STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	601 North Columbia West Frankfort, IL 62896

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observation and record review the facility failed to treat residents with dignity, respond to residents quickly, and speak to residents respectively for 14 (R4, R5, R6, R8, R10, R13, R14, R16, R17, R23, R26, R28, R29, R32) of 14 residents reviewed for dignity in a sample of 32.Findings include:1. On 04/30/26 at 10:55 AM there was a puddle of urine under R26's chair. The puddle was over 12 inches by 7 inches, R26 was sitting at a table in the center of the dining room. At 11:23 PM the puddle was bigger approximately 14 inches by 9 inches and R26's shorts were visibly wet. At 11:40 AM V26 (Social Services Director) gave R26 hand sanitizer and walked right by the puddle of urine under his chair. At 12:05 PM R26 was still sitting in the dining room with the puddle under him. During this time, several staff walked by R26 bringing residents into the dining room and delivering food trays.On 05/04/26 at 7:35 AM there was a puddle of urine under R26's chair in the dining room, the puddle was approximately 12 inches by 6 inches. At 8:15 AM R26 left the dining room with his walker, his soaked feet stepped in the puddle while he was getting up and R26 made wet footprints down the hall. While R26 was walking down the hall V9 (CNA) stated to R26, lets go to the bathroom down here, and R26 followed.On 05/06/26 at 7:20 AM R26 was sitting at a table in the center of the dining room, there was a large puddle of urine under R26's chair in the dining room. R26 was eating breakfast. The puddle was over twelve inches in length and approximately five inches wide. Between 7:50 AM and 8:10 AM V9 (CNA) walked by R26 several times, at 8:10 AM R26 got up and left the dining room with his walker and left wet footprints out of the dining room and down the hallway.On 05/07/26 at 1:30 PM, R26 was asked if it bothered him if they left him wet in the dining room. R26 looked down and looked embarrassed and stated, he knows, he doesn't mean to. Resident was alert and oriented at time of interview.On 05/12/26 at 12:28 PM, V1 (Administrator) stated her expectation is if a resident is viably wet in the dining room or any other place in the facility, they would be taken out and the resident cleaned and changed and brought back to the dining room or wherever in the facility. V1 stated her expectations would be for residents to be changed before and after meals. V1 stated, if it was overnight her expectation would be for the CNAs to make rounds and when they finish the rounds the CNAs would start the rounds over again.2. On 05/04/26 at 12:07 PM, V11 (CNA) was heard telling R23, Well if you're going to cuss in here you are going to have to leave surveyor was standing less than two foot away from R23 and did not hear R23 cuss at anyone.On 05/07/26 at 1:36 PM, R23 stated, Yeah when asked if they tell him he has to leave the dining room if he cusses, even if it is not very loud. R23 stated, Sometimes when asked if he felt staff didn't talk to him very nice. Resident was alert and oriented at time of interview.On 05/12/26 at 12:28 PM V1 stated, if a resident cussed in the dining room and it was not disruptive, she would expect the staff to find out what the problem was and hopefully be able to address what is bothering the resident and resolve the concern then. V1 stated, she would not expect the resident to be told they would have to leave the dining room.3. On 05/03/26 at 7:10 PM R28 stated, sometimes the staff are worse than other times about paying attention to his call light. R28 stated, today (05/03/26) and yesterday (05/02/26) after breakfast he turned on his call light to go to the bathroom and pooped his bed because the staff didn't get there in time. R28 stated, sometimes it takes them an hour to get there. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28 stated, he doesn't like to poop in his bed. Resident was alert and oriented at time of interview.On 05/12/26 at 12:28 PM, V1 (Administrator) stated, her expectation for a reasonable time a resident should wait or a call light to be answered in would be within 20 minutes.4. On 04/27/26 at 10:50 AM, R6 stated the staff in the early mornings and evenings can be short and snipy sometimes. Resident was alert and oriented at time of interview.On 04/27/26 at 11:09 AM, R5 stated the evening staff can be snipy, snappy and impatient at times, like they do not want to be there. Resident was alert and oriented at time of interview.On 04/27/26 at 11:10 AM, R4 stated staff in general can be snipy with the residents. Resident was alert and oriented at time of interview.On 04/27/26 at 11:27 AM, R14 stated previously it was only the night shift that had attitudes or were rude, but lately it is more of the staff. R14 stated, they will tell him, they do not have time to do whatever he has asked. R14 stated, the staff can be rude, unkind, to almost hateful sometimes. Resident was alert and oriented at time of interview.On 04/27/26 at 1:50 PM, R10 stated the staff can be snippy and rude, especially on the weekend. R10 stated maybe the staff are rude because they are running and don't have enough of them to get things done. Resident was alert and oriented at time of interview.On 04/28/26 at 10:37 AM, R17 stated at times the staff can have attitudes and be rude, he is not sure if it is any shift in particular anymore. R17 stated, sometimes the residents may say something and the staff will just be rude back to them. R17 stated, he has heard the staff tell the residents to shut up before. Resident was alert and oriented at time of interview.On 04/29/26 at 2:28 PM, R16 stated the weekend staff are probably the lowest staffed and they can get impatient with the residents because they are getting pulled in so many different ways. R16 stated she believes the staff are disgruntled because they are working short that they take it out on the residents. Resident was alert and oriented at time of interview. On 04/30/26 at 2:18 PM R16 stated, some of the staff do give them attitudes and are rude to them, she feels bad for some of the other residents. Resident was alert and oriented at time of interview.On 04/28/26 at 1:24 PM, R8 stated the CNA's (Certified Nursing Assistants) all can have attitudes and be rude, she feels like it is because they are short staffed. R8 stated, they had two CNAs last night and she believes Wednesday and Sunday. Resident was alert and oriented at time of interview.On 04/29/26 at 3:00 PM, R13 stated, everyday staff are snipy, snappy, have attitudes, and have been rude to him. The staff will chastise him. Resident was alert and oriented at time of interview.On 05/04/26 at 2:23 PM, R14 stated the staff will snip at you if you ask a question. Resident was alert and oriented at time of interview.On 05/07/26 at 10:00 AM this surveyor attended a resident council meeting with R4, R16, R29, R8 and R10. During this meeting residents stated CNAs attitudes are bad, they show favoritism.The resident council minutes dated 05/07/26 at 10:06 AM documents: staff have bad attitudes towards residents and each other and residents feel as if some residents get more attention and care than others, leaving some residents wet for long periods of time, they are also leaving beds unmade and residents are laying on bare mattresses.The resident council minutes dated 04/02/26 document: nursing: CNAs are cranky.The undated facility policy titled, Resident's Rights Policy documents: 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. In addition, all staff are reminded that every employee has a responsibility to answer a call light when a resident requires assistance. Employees that fail to provide superior care will be subject to corrective action, up to and including termination of employment. Resident's Rights: The residents have certain fundamental rights guaranteed by law, including, but not limited to, the following: to live a dignified existence and engage in self-determination. The (facility name) expects that each employee's conduct and performance will conform with the highest standards of professionalism with respect to the treatment of all residents, visitors and their families and our ethical practices; the requirements of their job; published and common-sense health and safety rules; and applicable federal, state and local laws, rules and regulations.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview, observation, and record review the facility failed to provide working showers and toilets and failed to provide an environment free of sewage backup and odors for 17 (R4, R5, R10, R14, R16, R17, R18, R19, R21, R22, R23, R26, R27, R29, R30, R31, R32) of 17 residents reviewed for sanitary environment in a sample of 32.Findings include:1. On 04/27/26 at 11:09 AM, R5 stated they only have one shower that works so there are times you have to wait for the shower to be open. Resident was alert and oriented at time of interview.On 04/27/26 at 11:10 AM, R4 stated they only have one shower that works so sometimes you have to wait. Resident was alert and oriented at time of interview.On 04/27/26 at 11:17 AM the shower room on the 300 hall did not have a shower head on the shower.On 04/27/26 at 11:22 AM, V4 (Certified Nurse Aide/CNA) stated the showers on the 200 hall and the 300 hall do not work, only the shower on the 100 hall works. V4 stated, the other showers have not worked for months.On 04/27/26 at 11:23 AM, V5 (CNA) stated the showers on the 200 and 300 halls do not work, only the shower on the 100 hall works. V5 stated, the other showers, besides the 100 hall, have not worked for months.On 04/27/26 at 11:27 AM, R14 stated they only have one shower that works. R14 stated he has refused showers lately because the CNAs have to do almost back to back showers to get them done and there was still feces in the shower room when he went in so he was not going to shower in there. R14 stated another time he didn't want to shower at that exact minute so they just put refused. Resident was alert and oriented at time of interview.On 04/28/26 at 12:03 PM, V8 (CNA) stated it can make it challenging with other CNA duties to get the showers done especially with one shower room. V8 stated, sometimes they run a little behind because of something happening and residents will refuse their shower because they don't want to take it later.On 05/03/26 at 5:40 PM, V27 (Licensed Practical Nurse/LPN) stated, the only shower room that works is the 100 hall.On 05/03/26 at 6:51 PM, V10 (CNA) stated they only use the shower room on the 100 hall because the shower rooms on the 200 and 300 halls do not work.2. On 04/27/26 at 1:50 PM, R10 stated there are always urine and feces odors on both halls. Resident was alert and oriented at time of interview.On 05/03/26 at 5:45 PM the men's bathroom on the 300 hall had a distinct odor of urine and feces.On 05/03/26 at 8:28 PM the men's bathroom on the 300 hall had a distinct odor of urine and feces.On 05/04/26 at 7:40 AM the 100 hall hallway had a smell of urine.On 05/04/26 at 7:50 AM the men's bathroom on the 300 hall had a very strong smell of urine.On 05/04/26 at 7:50 AM, R5 stated the toilet on the 300 hall does not flush all the way, the solids don't want to go down. R5 stated, the toilet is always clogged up. Resident was alert and oriented at time of interview.On 05/04/26 at 7:53 AM the men's restroom on the 300 hall had a small amount of fecal matter in the bottom of the toilet, the toilet was flushed and the fecal matter did not flush down the toilet and the water rose to the inside rim of the toilet bowl.On 05/04/26 at 7:55 AM, V30 (Housekeeping) stated the men's bathroom on the 300 hall does have odors. The men tend to miss the toilet and they will have to mop it up several times a day. V30 stated, if the urine does not get mopped up frequently it soaks into the tiles. V30 stated, the weekend housekeeping staff leave at 2:00 PM so then it is up to the CNAs to mop it up when they see it and have time.On 05/07/26 at 10:00 AM during resident council, R32 stated, there are odors on some of the halls.On 05/07/26 at 10:00 AM during resident council residents stated, staff need to check residents more often because they are wet and have odors.The resident council minutes dated 05/07/26 at 10:06 AM document Housekeeping: They do a great job working hard to clean up; however, there are some residents who miss the toilets when using the restroom, therefore bathrooms need cleaned more frequently. Bad smells are lingering in halls and bathrooms, especially.3. On 05/04/26 at 7:55 AM, V30 stated there was sewage that backed up on the hall through the floor drains on 04/17/26. V30 stated, they sanitized everything after they got it fixed. On 05/06/26 at 8:17 AM, V30 stated, the 200 hall did have sewage up by the double doors. V30 stated, the sewage was coming up through the floor drains, V30 stated, the 100 hall was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worse.On 05/04/26 at 2:23 PM, R14 stated, when the sewage was in the facility it was coming up through the floor drains and was on the floors in the bathrooms and the shower room. Resident was alert and oriented at time of interview.On 05/06/26 at 8:32 AM, V31 (Housekeeping) stated there was sewage water coming up through the floor drains and under the toilet in the first bathroom on the left side on the hall. V31 stated the sewage was about two feet out around the drains and from the toilet. V31 stated, sewage also came up through the drain in the shower room the sewage was about four foot out from the drain in the shower room. V31 stated, the water was a brown color and did have particulates in it. V31 stated, they put two blankets over the drains to soak up the water. V31 stated, after they got it fixed, they cleaned and sanitized all the areas.On 05/06/26 at 2:14 PM, V25 (Plumber) stated, they came to the facility and was unable to unstop the drain. V25 stated, the kitchen area was backing up and other areas in the facility. V25 stated, they were able to get the drains unclogged from the outside. They were able to go into the pipes from the south side of the building and went in approximately 40 feet and were able to fix the clog and get the pipes moving again.The Plumbing work order/Invoice dated 04/17/26 documents description of work: camera and jet sewer pipes backing up.The resident roster documents R4, R5, and R29 reside on the 300 hall and use the men's bathroom and R16, R17, R18, R19, R21, R22, R23, R26, R27, R30, and R31 reside on the 100 hall.The undated facility policy titled, Physical Plant & Environmental Policy & Guidelines documents: policy statement: It is of the utmost importance to provide a safe, hospitable, clean and organized facility and grounds to ensure an environment that is conducive to providing the best care, comfort and home-like surroundings for residents. A well maintained building and environment is also important for creating safe work surroundings across all departmental staffing and their ability to effectively, and efficiently provide care and great living environment to all residents and all necessary resources to do so. The building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping, and ensuring compliance with current federal, state, local and NFPA (The National Fire Protection Association) codes. This includes making certain a safe and hospitable environment as possible is maintained in the event of an emergency for sheltering in place. policy implementation: the facility administrator must ensure that the overall scope and effective procedures are followed by each departments supervisors and staff or request of approved contractors for creating and maintaining a safe and comfortable environment for the residents, visitors and staff. Maintenance/approved contractors; routine care and repairs to interior finishings -repairing ceiling/wall damage, painting, floor, general plumbing - drains, faucets, showers, are maintained. Housekeeping: routine daily room cleaning and sanitizing, routine daily cleaning of all common areas and dining areas, routine daily cleaning of all shower rooms and restrooms, monthly scheduled room deep cleaning and organizing, and monthly scheduled shower room deep cleaning.

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the notifications and required reasons for transfer/discharge were adequately communicated and documented in the medical record and failed to permit a resident to return to the facility after hospitalization for two (R1 and R2) of three residents reviewed for inappropriate transfer and discharge in the sample of 32. This failure would cause a reasonable person to experience feelings of fear, agitation, anxiety, and distress as a result of being removed from their home and taken to an unfamiliar location with unfamiliar people, far away from family. Findings include:1. R1's admission Record documented an admission date of 10/23/25 and included diagnoses of Cerebral infarction due to thrombosis of right middle cerebral artery, cerebral infarction due to embolism of left middle cerebral artery, dysphagia, major depressive disorder, adjustment disorder with depressed mood, vascular dementia with anxiety, vascular dementia with other behavioral disturbance, and vascular dementia with agitation. R1's admission Record also documents a discharge date of 2/25/26 to an Acute Care Hospital. Under Contacts V16 (Family-Power of Attorney/POA) is documented as R1's Emergency Contact #2 and V18 (Family) is documented as R1's Emergency Contact #1. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely/never understood. Under the Staff Assessment for Mental Status, R1 is documented as having a short term memory problem. Regarding cognitive skills for daily decision making the MDS documents R1 is moderately impaired, noting decisions poor and cues/supervision required. Under signs/symptoms of delirium, the MDS documents Inattention - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? which was answered with behavior present, fluctuates (comes and goes, changes in severity. R1's Care Plan includes (but not limited to) Focus Areas of Impaired Social Interaction, Behavior Management, Resistive to care, Physical Aggression, Wandering/Poor Safety Awareness, Impaired Communication, and Vascular Dementia with multiple interventions listed. The Care Plan does not include any Focus Area specific to discharge planning but has a Focus Area documenting I have expressed a desire to remain at (name of facility) for permanent placement. (initiated 10/27/25 and revised on 11/19/25). Corresponding interventions listed document: Arrange transportation PRN (as needed) to medical appointments (initiated 10/27/25), Concerns will be addressed in a timely manner (initiated 10/27/25), Resident and POAHC (Power of Attorney for Health Care) will be invited to bring any concerns to facility staff (initiated 10/27/25), and Will state comfort with current setting when questioned (initiated 10/27/26 and revised 1/26/26). This focus area does not include any new interventions after 1/26/25 and does not include any information regarding transfer/discharge plans related to seeking alternative placement for behavioral evaluation. On 04/28/26 at 12:15 PM, V17 (Hospital Case Manager) stated R1 came to them from a nursing facility 5 hours away, and they brought R1 up in the facility's van. The hospital was able to get R1 stable and tried to get her back to the facility but V1 (Administrator) has given them a hard time. V17 said V1 first stated they did not have transportation, then said they did not have a room for R1 because they were using it for an isolation room, and another person was currently in it. V17 said when she tried to reach back out to the facility, they would not take R1 back and then started not returning phone calls. V17 stated after V1 said R1 was not able to return to the facility, they advised V16 (Family Member-Power of Attorney/POA) of this and V16 went to go get R1's personal items. V16 then told V17 there was no one in R1's room and her items were still by her bed. V17 stated she has an email thread of the conversations between her and the facility. On 04/28/26 at 1:31 PM, V16 (Family Member/POA) stated she was at the facility for R1's birthday on 02/22/26, which was three days before R1 was sent to the hospital up north on 02/25/26. V16 stated she had a care plan meeting (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	scheduled for R1 on 2/24/26 but unfortunately, V16 was in the hospital that day and did not make it to the facility for the meeting. V16 stated facility staff did not inform V16 they were sending R1 to (name of city approximately 5 hours north) while she was at the facility (on 02/22/26) nor did they call to tell V16 they were sending R1 to (name of city) until after R1 was there for 2 hours. V16 stated she even checked her phone call log to make sure she did not miss the call. V16 said she did not receive a text from V1 either and there are times V1 will text information. If the facility had called when she was in the hospital, someone would have answered the phone. V16 stated the hospital up north told her R1's facility would not take R1 back and that they had given R1's bed away, so V16 went to go get R1's personal items. V16 said R1's items were still by her bed and there was no one in her bed. V16 said she would like R1 closer to (home) because then she could visit, and she was able to visit R1 frequently before the facility discharged her on 02/25/26. V16 stated she went and retrieved R1's belongings because she was told the facility would not take R1 back. V16 said she never stated that she did not want R1 to return to the facility. V16 said she thought R1 was originally supposed to be returning to the facility after three days. V16 stated she has not received any paperwork from the facility regarding R1 leaving the facility, being transferred to a hospital, a bed hold policy, or any other paperwork. V16 stated the first she knew about R1 being discharged to the hospital was when the hospital told her on 2/25/26. V16 stated R1 would get agitated at the facility because of things she wanted, the pureed diet she was on and the thickened liquids they gave her. V16 said she tried to sign a waiver for R1 to have different food, but the facility would not let her, stating R1 could only have different food if V16 brought it in for her. V16 said she would bring R1 fast food with a soda and she would eat it but would just have to take drinks between her bites. V16 stated R1 hated the pureed food, and it would make her angry to eat it. V16 said there were also times the facility would call her because R1 would get agitated and they would want V16 to come by and calm R1 down, which she would do if she was able to get there. On 04/29/26 at 9:45 AM, V15 (Transportation) stated she has seen V16 (Family Member) and V18 (Family Member) visiting R1 at the facility. V15 was unaware if V16 was notified of R1 leaving the facility before they left (on 2/25/26). V15 stated she believes the paperwork they took with them was screening paperwork. V15 stated they originally took R1 to the front entrance but apparently that was not where they were supposed to go because they did not seem to know about the situation. V15 stated they went to the emergency room entrance next, and they must have sat there and waited about five hours before they were given a room to go to. V15 stated the trip was fine, R1 had no behaviors, and they even had to stop and go to the bathroom a couple of times. V15 said R1 didn't even have any behaviors when they were sitting in the waiting room for five hours. V15 said R1 did not have any behaviors until they went to her room and R1 realized that she was staying, and they were leaving. On 04/29/26 at 10:24 AM, V3 (Medical Director) stated he heard about the facility inquiring about a behavior hospital visit for R1 via hearsay, but they may have discussed it with V19 (Nurse Practitioner/NP). V3 stated he was not aware of a discharge or an involuntary discharge with R1. On 04/29/26 at 10:36 AM, V19 (NP) stated he was aware R1 is no longer at the facility. V19 stated he vaguely remembers R1, and that R1 had abnormal behaviors and was receiving Haldol and Ativan. V19 stated he does not see in his notes where he consulted or assisted with R1 going to a behavioral hospital or a facility-initiated discharge. On 04/29/26 at 6:57 PM, V7 (Licensed Practical Nurse/LPN) stated the facility found a place in (city name) for R1 to go to. V7 said R1 would hit, kick, bite, and throw things. V7 stated she does not know if R1 always just threw things at staff, the things R1 threw would just land where they landed. V7 stated she thought R1 was supposed to come back to the facility, but she wasn't sure. On 04/29/26 at 1:20 PM, V1 (Administrator) stated R1 was admitted to a hospital psych (psychiatric) unit in (city name approximately 5 hours away). V1 stated they were working with the psychiatric provider they utilize at the facility and V16 (Family Member). V1 stated they had a care plan meeting scheduled (02/24/25) and V16 did not show up but they were going to tell V16 then. V1 stated they had been working for months on trying to find a place that would evaluate R1 for increased (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	behaviors/aggression. V1 stated V16 has come to R1's care plan meetings before and they had discussed it at length. The psychiatric provider they utilize made the recommendation for two facilities and the first one (facility name) was unable to take R1. V1 stated when she talked to V16 about R1 being admitted to the facility in (name of city approximately 5 hours away), she stated it was for an evaluation. V1 stated she was under the impression R1 was returning. V1 said that V16 was the one who told them R1 was not returning to the facility. V1 stated she never said R1 could not come back to the facility. V1 said she told the hospital they just needed four days before R1 could return because they were using the room for an isolation room and after that, she did not hear any more from the hospital. V1 stated she was under the impression the hospital was looking for different placement for R1. V1 stated V3 (Medical Director) was aware of the situation. On 04/30/26 at 10:37 AM, V17 (Hospital Case Manager) stated that V1 told them the facility would not accept R1 back straight out. V17 said V1 or V2 (Assistant Director of Nursing/ADON) never expressed to her that they only needed four more days before they could come and get R1. V17 stated V1 quit communicating with V17 after V1 said they would not take R1 back. V17 stated V1 was communicating and cooperative until she was told R1 was ready to return to the facility, then they quit answering the phone and returning phone calls. V17 stated they are a hospital, not permanent housing, so after V1 refused to take R1 back, they told V16 (Family/POA) that V1 would not take R1 back. After a discussion with V16 about R1 not being allowed to return, V16 agreed to have V17 send out some referrals to other facilities, however V16 said she would like the first referrals to go to locations in (V16's local area) so she could still see R1. V17 said after those referrals were denied, then V16 agreed to have referrals sent to other places. V17 stated it was her understanding that V1 was going to call V16 and tell her R1 could not return to the facility. On 04/30/26 at 10:46 AM, V16 stated she had never said she did not want R1 to return to the facility she was at. V16 stated someone at the hospital in (city name) told her on 03/19/26 that R1 was not being allowed to return to the facility, so she went to go get R1's belongings. V16 stated she was aware in February the facility was looking for a place to send R1 for an evaluation. V16 stated she knew they attempted referring to (hospital facility name) mid- February but that facility denied R1's admission. V16 said on 02/15/26 at 10:18 AM, V1 sent her a text asking if V16 could drive R1 to a hospital in the area (local hospital name) because they had a unit that could evaluate R1. V16 said she returned a text back to V1 at 10:22 AM that her vehicle is too high for R1 to get into and be transported. V16 stated she was not sure why they did not take R1 in the facility van. V16 stated V1 never told her about the hospital up north in (city name). V16 said the first time she was made aware was on 02/25/26 at 3:29 PM when that hospital let her know that R1 had been transferred up north to (city name) and she was already there. V16 stated neither she, her spouse, nor V18 (Family) ever stated they did not want R1 to return to the facility. When she was told R1 was in the hospital up north, it was her understanding that R1 would be returning. V16 stated every time she and the facility discussed R1 going anywhere for an evaluation it was always with the understanding it would be a temporary stay, and she would return to the facility. On 04/30/26 at 4:40 PM, V20 (Psychiatric Nurse Practitioner) stated R1 was having frequent episodes of aggression towards staff and due to her dementia, she could not be redirected. These episodes were becoming bad enough that staff felt R1 needed a higher level of care. V20 stated she is unaware if the plan was for R1 to return or not. The facility felt her aggression was out of control. V20 stated she had not spoken one to one with V16 (Family), usually the facility does that. V20 said in early February, staff had started requesting hospitalization for R1 and they suggested some hospitals they had worked with in the past. V20 stated she has not had any contact with the hospital R1 was sent to. V20 said sometimes it is a complicated situation with dementia when they do not respond to medications well. V20 stated R1 may respond better to redirection and to one-to-one care. V20 said there are times when R1's aggression was directed at staff; she is not sure if it was directed towards residents. V20 stated she was not sure what the plan for R1 was after hospitalization. R1's Progress Note dated 02/18/26 at 8:11 AM documents: received new orders from (psychiatric company) at this (continued on next page)

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	145664	A. Building B. Wing	05/12/2026

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F 0627 Level of Harm - Actual harm Residents Affected - Few	time. New orders as follows: Haldol 5mg (milligrams) po (per oral) Q (every) 8 hours prn (as needed) x (times) 14 days and Ativan 2mg IM (intramuscularly) Q 8 hours prn x 14 days. Called and spoke with V16 and was given verbal consent to begin medications. The orders were processed. Will monitor for change. R1's Progress Note dated 2/18/2026 at 5:02 PM documents: R1 self propelling with cup of hot coffee and proceeded to throw it on a staff member. PRN IM Haldol utilized at this time. R1's Progress Note dated 2/19/2026 at 12:14 PM documents: R1 was seen by facility nurse practitioner with (psychiatric company). No new orders. R1's Progress Note dated 2/20/2026 at 2:17 AM documents: no adverse effects noted related to recent medication change: Ativan and Haldol PRN. No behaviors noted and no complaints voiced. R1 is resting quietly in bed, call light in reach. No PRN Ativan or Haldol given this shift. R1's Progress Notes dated 2/20/2026 at 12:21 PM documents: called and spoke with V16 related to telehealth visit today and new orders. Medications explained along with desired benefits and possible ASE's (adverse side effects), received verbal consent to proceed with new medication orders. R1's Progress Note dated 02/21/26 at 5:53 AM documents: this nurse called POA, (V16) to notify her of resident being on floor at 12:10 AM. V16 thanked nurse for calling and had no further questions. R1's Progress Note dated 02/21/26 at 3:15 PM documents: resident in room at this time. No complaints of pain or discomfort. No s/s (signs or symptoms) of acute distress. No cough or sob (shortness of breath) noted. No adverse reactions noted related to change in psychiatric medications. No behaviors noted. Call light within reach. Will continue to monitor for change. R1's Progress Note dated 02/22/26 at 3:29 AM documents: No adverse effects noted related to recent medication change: Ativan prn, Haldol prn, start melatonin, start Depakote. No behaviors noted, no complaints voiced. Resting quietly in bed with eyes closed, respirations even and non labored. Call light in reach. No prn Ativan and no prn Haldol given this shift. R1's Progress Note dated 02/22/26 at 5:23 PM documents: the resident is on daily monitoring related to starting Melatonin, Depakote, Ativan IM PRN, and Haldol IM PRN. PRN medications have not been administered at this time. No adverse reactions noted/reported. No complaints noted. No signs of distress were noted. V16 was in to see the resident today. No behaviors present at this time. The plan of care is ongoing. R1's Progress Note dated 02/23/26 at 1:12 AM documents: R1 resting in bed, no behaviors noted at this time, call light within reach, will continue to monitor for change. R1's Progress Note dated: 02/24/26 at 10:00 AM documents late entry: V16 did not attend scheduled care plan meeting. R1's Progress Note dated 02/25/26 at 10:13 AM documents: late entry: Social Service supportive documentation note; documents: Behavioral symptoms: A. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): Behavior of this type occurred 1 to 3 days B. Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) Behavior not exhibited C. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds): Behavior of this type occurred 1 to 3 days D. Were any behavioral symptoms in question E0200 coded 1,2, or 3? Yes Provide examples of said behaviors from A, B, or C during the look back period, including dates. Resident gets mad at mealtime when she is given puree food. Or when certain staff is here that she thinks is someone else or she don't get her way. R1's Progress Note dated 02/25/26 at 2:07 PM documents: Yesterday I contacted (hospital name) in (city name) for services for (R1). They stated they needed current labs, doctor notes, face sheet, behaviors, and medication list. I sent that all over to them before lunch. They called back and stated they needed a petition for involuntary admission. I had never done one of those before, so (V2) (ADON) filled it out, and I sent it back over to (name of hospital). They then called back an hour or so asking when her ETA (estimated time of arrival) was, I told them I never did get an answer stating they was going to accept her and that we were five hours away and couldn't leave without a for sure admission. She stated please don't bring resident yet before I receive the original petition. I told her I was far away and it wouldn't be till tomorrow morning when we were leaving with (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	fax updates to our facility. R1's hospital Case Management Note dated 03/11/26 at 10:35 AM documents: the writer spoke with V1 from (facility name) to follow up regarding the patient's discharge and potential transportation arrangements. At this time, the facility is unable to provide a confirmed date or time for when they will be able to pick R1 up. The writer faxed updated clinical information to the facility to provide an update on the patient's current medical status and to assist with discharge coordination. The writer will continue to follow up with V1 at (facility name) regarding transportation arrangements and discharge planning. R1's Progress Note dated 03/11/26 at 4:05 PM documents: Late Entry: Note Text: (V17) with (hospital name) called to follow up with us on the updated records she sent us earlier this AM. She requested to speak with ADM (V1/Administrator), explained she was already gone for the day and asked if I could help her with anything. She explained she was wanting to get transportation set up for (R1) to return to our facility. I explained that we did receive records earlier in the day and I was aware of a few questions that Administrator (V1) had; she is requesting information on when restraints were removed (date) and if (R1) was being compliant with taking her medication. (V17) informed me that the restraints had been off for a few days. I requested we be sent documentation on the date this took place along with how she has responded since. As far as her taking her medication (V17) informed me that (R1) 1. ?told them she was ready to go back to her facility.' 2. She was ?not doing what they wanted until they put her back in her wheelchair and sent her back to her facility.' I clarified with (V17) that (R1) verbally told them these things to which she again replied ?Yes.' I informed (V17) that (R1) was non-verbal at this point. (V17) stated well, ?she wrote this out for the therapist' I requested she send our facility these notes along with the previously requested information and follow up with us in the AM once we had received the information and had time to review it, voiced understanding. R1's Progress Note dated 3/12/2026 at 3:29 PM documents: Called and spoke with V17 (Hospital Case Manager), at (hospital name) since she has not follow up with us yet today. Informed her we did receive the one note she sent this morning with the hand written message at time stating this shows date restraints were removed. I did question what kind of diet (R1) was currently receiving and how she was tolerating it. V17 reported a pureed thin diet and that she was tolerating it well. I requested a current weight and was given a weight of 168.0 pounds however was unable to provide a date of this weight. I also inquired if she still had a 1:1 sitter and was informed she did currently still have a sitter for her safety. I requested they supply us with behavior charting notes/documentation, stated they do not have anything like that. I requested nursing documentation and was told she could send safety notes. We scheduled a call between our two facilities for 03/13/2026 at 10:30 AM. R1's hospital Case Management Note dated 03/12/26 at 4:32 PM documents: the writer spoke with V2 (ADON) at (facility name) regarding R1 and discharge planning. V2 stated that the facility will need updated behavioral notes before making a decision about accepting the patient back. V2 also expressed concern that the hospital may be attempting to discharge the patient due to R1's stay being denied by the insurance company. V2 stated that the facility would like to have a phone meeting to further discuss R1's behaviors and discharge needs. The writer, along with the nurse, is scheduled to participate in the phone meeting with the facility tomorrow at 10:30 AM to further discuss R1's behavior and discharge planning. The writer will continue to follow up with the facility and care team regarding the outcome of the meeting and next steps. R1's hospital Case Management Note dated 03/13/26 documents: the writer contacted V1 at (facility name) in preparation for the scheduled meeting with the writer and the charge nurse to discuss R1's discharge planning and potential return to the facility. During the conversation, V1 expressed significant concerns regarding the patient's case and the documentation that had previously been faxed to the facility. V1 stated that she believed the clinical documentation that was faxed to the facility regarding R1's status was falsified. V1 communicated this concern in a confrontational and unprofessional manner during the call. The writer clarified that the documentation provided was based on the most recent clinical updates available in R1's medical record and was shared to assist with discharge planning and coordination of care. V1 further stated that (facility (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	name) will not coordinate transportation for R1's return to the facility at this time. V1 indicated that the facility intends to consult with their legal team regarding R1's discharge and potential return to the facility before making any further arrangements. Additionally, V1 reported that the facility has reassigned R1's previous bed for use as an isolation room and stated that they currently do not have a bed available for R1. V1 also expressed concerns regarding R1's previous aggressive behaviors, which she stated contributed to the facility's decision not to hold the bed. The writer documented the conversation and will update the medical team regarding the facility's position and concerns. The writer will continue to collaborate with nursing staff, leadership, and the interdisciplinary team to determine appropriate next steps for discharge planning and potential alternative placement if necessary. The writer will continue to follow up. R1's medical record had no documentation of the facility participating in the 03/13/26 phone meeting with the hospital and although requested from V1, no reproducible evidence of this phone meeting was provided during the course of the investigation. R1's hospital Case Management Note dated 03/16/26 at 11:05 AM documents: spoke with V1 and she stated that the patient is still aggressive and medication regime has not [sic] successful based on the documentation. V1 further stated that R1's room is not available due to another patient is on isolation, the person will not be out of the room until about the 19th. V1 requested that we find alternative placement in (name of city approximately 5 hours away) for the patient (R1). Explained that we would need to get approval from the POA (V16) otherwise R1 would need to return to the nursing home facility. R1's hospital Case Management Note dated 3/19/26 at 9:50 AM documents: the writer contacted (V16), the patient's POA to discuss ongoing discharge planning and current barriers to placement. V16 was informed that R1 is unable to return to the previous nursing home due to behavioral concerns. The writer provided an update regarding R1's aggressive behaviors, which have impacted placement options. V16 verbalized understanding of the situation and acknowledged the challenges associated with securing an appropriate facility given R1's current presentation and care needs. The writer discussed the importance of identifying a safe and suitable discharge plan that aligns with R1's medical and behavioral needs. The writer will continue to collaborate with attending physician and interdisciplinary team to explore alternative placement options. The writer will also maintain ongoing communication with V16 to provide updates and involve her in discharge planning decisions. The writer will continue to follow up with (V16) and support coordination efforts to ensure a safe and appropriate discharge disposition. R1's Progress Note dated 03/19/26 at 9:58 AM documents V16 (Family) called at this time and stated resident will not be coming back to facility and that she would be coming to get her belongings. V2 (ADON) and V1 (Administrator) notified. (R1's) medication returned to pharmacy and narcotics destroyed per 2 nurses. Follow-up progress note dated 3/19/26 at 10:58 AM documents (V16) came and got R1's belongings. R1's hospital Case Management Note dated 3/19/26 at 3:22 PM documents: The writer spoke with (V16) to discuss alternative placement options. (V16) was informed of the current barriers to placement and expressed interest in identifying facilities closer to family for additional support. The writer faxed referrals to (name of 3 facilities in V16's local area) to assist with discharge planning. The writer will continue to follow up with the facilities regarding referral status and collaborate with (V16) to ensure an appropriate and safe discharge placement. R1's hospital Case Management Note dated 3/23/26 at 12:07 PM documents: The writer spoke with (V16) regarding discharge planning and placement status. T

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to provide bed hold policy before/upon transfer from the facility for one (R1) of three residents reviewed for discharge process in the sample of 32.Findings include:On 04/27/26 at 3:44 PM, V6 (Ombudsman) stated the Ombudsman's office has not received any bed hold or transfer/discharge paperwork for R1 or R2 from (facility name).On 04/30/26 at 10:46 AM, V16 (Family-Power of Attorney/POA) stated she has never received any documents concerning R1's discharge or bed hold information.On 04/29/26 at 1:20 PM, V1 (Administrator) stated they did not send any paperwork to the Office of the Ombudsman and she is unaware if any paperwork was sent to V16.The Notice of Transfer and Discharge policy 08/14/17 documents: prior to discharge or transfer the facility will: notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility will send a copy of the notice to a representative of the office of the State Long-Term Care Ombudsman.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to maintain free passage through exit doors in case of emergency procedures. This failure has the potential to affect the 31 residents residing on the 200 and 300 Halls.Findings include:On 04/27/26 at 11:09 AM, R5 stated sometimes they would put the blue towel cart in front of the door on the other hall (R5 indicated the south hall/200 hall) to prevent R19 from hitting the door alarm or going out the door. Resident was alert and oriented at time of interview.On 04/27/26 at 11:10 AM, R4 stated he has seen the blue towel cart in front of the far door (R4 indicated the south hall) to keep R19 from hitting the door alarm. Resident was alert and oriented at time of interview.On 04/27/26 at 1:50 AM, R10 stated she has observed the linen tower in front of the door on the 200 hall. R10 stated, she believes they put it there to keep R19 from getting out. Resident was alert and oriented at time of interview.On 04/29/26 at 9:30 AM there was a plant cart in front of the exit door on the 300 hall, at 11:20 AM the plant cart was still in front of the door, at 2:07 PM the plant cart was still in front of the door, at 3:10 PM the plant cart was still in front of the door.On 04/29/26 at 2:28 PM, R16 stated she has seen the staff put the blue linen cart in front of the exit door on the 200 hall at night, she believes it is due to R19 hitting the door alarm and setting it off several times during the evening. Resident was alert and oriented at time of interview.On 04/28/26 at 1:24 PM, R8 stated she has seen the linen cart in front of the door on the 200 hall because of R19. Resident was alert and oriented at time of interview.On 04/30/26 at 12:20 PM R15 stated, she has seen the blue linen cart in front of the exit door on the 200 hall. R15 stated, she believes they do that because R19 will keep hitting the door alarm and [NAME] to get outside. Resident was alert and oriented at time of interview.On 04/30/26 at 1:30 PM, V1 (Administrator) stated there should not be anything in front of any of the exit doors.The facility's Room Roster dated 4/27/26 documents there are 22 residents living on the 200 hall and 9 residents living on the 300 hall.The undated facility policy titled, Physical Plant & Environmental Policy & Guidelines documents: policy statement: It is of the utmost importance to provide a safe, hospitable, clean and organized facility and grounds to ensure an environment that is conducive to providing the best care, comfort and home-like surroundings for residents. A well maintained building and environment is also important for creating safe work surroundings across all departmental staffing and their ability to effectively, and efficiently provide care and great living environment to all residents and all necessary resources to do so. The building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping, and ensuring compliance with current federal, state, local and NFPA (The National Fire Protection Association) codes. This includes making certain a safe and hospitable environment as possible is maintained in the event of an emergency for sheltering in place. Policy implementation: the facility administrator must ensure that the overall scope and effective procedures are followed by each departments supervisors and staff or request of approved contractors for creating and maintaining a safe and comfortable environment for the residents, visitors and staff.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, observation, and record review the facility failed to provide enough staff to perform care duties timely. This failure has the potential to affect all 49 residents residing at the facility.Findings include:On 04/27/26 at 11:27 AM, R14 stated previously it was only the night shift that had attitudes or was rude, but lately it is more of the staff. R14 stated, they will tell him, they do not have time to do whatever he has asked. Resident was alert and oriented at time of interview.On 04/27/26 at 1:50 PM, R10 stated the staff can be snippy and rude, especially on the weekend. R10 stated, maybe the staff are rude because they are running and don't have enough of them to get things done. Resident was alert and oriented at time of interview.On 04/28/26 at 12:03 PM, V8 (Certified Nursing Assistant/CNA) stated they start showers usually after breakfast but sometimes someone will be up at 6:00 AM or 6:30 AM and they can get a shower in before breakfast. V8 stated, it takes approximately 20 minutes to give a shower for most, a little less or a little more for some residents. V8 stated, they clean the shower between residents. V8 stated, it can make it challenging with other CNA duties to get the showers done especially with one shower room. V8 stated, sometimes they run a little behind because of something happening and residents will refuse their shower because they don't want to take it later.On 04/30/26 at 12:20 PM, R15 stated the other day they only had two CNAs and they did not have time to pass snacks, water or ice. R15 stated, there were a few residents that got their own ice out of the cooler but she did not because she knows their hands were not clean. R15 stated, sometimes they have run out of bed pads and wash cloths due to laundry getting behind. Resident was alert and oriented at time of interview.On 04/29/26 at 2:28 PM, R16 stated the weekend staff are probably the lowest staffed and they can get impatient with the residents because they are getting pulled in so many different ways. R16 stated, she believes the staff are disgruntled because they are working short that they take it out on the residents. Resident was alert and oriented at time of interview.On 05/03/26 at 6:17 PM, R10 stated they do not always get snacks because they are too low on snacks or they do not have enough staff to pass snacks and water. Resident was alert and oriented at time of interview.On 05/03/26 at 6:51 PM, V10 (CNA) stated there have been shifts lately that they did not have time to pass snacks, ice, or get all the showers completed because they did not have enough time.On 05/03/26 at 7:10 PM, R27 stated, sometimes it takes them longer than other times to answer his call light and sometimes it is a long time. Resident was alert and oriented at time of interview.On 05/07/26 at 6:44 AM, V28 (CNA) stated he has not been able to get the expected duties done several times due to not having enough staff.On 05/04/26 at 7:55 AM, V30 (Housekeeping) stated, the men's bathroom on the 300 hall does have odors. The men tend to miss the toilet and they will have to mop it up several times a day. V30 stated, if the urine does not get mopped up frequently it soaks into the tiles. V30 stated, the weekend housekeeping staff leave at 2:00 PM so then it is up to the CNAs to mop it up when they see it and have time.On 04/28/26 at 1:24 PM, R8 stated the CNAs all can have attitudes and be rude, she feels like it is because they are short staffed. R8 stated, they had two CNAs last night and she believes Wednesday and Sunday. Resident was alert and oriented at time of interview.On 05/03/26 at 7:10 PM, R28 stated, sometimes the staff are worse than other times about paying attention to his call light. R28 stated, today (05/03/26) and yesterday (05/02/26) after breakfast he turned on his call light to go to the bathroom and pooped his bed because the staff didn't get there in time. R28 stated, sometimes it takes them an hour to get there. R28 stated, he doesn't like to poop in his bed. Resident was alert and oriented at time of interview.On 05/03/26 at 7:10 PM, R28 stated there are times the staff forget to or don't have time to bring him an evening snack. Resident was alert and oriented at time of interview.On 05/12/26 at 12:28 PM, V1 (Administrator) stated, her expectation for a reasonable time a resident should wait for a call light to be answered in would be within 20 minutes.On 5/6/26 at 9:05am, V23 (Housekeeping Supervisor) said they cannot find anyone who wants to work in the laundry on (continued on next page)

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	145664	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	601 North Columbia West Frankfort, IL 62896

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Saturday and Sunday evening shift. V23 said the facility has a lack of laundry staff and the CNAs are expected to help out when no housekeeping or laundry staff are scheduled. V23 verified the facility does not have a laundry aide after the dayshift on Saturdays or Sundays. V23 said without the weekend staff, laundry doesn't get done in a very timely manner due to the lack of staff.On 05/12/26 at 12:28 PM, V1 stated her expectation of the CNAs are for the residents to be cared for and their needs met. V1 stated, some of these needs would include: assist residents with meals, pass trays, assist with ADLs (Activities of Daily Living), toilet resident, assist with transfers, changing residents, answering call lights, showers, passing snacks and water, the two 40 minute smoke breaks would alternate between CNAs and housekeeping if housekeeping are working. V1 stated, when there are not any housekeeping or laundry staff working then CNAs would clean the bathrooms and do any laundry if anything is running low. V1 stated, her expectation with approximately 49 residents they would need about 4 CNAs to 4.5 CNAs sometimes.Resident council minutes dated 05/07/26 at 10:06 AM documents: staff have bad attitudes towards residents and each other and residents feel as if some residents get more attention and care than others, leaving some residents wet for long periods of time, they are also leaving beds unmade and residents are laying on bare mattresses.The facility schedule dated 04/19/26-05/02/26 and payroll date in and out report documents on 04/25, 04/26, 04/27, 05/01, and 05/04 there were only two CNAs working the 2:00 PM -10:00 PM shift.The facility's Room Roster dated 4/27/26 documents a total of 49 residents currently reside at this facility.A facility policy titled Nurse Staffing (non-dated) documented in part: It is the policy of (facility name) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental and psychological well-being of each resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review the facility failed to provide food at a palatable temperature for 5 (R10, R13, R14, R30, R31) of 5 residents reviewed for cold food in a sample of 32.Findings include:On 05/03/26 at 6:17 PM, R10 stated the food is cold frequently. Resident was alert and oriented at time of interview.On 05/04/26 at 7:15 AM a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. The week at a glance documents breakfast day 9: assorted juice, choice of cereal, western egg bake, toast, margarine/jelly, milk and hot beverage.On 05/04/26 at 7:27 AM R10 received her breakfast in her room. R10's breakfast was 2 pieces of toast, 1 sausage patty, a bowl of dry cereal, a glass of milk and coffee. R10 stated, her sausage was cold, she was not eating it. R10 told surveyor to take the temperature of the sausage and tell her if it was considered cold. The temperature of the sausage patty was 86.0 degrees Fahrenheit. R10 stated her milk is warm so she does not want to use it for her cereal either, her milk was 51 degrees Fahrenheit. R10 stated, the coffee is not hot either but she will drink it. Resident was alert and oriented at time of interview.On 05/04/26 at 8:50 AM, V24 (Dietary Manager) stated they had to change the menu this morning to sausage, cereal, and toast.The week at a glance documents lunch day 9: beef pepper steak, mashed potatoes, steamed vegetables, fresh baked cookies, and a beverage.On 05/04/26 at 11:55 AM a refused tray by a resident was obtained by this surveyor, it contained a hamburger, mashed potatoes, and mixed vegetables of carrots, peas, and corn. The temperature of the hamburger was 105 degrees Fahrenheit (F), the mashed potatoes were 107 degrees F, and the vegetable was 111 degrees F.On 05/04/26 at 12:50 PM, V4 (Certified Nurse Aide /CNA) stated, the substitute today was a hamburger.On 05/04/26 at 2:19 PM, R30 stated sometimes the food is barely warm. Resident was alert and oriented at time of interview.On 05/04/26 at 2:23 PM, R14 stated the food is cold frequently. Resident was alert and oriented at time of interview.On 05/04/26 at 2:26 PM, R31 stated when he receives food that is cold, he sends it back. Resident was alert and oriented at time of interview.On 05/06/26 at 7:05 AM a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/_ 2 degrees Fahrenheit. The week at a glance breakfast day 10 documents: assorted juice, choice of cereal, bacon, French toast casserole, syrup, milk, and a hot beverage.On 05/06/26 at 7:10 AM R10 refused her breakfast plate. R10 stated, she has told them several times she does not like the eggs and they are probably cold. R10 stated, she will just eat the cold cereal. The eggs temperature was measured, the scrambled eggs were 103 degrees F. The eggs tasted cold. Resident was alert and oriented at time of interview.On 05/05/26 at 8:22 AM, V5 (CNA) stated, they had to switch the breakfast days and today was eggs, toast and cereal.The week at a glance lunch day 10 documents: sweet & sour pork, white rice, broccoli, egg roll, gelatin with whipped topping, and a beverage.On 05/06/26 at 12:02 PM, R13 received and refused his lunch tray. The food on the tray had the temperature measured, the broccoli was 97.2 degrees Fahrenheit (F), the rice was 113.5 degrees F, and the pork was 109.1 degrees F. The food tasted cold.On 05/07/26 at 6:44 AM, V28 (CNA) stated residents have complained to the CNAs about the food being cold.On 05/07/26 at 1:52 PM, V24 stated the residents should receive the food at approximately 135 degrees F if it is hot food items.The resident council minutes dated 05/07/26 at 10:06 AM document: food arrives cold, particularly on the hall.The food committee meeting minutes dated 05/07/26 documents under the heading: complaints/concerns: cold food.The undated policy titled, Food & Beverage Temperature Control documents: eggs should be cooked to 145 degrees Fahrenheit (F) if served immediately, to 155 degrees F for eggs held for service, and egg dishes are cooked to 160 degrees F. Hot foods are served at 135 degrees or higher and cold foods/beverages are served at 41 degrees or lower. Hot beverages such as coffee, hot tea, hot cocoa, and soups ideal service temperatures between 145 - 155 degrees F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to discontinue using the kitchen for food preparation during a sewage backup affecting the kitchen. This failure has the ability to affect all 49 residents residing in the facility.Findings include:On 05/04/26 at 2:48 PM, V24 (Dietary Manager) stated he was at the facility the day the sewer water was coming into the facility. V24 stated, the sewer water started coming in around 9:00 AM and the plumbers were called in. V24 stated, they were able to get the problem fixed at approximately 2:30 PM. V24 stated, the sewer water came up through the floor drains and accumulated as standing water about three feet out around the floor drains in the kitchen. V28 stated, he received a text at approximately 2:30 PM they were able to fix the problem with the sewage water but the staff was falling behind preparing dinner so he came in and cleaned and sanitized the floor.On 05/04/26 at 2:48 PM the floor drain by the dish machine was about 2.5 feet from the dish machine, the floor drain in front of the bathroom was off the left side of the kitchen area, and the drain in front of the cooler and freezer is in the main area of the kitchen and to get to the stove, oven and steamtable you need to walk with in approximately three feet of the floor drain.On 05/06/26 at 2:14 PM, V25 (Plumber) stated they came to the facility and was unable to unstop the drain. V25 stated, the kitchen area was backing up and other areas in the facility.The Plumbing work order/Invoice dated 04/17/26 documents description of work: camera and jet sewer pipes backing up.On 05/07/26 at 1:52 PM, V24 stated they did prepare and serve lunch and prepare dinner when there was sewage water in the kitchen. V24 stated, he was not told what the appropriate procedure was until after the day they had sewage water in the kitchen. V24 stated, he should not have prepared or served any food in the kitchen when there was sewage water in the kitchen and he should have served cold sandwiches out of a different room such as the breakroom.The facility's Room Roster dated 4/27/26 documents a total of 49 residents currently reside at this facility.The undated facility policy titled, Sanitation of Dining and Food Service Areas documents: the dining services staff will uphold sanitation of the dining areas according to a thorough, written schedule. 7. If indicated, additional infection control procedures should be followed for disinfecting high touch-point areas. It is recommended to use an approved disinfectant solution allowing for minimum contact time.The [NAME] County Food Sanitation Ordinance signed and approved on 7/17/2018 documents in part: Imminent health hazards and food protection: In the event of a fire, flood (including sewage backup), power outage, misuse of poisonous or toxic materials, foodborne illness outbreak, or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the permit holder or person in charge shall cease operations and contact the Health Department. Upon receiving notice of this occurrence, the Health Department shall take whatever action it deems necessary to protect the public health. If operations are ceased, the establishment must get approval from the Health Department to reopen. A permit holder is not required to discontinue operations in an area of the establishment that in unaffected by the imminent health hazard.