

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of West Frankfort		STREET ADDRESS, CITY, STATE, ZIP CODE 601 North Columbia West Frankfort, IL 62896	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to respect the resident rights to have an environment that promotes maintenance and enhancement of his or her quality of life for 40 of 40 residents (R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, R13, R15, R16, R17, R18, R19, R21, R23, R24, R25, R26, R27, R29, R30, R31, R32, R33, R35, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48) that live on the north and south halls reviewed for resident rights in a sample of 48. The findings include: R3's Transfer/Discharge report dated 08/28/25 documents an admission date of 06/12/24 with diagnoses in part of bipolar disorder, delusional disorder, major depressive disorder, schizophrenia, borderline personality disorder, anxiety, and need for assistance with personal care. R3's MDS (Minimum Data Set) dated 06/30/25 documents in Section C a BIMS (Brief Interview Mental Status) score of 15 which indicates cognitively intact. R3's Care Plan documents a focus area of I have increased agitation; restlessness with a date initiated 06/10/25 with an intervention in part of offer resident quiet, calming environment in which to voice cause of agitation to staff.</p> <p>On 08/28/25 at 11:35AM, R3 stated that staff gets loud and fights a lot on evening shift and yells and screams at each other in front of the residents.</p> <p>On 09/09/25 at 1:15 PM, V18 (Certified Nurse Assistant/CNA) stated that on 07/20/25 she was working on evening shift with V32 (CNA) who got upset over the staffing assignment. V18 said that V32 came down the hall cussing and yelling at her about the staffing assignment. V18 said she told V32 that she didn't make the staffing assignment up and to take it up with the nurse who was working. V18 stated that she tried to walk down the hallway and V32 was blocking the hallway and wouldn't let her get passed. V18 said that she finally did get passed V32 then V32 came running down the hallway after her yelling and cussing. V18 said that it was getting so bad that V32 was yelling at her around the nurses' station as well. V18 said that V39 (CNA) another staff member came into work. V18 said she went to get food and went to shut the door to the break room and that V39 came in asking V18 what her problem was. V18 said she went to shut another door and that V39 came in and asked her why she was slamming doors and V18 said that she told V39 she wasn't and that V39 told her she was weird. V18 said they have their own group on evening shift, and she wasn't in their group. V18 said that V27 (Agency Licensed Practical Nurse/LPN) told V18 to just stay on her hall and try to stay away from V32 and V39. V18 said that V32 and V39 just kept harassing her and that V27 called V1 (Administrator) and V2 (Director of Nursing/DON) about how V32 and V39 was acting towards V18. V18 said V32 came up to the nurses' station yelling at her and that V27 had to tell her to stop. V18 stated that it just continued and that she finally didn't feel safe at work and that the nurse called someone and asked if she could go home. V18 said she was given approval to go home, and she was waiting for her ride outside and that V32 and V39 both leaned outside of the facility and told her to leave and don't fu**ing come back b***h.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/09/25 at 2:50 PM, V29 (Activity Director) stated that she was working as weekend manager one weekend she said she usually works around 4 hours. V29 said that she could hear staff yelling and screaming at each other. V29 said that she went to see who it was she said that it was V32 (CNA) and V18 (CNA). V29 said V18 told her that she was in a resident's room and that V32 came down to that resident room and was jumping all over her about the staff assignment. V29 said V18 told her that V32 was blaming her for upsetting other staff V24 (CNA) and V9. V29 said that she went and talked to V24 and V9 asking them if V18 had done anything to upset them and they stated no. V29 said that V24 was a little upset not at V18 but overall, the drama at the facility. V29 said that V24 left and that is when V39 came into work. V29 said V18 told her that she was going into a room and that she shut the door with her foot because she has just put gloves on and that V39 opened the door and asked her why she slammed the door and V18 told V39 that she did not slam the door and then V39 told V18 she is just weird. V29 said that V1 did know about V18, V32, and V39 yelling at each other and of the way they were acting in the facility.</p> <p>On 09/03/25 at 4:41 PM, V27 (Agency Licensed Practical Nurse) stated, the second night she worked, the CNAs were yelling and screaming at each other down the halls. V32 (CNA) was following V18 (CNA) down the hall yelling at her. V32 was starting arguments with V18 because of the things that took place the night before. The CNA (V18) that was getting followed down the hall went home early because she didn't feel comfortable with the situation. V27 stated, she could hear them on the two main halls (the north and south halls). V27 stated, the place had all kinds of drama going, it was crazy.</p> <p>The timecard reports document on 07/20/25 the CNAs working the 2:00 PM - 10:00 PM shift were V9, V32, V24, and V18 and the only CNA to leave early was V18.</p> <p>The room roster provided on 08/28/25 documents R2, R23, R4, R18, R11, R33, R24, R29, R10, R6, R13, R38, R39, R35, R32, R1, R19, R15, R40, R41, R25, R8, R30, R26, R42, R27, R43, R5, R44, R45, R21, R12, R16, R17, R7, R31, R46, R47, and R48 live on the north and south halls.</p> <p>On 09/08/25 at 10:44 AM, V40 (Agency LPN) stated, the time he worked at the facility, he remembers CNA's yelling at each other, you could hear them from the nurse's station on the north and south hall. Residents wanted to go to the bathroom and they couldn't. V40 stated it was chaos at the facility.</p> <p>The facility's undated Resident Rights policy documents in part, "Our most important goal is to provide the highest standard of care to our residents in an environment safe, secure, and free of clutter. All employees of (Name of Facility) are expected to treat all residents, their family members, co-workers, and visitors with the utmost respect, kindness, and professionalism at all times&hellip; Employees that fail to provide superior care will be subject to corrective action, up to and including termination of employment.</p> <p>&rdquo;</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a method for altering staff when resident's need assistance for 5 (R4, R7, R15, R17, R30) of 15 residents reviewed for call lights in reach in a sample of 48. Findings include: 1. R15's transfer/discharge report documents an admission date with diagnoses including: chronic respiratory failure, chronic obstructive pulmonary disease, anxiety disorder, depression, shortness of breath, cachexia, chronic viral hepatitis C, peripheral vascular disease, and muscle wasting and atrophy.</p> <p>R15's Minimum data set (MDS) dated [DATE] documents a brief interview of mental status of 12 indicating R15 is moderately impaired. Section GG documents sit to stand, chair/bed to chair transfer and toilet transfer as partial/moderate assistance with walk ten feet documented as not attempted due to medical condition or safety concerns.</p> <p>On 08/28/25 at 1:35 PM, R15's oxygen tubing was not in place, it was around her face but it was approximately an inch away from her nose. R15 was laying in bed sleeping and her call light was on the far side of her bedside table approximately three feet from her.</p> <p>On 09/03/25 at 10:10 AM, R15 was laying in her bed sleeping, R15's call light was on the bedside table approximately three feet from her.</p> <p>2. R17's admission record documents an admission date of 05/04/20 with diagnoses including: cerebral infarction, vascular dementia, obsessive compulsive personality disorder, anxiety disorder, major depressive disorder, depression spondylolysis, need for assistance with personal care, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, repeated falls, and bradycardia.</p> <p>R17's Minimum Data Set, dated [DATE] documents a BIMS score of 15 indicating R17 is cognitively intact. Section GG documents lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer as partial to moderate assistance needed with walk 10 feet as not applicable.</p> <p>R17's care plan documents a focus area of: risk for falls dated 04/11/24 with an intervention listed as: fall intervention to include resident education on fall prevention, encourage resident to ask for assistance when needing something dated 04/29/25.</p> <p>On 08/28/25 at 1:34 PM, R17's call light was not in reach, R17 was laying in bed and his call light was on his bedside table, approximately three feet from him.</p> <p>3. R7's transfer/discharge report documents an admission date of 06/25/25 with diagnoses including: acute and chronic respiratory failure with hypoxia, chronic kidney disease, dependence on supplemental oxygen, essential hypertension, human immunodeficiency virus, muscle weakness, atherosclerotic heart disease, chronic obstructive pulmonary disease with acute exacerbation, encounter for palliative care, anxiety disorder, and need for assistance with personal care.</p> <p>R7's MDS dated [DATE] documents a BIMS score of 15 indicating R7 is cognitively intact. Section GG documents R7's ability to: sit to stand, chair/bed to chair transfer as dependent. Toilet transfer is dependent. R7's ability to walk 10 feet is not applicable.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R7's care plan documents a focus area of at risk for falls dated 06/25/25 with an intervention dated 07/11/25 of ensure call light is available to resident. R7's care plan documents a focus area of: I have an ADL (activities of daily living) self-care performance deficit dated 07/11/25 with an intervention of encourage the resident to use bell to call for assistance dated 07/11/25. R7's Care plan documents a focus of risk for falls with a revision date of 09/09/25 with intervention of ensure call light is available to resident. Another focus area of I have an ADL (Activities of Daily Living) self-care with a revision date of 09/09/25 with an intervention of encourage the resident to use bell to call for assistance.</p> <p>On 08/28/25 at 1:58 PM, R7's call light was not in reach. R7 was sitting in her recliner in front of her TV. The call light was on the floor over by the bedside table approximately five feet away. When R7 was asked if she knew where her call light was and if she could reach it, R7 started trying to get out of her recliner to find and get her call light. Surveyor stopped her and stated the call light was found. When trying to put the call light in R7's reach, the call light would not reach to where R7 was sitting.</p> <p>On 08/28/25 at 11:16 AM, R7 stated that staff has taken her call light away from her and placed it out of her reach and hide it. R7 said they take it away from me and put it out of my reach on days and evenings.</p> <p>4. R30's admission record documents an admission date of 02/28/25 with diagnoses including: panlobular emphysema, chronic obstructive pulmonary disease, supraventricular tachycardia, Alzheimer's disease, severe protein calorie malnutrition, cervical disc degeneration, bilateral primary osteoarthritis of knee, age related osteoporosis, lack of coordination, depression, major depressive disorder, wandering, spondylosis, muscle wasting and atrophy, cognitive communication deficit, and need for assistance with personal care.</p> <p>R30's MDS dated [DATE] documents a BIMS score of 04 indicating R3 has severe cognitive impairment. Section GG documents R30 requires partial to moderate assistance for: sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer.</p> <p>R30's care plan documents a focus area of: risk for falls dated 03/04/25 with an intervention listed as; ensure call light is available to resident dated 03/01/25.</p> <p>On 09/09/25 at 2:34 PM, R30 was laying in bed, R30's call light was on the floor with the cord under the legs of the bedside table with the button under her roommates bed, R30 did not provide a relevant response to the question asked about the call light.</p> <p>5. R4's admission record dated 09/12/25 documents an admission date of 12/07/22 with diagnoses in part of major depressive disorder, overactive bladder, panic disorder, pelvic and perineal pain, personal history of malignant neoplasm of cervix, weakness, and need for assistance with personal care.</p> <p>R4's MDS (Minimum Data Set) dated 06/18/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 06 which indicates R4 has severely impaired cognition. Section GG documents toileting. Functional abilities dependent with sit to stand, chair to bed transfers, lying to sitting.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R4's Care Plan documents a focus area of Alteration in bed mobility with a revision date of 09/03/24 interventions include in part, Keep frequently used items in reach while in bed. Position at side of bed for optimal reach. Keep Call Light in reach and answer promptly.</p> <p>On 08/28/25 at 10:00AM, R4 who was alert and oriented at the time stated that she has a problem with staff taking away her call light all the time. R4 stated that they will put the call light on top of her bed light so she can't reach it. R4 stated that staff has told her that she uses the light too much and that she really doesn't need anything all the time, so they take away the call light and put it on top of the bed light or out of reach of her.</p> <p>On 08/28/25 at 10:03AM, observed R4's who was laying in bed in her room with her call light wrapped around R4's bed light and out of reach of R4.</p> <p>On 09/04/25 at 1:40PM observed R4 sitting in the dining room in her reclining chair no other resident observed in dining room wet floor signs up on dining room entrance along with plastic chains. R4 yelling out that she wants to go to her room and lay down. Observed staff sitting up at the nurse's station not acknowledging R4.</p> <p>On 09/04/25 at 1:50PM observed R4 still in the dining room yelling out she wanted to lay down.</p> <p>On 09/04/25 at 1:52PM observed staff coming to get R4 to take to her room.</p> <p>On 09/09/25 at 2:25PM, observed R4 who was sitting in her reclining wheelchair next to her bed with her call light sitting on the floor out of the reach of R4 who was in her room at the time. Observed R4 holding up her cup yelling out saying that she doesn't want to drop her cup asking for help.</p> <p>On 09/08/25 at 2:24 PM observed R4 who was in bed and R4's call light was on her bedside table approximately four feet from her, not where she could reach the light.</p> <p>On 09/09/25 at 2:30PM, V26 (Family Member) stated when she comes in to visit R4 that her call light is on the floor often out of reach of R4.</p> <p>On 09/09/25 at 1:12 PM, R29 who is alert and oriented, stated, she used to be R4's roommate and she used to turn her call light on for R4 when R4's light was not in reach for R4.</p> <p>On 09/03/25 at 4:41 PM, V27 (Licensed Practical Nurse) stated, she specifically remembers R4 did not have her call light in reach every time she entered her room and she would keep putting it back in place for R4. V27 stated, she remembers this because she heard R4 yelling out once and she went into her room to see why she was yelling and R4 stated, because she did not have her call light, so she yelled for help. V27 stated one time she went into R4's room and she saw her call light and it was not in reach again. V27 stated, she even asked the CNAs who put her to bed because her call light was not in R4's reach again. V27 stated, there were other times the CNA's would say, R4 couldn't get up this time.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/03/25 at 11:06AM, R20 stated that she has heard residents complain about not having their call lights in reach. R20 said that call lights are left on the floor often. R20 said that she will have to make sure she has her own call light and sometimes other residents as well. R20 said that residents will tell her that staff don't care if their call lights are in reach or on the floor. R20's MDS dated [DATE] documents in Section C a BIMS score of 14 which indicates R20 is cognitively intact.</p> <p>On 09/03/25 at 3:19PM, V18 (Certified Nurse Assistant/CNA) stated that it was a common thing for staff to take away some of the resident call lights. V18 stated they would take away R4, and R7's call lights often they wouldn't really hide them they would just make it to where the resident couldn't reach them.</p> <p>On 09/04/25 at 9:54AM, V5 (CNA) stated that they do have a resident who says that her call light is out of reach often it is R4. V5 said that she doesn't know how, but it is at the end of the bed or on the floor sometimes. V5 said that when she works, she tries to connect it to the bed rail or to the resident bed with the clip. V5 said she knows there are a couple of other residents who complain that their call light is not in reach as well, but she couldn't remember who all it was.</p> <p>The Facility policy titled "Call Light" with a revision date of 02/02/2018 which documents the purpose as: to respond to resident' request and needs in a timely and courteous manner. 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside to other reasonable accessible location. Note: In the event the bed is positioned in a manner that is not within the resident' reach notify maintenance for a call light cord extension.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure privacy was maintained for residents. This deficient practice has the potential to affect all 52 resident that reside in the facility. The findings include: 1. On 08/28/25 at 1:30 PM, R13 stated he has heard staff talking about other residents' health issues and conditions where other residents could overhear. R13's Minimum data set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 15, indicating R13 is cognitively intact.</p> <p>2. On 09/08/25 at 2:55 PM, R33 stated he has heard staff talk about other residents and their health issues and backgrounds. R33's Minimum data set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 10, indicating moderately cognitively impaired.</p> <p>3. On 08/28/25 at 11:35AM, R3 who was alert and orientated stated that a lot of the staff talk about other resident's care and stuff in the dining room and in common areas in front of families and other residents that the care isn't about. R3 said that they talk about all kinds of things about other resident and staff will even make fun of some of the residents. R3 could not give names of any specific residents.</p> <p>4. On 08/28/25 at 1:37PM, R12 who was alert and orientated stated that he has overheard staff talking about resident care in common areas, in the dining room and in his room. R12 could not remember the residents' names that staff were talking about.</p> <p>5. On 08/28/25 at 1:40PM, R27 who was alert and orientated stated that she has heard staff talking about other residents' care in common areas and outside when they are smoking. R27 could not remember who all staff has talked about in those areas.</p> <p>6. On 08/28/25 at 1:43PM, R28 who was alert and orientated stated that she has heard staff talking about other residents' care in common she couldn't remember who all the staff talked about.</p> <p>7. On 09/03/25 9:42AM, R23 who was alert and orientated stated that she has heard V5 (Certified Nurse Assistant/CNA) sit outside when they are smoking and talk about other resident's care and how some of the other residents at the facility are nuts or crazy. R23 doesn't remember who all V5 talked about when she was outside talking about resident care and saying the resident was nuts.</p> <p>8. On 09/02/25 at 11:06AM, R20 who was alert and oriented stated that she has heard staff talk about residents and their care in the dining room, in front of another resident. R20 stated that staff talks about other residents all the time all over the building in front of other residents. R20 said that staff will even make fun of the residents they are talking about. R20 did not give the names of the staff that was talking about resident care, and she did not give the names of the resident that staff was talking about.</p> <p>On 09/03/25 at 11:43AM, V9 (Certified Nurse Assistant/CNA) stated that she has heard staff talk about resident care in common areas such as the dining room, but most of the time when they talk about resident care it's in the break room.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 09/03/25 at 3:19PM, V18 (CNA) stated that she no longer works at the facility, but that she would hear staff talking about other resident's care in the dining room and in common areas where families and other resident were. V18 stated that some of the staff would also make fun of some of the residents. V18 said that some staff didn't care where they were, they would talk about the residents and say their names when they were talking about the resident care.</p> <p>On 09/09/25 at 2:50PM, V29 (Activities Director) stated that she has heard staff talking about resident care in common areas such as in the dining room where families and other resident could hear and say names.</p> <p>The Facility room roster undated presented on 08/28/25 documents the facility total census is 52.</p> <p>The facility document titled "Confidentiality Agreement" undated documents in part Under HIPPA policies, employees are prohibited from directly or indirectly divulging, using or permitting the use of any patient confidential information, including medical information, records and invoices, except as required in the course of employment with the facility. Employees work closely with residents, their doctors, and other staff all information concerning residents, their medical conditions or treatment, their finances, and their families or friends, is to be kept strictly confidential. This confidential information should not be given to other residents, persons outside of this facility, or even other employees unless 1.) withholding the information would hinder the resident's care, health, or safety. 2.) your supervisor or Department Director, or the Administrator, request the information, or 3.) disclosure properly is sought by an investigator/inspector from a government agency. Any employee violation this policy is subject to discharge.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on interview and record review the facility failed to provide a smoke/vape free building for 5 of 5 residents (R2, R5, R6, R18, R23) reviewed for environment in a sample of 48. Findings Include: On 08/28/25 at 10:06AM, R2 who was alert and orientated stated that she has observed a staff member who was vaping in the hallway of the building. R2 stated that she doesn't know the staff name, but she is the one who looks like a boy.</p> <p>On 08/28/25 at 10:08AM, R6 who was alert and orientated stated that he has witnessed staff vaping in the hallway. R6 said that they vape in the hallway on day and evening shift. R6 said that it has been several staff and didn't want to name any names.</p> <p>On 08/28/25 at 11:23AM, R5 who was alert and orientated stated that she has witnessed staff vaping in the hallways and in some resident rooms. R5 said that they pull out their vapes often.</p> <p>On 09/03/25 9:38AM, R18 who was alert and orientated stated that she has witnessed staff in the building vaping in the hallway.</p> <p>On 09/03/25 at 9:42AM, R23 who was alert and orientated stated that she has witnessed staff vaping in the building. R23 said that she has witnessed V5 (Certified Nurse Assistant/CNA) take a hit off her vape in the hallways as she is pushing a resident down the hall in a wheelchair.</p> <p>On 09/03/25 at 12:54PM, V13 (CNA) stated that she has observed several staff vaping in the break room on several occasions on 2-10 shift. V13 stated that they were in-service a while back about vaping in the building when she first started.</p> <p>On 09/03/25 at 3:19 PM, V18 (CNA) stated that she has seen staff vaping in the building around the break room.</p> <p>On 09/09/25 at 2:50PM, V29 (Activities Director) stated that she has witnessed staff vaping in the building. V29 said that she has witnessed V24 (CNA) do it often. V29 stated that V24 doesn't work at the facility now she quit to go back to Florida.</p> <p>On 09/03/25 at 4:41 PM, V27 (Agency Licensed Practical Nurse) stated, the couple days she worked at the facility, there were CNA's (Certified Nurse Aides) that were vaping in the facility.</p> <p>The facility document titled, Inservice Form dated 04/15/25 documents: in service title- vaping, with the summary of the in service listed as there is to be no vaping within the building.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of West Frankfort		STREET ADDRESS, CITY, STATE, ZIP CODE 601 North Columbia West Frankfort, IL 62896	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility Employee Standards of Conduct documents &ldquo;(The Facility) expects that each employee's conduct and performance will conform with the highest standards of professionalism with respect to treatment of all residents, visitors and their families and our ethical practices; the requirement of their job; published and common-sense health and safety rules; and applicable federal, state, and local laws, rules and regulations. While it is impossible to provide an exhaustive list of conduct that is not appropriate in the work setting, the following list provides some examples of conduct that is not permitted. This list is not intended to, nor does it alter the &ldquo;at-will&rdquo; nature of your employment, which means that you or &ldquo;The Facility&rdquo; may end the employment relationship at any time, for any reason that is not legally protected, with or without advance notice. Violation of &ldquo;The Facility&rdquo; standards of conduct may lead to corrective action, up to and including immediate termination. Violations of conduct standards that constitute ground for immediate dismissal include in part Violating &ldquo;The facility&rdquo; drug/alcohol-free workplace policy and violating &ldquo;The Facility&rdquo; non-smoking policy.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to address a concern area discussed and documented in resident council. This failure has the potential to affect all 52 residents residing at the facility. Findings include: Resident council minutes dated 08/07/25 documents under the section titled, Nursing: some CNAs have hateful attitudes.</p> <p>On 09/05/25 at 3:10 PM (during resident council) R27, stated, the previous concern of CNAs having hateful attitudes has not been resolved. Resident council stated, they have not been given any resolution for that concern. The CNAs act like they do not want to come help you. The staff are always on their phones and some staff still have hateful attitudes.</p> <p>On 09/03/25 at 11:10 AM, V3 (Assistant Director of Nursing) stated the concern of CNAs having hateful attitudes should have been brought up at the morning meeting but she does not remember discussing it. V3 stated, there probably should have been a concern or grievance form documenting a resolution. V3 stated, there is no in-service addressing that concern.</p> <p>On 09/03/25 at 4:14 PM, V29 (Activities Director) stated there is no concern form for the concern of CNAs with hateful attitudes from the resident council meeting on 08/07/25. V29 is not aware of any in-service or any other method of addressing that concern.</p> <p>On 09/09/25 at 11:55AM, V25 (Social Service Director/SSD) stated that usually she is the one to fill out a grievance or concern form when the residents have them. V25 stated that she did not know that residents had a concern in resident council about staff being rude to them. V25 stated she doesn't know if V29 might have filled one out since she did resident council.</p> <p>On 09/04/25 at 10:50AM, R1 stated that she used to have a problem with a bigger girl who worked at the facility. R1 said that she would be so rude to her when caring for her. R1 stated that she doesn't see the girl at the facility much anymore. R1 was alert to person and place.</p> <p>On 09/04/25 at 11:04AM, R2 stated that she has had a problem with staff being rude with her. R2 stated they talked about staff being rude in resident council. R2's MDS (Minimum Data Set) dated 08/13/25 documents in Section C a BIMS score of 15 indicating R2 is cognitively intact.</p> <p>On 08/28/25 at 11:16AM, R7 stated that staff is just downright rude at times when they talk to you or answer you. R7's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R7 is cognitively intact.</p> <p>On 09/09/25 at 11:30AM, R27 stated that staff are just rude to them at times. R27 said she will ask the staff for help with something and they will say with an attitude, "We are busy what do you want" or they will just say, "We are Busy" with a slight aggressive tone. R27 said that she couldn't provide us with the staff names, because none of them ever wear a name tag. R27's MDS dated [DATE] documents in Section C a BIMS score of 13 which indicates R27 is cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 09/03/25 at 12:54PM, V13 (Certified Nurse Assistant/CNA) stated that they did have staff that were rude to the residents and it was V18 (CNA) and V24 (CNA). V13 stated that neither of them work at the facility anymore.</p> <p>On 09/03/25 at 3:19PM, V18 (CNA) stated that she has observed V32 (CNA) be rude to several residents. V18 said V32 would say terrible things to residents. V18 could not remember what all V32 said or to whom she said it just that she would always have an attitude.</p> <p>On 09/09/25 at 2:50PM, V29 (Activity Director) stated that she has heard staff be rude to residents. V29 said that V35 (CNA) she has heard be rude with resident when talking to them. V29 said when she had resident council that some of the residents were complaining about staff being rude. V29 stated that she is sure she wrote up a grievance/concern form about it. V29 stated that she does not know what happened to the grievance/concern form about staff being rude.</p> <p>On 09/09/25 at 3:51PM, V1 (Administrator) stated that she was not aware of any complaints about staff being rude to residents.</p> <p>On 09/10/25 at 11:02AM, V2 (Director of Nursing) stated that she was not aware of residents complaining in resident council about staff being rude. V2 stated she was not aware of any staff being rude to any residents at all.</p> <p>The undated room roster presented on 08/28/25 documents 52 residents residing at the facility.</p> <p>The facility policy dated 09/25/17 titled, Grievances documents: All alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, will be immediately reported to the administrator and as required by State law. All written grievances shall include: the date the grievance was received, a summary statement of the grievance, department assigned to investigate, steps taken to investigate the grievance, summary of the pertinent findings or conclusions regarding the concern(s) 2 statement as to whether the grievance was confirmed or not confirmed, corrective action taken or to be taken by the facility as a result of the grievance, including measures taken to prevent further potential violations of any resident right while the alleged violation is being investigated, the date the written decision was issued to the resident or the complainant. Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days (excludes weekends and holidays). Under certain circumstances, additional time may be needed to complete an investigation and implement measures to resolve the grievance. In such cases, the resident or complainant should be notified of the extension.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure residents were free from mental abuse for 1 of 15 residents (R34) reviewed for abuse in a sample of 48. Findings include:R34's admission record documents an admission date of 08/27/25 with diagnoses including: chronic obstructive pulmonary disease with acute exacerbation, acute embolism and thrombosis of femoral vein, enlarged lymph nodes, diverticulitis, nicotine dependence, erythema intertrigo, depression, and anxiety disorder. R34's care plan documents a focus area of: I am at risk for abuse/neglect. Date initiated 8/27/25. Goal, I will be cared for in a safe manner and verbalize to staff any incidences of abuse. Date initiated 9/2/25. Interventions include, Assess resident for risk of abuse, educate resident to speak to staff if feeling uncomfortable with a situation, ensure safety if feeling unsafe, observe resident in care situations, observe resident in company of peers, report any verbalization of abuse or neglect to administrator immediately. All initiated 8/27/25. A report sent to IDPH regarding an incident involving R34 dated 09/05/25 documents: Description of Occurrence: Alleged report of staff to resident verbal abuse. This alleged incident occurred on August 30, 2025 but was reported to the Administrator this morning, September 2, 2025 at approximately 9:00 am after a full investigation, it was determined that a staff member (V30, Certified Nursing Assistant/CNA) was showing other staff members a picture of a character from a TV show. This image was meant to make fun of the resident for his appearance and intelligence. The resident observed this staff member showing the image and pointing then laughing at him. The resident did not know what the image was but felt that the staff member was making fun of him and this humiliated him. Follow up/Report Summary: Investigation included interviews with the staff members that this staff member showed the image to on her cell phone. It was determined that no other residents were aware of this incident as it occurred. When interviewing the staff member, she acknowledged the incident but claimed she was not making fun of the resident. It was then determined that this was an incident of mental abuse and the staff member was terminated from her employment. In-services were conducted with all staff of residents' rights and dignity. On 09/08/25 at 1:48 PM, V43 (Family) stated that R34 was currently in the hospital. V43 stated that R34 told her the staff at the facility were making fun of him. V43 stated R34 was upset that he was being mocked. V43 stated, one of the workers also got onto him for sitting next to the dining room. V43 stated, R34 was mortified when they were making fun of him and he does not want to return to the facility.On 09/09/25 at 1:11 PM, V42 (Dietary) stated, V30 did show a picture on her phone in the dining room of the character named Bubbles from the show Trailer Park Boys stating the new guy R34 looked like Bubbles from the show. V30 did show the picture to several people. V42 admitted some would not take it as a compliment to be compared to Bubbles from that show. On 09/09/25 at 3:10 PM, V29 (Activities Director) stated she was in the dining room when V30 was showing the picture of Bubbles on her phone to others stating she thought R34 looked like the character. V29 stated, Bubbles is a character from the show Trailer Park Boys. V29 stated, she could see where some would not take that as a compliment to be compared to Bubbles from that show. V1's written statement dated 09/02/25 documents: Resident (R34) stated the female caregiver was showing other staff members her phone and pointed at him, then she laughed Resident (R34) stated he did not know what was on the phone but he felt humiliated. V45's (CNA) written statement dated 09/03/25 documents: (V30) walked up to me in the hallway to show me a picture of Bubbles from Trailer Park Boys and said, Doesn't he look like Bubbles talking about (R34).V30's written statement dated 09/02/25 documents: On Saturday (08/30/25) we were in dining serving breakfast and (R34) said something and I said it reminded me of Bubbles off of a TV show. (V36) asked who that was so I pulled up a picture. I was not making fun of him. Simply said it was funny and reminded me of that person on that show.The facility policy dated 12/17/21 titled, Abuse Prevention and Reporting - Illinois 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. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to report and allegation of staff to resident abuse to the state agency (Illinois Department of Public Health) and failed to report an allegation of staff to resident abuse to the Administrator for 1 of 15 residents (R4) reviewed for abuse and neglect in the sample of 48. The Findings include: 1. R4's admission record dated 09/12/25 documents an admission date of 12/07/22 with diagnoses in part of major depressive disorder, overactive bladder, panic disorder, pelvic and perineal pain, personal history of malignant neoplasm of cervix, weakness, and need for assistance with personal care. R4's MDS (Minimum Data Set) dated 06/18/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 06 which indicates R4 has severely impaired cognition. Section GG documents toileting as dependent. R4's Care Plan a focus area with a date initiated of 03/06/25 of Behavior Management with an intervention in part of toilet resident routinely and upon request. If resident requests are continuous remind her of the last time she was toileted. Another focus area with a date initiated of 04/04/24 document, at risk for Abuse with intervention in part of investigate statements/allegations per facility protocol. Check resident for any physical marks, injury, interview personal assigned to provide care and notify abuse care coordinator of any abuse allegation immediately. R4's progress notes dated 07/22/25 at 8:20AM completed by V3 (Assistance Director of Nursing) documents, This nurse was alerted by V29 (Activity Director) that resident was accusing V34 (transportation) during breakfast of stating, I will take you to your bedroom and beat your ass. The resident then told other staff members that the person that made the statement was V33 (Certified Nurse Assistant/CNA). This nurse notified V1 (Administrator) and V2 (Director of Nursing) of accusation. This nurse spoke with V33 (CNA), V34 (Transportation), V35 (CNA), and V37 (CNA), and V36 (CNA). These staff members stated that the statements were never said, and they were simply trying to explain to the resident that they were in the middle of breakfast and would take her back to her bedroom after breakfast. The nurse gave V1 all the statements. On 09/04/25 at 11:02AM, R4 stated that she knows someone was mean to her in the dining room and that they told her that she couldn't go to the bathroom. R4 stated that she doesn't remember who it was that told her that or when it was. On 09/03/25 at 4:05 PM, V38 (Vice President of Operations) stated, (after reading the behavior note for R4 dated 07/22/25 at 8:20 AM) yes that incident should have been reported and investigated. On 09/04/25 at 9:27AM, V1 (Administrator) stated that she did not send in an investigation into IDPH regarding the allegations made by R4. V1 stated that she did not get any statement from resident on 07/22/25. 2. On 09/03/25 at 4:03 PM, R4 stated she did have a problem with a staff member who put shampoo on her head and then let the shampoo run into her eyes. R4 stated, at first, she thought it was a man, but it was a female staff member. R4 said she did not know the staff member's name. R4 said the female staff member let the shampoo run into her eyes and it was burning, and she wouldn't wash it out. R4 stated that she felt like the staff member did this on purpose, because she wouldn't wash the shampoo out of her eyes, she just left it there. R4 said she did tell one of the staff about it, but she couldn't remember who it was she told it to. R4 said that it upset her a lot and she said that this took place several weeks ago. On 09/09/25 at 1:05 PM, V18 (Certified Nurse Assistant/CNA) stated on 07/19/25 she heard R4 yelling out from the shower room. V18 stated, V32 was giving R4 a shower and she could hear R4 yelling from the break room. V18 stated, she walked into the shower room and could see V6 (CNA) standing in the corner while V32 (CNA) was giving R4 a shower. V18 stated, R4 had soap all over her face and she was yelling that her eyes were burning and V32 kept telling R4 that she was fine. V18 stated, V32 never offered to rinse the soap out of R4's eyes or give R4 a towel. V18 stated, V32 just kept telling R4 she was fine and to get over it. V18 said R4 just kept saying it burns and yelling out. V18 said she looked over at V6 who was just standing there rolling her eyes. V18 stated, she reported this to V27 (Agency Licensed Practical Nurse). V18 stated, R4 also told V27 what happened. On 09/03/25 at 4:41 PM, V27 (Agency Licensed Practical Nurse) stated, the first night she worked, R4 was screaming during the shower she was given, R4 was screaming to the point she walked down to check on them. The CNA's (V9 and V32) giving R4 the shower stated, oh, her (R4) screaming is just her behavior and waved her off. V27 stated, she did not report this to V1 because she did not know the resident's behaviors and the other nurse working V16 (LPN) knew about the situation. V27 stated, she did not hear R4 yelling at any other time unless she needed something and her call light was not in reach. On 09/09/25 at 3:51PM, V1 (Administrator) stated no one ever told her about the incident with V32 and R4 in the shower until it was reported to her by IDPH. V1 stated that V18, V27, nor V16 (Licensed Practical Nurse) ever said anything about this incident, and they all have her</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to thoroughly and timely investigate an allegation of staff to resident abuse for 1 of 15 residents (R4) reviewed for abuse in a sample of 32 Findings include:1. R4's admission record dated 09/12/25 documents an admission date of 12/07/22 with diagnoses in part of major depressive disorder, overactive bladder, panic disorder, pelvic and perineal pain, personal history of malignant neoplasm of cervix, weakness, and need for assistance with personal care. R4's MDS (Minimum Data Set) dated 06/18/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 06 which indicates severely impaired cognition. Section GG documents toileting as dependent. R4's Care Plan a focus area with a date initiated of 03/06/25 of Behavior Management with an intervention in part of toilet resident routinely and upon request. If resident requests are continuous remind her of the last time she was toileted. Another focus area with a date initiated of 04/04/24 document, at risk for Abuse with intervention in part of investigate statements/allegations per facility protocol. Check resident for any physical marks, injury, interview personal assigned to provide care and notify abuse care coordinator of any abuse allegation immediately. R4's progress notes dated 07/22/25 at 8:20AM completed by V3 (Assistance Director of Nursing) documents, This nurse was alerted by V29 (Activity Director) that resident was accusing V34 (transportation) during breakfast of stating, I will take you to your bedroom and beat your ass. The resident then told other staff members that the person that made the statement was V33 (Certified Nurse Assistant/CNA). This nurse notified V1 (Administrator) and V2 (Director of Nursing) of accusation. This nurse spoke with V33 (CNA), V34 (Transportation), V35 (CNA), and V37 (CNA), and V36 (CNA). These staff members stated that the statements were never said, and they were simply trying to explain to the resident that they were in the middle of breakfast and would take her back to her bedroom after breakfast. The nurse gave V1 all the statements. On 09/04/25 at 11:02AM, R4 stated that she knows someone was mean to her in the dining room and that they told her that she couldn't go to the bathroom. R4 stated that she doesn't remember who it was that told her that or when it was. On 09/03/25 at 4:05 PM, V38 (Vice President of Operations) stated, (after reading the behavior note for R4 dated 07/22/25 at 8:20 AM) yes that incident should have been reported and investigated. On 09/04/25 at 9:27AM, V1 (Administrator) stated that she did not send in an investigation into IDPH. V1 stated that she did not get any statement from resident on 07/22/25. V1 said that R4 has behaviors of yelling out often. V1 said that they did talk to a couple of the staff working that day and take statements from the them asking them if V34 told R4 that she was going to beat her ass. V1 said that V34 (Transportation) was just telling R4 that she was already in the bathroom before she went to the dining room for breakfast, because R4 was yelling out in the dining room that she had to go to the bathroom. V1 said that R4 has a behavior of saying she has to go to the bathroom and doesn't go. V1 said the facility has taken R4 to several doctor's appointments regarding her asking to go to the bathroom all the time. V1 stated that V33 (CNA) had taken R4 to the bathroom, before she came into the dining room. V1 stated that R4 did go to the bathroom with V33 (CNA). V1 stated on the witness statement it does say that V33 (CNA) stated don't argue with her she is always right meaning R4 and directed to R4. V1 said V33 (CNA) should not have said that to R4. V1 said that was V33's way of dealing with the situation. V1 stated that V33 (CNA) should have taken R4 to the bathroom again instead of telling her she already went even though it is a behavior. V1 said that yes it does say in the care plan when the resident request to go to the bathroom they should take her. V1 stated that R4 is not on a scheduled toileting program. On 09/09/25 at 3:51PM, V29 (Activity Director) she did report to the nurse on 07/22/25 that R4 was making allegations regarding V33 (CNA) and V34 (Transportation) saying that they were going to beat her ass. V29 stated that she did not hear V33 (CNA) or V34 (Transportation) make any statement about beating R4's ass. On 09/10/25 at 11:02AM, V2 (Director of Nursing/DON) stated that she wasn't working on 07/22/25 when the allegation was made regarding V33 (CNA) and V34 (Transportation) regarding making negative comments. V2 stated that she was not aware of the allegation until recently. V2 stated that V33 (CNA) should have taken R4 to the restroom when she requested. On 09/12/25 at 8:10AM, V34 (Transportation) stated that she worked on 07/22/25 and that she was passing trays in the dining room when R4 started yelling out that she had to piss. V34 said that R4 was getting really loud and disrupting the dining room. V34 stated that she told R4 that she had just got up and went to the bathroom. V34 stated she was trying to talk to R4, but she just kept yelling out that she had to piss and started to cuss at all the staff. V34 said she thought that R4 was on a toilet every two hours toileting schedule. V34 told R4 that she was on a every two-hour toileting schedule.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review the facility failed to provide supervision during smoking to prevent an accident and failed to provide an appropriate intervention to prevent future falls for 1 of 15 residents (R27) reviewed for accidents in a sample of 48. This failure resulted in R27 falling outside in the designated smoking area and then having to be sent out to the emergency room for laceration on her left and right arm and having to be seen by a wound care specialist. Findings include:</p> <p>R27's admission Record dated 09/10/25 documents an admission date of 06/06/25 with diagnoses of history of falling, tobacco use, type 2 diabetes mellitus with diabetic neuropathy, unspecified sequelae of nontraumatic intracerebral hemorrhage.</p> <p>R27's MDS (Minimum Data Set) dated 08/18/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 13 which indicates R27 is cognitively intact. Section GG documents walk 10 feet as supervision and touching assistance, walk 50 feet with two turns as supervision and touching assistance, and walk 150 feet as supervision and touching assistance.</p> <p>R27's Care Plan with a revision date of 06/10/25 with a focus area of Risk for falls which has a goal of resident will be free of falls. Interventions for this focus include 08/04/25 Fall intervention updated to include maintenance supervisor to fix concrete in courtyard, 06/06/25 determine residents' ability to transfer, 06/06/25 ensure call light is available to resident, 06/06/25 evaluate fall risk on admission and PRN (as needed), 06/06/25 if fall occurs, alert provider, and 06/06/25 if fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol.</p> <p>R27's witnessed fall report dated 08/03/25 document's incident location: Outside, Nursing Description: Nurse visualized pt (Patient) laying on back outside on floor, skin tear to the left wrist, left forearm, right forearm with blood present applied pressure to the skin tear to stop bleeding. Pt voiced no pain in lower extremities, no inverting turn to feet. VS (Vital Signs) obtained other nurse called appropriate persons. Pt sent to (Local Hospital) with bed hold policy. Resident Description: Patient stated she was trying to get out of the way of another pt when she tripped and lost her balance. Pt stated she did not have pain in lower extremities, but her arms were a 10/10. Injuries observed at time of incident: laceration left forearm, skin tear left wrist, and skin tear right forearm.</p> <p>A statement taken by V2 (Director of Nursing) from V24 (Certified Nurse Assistant/CNA) dated 08/03/25 documents under statement: "I was passing cigarettes to the residents and heard yelling. I saw (R27) on the concrete next to the railing holding her arm saying I was trying to get out of his way."</p> <p>R27's hospital discharge records from local hospital dated 08/03/25 documents her diagnosis as other skin changes- large skin tears bil (Bilateral) forearm left greater than right. Special notes document leaves covered, until you can get an appt (appointment) with pcp (Primary Care Physician) or wound care. R27's hospital records document that R27 was sent back to the facility with a prescription for Doxycycline Hyclate (antibiotic) every 12 hours and Hydrocodone-Acetaminophen (pain medication) every 6 hours for pain control.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R27's hospital records for a visit on 8/5/25 document, &ldquo;Pt (patient) states, &ldquo;I was trying to move away from somebody yesterday and I was kind of knocked over and I fell and I hit the concrete my body and scraped my arms real bad. They sent me to (Name of local ER). Today my arm just won't stop bleeding so they sent me back in.&rdquo; These records document Final diagnoses as skin tear of left upper extremity and hand swelling.</p> <p>R27's wound assessment and plan from the wound care doctor dated 08/05/25 documents right forearm wound measurement 4 cm (centimeter) length X 5 cm width X 0.1cm depth and left forearm wound measurement: 10 cm length X 6.5 cm width X 0.1cm depth.</p> <p>On 09/09/25 at 9:40AM, R27 stated on 08/03/25 that she was walking outside down the ramp to go smoke with all the smokers. R27 said she had her rolling walker and was holding on to the rail to go down the ramp. R27 stated she was trying to go down that ramp when she saw R10 who had already gone down the ramp and was coming back her way, R27 said she was trying to get out of his way because he doesn't pay attention, and he will run you down. R27 said that she was trying to get out of his way and tried to back up, but his walker bumped into her walker, and she went back and fell. R27 said that R10 didn't stop he just kind of bumped her as he went past, and she was on the ground bleeding. R27 said that she had large skin tears to both of her arms from the fall and that there was blood all over. R27 said that she was yelling out in pain. R27 said that the staff had her sit up on her wheeled walker and was trying to get the bleeding to stop. R27 stated that she did not trip or fall over any cracks or broken concrete. R27 stated she heard that R10 bumped into another resident the next day she didn't know who it was. R27 said that her wounds on her arms were so bad she had to have a wound doctor take care of them and they talked about a wound graft to the left arm, but they didn't have to do a graft. R27 said that the wounds to her arms are just now starting to heal. R27 stated that she doesn't feel safe around R10 when they go out to smoke.</p> <p>R10's admission Record dated 09/10/25, documents an admission date of 05/11/21 with diagnoses schizophrenia, need for assistance with personal care, anxiety, depression and nicotine dependence.</p> <p>R10's MDS dated [DATE] documents in Section C a BIMS score of 11 which indicates R10 has moderately impaired cognition. Section GG documents walk 10 feet as supervision or touching assistance, walk 50 feet as supervision and touching assistance, and walk 150 feet as supervision and touching assistance.</p> <p>R10's Care Plan has a focus area of Tobacco use with a revision date of 04/24/25 with an intervention in part of: The resident requires supervision while smoking with a date initiated of 05/10/25. Another focus is: The resident has a history of being impatient during smoke breaks when he is waiting in line to enter/exit building r/t (related to) poor impulse control with a revision date of 09/09/25 with interventions in part of: The resident's triggers for impatience are during smoke breaks when entering/exiting the building d/t (due to) becoming impatient with peers. Resident is educated on single file line with peers wanting to enter/exit also and that cutting in line is not allowed. Resident educated at each smoke break time to reduce aggression revision on 09/09/25, Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of resident posing danger to self and other with a date initiated of 08/20/24, 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 calmly away, and approach later revision on 09/09/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/09/25 at 10:58AM, R10 stated he has bumped into several residents before when going outside for his designated smoke break. R10 stated that it is his fault sometimes when he bumps into other residents and other times it is the other resident fault. R10 stated he remembers R27 falling outside on one of their designated smoke breaks. R10 said that the resident doesn't get out of his way. R10 said that when R27 fell she was yelling and bleeding all over. R10 said that he doesn't know who all he has bumped into at the facility. R10 said that when he goes out to smoke, they try to make him last in the line. R10 said that he doesn't know why he must be last that is just what they told him at the facility.</p> <p>On 09/09/25 at 11:30AM observed R27 right and left arm. R27 had an area to her left forearm which appeared to be approximately 10cm long and around 7 cm wide with some redness noted, along with areas that appeared to be scar tissue and raised. R27's right forearm arm had an area which appeared to be scar tissue no open area noted areas appears to be approximately around 5cm in length.</p> <p>On 09/08/25 at 3:00PM, R26 who was alert and oriented stated she is a smoker, and she was outside on the designated smoke break when R10 fell. R26 stated R10 was trying to hurry up and get his cigarette and R27 was coming down the ramp and that R27 was trying to get out of the way of R10 and R27 backed up and fell. R26 stated that R10 just went over and bumped R27 as she was laying on the ground. R26 stated that a nurse has her write a statement about what happened on 08/03/25 with R27's fall. R26 stated that R10 is always in a hurry and doesn't look where he is going and bumps into everyone. R26 said R10 has bumped into her before.</p> <p>On 09/09/25 at 10:38AM, R3 who was alert and oriented stated that she is a smoker and that she was outside on 08/03/25 when R27 fell. R3 stated that R27 was coming down the ramp to go outside to smoke and that R10 was going to run over R27 with his rolling walker so R27 was trying to get out of the way and fell. R3 said after R27 fell that R10 plowed right over her. R3 stated that R10 has bumped into her with his rolling walker and caused a skin tear to her leg. R3 said that R10 is always in a hurry to be the first out to smoke and he wants to get his cigarettes first. R3 said that she thought he has bumped into another resident legs and caused a skin tear.</p> <p>On 09/09/25 at 10:46AM, R28 who was alert and orientated stated that she is a smoker and goes out for the designated smoke breaks. R28 stated she remembers when R27 had her fall outside on 08/03/25. R28 stated R27 was trying to get out of the way of R10 so he didn't run her over. R28 stated she is not sure if R10 bumped her or pushed her causing the fall. R28 said R10 is always in a hurry to get outside to smoke and will pass all the residents up on the ramp and try to get outside first. R28 stated that she knows that R10 has bumped into a couple of residents while trying to get outside to smoke. R28 could not remember who all R10 has bumped into.</p> <p>On 09/09/25 at 2:25PM, R4 who was alert and oriented at that time stated that she does go outside to smoke. R4 stated that she thought a guy bumped into her when she was outside smoking but couldn't remember who it was. R4 stated that she didn't know if she got a skin tear or not from the guy bumping into her.</p> <p>On 09/08/25 at 3:00PM, V16 (Licensed Practical Nurse/LPN) stated that R27 fell on [DATE]. V16 said that she wasn't outside when R27 fell but that she heard that R27 was trying to get out of the way of R10 and that R27 fell and received skin tears to both arms. V16 said that she was taking witness statements to help the agency nurse out because residents were saying R10 bumped into R27.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/08/25 at 3:13PM, V1 (Administrator) stated that R27's accident on 08/03/25 when R27 fell outside on the designated smoking break was because R27 was trying to back up out of R10's way and then she fell.</p> <p>On 09/08/25 at 3:31PM, V22 (Agency LPN) stated that R27 fell outside on her designated smoke break on 8/3/25. V22 stated that when R27 fell outside she caused skin tears to both arms that were bleeding bad and that she had to send R27 out to the local hospital.</p> <p>On 09/09/25 at 11:55AM, V25 (Social Service Director) stated that she has only worked at the facility for around month. V25 said that R10 must go last in the line when they are going out on the designated smoke breaks. V25 stated that when she started working at the facility that is what they told her, she didn't remember who told her. V25 said she doesn't know why they didn't make him the first person to go out because he is always in a hurry to get outside and smoke. V25 said that R10 gets in hurry and tries to get down the ramp as fast as he can. V25 stated that when she takes the residents outside for their designated smoke breaks, she has heard several residents talking about how R10 has bumped into them, but she has never had any of those residents come to her complaining about it. V25 said she tries to wait to pass out the cigarettes to the residents until all the residents are outside so she can make sure all the residents get outside first safely.</p> <p>On 09/09/25 at 2:33PM, V28 (MDS/Care Plan Nurse) stated that R10 use to have a focus area on the Care Plan about his impulse control of getting in a hurry to go outside and smoke. V28 stated that she resolved that focus area on the care plan because she went back and looked at the social service notes and nurses' notes and did not see any more concerns with R10 rushing to get outside to smoke. V28 stated the last incident that R10 had with getting into a hurry was back on 03/11/25 when R10 was in a hurry to get out and bumped someone with his rolling walker. V28 said that she was putting the focus area back on R10's care plan today about him having impulse control and getting in a hurry to smoke. V28 said that the reason she was putting the focus area back on his care plan is because she was told today that R10 was rushing and getting in front of people to get outside.</p> <p>On 09/09/25 at 3:46PM, V21 (Maintenance Director) stated that he did repair some concrete out in the designated smoking area. V21 stated that he didn't know why he must repair the area. V21 said that the concrete around the smoking area did have a few cracks, and it had a dip in one of the areas and he filled it the best he could. V21 said that he didn't know if some of the wheels on the wheelchairs were getting stuck on the cracks or what. V21 said that the cracks and the dip are on the patio part not by the handrail. V21 said that he doesn't remember if he got a work order about it or if he was just told about the cracks.</p> <p>On 09/09/25 at 3:51PM, V1 stated that when R27 fell outside in the designated smoking area they talked about her fall in their daily meeting. V1 said they were trying to figure out how R27 fell so they went outside to the designated smoking area and found some cracks in the concrete, and they thought those could be a fall hazard, so they had V21 repair the cracks. V1 said that she doesn't know why R10 is last coming when they take the residents out on their designated smoke breaks, but she is currently doing an in-service with staff about taking residents out to smoke and monitoring for behaviors when they are outside smoking along with being mindful about what is going on outside when the residents are smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/10/25 at 11:02AM, V2 (Director of Nursing) stated on 08/03/25 R27 was trying to get out of the way of R10 when she fell. V2 stated that the staff member who was outside supervising when R27 was R24. V2 said that R24 said in her statement that she was passing out cigarettes when R27 fell, and she heard her yelling. V2 said that R24 should not have passed out any cigarettes until she had made sure that all the residents made it out to the smoking area and was able to observe all resident when they smoked. V2 said that she thought fixing the cracks in the concrete was an appropriate intervention for R27's fall, because she thought it said somewhere that R27 fell because of the cracks.</p> <p>On 09/09/25 at 3:45 PM there were six residents outside smoking with nine residents lined up making their way out the door to the smoking area. R10 was in line to go out to the smoking area. R10 would shuffle his feet pushing his walker forward coming within approximately an inch of hitting the resident in front of him and then would move backwards almost stepping into the resident behind him. This action continued until R10 was in the outside area.</p> <p>The facility policy titled "Fall Prevention Program" with a revision date of 11-21-17 documents the purpose as: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines include in part: Methods to identify risk factors.</p> <p>The facility policy titled "Safe Smoking and Vaping Policy/Procedure" with a last update date of 09/10/25 documents under policy: The facility works to provide appropriate care for residents, keeping safe and comfort in mind. Residents may have the desire to smoke/vape, and accommodations will be provided as the facility deems appropriate. The facility treats the use of vaping products the same as traditional smoking products. Procedure documents in part: 3. The rules are as followed # 3. Conduct while smoking must promote safety. #4. No negative behaviors related to smoking are permitted. B. The timeframes above are the only times smoking materials may be distributed. Continued disruption of resident care responsibilities over smoking break times constitutes a violation of the "No negative behaviors related to smoking are permitted."</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the menu provided to the facility and correct portion sizes directed by the menu for 7 (R2, R3, R6, R9, R11, R13 and R27) of 15 residents reviewed for following the menu in a sample of 48. Findings include:1. R2's admission record dated 09/10/25 documents an admission date of 09/01/20 with diagnoses in part of need for assistance with personal care and unspecified protein-calorie malnutrition.</p> <p>R2's MDS (Minimum Data Set) dated 08/13/25 documents in Section C a BIMS score of 15 indicating R2 is cognitively intact. Section GG eating as supervision or touching assistance.</p> <p>R2's Care Plan documents a focus area of Resident hoards food with a date initiated of 04/03/24. Another focus area of Risk for Malnutrition with a date initiated of 04/03/24 with an intervention in part of provide supervision during meals.</p> <p>On 08/28/25 at 10:06AM, R2 stated that the facility does run out of food often. R2 said they won't have enough food for everyone and then they give the residents smaller serving sizes. R2 said that recently they had a taco bake and that staff was eating it along with the residents and they ran out of the taco bake. R2 said that one of the nursing staff V11 (Licensed Practical Nurse/LPN) knew they kept running out of food and that she went to V1 (Administrator/ADM) about it. R2 said that they did go buy a big ham for the facility for the residents, but the kitchen staff left it out and it went bad. R2 said they also run out of supplies like, sugar, salt, and Catsup often.</p> <p>2. R3's Transfer/Discharge Report dated 08/28/25 documents an admission date of 06/12/24 with diagnoses in part of acquired absence of other specified part of digestive tract, gastro-esophageal reflux disease, need for assistance with personal care and other vitamin b12 deficiency anemias.</p> <p>R3's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R3 is cognitively intact. Section GG documents eating as independent.</p> <p>R3's Care Plan documents a focus area of at risk for impaired nutrition with a revision date of 06/13/24 with intervention in part of monitor eating environment.</p> <p>On 08/28/25 at 11:35AM, R3 stated the kitchen runs out of food all the time. R3 said the kitchen will give some of the staff food at times or sometimes the staff will just go in the kitchen and get some of the main meal. R3 said when that happens, they don't have enough food to be able to feed all the residents. R3 said if they are close to running out of the meal that they will cut the resident portions into smaller portions. R3 said that she doesn't think the kitchen has enough of the meal to be able to serve all the residents already and if the staff eats any of the food, then they don't have enough.</p> <p>3. R6's admission record dated 09/10/25 documents an admission date of 04/04/25 with diagnoses in part of gastro-esophageal reflux disease, muscle wasting and atrophy, and need for assistance with personal care.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R6 is cognitively intact. Section GG documents eating as supervision and touching assistance.</p> <p>R6's Care Plan documents a focus of, &ldquo;l have a potential nutritional problem&rdquo; with a revision date of 07/11/25 with interventions in part of provide, serve diet as ordered. Monitor intake and record every meal.</p> <p>On 08/28/25 at 10:08AM, R6 stated that the facility has ran out of food many of times. R6 said that last week they ran out of food, and they didn't have anything to give him except for 2 Jello cups.</p> <p>4. R9's Transfer/discharge Report dated 08/28/25 documents an admission date of 03/14/25 with diagnosis in part of Vitamin d deficiency and need for assistance with personal care.</p> <p>R9's MDS dated [DATE] documents in Section C a BIMS score of 07 which indicates severely impaired cognition. Section GG eating as supervision and touching assistance.</p> <p>R9's Care Plan documents a focus area, &ldquo;l have a potential nutritional problem&rdquo; with a revision date of 05/28/25 with interventions in part of provide, serve diet as ordered.</p> <p>On 08/28/25 at 11:15 AM, R9 who was alert and oriented stated that the facility has a big problem with running out of food consistently she said that they sometime let the staff eat as well and then they don't have enough food and other times they just run out of food. R9 said when they are close to running out of food they cut their portions into smaller sizes.</p> <p>5. R27's admission record dated 09/10/25 documents an admission date of 06/06/25 with diagnosis in part of unspecified protein-calorie malnutrition, type 2 diabetes mellitus, deficiency of other specified B group vitamins, and vitamin D deficiency.</p> <p>R27's MDS dated [DATE] documents in Section C a BIMS score of 13 which indicates R27 is cognitively intact. Section GG documents eating as set-up and supervision.</p> <p>R27's Care Plan a focus area of, &ldquo;l have Diabetes Mellitus&rdquo; with a date initiated of 06/23/25. Another focus area of, &ldquo;l have a potential nutritional problem&rdquo; with a revision date of 06/23/25 and an intervention in part of provide, serve diet as ordered. Monitor intake and record q (Every) meal.</p> <p>R27's Order Summary Report documents an order on 06/06/25 and no end date for CCD (Controlled Carb Diet) regular texture, regular/thin consistency.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of West Frankfort		STREET ADDRESS, CITY, STATE, ZIP CODE 601 North Columbia West Frankfort, IL 62896	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/09/25 at 11:30AM, R27 stated she is a diabetic and one morning recently they didn't have any breakfast meats and no eggs so for breakfast she got two cinnamon rolls and a bowl of cereal. R27 stated that she shouldn't get anything like that for breakfast with her being a diabetic. R27 said that staff told her that they didn't have anything else to give her. R27 said that she is glad her diabetes is under control well or it could have been bad with her eating that stuff. R27 said that she didn't have any choice, but to eat the cinnamon rolls and cereal or she wouldn't have gotten anything. R27 said that on the main meal if she wants seconds, she will ask that Certified Nurse Assistant, and they will ask the kitchen, and kitchen will tell staff they don't have anymore. R27 said that some residents might get seconds, but not all residents if they want it. R27 said that they won't even offer her anything else. R27 said other days she will notice her portion size or meat if much smaller than other residents.</p> <p>On 09/03/25 at 10:53AM, V6 (Certified Nurse Assistant/CNA) stated the facility does have enough food to serve all the residents, but sometimes they do not have enough food to give the residents seconds.</p> <p>On 09/03/25 at 11:41AM, V8 (CNA) stated that they do run out of food she said that usually they have enough to serve residents the main meal and then kitchen will get rid of the food that is left over and then residents will request some more food and they won't have any to give them, so they get nothing else.</p> <p>On 09/03/25 at 11:43AM, V9 (CNA) stated yes, the facility does run short on food, and they cut the portions down for the residents when they are getting low on food when serving.</p> <p>On 09/03/25 at 12:15PM, V10 (CNA) stated the kitchen was running short on food for the meals at times. V10 stated that they maybe have enough food to get all the residents the main meal. V10 said if a resident wants seconds, they don't usually have enough for that.</p> <p>On 09/03/25 at 12:23PM, V11 (Licensed Practical Nurse/LPN) stated that they have ran out of stuff in the kitchen like they ran out of breakfast meats to be able to serve the residents. V11 said that facility did not have any protein to be able to serve the residents at breakfast. V11 said that she had a resident who was a diabetic receive two cinnamon rolls and a bowl of fruit loops for breakfast. V11 said that she did ask the kitchen why a diabetic was getting two cinnamon rolls and a bowl of fruit loops, and they told her they didn't have no breakfast meats to be able to serve her.</p> <p>On 09/03/25 at 3:19PM, V18 (CNA) stated the kitchen would run out of food often in the evening and wouldn't have anything to replace it. V18 said that is they did have enough to be able to serve all the resident the main meal, the kitchen staff would throw the rest away and residents would ask for seconds, and they wouldn't have anything to be able to give the residents.</p> <p>On 09/04/25 at 2:11PM, V19 (CNA) stated that they usually have enough food to serve residents the main meal, but if a resident wants seconds, they usually don't have enough to be able to serve them seconds.</p> <p>On 09/04/25 at 2:32PM V20 (CNA) stated they don't have enough food for the residents he said that several of the residents will request seconds, and they don't have anything to give them or anything else.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/09/25 at 2:50PM, V29 (Activity Director) stated that yes some of the staff eat out of the kitchen after all the residents receive a meal if there is anything left over. V29 stated that the kitchen did have a problem with running out of food. V29 said that the spreadsheets didn't match the menu. V29 stated that she used to work in the kitchen. V29 said they use to run out of food for the residents because they didn't make enough. V29 said the facility did run out of breakfast meats and eggs one morning a couple of weeks ago. V29 said they did serve diabetics two cinnamon rolls and a bowl of cereal.</p> <p>On 09/09/25 at 3:51PM, V1 (Administrator) stated that the facility does have enough food for the residents. V1 said that she is having the kitchen work with their dietary service on making sure they follow the menus.</p> <p>On 09/08/25 at 10:44 AM, V40 (Agency LPN) stated the time he worked at the facility, they ran out of food for the residents.</p> <p>On 09/08/25 at 1:11 PM, V42 (Dietary) stated she has been serving dinner before and it will be getting close to the end so she will put a smaller portion of food on the plate to make sure she has enough food for all the residents, she will then try to go back and put some more food on the plates after she has put food on all the plates to make sure all the residents get food.</p> <p>On 09/10/25 at 11:02AM, V2 (Director of Nursing) stated that she was aware of residents complaining they weren't getting seconds, but not of them not getting any food.</p> <p>The Concern/Compliment Form dated 08/07/25 by R11 documents nature of concern/compliment: not enough snacks at night. Dinner meal time at 5 PM then breakfast at 7 AM is a long time without meals and snacks. Bigger portions would be nice.</p> <p>The Concern/Compliment Form dated 08/07/25 by R13 documents nature of concern/compliment: bigger portions of food.</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide beverages to residents. This failure has the potential to affect all 52 residents residing at the facility. Findings include: 1. R1's Transfer/Discharge report dated 08/28/25 documents in part an admission date of 04/12/23 with diagnoses in part of acute kidney failure, urinary tract infection and need for assistance with personal care.</p> <p>R1's MDS (Minimum Data Set) dated 06/30/25 documents a BIMS (Brief Interview for Mental Status) score of 03 which indicates severely impaired cognition.</p> <p>R1's Care Plan documents a focus of risk for dehydration with a date initiated of 04/08/24.</p> <p>On 08/28/25 at 12:47PM, V31 (Family Member) stated he must ask the facility to pass out water more often for R1, because they don't pass out ice and water all that often. V31 said that R1 had a history of urinary tract infections and when he visits R1 she doesn't have any water available in her room.</p> <p>2. R2's admission record dated 09/10/25 documents an admission date of 09/01/20 with diagnoses in part of atrial fibrillation and need for assistance with personal care.</p> <p>R2's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R2 is cognitively intact.</p> <p>R2's Care Plan documents a focus area of risk for dehydration with a date initiated of 04/03/24.</p> <p>On 09/03/25 at 1:45PM, R2 stated that over the weekend they did not get passed any water on day shift or evening shift. R2 said she was dying of thirst and had to ask the midnight staff to get her some water since they didn't get passed any water at all. R2 stated she has brought up in resident council about staff not passing ice and water out.</p> <p>3. R4's admission record dated 09/12/25 documents an admission date of 12/07/22 with diagnoses in part of epilepsy, need for assistance with personal care, and overactive bladder.</p> <p>R4's MDS dated [DATE] documents in Section C a BIMS score of 06 which indicates severely impaired cognition.</p> <p>R4's Care plan documents a focus area of Risk for dehydration with a date initiated of 04/04/24.</p> <p>On 08/28/25 at 10:00AM, R4 who was alert and oriented stated that she has a problem with them not giving her water often. R4 said that she will go all day and then maybe they will give her water in the evening.</p> <p>On 09/09/25 at 10:50AM, observed R4 in her room saying that she was thirsty. There was no water in her room or even a cup within reach of resident.</p> <p>(continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 09/09/25 at 2:30PM, V26 (Family Member) stated that when she comes to visit R4 that sometimes she will have water in her room other times she will have to go get R4 some water and ice.</p> <p>4. R7's admission record dated 09/13/25 documents an admission date of 06/25/25 with diagnoses in part of iron deficiency anemia, muscle weakness, and need for assistance with personal care.</p> <p>R7's MDS dated [DATE] document in Section C a BIMS score of 15 which indicates R7 is cognitively intact.</p> <p>R7's Care plan documents a focus of Risk for dehydration with a revision date on 09/09/25.</p> <p>On 08/28/25 at 11:16AM, R7 stated that staff doesn't bring her drinks often. R7 stated they will pass out water sometimes but not all the time.</p> <p>5. R20's Transfer/Discharge report dated documents an admission date of 05/28/25 with diagnoses in part of need for assistance with personal care, thrombocytosis, cirrhosis of liver, diarrhea, and polyneuropathy.</p> <p>R20's MDS dated [DATE] documents in Section C a BIMS score of 14 which indicates R20 is cognitively intact.</p> <p>R20's Care plan documents a focus area of Risk for Dehydration with a revision date of 05/03/24.</p> <p>On 09/03/25 at 11:06AM, R20 stated that they sometimes pass water and ice at the facility, but not all the time.</p> <p>On 09/03/25 at 12:15PM, V10 (Certified Nurse Assistant/CNA) stated that some of the residents complained that they don't get water and ice on day shift and that he tries to make sure to pass water and ice when he works.</p> <p>On 09/09/25 at 2:50PM, V29 (Activity Director) stated the facility does have a problem with not passing ice and water out to the residents.</p> <p>On 09/10/25 at 11:02AM, V2 (Director of Nursing) stated they did have a complaint in resident council about residents not getting water and ice. V2 said that she did do an in-service with staff about making she they passed ice and water. V2 stated that she has not done a follow up with the residents to see if staff passing ice and water had improved.</p> <p>On 09/08/25 at 10:44 AM, V40 (Agency LPN) stated residents did not get drinks passed to them. V40 stated, he felt they did not have enough staff.</p> <p>The concern/compliment form by R2 dated 08/30/25 documents the nature of concern/compliment as: ice water not being passed in the morning.</p> <p>The concern/compliment form by V31 (Family) concerning R1 dated 08/30/25 documents the nature of concern/compliment as: ice water being in her room and within reach.</p> <p>(continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The concern/compliment form by R11 dated 08/07/25 documents the nature of concern/compliment as: no drinks at night but water, CNA gets mad when asked for something different than water.</p> <p>The concern/compliment form by R13 dated 08/07/25 documents the nature of concern/compliment as: they do not leave anything to drink between meals.</p> <p>The facility document titled, Inservice Form dated 07/18/25 documents: in-service title snacks & water with the summary of the in-service stating: pass ice water and snacks (pureed or cooled snacks will be in the milk cooler).</p> <p>Resident council minutes dated 07/07/25 document under the section titled, Nursing ice water not being passed.</p> <p>The room roster provided 08/28/25 documents 52 residents residing at the facility.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide enough evening snacks so every resident may have a snack in the evening for 8 residents of 17 residents (R2, R3, R7, R11, R20, R27, R29, and R35) reviewed for evening snacks in a sample of 48. Findings include:R2's admission record dated 09/10/25 documents an admission date of 09/01/20 with diagnoses in part of need for assistance with personal care and unspecified protein-calorie malnutrition.</p> <p>R2's MDS (Minimum Data Set) dated 08/13/25 documents in Section C a BIMS score of 15 indicating R2 is cognitively intact. Section GG eating as supervision or touching assistance.</p> <p>R2's Care Plan documents a focus area of Resident hoards food with a date initiated of 04/03/24. Another focus area of Risk for Malnutrition with a date initiated of 04/03/24 with an intervention in part of provide supervision during meals.</p> <p>On 09/03/25 at 1:45PM, R2 stated that the facility had crappy snacks in the evening or they don't have enough snacks for all of the residents at the facility. R2 said that they maybe will get two saltine crackers as a snack. R2 said how is that a snack, she said why couldn't they put peanut butter on them for the diabetics.</p> <p>On 09/03/25 at 10:53AM, V6 (Certified Nurse Assistant/CNA) stated she isn't sure if they have enough snacks in the evening, she thinks they do, but she knows that some of the resident will come and pick out the better snacks and then the other residents don't want what is left.</p> <p>On 09/03/25 at 11:41AM, V8 (CNA) stated they don't have a lot of snacks. She stated they have a few items on the cart and the ambulatory resident will get the snacks that they want and then there isn't really anything left for the other residents.</p> <p>On 09/03/25 at 12:15PM, V10 (CNA) stated they don't have enough snacks at night a lot of the time. V10 said they maybe have enough snacks to pass one hall snacks.</p> <p>On 09/03/25 at 12:23PM, V11 (Licensed Practical Nurse/LPN) stated that sometimes they don't have the best snacks in the evening. V11 said they might have two saltine crackers or some graham crackers.</p> <p>On 09/03/25 at 1:47PM, V14 (CNA) stated the facility does run out of snacks to give the residents. V14 said it is a hit and miss sometimes they have enough snacks to give all the residents other times they do not have enough snacks to give all the residents a snack. V14 said last week they did not have enough snacks to be able to give all the residents a snack.</p> <p>On 09/03/25 at 2:30PM, V16 (LPN) stated that residents do get snacks, but that she feels like they don't get enough snacks for all the residents in the building to be able to get a snack. V16 said the kitchen will leave some saltine crackers or graham crackers out for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/03/25 at 3:19PM, V18 (CNA) stated that the facility did not have enough snacks for all of the residents. V18 said that none of the mechanically altered diets would get any snacks in the evening because they didn't send anything for them to be able to eat.</p> <p>On 09/04/25 at 2:11PM, V19 (CNA) stated that they do have snacks but sometimes they don't have enough snacks for all the residents.</p> <p>09/04/25 at 2:28PM, V5 (CNA) stated the facility is short on snacks all the time. V5 said that they only have dry snacks and only a few. V5 said they can usually only get one hall pass with snacks. V5 said that they only have a few snacks to be able to offer those residents. V5 said that they can't even get any extra snacks because they lock up the refrigerator.</p> <p>On 09/04/25 at 2:32PM, V20 (CNA) stated the facility runs out of snacks all the time and they don't have enough to be able to give all the residents a snack in the evening.</p> <p>On 09/09/25 at 2:50PM, V29 (Activity Director) stated she does know that the facility was having a problem with not having enough snacks. V29 said that she thought it had gotten better. V29 said that the snacks are just sitting on the table and not passed till later and the smokers will go out for their 8pm smoke break and they will take what snacks they want and then they don't have enough snacks left over for all the residents.</p> <p>On 09/09/25 at 3:51PM, V1 (Administrator) stated that she knew that they having enough snacks was a problem and she makes kitchen staff send a picture of the snacks that they leave out for the staff to pass, and she said that she knows they have enough snacks because she gets pictures of the snack basket.</p> <p>On 09/04/25 at 3:10 PM, during a Resident Council meeting R2 stated, they had not been received evening snacks or fresh drinks in the evening until the last two days, R20, R29, R27, R35 agreed.</p> <p>On 09/04/25 at 8:45 AM, R7 who was alert to person, place and time stated, she does not always get snacks in the evening.</p> <p>On 09/08/25 at 1:11 PM, V42 (Dietary) stated, the afternoon dietary aide or sometimes the afternoon cook will get the evening snack basket together for the evening snacks. They will put some saltine crackers, oatmeal cream pies, cookies, puddings and some half peanut butter and jelly sandwiches. She is guessing all together there could be 35 to 40 snacks in the basket, maybe 50 at most. V42 stated, they have approximately ten to twelve diabetics at the facility currently. V37 stated, they take a picture of the snack basket every night and send it to V1 (Administrator) to show her snacks were put together. V42 stated, she does not know if the certified nurse aides (CNA's) pass them out every evening. V42 stated, the packages of saltines have two saltine crackers in each package and residents probably would take more than one package of saltines with a fourteen-hour time frame between meals.</p> <p>On 08/28/25 at 11:35 AM, R3 who was alert to person, place and time stated they don't have hardly any snacks in the evening.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility document titled, Inservice Form dated 07/18/25 documents: inservice title snacks & water with the summary of the inservice stating: pass ice water and snacks (pureed or cooled snacks will be in the milk cooler).</p> <p>The Concern/Compliment Form dated 08/07/25 by R11 documents: not enough snacks at night. Dinner mealtime at 5 PM then breakfast at 7 AM is a long time without meals and snacks.</p> <p>The Concern/Compliment Form dated 08/30/25 by R2 documents: they don't have enough snacks in the evenings, only thing offered to her is saltine crackers. If they would add peanut butter, that would make them feasible to eat.</p> <p>Resident council minutes dated 07/07/25 document under the section titled, Nursing ice water not being passed, snacks only offered to smokers at 8:00 PM.</p> <p>On 09/08/25 at 1:03 PM the picture of the snack basket, which was a plastic tote container, approximately 16 inches by approximately 13 inches. This container appeared to hold approximately: 7 packages of saltines, 7 oatmeal cream pies, 4 packages of cookies, 7 pudding containers, 8 peanut butter and jelly half sandwiches.</p> <p>On 09/08/25 at 1:03 PM, V41 (Dietary) stated, sometimes she makes the snack basket for the evening snacks. V41 stated, she will put a handful of crackers, a handful of oatmeal cream pies, some fruit cups, and some gelatin cups in the basket. V41 stated, she does not count the snacks in the basket.</p> <p>On 09/08/25 at 10:44 AM, V40 (Agency LPN) stated, residents did not drinks passed to them, they did not have enough snacks. V40 stated, he felt they did not have enough staff.</p> <p>The policy dated, 2025 titled, (company name) dietary policies and procedures documents: snacks: the food and nutrition department may provide snacks as requested by residents and HS ([NAME] somni (before bed)) snacks daily, per facility protocol.</p>		