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 03/02/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to provide a functioning call light in the south hall shower room. This has the potential to affect all 36 residents that reside on the south hall reviewed for call lights in a sample 52. Findings include: On 02/26/26 at 11:50 AM, V2 (Director of Nursing) stated they use the two shower rooms on the south halls for all the residents on the south hall. On 02/26/26 at 12:24 PM, V21 (Certified Nursing Assistant/CNA) stated the shower room across from the nurses' station and the one next to it are both used to give showers to residents on the south halls.On 02/26/26 at 12:36 PM, the call light in the shower room across from the nurses' station on the south hall did no function and was not accessible from the floor. The shower stall had water on the floor and walls giving the appearance the shower stall had just been used.On 02/26/26 at 12:39 PM, V21 (CNA) stated it has been a couple days since the call light has worked in that shower room.On 02/26/26 at 12:53 PM, V24 (Maintenance) stated he does not have a work order for the call light in the shower room. V24 stated he was unaware it was not working. V24 flipped the switch of the call light a couple times and stated, the call light does not work. V24 stated he will look into getting it repaired and get a string on it to make sure it can be reached from the floor if needed. The undated facility policy titled, Preventive Maintenance and Inspections documents: in order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program has been implemented to promote the maintenance of fixtures and equipment in a state of good repair and condition. Routine inspections promote safety throughout the facility and aid in keeping fixtures and equipment in good working order and operating in accordance with manufacturer's guidelines. Regular inspection, testing, and replacement or repair of equipment and operational systems contribute to preservation of the facility's assets. Work orders and service requests: a system for work orders is established among all staff, elders, and employees that provides rapid communication regarding equipment problems. The Midnight Census report dated 02/23/26 documents that there are a total of 36 residents that reside on the south hall.

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

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 03/02/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to attempt non-pharmacological interventions prior to administering a PRN (as needed) psychotropic medication for 1 of 5 residents (R7) reviewed for unnecessary medications in a sample of 52.Findings include:R7's admission record documents R7 was admitted to the facility on [DATE] with diagnoses of Alzheimer's dementia with behavioral disturbance, cerebrovascular disease and oral phase dysphagia.R7's MDS (Minimum Data Set) dated 1/5/2026 documented R7 has a BIMS (Brief Interview for Mental Status) score of 1 out of 15 total, which indicates R7 has severe cognitive impairment.R7's Care Plan documents a Problem of resident is/has potential to be physically aggressive towards staff during care with an initiation date of 7/19/23 with interventions including: Monitor and document observed behavior and attempted interventions in behavior log; and when the resident becomes agitated: Intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, If response is aggressive, staff to walk away calmly and approach later with initiation dates 7/19/2023.R7's MAR (Medication Administration Record) documented on 1/30/2026, R7's physician ordered Lorazepam 0.5 mg (milligram) by mouth every 8 hours as needed for combativeness related to dementia with other behavioral disturbance. This same MAR documented R7 was administered the medication on 2/21/2026 at 4:14pm by V12 (Licensed Practical Nurse/LPN).There were no progress note are entries into R7's EMR (Electronic Medical Record) for the date of 2/21/2026.R7's behavior tracking dated 2/21/2026 documented with a check mark that R7 has no observable behaviors for that day.On 2/25/2026 at 1:00pm, V12 (LPN) said she did not attempt any non-pharmacological interventions prior to administering R7 the PRN lorazepam. V12 said she didn't know non-pharmacological interventions needed to be attempted prior to administering a PRN psychotropic medication to a resident. V12 said it is ok not to attempt any non-pharmacological interventions because R7 didn't take the PRN lorazepam very often and only took the medication once in a while.On 2/25/2026 at 2:15pm, V2 (Director of Nursing) said she expected the nursing staff to perform and document non-pharmacological interventions prior to administering a PRN psychotropic medication to any resident admitted to this facility.The facility policy titled Psychotropic Medication-Gradual Dose Reduction with revision date of 2/1/2018 documented the following: Purpose: to ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice and are prescribed at the lowest therapeutic dose to treat such conditions.

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 03/02/2026
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 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 observation, interview, and record review the facility failed to perform nail care for 3 of 3 residents (R22, R44, and R68) reviewed for ADL (Activities of Daily Living) care in a sample of 52.Finding include:1. R44's admission Record documents an admission date of 02/26/21 with diagnoses including: adult pulmonary Langerhans cell histiocytosis, moderate protein calorie malnutrition, dementia, delusional disorders, anemia, Alzheimer's disease, hyper lipidemia, acute coronary thrombosis, altered mental status, depression, disorientation, hearing loss, and dysphagia. R44's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 01, indicating R44 has severe cognitive impairment. The same MDS documents R44's personal hygiene performance as substantial/maximal assistance indicating helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. On 02/23/26 at 3:00 PM, 02/24/26 at 12:32 PM, 02/25/26 at 12:35 PM, and 02/26/26 at 12:17 PM, R44's nails had a black substance under her fingernails of both hands. 2. R22's admission Record documents an admission date of 04/26/25 with diagnoses including: wedge compression fracture of unspecified thoracic vertebra, multiple fractures of pelvis without disruption of pelvic ring, fracture of unspecified part of left clavicle, other intervertebral disc degeneration of lumbar region with discogenic back pain only, Alzheimer's disease, muscle wasting and atrophy, dementia, and age related osteoporosis. R22's MDS dated [DATE] documents a BIMS score of 03, indicating R22 has severe cognitive impairment. The same MDS documents R22's personal hygiene performance as substantial/maximal assistance indicating helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. On 02/23/26 at 2:23 PM, 02/24/26 at 12:32 PM, 02/25/26 at 12:35 PM, and 02/26/26 at 12:17 PM, R22's nails had a black substance under her fingernails of both hands. On 02/26/26 at 12:18 PM, V22 (Family) stated R44's nails were dirty and need cleaned and R22 and R44 will eat with their fingers. On 02/26/26 at 1:07 PM, V19 (Certified Nursing Assistant/CNA) stated R22 and R44's nails are dirty and they do need to be cleaned. V19 stated nails are supposed to be cleaned on shower days and anytime they are noticed to be dirty in between. 3. R68's admission Record documents an admission date of 08/08/25 with diagnoses including: acute and chronic respiratory failure, severe sepsis with septic shock, encounter for other orthopedic aftercare, displaced fracture of second metatarsal bone, right foot, muscle wasting and atrophy, unsteadiness on feet, lack of coordination, major depressive disorder, hyperaldosteronism, extrapyramidal and movement disorder, unspecified convulsions, anxiety disorder, and unilateral primary osteoarthritis of the left knee. R68's MDS dated [DATE] documents a BIMS score of 10, indicating R68 has moderately impaired cognition. The same MDS documents that R68 requires substantial/ maximal assistance with lower body dressing, dependent for putting on/taking off footwear, and partial/moderate assistance with personal hygiene. On 02/26/26 at 2:41 PM, R68 stated she needs her toenails trimmed. On 02/26/26 at 2:41 PM R68's toenails were observed to be long and in need of being trimmed. On 02/26/26 at 2:42 PM, V1 (Administrator) stated R68's toenails do need trimmed and she will get someone down to take care of it. The facility policy dated 01/25/18 titled, Nail Care documents: 1. Observe condition of resident nails during each time of bathing, note cleanliness, length, uneven edges, hypertrophied nails. 4. After bathing, use orange stick, and clean debris from around and under finger and toe nails.

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 03/02/2026
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide supplementation to maintain or gain weight for residents with low body weights for 1 of 5 residents (R10) reviewed for nutrition in a sample of 52.Findings include:R10's admission Record documents an admission date of 01/02/26 with diagnoses including: chronic obstructive pulmonary disease, respiratory failure, severe protein calorie malnutrition, chronic diastolic heart failure, disorder of bilirubin metabolism, rhabdomyolysis, encephalopathy, hyperlipidemia, chronic cholecystitis, gastro esophageal reflux disease without esophagitis, neuromuscular dysfunction of bladder, and essential hypertension. R10's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 11, indicating R10 has moderate cognitive impairment. R10's Care Plan documents a focus area of R10 has pressure ulcers dated 01/14/26 with an intervention of monitor nutritional status, serve diet as ordered, and monitor intake and record dated 01/13/26. R10's Care Plan also documents a focus area of R10 is in a terminal condition and is receiving hospice services dated 01/14/26. R10's care plan does not document a focus area of nutritional status or weight status. On 02/25/26 at 9:50 AM, R10 stated he is tired of eggs, there are a lot of eggs here. R10 stated he gets what is on the ticket (the dietary ticket) but he does not get extra protein that he is aware of, or a drink that is thicker like a milk shake, or a little cup of anything that looks like ice cream. R10 stated, he will get milk sometimes and coffee, he does like coffee. R10 stated he eats the food but it is not that great to him. R10 stated the coffee is better than some he had at times when he was in the military though. R10 stated, he might try some of those other food items if he liked them, but he has never had them. On 02/26/26 at 1:52 PM, V9 (Dietary Manager) stated R10 is very thin and he was aware he admitted to the facility underweight but he did not give him any type of nutritional supplementation but he did refer him to V23 (Registered Dietician).On 02/26/26 at 2:26 PM, V1 (Administrator) stated R10 did admit to the facility very underweight and even though he is currently on hospice, he should have received some nutritional supplementation to either maintain weight or assist with weight gain. On 03/02/26 at 9:29 AM V23 (Registered Dietician) stated, R10 was admitted on [DATE] and she did his initial assessment on 01/24/26. V23 stated R10 was 75 inches tall and 121.3 pounds. V23 stated that is considered underweight for a male of his height. V23 stated an ideal body weight for someone of that height would be 176 - 215 pounds. V23 stated that R10 admitted underweight and was on hospice when she evaluated him, he did not have any weight loss then, so she was going to monitor to see if his weight was stable or if he had any weight loss before she recommended anything. V23 stated, she can see where R10 is down a couple pounds now and is about 118 pounds. R10's weights and vitals summary documents: on 01/02/26 at 2:55 PM R10's weight was 121.1 pounds and on 02/04/26 at 2:19 PM R10's weight was 119.0 pounds. R10's Nutrition assessment dated [DATE] documents: most recent height of 75 inches tall at 01/03/26 at 11:21 AM with a most recent weight of 122.3 pounds on 01/05/26 at 8:41 AM. R10's BMI (Body Mass Index) is listed as 15.3% (underweight). R10's oral/nutrition intake for food is listed as 26-75% of estimated needs met and physical/mental function is alert, hearing and vision are within normal limits. The nutritional approach adequate to meet nutritional needs as evidenced by: admission assessment: weight (1/5/26) 122.3 pounds with a BMI of 15.3 % (underweight), diet is regular with mechanical soft texture with nectar thick liquids and PO (per oral) intake is reported as 0-100% of meals with an average of 50% noted per the 14 ay look back report. R10 has a PEG (Percutaneous Endoscopic Gastrostomy) tube that is not currently in use. No skin breakdown is reported at this time. Hospice care services are in place. Continue current plan and V23 to follow up as needed. The facility document from the Guideline & Procedure Manual 2020 titled, Fortified food, Supplements, and Snacks documents: residents who cannot consume adequate amounts of regular foods at meals to meet their nutritional needs may be considered for fortified foods, snacks, or supplements in order to increase nutritional intake, Residents will be evaluated by (continued on next page)

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 03/02/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Registered Dietitian when additional nutritional intervention is warranted. Commercially prepared supplements, including (brand name supplement) products, will be ordered by the physician. Fortified foods, house supplements, or snacks will be provided within the specifications of the diet order. 2. resident classified as persons at risk and or with poor nutritional intake, declining intake, weight loss, and/or pressure ulcers will be referred to the Registered Dietician. The facility document from the Long Term Care Diet Manual 2022 titled, Unintentional Weight loss documents: unintentional weight loss can have serious implications for older adults. Studies indicate unintentional weight loss can lead to malnutrition, poor wound healing, risk of pressure ulcers, decline in function and inability to fight infection. Unintentional weight loss can be rapid or sometimes slow and insidious. It is important that systems are in place to detect, assess and develop and individualized plan of care for persons with unintentional weight loss. Other risk factor for unintentional weight loss include dementia, a low BMI (<18.5), dentition problems or poor condition of teeth, dysphagia, depression, Parkinson's disease, medications environmental factors, restrictive diets, treatments such as chemotherapy and radiation, COPD (chronic obstructive pulmonary disease), diarrhea and others.

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 03/02/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow the facility's policy and perform pain assessments to assist with pain management for 1 of 1 resident (R68) reviewed for pain in a sample of 52.Findings include:R68's admission Record documents an admission date of 08/08/25 with diagnoses including: acute and chronic respiratory failure, severe sepsis with septic shock, encounter for other orthopedic aftercare, displaced fracture of second metatarsal bone, right foot, muscle wasting and atrophy, unsteadiness on feet, lack of coordination, body mass index of 50.0-59.9, major depressive disorder, and unilateral primary osteoarthritis of the left knee. R68's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 10, indicating R68 has moderately impaired cognition. Section J of the same MDS documents that R68 receives PRN (as needed) pain medication and receives non-medication interventions for pain. Under Pain Assessment Interview, it documents that R68 sated no to have you had any pain or hurting at any time in the last 5 days. R68's Care Plan documents a focus area of R68 has chronic pain relating to depression, fracture prior to admission to long term care, medical procedure, and surgical procedure and has Celebrex, Tylenol, and hydrocodone as ordered dated 9/23/25 with interventions including: Administer analgesia as per orders. Give 1/2 hour before treatments or care, Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions per facility protocol. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function, identify, record and treat the resident's existing conditions which may increase pain and or discomfort examples include arthritis, neuropathies, cancer, osteoporosis, fractures, shingles, peripheral vascular disease, ulcers, contractures, parathesis relating to stroke, monitor/document for probable cause of each pain episode. Remove/limit causes where possible, monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls and report occurrences to the physician, monitor/record pain characteristics per facility protocol: quality (e.g. sharp, burning); severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors and relieving factors, monitor/record/report to nurse any sign or symptoms of non-verbal pain: changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying, worried, scared, clenched teeth, grimacing) body (tense, rigid, rocking, curled up, thrashing), monitor/record/report to nurse loss of appetite, refusal to eat and weight loss, monitor/record/report to nurse resident complaints of pain or requests for pain treatment, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (Range or Motion), withdrawal or resistance to care, provide the resident with reassurance that pain is time limited. Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultra-sound, provide the resident and family with information about pain and options available for pain management, discuss and record preferences, report to nurse any change in usual activity attendance patterns or refusal to attend activities related to signs or symptoms or complaints of pain or discomfort, the resident is able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain all dated 10/23/25.On 02/23/26 at 6:50 AM, R68 was observed lying in bed, with her face grimaced. R68 (continued on next page)

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 03/02/2026
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, she did not want breakfast today, it just hurts. R68 stated, she gets some pain medication and sometimes it helps and sometimes it doesn't. On 02/24/26 at 11:53 AM, R68 was observed in her wheelchair in the hallway by the nurses' station heading towards the dining room. R68 had a slight grimace on her face and was trying to shift in her wheelchair. R68 stated her back hurts.On 02/24/26 at 12:18 PM, R68 asked the CNA (Certified Nursing Assistant/CNA) in the dining room if she could move from her wheelchair to a regular chair to maybe help with her back hurting. R68 moved to a regular chair and stated, it was helping her back some. On 02/25/26 at 1:22 PM, R68 stated her back hurts, she is going to lay down and hopefully that will help her back. R68 stated she was given a pain pill but sometimes it still hurts. On 02/26/26 at 1:07 PM, V8 (Minimum Data Set Coordinator/MDS) stated, they do not have any pain assessments for R68 besides what is in the MDS. V8 stated, they will document a numerical value for her pain when they give her pain medication. On 02/26/26 at 1:18 PM, V19 (CNA) stated R68 does complain of pain at times, it seems like she has complained of more pain since she has returned from the hospital. The facility policy dated 07/06/18 titled, Pain Management Program the resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes, and changes in behavior and mood will be used to determine the present of pain. The pain management program includes the following components: documentation of pain assessment and monitoring, assessment of non-verbal residents for signs and symptoms of pain, and quality assurance audit activities to monitor the program's effectiveness. 1. pain assessment protocol will be initiated under any of the following situations: any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain, when the MDS triggers an indication of pain, resident receives routine pain medication and/or pain in not controlled, an interdisciplinary process and care plan will be developed and implemented based on the assessed findings, pain rating scale, and pain relieving strategies (interventions), care plans will be reviewed and updated each time the resident's pain management plan if is found not to be effective and at least at each quarterly care conference. 10. documentation of assessments and the resident's response to the pain management plan will be made with each assessment.

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 03/02/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow guidelines consistent with current standard of practices to prevent/decrease risk of infection to wounds for 2 of 2 residents (R1 and R16) observed for infection control in the sample of 52.The findings include:1. R1's admission Record documents an admission date of 9/8/23 with diagnoses including but not limited to Type II Diabetes Mellitus, Atherosclerosis of both legs, and lymphedema.R1's Physician's Order Sheet (POS) with a print date of 2/26/26 documents a current physician's order for left lateral lower leg: cleanse with wound cleanser. Apply Santyl to wound bed, ABD (abdominal pad), (gauze wrapping), wrap with (elastic) wrap daily and PRN (as needed).R1's most recent Care Plan documents Resident has other potential/actual impairment to skin integrity r/t (related to) fragile skin Date Initiated: 7/12/2024 Revision on: 10/23/2025. Interventions for this focus area include but are not limited to, Follow facility protocols for treatment of injury. Date Initiated: 07/12/2024 Revision on: 8/19/2024. Another focus area documented on R1's care plan documents, I have a venous/stasis ulcer of the left leg and top of right foot r/t (related to) venous/ulcer stasis Date Initiated: 10/23/2025 Revision on: 10/23/2025. Interventions for this focus area include but are not limited to, Treatment as ordered Date Initiated: 10/23/2025.R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview for Mental Status (BIMS) score of 11 indicating R1 has moderately impaired cognition. The same MDS documents R1 is at risk for pressure ulcers and R1 has 2 venous/arterial ulcers.On 2/25/26 at 10:27 AM, R1 dressing change was observed to R1's venous stasis ulcer to left lateral calf region performed by V7 (Licensed Practical Nurse/Assistant Director of Nurses). V7 performed hand hygiene and donned gown and gloves appropriately and provided privacy by shutting the door to the room. V7 placed clean barriers down on surfaces being utilized with supplies on the barriers. V7 removed the old dressing with scissors. V7 then changed gloves but did not perform hand hygiene by using alcohol-based hand sanitizer or hand washing. V7 then cleansed the wound according to physician's orders with (brand name) solution and 4x4 gauze sponges and patted dry. V7 then changed gloves again but did not perform hand hygiene. V7 then applied Santyl ointment as ordered by physician. V7 applied abdominal/ABD pad, then wrapped leg with gauze wrap and (elastic wrap) for compression. V7 then gathered up her trash, disposed of it properly, removed gown and gloves, and performed hand hygiene.On 2/25/26 at 10:41 AM, V7 stated in relation to not performing hand hygiene between glove changes while doing R1's dressing change, she (V7) had forgotten to bring alcohol based hand rub with her into the room initially and didn't think she could stop and obtain some. V7 stated she should have performed hand hygiene between glove changes to decrease risk of infection to R1's wound. On 2/26/26 at 2:47 PM, V8 (Infection Preventionist) stated use of hand sanitizer between glove changes is expected while performing dressing changes. V8 stated V7 should have performed hand hygiene between glove changes. V8 stated not performing hand hygiene between glove changes during dressing changes could increase risk of infection.On 2/26/26 at 2:54 PM, V2 (Director of Nursing/DON) stated V7 should have performed hand hygiene between glove changes while performing dressing change. V2 stated not performing hand hygiene between glove changes increases risk for infection.2. R16's admission Record documents an admission date for R16 of 2/27/25. The same admission Record documents diagnoses including but not limited to cellulitis of right lower limb, type I diabetes, and non-pressure chronic ulcer of unspecified foot.R16's POS dated 2/26/26 documents current physician's orders including but not limited to, Contact/enhanced barrier precautions related to chronic wounds. Right plantar foot: cleanse with wound cleanser, pack wound with calcium alginate silver cover with ABD (abdominal pad) and wrap with (gauze wrap) daily and PRN (as needed) every day shift.R16's Care Plan documents a focus area for enhanced barrier precautions related to chronic wounds dated 6/17/25. Interventions for this focus area include but are not limited to gown and glove during high contact resident care activities dated 6/17/25.R16's MDS (continued on next page)

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 03/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] documents R16 has a BIMS score of 15, indicating R16's cognition is intact. The same MDS documents R16 has a diabetic foot ulcer and infection of the foot.On 2/24/26 at 2:54 PM, V11 (Licensed Practical Nurse/LPN) was observed performing the dressing change on R16's diabetic ulcer of the right foot. V11 washed her hands, donned gown and gloves and supplies were already ready. V11 then removed R16's old dressing by cutting it off with scissors. Scissors were then placed on clean barrier V11 had placed down for her supplies. V11 then removed her gloves, performed hand hygiene with alcohol-based hand sanitizer and donned new gloves. V11 then cleaned R16's wound with wound cleanser and 4x4 sponges. V11 then performed hand hygiene and changed gloves. V11 then took the same scissors she had cut off the old bandage without sanitizing them and cut the sterile calcium silver alginate with those same bandage scissors. V11 then took the piece of calcium silver alginate section she had cut with the contaminated scissors and packed it into the wound. V11 then applied an abdominal pad and wrapped the bandage and foot with gauze wrap. V11 then cleaned her work area disposed of her trash properly, removed her gown and gloves and performed hand hygiene. On 2/24/26 at 3:09 PM, V11 stated in relation to using the contaminated scissors to cut the alginate, she should have either sanitized the scissors or used a different pair to cut the sterile alginate packing for the wound. V11 stated using contaminated scissors to cut clean or sterile packing could increase risk for infection in the wound.On 2/26/26 at 2:47 PM, V8 (Infection Preventionist) stated he would not consider it appropriate to use same scissors used to cut the old bandage off of R16's foot to then cut the sterile packing that would go into the wound. V8 stated to use the contaminated scissors would be increasing risk of infection to the wound.On 2/26/26 at 2:54 PM, V2 (DON) stated V11 should have either sanitized the scissors used to cut the old bandage away from R16's foot or used a clean pair to cut sterile calcium silver alginate that V11 used for packing in the wound.The facility's Infection Precaution Guidelines policy dated 11/28/12, documents Standard Precautions defined as combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions, excretions (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions consist of a group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. The same policy documents, Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment. Alcohol-based hand rub may be used if hands are not visibly soiled. The same policy also documents, Gather all equipment and supplies needed before going into the room. Only take needed supplies into the room. When possible dedicate the use of noncritical resident-care equipment to a single resident or cohort of residents infected or colonized with the pathogen requiring precautions. When use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another resident.