident (R9) was eating dinner when the other resident (R7) involved walked up and put his hands around this residents (R9) throat.R9's progress note dated 12/28/25 at 6:43 PM, created by V8 (Assistant Director of Nursing/License Practical Nurse) documents Spoke with wife (name) regarding altercation with another resident. She voiced understanding. Informed that resident will continue to be monitored.On 1/12/26 at 10:51 AM, V9 (CNA) stated R7 was agitated most of the day the day of the incident with him and R9. V9 stated R7 was bickering most of the day with everyone and when he was in the dining room, he was mouthing (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	everyone, R9 turned to R7 and said something to him then R7 stood up and grabbed R9 by the throat and pushed him out of the dining room door into the hallway, R9 was in his wheelchair at the time. V9 stated she removed R8's hand from R9's neck and told them to stop and yelled for help and the nurse and some other staff came in and took over the situation. V9 stated she doesn't remember who came in to help.On 1/13/26 at 11:12 AM, V8 (Assistant Director of Nursing) stated she did not witness the incident between R7 and R9. V8 stated she was in her office, and someone yelled at her, so she went to the unit, and she took R7 to the family room on the unit and shut the door and talked with him. V8 stated she did give R7 a dose of intramuscular Ativan. V8 stated R7 told her he couldn't do this anymore and she asked what this was, and he told her he was just really agitated and didn't know what to do. V8 stated she asked R7 if he wanted to watch a movie, and he said yes so, she turned on a movie. R8 stated shortly after that it was time for dinner, and she asked him if he wanted to eat in the family room or go to the dining room and he requested to eat in the dining room with the other residents, so she walked with him into the dinner room. V8 stated R7 started eating dinner in the dining room with the other residents and then she left.4. R6's admission Record documents an admission date of 9/17/25 with diagnoses including in part anxiety disorder, anoxic brain damage, catatonic disorder due to known physiological condition, and depression.R6's MDS dated [DATE] documents a BIMS of 02, indicating severe cognitive impairment.R6's Care plan documents R6 is a risk for abuse/neglect with an initiated date of 9/25/25.A final incident report sent to the state surveying agency documents that on 12/28/25 around 10:50pm, R7 allegedly walked up behind R6 and grabbed her breast. No injuries were noted. Residents were immediately assessed and R7 was placed on one-on-one supervision. Final summary documents, During investigation, (V10) CNA stated that (R7) walked up behind (R6) and reached around from her back and grabbed her breast. (V10) immediately separated residents. (R7) was placed on one-on-one supervision. (R6) resumed normal activity with no ill effects. (R7) was admitted to (name of local behavioral hospital) on 12-29-25.A facility document titled #802 Res/Res Altercation for R6 dated 12/28/25 documents under Incident Description, Nursing Description: A male resident grabbed this resident's (R6) breast. Under Resident Description it documents Resident (R6) unable to give description. In the same document under Statements, it documents a stated by V10 (CNA) I witnessed resident (R7) reach around from the back and grope (R6)'s breast. Told him to let go and he said no and then I removed hand from breast.On 1/13/26 at 10:07 AM, V10 (CNA) stated on the day of the incident between R7 and R6, R7 was agitated all day that day. V10 stated R7 was kind of targeting R6 all day, following her around. V10 stated R7 was walking around, and he came up behind R6 and reached around her and grabbed her breast. V10 stated she redirected R7 to step away from R6 and he listened and walked away.On 1/13/26 at 10:14 AM, V26 (CNA) stated she did not witness the incident between R7 and R6, but R7 was agitated most of the day prior to the incident. A facility policy titled Abuse Prevention and Reporting-Illinois dated 11/28/16 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. This same policy defines abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. In the same policy it documents under Protection of Residents: Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employes of the facility. In addition, the facility shall take all steps (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	necessary to ensure the safety of residents including, but not limited to, the separation of the residents.