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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, observation, and record review, the facility failed to implement care plan fall interventions for 3 (R2, R4, and R13) of 5 residents reviewed for accidents in a sample of 46. This failure resulted in R2 being sent to the hospital after a fall and diagnosed with a closed fracture of left orbit and closed fracture of left side maxilla. The findings include:1. R2's admission record documents an admission date of 11/06/25 with diagnoses of Parkinson's disease, vitamin d deficiency, muscle wasting and atrophy, lack of coordination, dementia, and need for assistance with personal care.R2's MDS (Minimum Data Set) dated 02/13/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 13 which indicates R2 is cognitively intact. Section GG documents toileting and toileting transfer as dependent. Chair/bed to chair transfer as partial/moderate assistance. Section J documents has the resident had any falls since admission/entry or reentry or the prior assessment as yes. Number of falls since admission or prior assessment -no injury documents two or more. Injury (except major) documents two or more.R2's Care plan has a focus area of: I've had a recent fall that has caused a brain bleed with a date initiated of 11/24/25 with interventions of 1. administer medications per Dr. (Doctor) order. 2. Assess neurological status per facility policy and PRN. 3. Monitor for headaches, nausea, and vomiting and PEARL (Pupils, Equal, and Reactive to Light) 4. Monitor for pain per facility policy and PRN (as needed). 5. Monitor for seizures activity. Notify Dr. of any activity. 6. Monitor vital signs per facility policy and PRN. R2's Care plan has another focus area of: Risk for falls with interventions of 1. 01/16/26 Fall intervention updated to include assist resident to/from all destinations with staff attending needs before exiting. Staff to leave call light within reach. 2. 01/02/25 Fall Intervention updated to include encourage the resident to ask for help when he needs something picked up off the floor. 3. 01/2/26 Fall intervention updated to include educate resident on asking staff for assist with transfers. 4. 1/21/26 Fall Intervention updated to include new wheelchair with adjusted height for legs. 5. 01/27/26 Fall Intervention updated to include personal items within reach. 6. 01/28/26 Fall Intervention updated to include all personal items be within reach and at eye level. 7. 11/10/25 Fall intervention updated to include frequent checks when in bed. 8. 11/14/25 Fall intervention updated to include call light wrapped with yellow tape as visual reminder to ask for assist. 9. 11/24/25 Fall intervention updated to include move closer to nurse's station. 10. 12/13/25 Fall Intervention updated to include verbal reminder to use call light and wait for staff assist. 11. 12/13/25 Fall Intervention updated to include ensure bed is kept in lowest position. 12. 12/23/25 Fall Intervention updated to include 15-minute checks. (R2) continues to be seen by PT (Physical Therapy)/OT (Occupational Therapy) and a Call, don't fall sign placed in room. 13. 12/30/25 Fall intervention updated to include Call Don't fall sign place in room. 14. 02/10/26 Fall intervention updated to include continue antibiotic therapy for urinary symptoms. 15. 02/14/26 Fall Intervention updated to include PT/OT to evaluate and off frequent position changes. 16. 02/15/26 Fall intervention updated to include assist resident with transfers, utilizing therapy recommendations. 17. 02/17/26 Fall intervention updated to include activity director to assess for independent activities. 18. 02/19/26 Fall intervention updated to include to remind staff that AROM (active range of motion) can be performed PRN when (R2) wants to exercise. 19. 02/24/26 Fall Intervention updated to include (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 0689 Level of Harm - Actual harm Residents Affected - Few	snacks moved within reach of (R2). 20. 02/28/26 Fall Intervention move resident into room closer to the nurse's station to allow staff to better observed resident. 21. 02/07/26 Fall Intervention updated to include continue to monitor for abnormal behavior. Notify Dr. of change in behavior. 22. 02/07/26 Fall intervention updated to include encourage water intake and continue safety checks. 23. 03/30/26 Fall intervention updated to include grippy socks/proper footwear at all times. 24. 04/03/26 Fall intervention update to include med review. 25. 04/05/26 Fall Intervention updated to include activities to reassess resident interests and provide individual engagement (TV (television), music, structed activities) to reduce boredom, confusion and misperception-related behaviors, promoting safety. 26. 04/05/26 Fall intervention updated to include schedule telehealth with (Psychiatrist). 27. Ensure call light is available to resident. 28. Evaluate fall risk on admission and PRN. 28. Fall intervention updated for activities to reassess for interest, TV, music to provide when in room. 29. Fall Intervention updated to include Flomax time change to HS (Night) to help decrease urge to void. 30. Fall intervention updated to include monitor for s/sxs (signs and symptoms) of Delirium and notify MD (Medical Doctor). 31. If fall occurs, alert provider. 32. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. R2's fall investigation dated 01/01/26 at 3:30PM documents under incident description: Nursing Description- This nurse was walking up the hallway when this nurse observed the resident drop an item onto the floor on the south hallway before this nurse could help the resident. The resident leaned forward to pick up the item and fell onto hand and knee. This resident did not hit his head. This nurse began to assess the resident and found no injuries. The resident did not have any complaints of pain ROM (range of motion) WNL (within normal limits). Resident description- I dropped something and was trying to pick it up. Immediate action taken. Intervention- Encourage the resident to ask for help when he needs something picked up off the floor. R2's fall investigation dated 01/02/26 at 10:30PM documents under incident description: Nursing description- This nurse and CNA (Certified Nurse Assistant) were walking past resident room and noted resident on floor. Upon entering room, resident noted laying on right side on floor at foot of bed with head towards door, facing the head of bed. Resident stated he was getting out of bed when he slid. Gripper socks on, blanket noted on floor on the side he stated he got out of bed on. Resident stated he hit his right knee and right elbow on the floor. Denies any pain at current time. No apparent injuries noted. ROM WNL Neuros WNL resident assisted to bed x 2 assist per resident request. 1:1 with resident about using the call light for assist with transfers. Resident stated he forgot to use call light. Call light clipped to shirt, resident stated, thank you, I think that will help me remember. Resident description- I slid when I was getting out of bed. Immediate action taken - resident assessed, assisted back to bed, 1:1 done with resident about asking for assist with transfers. Call light clipped to shirt rather than blanket. R2's fall investigation dated 01/15/26 at 12:30PM documents under incident description: Nursing description- CNA was walking by residents' room and observed him leaning forward out of wheelchair. Resident then dropped to knees and began crawling towards bed. CNA called for nurse and this nurse, and CNA assisted resident into bed for assessment. No injuries noted. Resident description- Resident unable to give description. Immediate action taken- resident assisted into bed and assessed for injuries. No injuries noted. Resident encouraged to use call light when needing assistance and stated, That's what i was trying to do. R2's fall investigation dated 01/20/26 at 3:30PM documents under incident description: Nursing description- This nurse was made aware by the MDS coordinator of the resident's fall. This nurse was not present for the resident's fall or when he was assisted back into his wheelchair. MDS coordinator stated that she was in dining room when resident was wheeling himself forward when he slowly started to lean forward and lightly fall out of wheelchair and onto his knees. Resident description- Resident unable to give description. Immediate action taken- This nurse was made aware and this nurse then requested a full set of vitals, assessed for injuries, began a neurological assessment, and then contacted the MD and POA (Power of Attorney).R2's fall investigation dated 01/26/26 at 5:20PM documents under incident description: Nursing description- This nurse was alerted by CNA that the resident was lying (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on the floor in his bedroom. This nurse immediately went to assess the resident and found the resident lying on his right side on the floor in the resident bedroom doorway. The resident was previously in the wheelchair. ROM WNL. Neuro checks initiated. The resident states that he did not hit his head and is not experiencing any pain. No evidence of head injury. No skin injuries observed at this time. Resident description- I was in my wheelchair trying to get my charger to plug my phone in. Immediate action taken- no intervention or action listed. R2's fall investigation dated 01/27/26 at 3:55PM documents incident description: Nursing description- This nurse was alerted by the resident that this resident (R2) was lying on the floor. This nurse went down to assess the resident, and the resident was up in the wheelchair. The resident stated that she saw the resident (R2) siting on the floor and watched the resident get back into the wheelchair. ROM WNL. No evidence of head injury. The resident declines hitting his head and declines any pain. No new skin injuries observed at this time. Resident description- The resident states that he was trying to get to his candy when his wheels on his wheelchair stopped and he fell forward landing on his knees. The resident states that he did not hit his head and he was not in any pain. Immediate action taken- intervention up at the nurse's station for monitoring. Review of R2's fall investigation dated 02/07/26 at 4:22AM documents incident description: Nursing description- This nurse was at nurses' station and heard someone down the hallway. Nurse looked and saw this resident standing outside of his door. Nurse got up to go to resident but could not get to resident fast enough. Resident fell to his left hitting the left side of his head on the door. Resident assessed. Denies pain, stated his head is a little sore. No red marks, bruising, open areas noted to left head. No apparent injuries noted. ROM WNL. Neuros WNL for resident. Wheelchair next to bed in res (resident) room. Resident assisted to wheelchair and brought to common area. Resident Description - I fell Immediate Action taken- Resident assisted to wheelchair and brought to common area. R2's fall investigation dated 02/07/26 at 6:10PM documents incident description: Nursing description- This nurse was in restroom when this nurse was made aware by nurse AM that resident was found on the floor on his knees beside the nurses' station closest to the exit. R2 stated he was trying to pull out the tubing to his catheter bag CNA's assisted resident up to his feet where they put him back in his bed. Resident description- resident unable to give description. Immediate action taken- This nurse ensured resident was helped safely to his room and placed in bed where she the instructed CNA to obtain vital signs and the nurse then began a neuro check. Following the initial neurological check, this nurse contacted the on-call provider at 1815 (6:15PM) where she instructed just to keep a close eye, continue neurological checks, and notify immediately of any changes. R2's fall investigation dated 02/14/26 at 11:30PM documents incident description: Nursing Description- Nurse at nurse's station, heard someone yelling help down south hall. This resident noted on hands and knees on floor with w/c (wheelchair) behind him in front of his door. denies pain. ROM WNL. Neuro WNL. No apparent injuries noted. Resident description- I fell out of my wheelchair 1:1 with resident to use call light if he needs anything, resident states understanding. R2's fall investigation dated 02/16/26 at 8:35PM documents incident description: Nursing description- This nurse was walking up north hall towards the nurse's station when this nurse observed the resident leaning forward with feet pulled up into the base of the wheelchair and fell onto his knees. The resident did not hit his head. The resident denies any pain. ROM WNL. No skin injuries. Resident description- I fell forward Immediate action taken- Intervention placed at nurses' station for monitoring. R2's fall investigation dated 02/19/26 at 12:10AM documents incident description: Nursing Description- Nurse heard noise down south hall. When investigating, this resident was noted on hands and knees on floor in front of his wheelchair in front of bathroom door in his room with a cup in the floor in front of him. Nurse asked resident what he was doing, resident states he needs to exercise. resident assessed, no apparent injuries noted. Denies pain. ROM WNL. Neuro checks WNL. While waiting on CNA to assist with getting resident up, resident got himself off of the floor and into wheelchair. Nurse SBA (stand by assisted), tried to encourage resident to wait for help. Resident declined to wait for assist. 1:1 with resident reminding him it is just after midnight, and everyone is sleeping. Resident agreed to go back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to bed and wait until morning to exercise. Resident assisted to bed with 1A (one assist) CNA, call light in reach. No further needs at this time. Resident Description- I was going to exercise out there. Review of R2's fall investigation dated 02/22/26 at 9:45PM documents incident description: Nursing Description- This nurse was sitting at the nurses' station when this nurse observed the resident propelling himself up the hallway in his wheelchair when he was leaning forward and fell out of his wheelchair onto his knees. The resident did not hit his head. No skin injuries observed. ROM WNL. Resident description- I fell Immediate action taken- Intervention placed at the nurses' station for monitoring. Review of R2's fall investigation dated 02/23/26 at 10:30PM documents incident description: Nursing description- bright red blood noted on resident floor, resident lying on his bed. Had been propelling himself in the hallway in his wheelchair on his way to his room, asked resident what happened, resident reports he fell forward out of his wheelchair and hit the floor. Bright red blood noted to chin area. No other injuries apparent, alert to self. Resident description- I fell forward out of my chair and hit my chin on the floor. Some of my teeth broke off and I just got myself up and climbed in bed. Immediate action taken- [NAME] area cleansed, bleeding subsides, BP (blood Pressure) 137/77, P (Pulse) 80, R (respirations) 16, T (temperature) 97.7, SPO2 (oxygen saturation) 97% on RA (room air), approx. 2mm (millimeter) laceration noted to chin, unable to determine if any teeth are missing from fall due to dental condition. Resident jokes saying well at least the dentist won't have as many to deal with, since they are rotten this nurse unable to find any broken teeth in room. R2's fall investigation dated 02/28/26 at 3:10AM documents incident description: Nursing description- Nurse at nurse station, heard a noise down south hall. Upon entering this resident's room, resident noted lying on his right side on the right side of the bed with head towards the bed, feet towards the door. Drink spilled on floor behind him, w/c (wheelchair) in front of him. Resident states, I was trying to get up to find you guys and I fell. Neuro checks WNL. ROM WNL. Denies pain. Denies slipping in drink, feet not wet. Resident description- I was trying to get up to find you guys and I fell. Immediate action taken- resident assisted back to bed per request. 1:1 related to using call light, frequent checks. R2's fall investigation dated 03/30/26 at 3:55AM documents incident description: Nursing description- This writer was called to residents' room by cnas who observed resident on floor beside bed. Resident reports he fell. Alert with usual confusion. No injuries noted. Denied hitting head. Resident has no footwear in place. assessed for injuries and assisted back in bed. grippy socks placed on resident at this time. Call light placed within reach. Neuro checks initiated. Resident description- resident unable to give description. Immediate action taken- assessed for injuries and assisted into bed. Grippy socks placed on resident. Neuro checks initiated. Review of R2's fall investigation dated 04/02/26 at 6:15AM documents incident description: Nursing description- CNA alerted this nurse resident was lying on floor next to his bed. Upon entering room resident lying on right side of bed on his stomach with head turned to the left side towards the bed. Resident description- Res. states he dropped a piece of cookie on the ground and was trying to pick it up. Immediate action taken- assessed for any possible injuries. VS (vital signs) obtained. Neuro checks initiated. Assisted into bed. Call placed to 911. R2's fall investigation dated 04/04/26 at 8:55AM documents incident description: Nursing description: CNA was walking by room when she noted resident was not in his bed. CNA alerted nurse. Upon entering room resident noted on his left side under his bedside table on the left side of his bed. Resident states he did not mean to get out of bed. Resident denies hitting head, denies any pain. ROM WNL. No apparent injuries noted. Resident description- I didn't mean to get out of bed. I leaned over too far and went in the floor. Immediate action taken- 1:1 with resident on use of call light. HOB (Head of Bed) lowered, resident repositioned in bed. R2's progress note dated 03/30/26 at 4:21AM by V4 (Licensed Practical Nurse) documents This writer was called to residents' room, observed resident in floor beside bed. Resident reports he fell. Alert with usual confusion. No injuries noted. Resident has no footwear in place. Assessed for injuries and assisted back in bed. Grippy socks placed on resident at this time. Call light placed within reach. Neuro checks initiated. ADON (Assistant Director of Nursing), administrator, MD (medical (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	doctor) and POA (power of attorney) notified. R2's progress note dated 03/30/26 at 6:47AM by V4 documents Resident has small amount of swelling noted to left cheek. Resident stated he couldn't remember if he hit his cheek during fall. POA called at this time and asked if she would like resident sent to hospital. She said only if resident has complaints of discomfort. Resident has no complaints at this time. Did report tooth discomfort and has several broken teeth which were like that prior to fall. Will continue to monitor and notify MD if swelling continues. Neuros continue WNL. R2's progress note dated 03/30/26 at 11:58AM (10:15) This nurse was alerted by CNA staff about the residents swelling/bruising. This nurse went down to assess the resident and found left sided facial and orbital swelling/bruising. Vital signs are as follows temp-97.3, RR (respiratory rate) 18, pulse 84, O2 97% on RA. and B/P 147/81. The resident states that he is experiencing head and neck pain. The resident is agreeable to be sent to the ER (emergency room) for further evaluation. (10:25) this nurse contacted (Local Ambulance) to have the resident transferred to (Local Hospital) (10:27) This nurse notified V1 of the resident being transferred to the ER. (10:30) this nurse attempted to contact (POA), no answer, unable to leave voicemail d/t (due to) mailbox being full. (10:35) MD was notified. (10:45) EMS (emergency medical services) arrived at the facility to transport the resident to (local Hospital) bed hold policy was sent. (10:53) This nurse called report into (Local Hospital emergency room). R2's progress note dated 03/31/26 5:23PM resident returned from hospital via ambulance with dx (diagnosis) of closed fracture of orbit. Resident very restless. New orders received and transcribed. R2's progress note dated 04/02/26 at 5:29PM CNA alerted nurse res was lying in floor next to his bed. Upon entering room, res lying on right side of bed on his stomach with head turned to the left side towards the bed. Resident reports he hit his head. Bruising r/t previous fall continues and is hard to tell if any new injuries are noted at this time. MD notified. New order: send to ER for eval and treat. POA notified. ADON here and aware of fall. EMS called and requested transfer to hospital for ground level fall. Awaiting EMS at this time.R2's progress note dated 04/02/26 at 9:53PM Spoke with (Local Hospital emergency room Nurse) at this time who stated while doing CT (Computed Tomography) scans, it did show old thoracic vertebrae fx,(fracture) that this is not new, but they do recommend spine surgery f/u. They have put in a referral. V2 and V1 aware.R2's local hospital emergency room records with a date of service of 03/30/26 documents under history of present illness facial trauma and periorbital swelling sustained facial injury after slipping and falling overnight/early morning on 03/30/26, struck L (left) face during the fall, swelling around the left eye, vision intact w/o (without) visual changes, no other visual changes and acute left sided neck pain mild left sided neck pain since fall, no shoulder pain, no difficulty moving arms. Clinical Impression documents closed fracture of let orbit and closed fracture of left side maxilla. fall encounter. R2's local hospital emergency room records with a date of service of 4/02/26 documents chief complaint fall. ED (emergency department) course documents 4/02/26 CT thoracic spine without contrast T4 spinous process fx (fracture) Pt. (patient) informed. Recommend spine surgery outpatient f/u (follow up). Clinical impression documents fall and head injury. On 04/12/26 at 9:03AM observed R2 door which was closed. Observed R2 lying in bed no staff observed in room. R2's call light out of reach of resident with no yellow tape wrapped around call light. On 04/13/26 at 10:22AM observed R2's call light which was out of reach of resident. No yellow tape wrapped around call light. Call light on top of nightstand on top of assistive devices. On 04/13/26 1:44PM observed R2's call light on nightstand on top of positioning device approximately 4 feet from where R2 was laying. R2 lying in bed. No yellow tape noted to call light. On 04/13/26 at 2:40PM observed R2's door closed and call light not in reach of resident and no yellow tape noted to call light. On 04/13/26 at 3:10PM observed R2's call light which was not in reach of resident who was lying in bed. Call light lying on nightstand on top of assistive device. No yellow tape observed on R2's call light. On 04/14/26 1:32PM observed R2's call light in reach of resident no yellow tape observed around R2's call light.On 04/15/26 at 1:02PM observed R2 wheeling himself in his wheelchair down the hallway back to his room no staff observed down the hallway or assisting R2 out of dining room. R2 was seen getting his front part of his wheelchair (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	caught on the corner of his doorway. Observed R2 get out of his wheelchair with no staff in site re-adjust his wheelchair and then sit back in his wheelchair, but the wheelchair was still stuck on the doorway. R2 then couldn't get his wheelchair to move so he stood back up and got his right foot tangled in his catheter tubing and then began walking down the hallway pushing his wheelchair with an unsteady gait and right leg still tangled in catheter tubing. R2 pushed his wheelchair all the way to the end of the hallway and almost all the way back no staff was observed in site this whole time. At 1:10PM observed V16 (Housekeeper) yelling for staff to assist R2 who was still walking with unsteady gait behind wheelchair and tubing tangled around right leg. At 1:11PM 3 staff members observed coming to assist R2 back into wheelchair. On 04/15/26 at 1:15PM, V4 (Licensed Practical Nurse) V4 stated that R2 does have a lot of falls especially on midnight shift. V4 said that she works day shift and night shift often. V4 said they try to prevent R2 from falling but he just seems like a different person at night. V4 said that some nights if they are having a bad night that R2's 15-minute checks might not get done. V4 said that the staff are very good about trying to get them done, but there are some nights that are unpredictable, and the checks might not all get done. V4 said that she was working on 03/30/26 and she said R2 was found on the floor beside his bed. V4 said R2 said he didn't hit his face or head. V4 said that later she was checking on R2 and observed swelling and she let the nurse who was taking over for her know that R2 had some swelling and a little bruising to his face. V4 said that the nurse who took over for her sent R2 out and he had a facial fracture. V4 said that several days later R2 had another fall, and she noticed some bruising on R2 hip area and couldn't tell if it was new bruising from the current fall or from the old fall on 03/30/36 so she got orders to send R2 to the hospital. V4 said that R2 did come back from the hospital, and they told them that he had an old thoracic fracture and that he didn't have any new fractures. They didn't know when the thoracic fracture happened. V4 said that even after that fall R2 had another fall several days later. V4 said that they try to prevent R2 from falling as best as they can. On 04/15/26 at 1:26PM, V2 (Assistant Director Nursing) stated that she wasn't aware of any residents being on 15-minute checks currently. V2 stated that she feels like staff should be able to do 15-minute checks on R2 if he had 15-miniute checks. V2 said that staff have a really good working relationship and can help each other out. V2 said that she would expect R2 and all residents to have their call lights in reach of them when they are in bed. V2 said that she would expect R2's door to be open when R2 is in bed unless staff is in the room providing care. V2 said that R2 was supposed to have yellow tape around his call light so he could find his call light easier. V2 said that she knew that R2 got moved closer to the nurses' station so staff could check on him more. On 04/15/26 at 1:50PM R2's door was observed closed no staff noted in room. R2's call light at the foot of his bed and no yellow tape noted to call light. On 04/15/26 at 2:00PM R2 stated that he doesn't know why he falls all the time. R2 stated that he has Parkinsons and maybe that is why he falls a lot. On 04/15/26 at 2:15PM, V7 (Minimum Data Set Coordinator) she stated that she is trying to come up with new interventions for R2 and all the residents. V7 stated that she doesn't know if the interventions she put in place are working or not. V7 said that it is hard to come up with new interventions, because R2 has had so many falls. V7 said that she tries to get more detail with some of the new fall interventions or figure out a new way to put the intervention to see if it works better. 2. R4's admission record documents an admission date of 04/30/24 with diagnoses in part of unspecified convulsions, cerebrovascular disease, muscle wasting and atrophy, lack of coordination, and need for assistance with personal care. R4's MDS (Minimum Data Set) dated 02/06/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 07 which indicates R4 has severely impaired cognition. Section GG documents toileting as dependent. Transfers as Substantial/Maximal assistance with transfers. Section J documents under has the resident had any falls since admission/entry or reentry or the prior assessment as yes. Number of falls since admission or prior assessment- no injury 2 or more. R4's Care Plan documents a focus area of Risk for falls with a revision date of 05/06/24 with interventions of 1. 01/14/26 fall intervention update to include staff to monitor position when in wheelchair. 2. 01/22/26 Fall intervention updated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to include Monitor Safety check 15 minutes r/t (related to) increased falls. 3. 01/05/26 Fall intervention updated to include encouraging the resident to ask for assistance during transfers. 4. 01/09/26 Fall intervention updated to include offer to lay down the resident after meals. 5. 10/13/25 Fall intervention updated to include Call Don't Fall sign in room. 6. 10/20/25 Fall intervention updated to include yellow on call light as visual reminder. 7. 10/31/25 Fall intervention updated to include proper footwear when out of bed. 8. 10/05/26 Fall intervention updated to increase visual checks when out of bed. 9. 12/30/25 Fall intervention updated to include nonskid mat on wheelchair. 10. 2/5/26 Fall intervention updated to include frequent checks when up. 11. 03/31/26 Fall intervention updated to include foam grip adaptive to regular spoon at meals. 12. 03/06/26 Fall intervention updated to include educate staff to anticipate resident needs during peak times of restlessness to provide assistance with transfers and prevent self-transfers.13. 04/05/26 Fall intervention updated to include resident be monitored at nurses' station after supper. 14. 09/12/25 Fall intervention updated to include education provided on using proper foot pedal/rest use. 15. Assist with Adl's (activities of daily living), transfers, PRN. 16. Educate on the importance of maintaining safe environment, free of potential fall hazards. 17. Ensure bed is kept in lowest position. 18. Ensure call light is available to resident. 19. Evaluate fall risk on admission and PRN. 20. Evaluate resident's environment to identify factors known to increase risk of falls, 21. Fall on 03/06/26 intervention educate staff to anticipate resident needs during peak times of restlessness to provide assistance with transfers and prevent self-transfers. 22. If fall occurs alert provider. 23. If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. 24. Review medication for drugs that increase the risk for falls.R4's Fall investigation dated 04/05/26 5:50PM documents under incident description: Nursing description- Staff observed the resident lying on the floor in the dining room. ROM WNL. No skin injuries observed at this time. Immediate Action taken- up at Nurses station for monitoring.On 04/12/26 at 9:16AM observed R4's room door closed no staff observed in room. R4 was lying in bed no call light in reach and no yellow tape noted to around call light.On 04/13/26 at 1:00PM observed R4 in a wheelchair wheeling self around facility from dining room. R4 was sitting on the edge of his wheelchair trying to propel himself around. Observed several staff going past R4. Observed R4 trying to get self out of wheelchair two times.On 04/14/26 at 1:35PM, V14 (Certified Nurse Assistant) stated that R4 is not on 15 minutes checks as far as she knows. V14 said that she is working on R4's hall today. V14 said all resident's call lights should be in reach of all residents when they are in bed, especially residents who are fall risk.On 04/14/26 at 1:37PM, V6 (Certified Nurse Assistant) stated that R4 is not on 15-minute checks. R4 said they did move R4 closer to the nurse's station, but he isn't on 15-minute checks. V6 stated that all resident call lights should be in reach of all residents when they are in bed.On 04/15/26 at 3:00PM observed R4 who was sitting in his wheelchair in foyer for over 16 minutes with no staff checking or monitoring R4.On 04/16/26 at 9:12AM, V7 (MDS Coordinator) stated that R4 is on 15 minutes checks and staff should be making sure that R4's call light is in reach of R4 at all times when he is in bed. R4 is also to have yellow tape wrapped around his call light to make it easier for R4 to find. V7 said that staff should also be offering to lay down R4 after meals and if they see R4 trying to get up or sliding out of his chair reposition him back in his wheelchair.On 04/16/26 at 9:53AM, V2 (Assistant Director of Nursing) stated that she doesn't know for sure if R4 is on 15-minute checks but if he is she would expect staff to be doing 15-minute checks. V2 said that all residents should have call light in reach of them when in bed. V2 said that if a resident is scooting out of their wheelchair, she would expect staff to assist them back in the wheelchair. V2 said that they should also be offering to lay down R4 after meals and assisting with toileting. V2 said that she would expect st[TRUNCATED

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to provide needed care in a timely manner. This failure has the potential to affect all 46 residents residing at this facility.Findings included:1. R23's admission Record documents an admission date of 10/20/2023 with diagnoses of chronic pulmonary edema, mild intellectual disability, morbid obesity and need for assistance with personal care. R23's MDS (Minimum Data Set) dated 1/15/26 documented R23 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15 total, which indicates R23 is cognitively intact. This same MDS documented R23 has impairment to both lower legs, uses a wheelchair and is dependent on staff for transfers and toileting care. On 4/12/2026 at 9:10am, R23, who is alert and oriented, said he had to wait 3 hours the previous night (4/11/2026) for his call light to be answered by staff because there are only two staff working on the night shift. R23 said this is how it is every night. R23 said he turned the call light on around 12:00am and the staff did not answer the call light until around 3:00am. R23 said most nights there are only two staff on the night shift and he must wait long periods of time for staff to provide him toileting care. 2. R22's admission Record documents an admission date of 3/31/2025 with diagnoses of peripheral vascular disease, muscle wasting/atrophy and chronic congestive heart failure. R22's MDS dated [DATE] documented R22 with a BIMS score of 15 out of 15 total, with indicates R22 is cognitively intact. This same MDS documented R22 has impairment in both legs, uses a wheelchair and is dependent on staff for toileting and personal hygiene care. On 4/12/2026 at 10:07am, R22, who is alert and oriented, said on the night of 4/11/2026, he had to wait two hours for his call light to be answered by staff. R22 said the facility needs more staff and only had two CNA's on staff last night. R22 said he turned on his call light around 1:00am and staff did not answer the call light until 3:10am. 3. R32's admission Record documents an admission date of 6/6/2025 with diagnoses of pulmonary fibrosis, atrial fibrillation, muscle wasting/atrophy and chronic congestive heart failure. R32's MDS dated [DATE] documents R32 with a BIMS score of 13 out of 15 total which indicates R32 is cognitively intact. This same MDS documented R32 uses a walker for ambulation and needs supervision/touch assistance for toileting and personal hygiene care. On 4/12/2026 at 11:10am, R32 said at night the facility only had two staff for all these people. R32 said it takes 30-45 minutes for the staff to answer my call light for help to the bathroom. R32 said she doesn't want to fall and get hurt. R32 said the facility needs more workers to care for the people who live here. 4. R15's admission Record documents an admission date of 12/12/2025 with diagnoses of emphysema, chronic obstructive pulmonary disease, seizures and need for assistance with personal care. R15's MDS dated [DATE] documents R15 with a BIMS score of 14 out of 15 total which indicates R15 is cognitively intact. This same MDS documents R15 has impairment to both legs, uses a wheelchair and is dependent on staff for toileting care. On 4/14/2026 at 12:04pm, R15, who is alert and oriented, was observed turning on her call light for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assistance. At 12:15pm, two staff were observed walking past R15's activated call light and did not answer the call light. At 12:21pm, staff answered R15's call light. 5. R38's admission record documents an admission date of 4/4/2025 with diagnoses of chronic obstructive pulmonary disease, hypertension, need for assistance with personal care and dependence on supplemental oxygen. R38's MDS, dated [DATE], documents a BIMS score of 15 out of 15 total, which indicates R38 is cognitively intact. This same MDS documents R38 has impairment in both legs, uses a wheelchair and needs partial moderate assistance with toileting from staff. On 4/14/2026 at 3:35pm, R38 said he had already turned on his call light for assistance with his oxygen concentrator and oxygen tubing. R38 stated his call light has been on for a while already. At 3:49 pm staff answered R38's call light and assisted R38. On 4/12/2026 at 9:30am, V14 (Certified Nursing Assistant) said the facility does not have enough help. V14 said she has trouble getting all the needs of the residents met in a timely manner due to the lack of staff. V14 said call lights are especially hard to answer in a timely manner. V14 said residents must wait as long as 30-45 minutes until I can get to them. V14 said we do the best we can, but we need more help. The facility's CNA (Certified Nursing Assistant) schedule titled April 5-April18, 2026, documents two CNAs scheduled from 10:00pm-6:00am for 4/5, 4/6, 4/7, 4/9, 4/10, 4/11, 4/12, 4/13. Only one CNA was scheduled 10:00pm-6:00am for 4/8/2026. A non-dated census list of residents with type of assistance needed for transferring was provided by the facility. The list documented 7 residents transfer with a full body lifting machine, 6 residents need two staff to transfer, and 12 residents need one staff to transfer. On 4/15/2026 at 12:05pm, V1 (Administrator) said she handles the nursing scheduling for this facility since they don't have a Director of Nursing. V1 reviewed the current CNA schedule (4/5/26-4/18/26) which revealed only two CNA's work 10:00pm-6:00am and said, I really don't know if two CNA's are enough staff to provide adequate resident care in a timely manner. I'd have to review our facility policy to see what it said. V1 was asked if two CNA's would be enough to evacuate during an emergency? V1 replied I don't know. Only having two CNA's on the nightshift is how we have always done it, so that is what I schedule, I really wouldn't know if two are enough staff or not. On 4/15/2026 at 12:30pm, V15 (Certified Nursing Assistant) said she works on the nightshift from 10:00pm-6:00am. V15 said the facility only schedules two CNA's for the nightshift but she doesn't think there is enough staff to provide timely care to the residents. V15 said it is hard to get 15-minute checks completed for residents with increased supervision and get bed check done and get the call lights answered, so most of the time the checks don't get done. V15 said many times residents must wait to get their call lights answered because everybody needs something at the same time it seems like. V15 said the staff do the best they can with the number of staff they have available at the time. V15 said R2 falls often during the night and V15 thinks R2 should have 1:1 supervision at time due to his sundowners, but they don't have enough staff to always monitor R2 when he is up at night. The facility's matrix dated 4/12/26 documents a total of 46 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a full time Director of Nursing and to have a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. This failure has the potential to affect all 46 residents residing at this facility.Findings included:On 4/14/2026 at 1:04pm, V1 (Administrator) said the facility did not have the required 8 consecutive hours per day of Registered Nurse coverage. V1 said some days we do not have the required RN coverage. The facility schedule titled April 5-April 18, 2026, documented no RN (Registered Nurse) coverage for dates of 4/13/2026.The facility schedule titled March 22-April 4, 2026, documented no RN coverage for dates of 3/24/26 and 3/25/26.The facility schedule titled March 8-March 21, 2026, documented no RN coverage for dates of 3/18/26 and 3/13/26.On 4/14/2026 at 1:45pm, V1 (Administrator) said the facility has not employed a Director of Nursing since V11 (Registered Nurse) stepped down from the position on November 2nd of 2025. V1 said the facility has not been able find another Director of Nursing since then. V1 said Regional Nurses are monitoring this facility for Director of Nursing needs from afar but are not physically at this facility on a daily basis and hardly come to the facility unless needed.On 4/14/2026 at 1:30pm, V2 (Assistant Director of Nursing) said the facility had not had a Director of Nursing since mid-November of 2025 as far as she could remember.On 4/14/2026 at 2:00pm, V3 (Regional Nurse) said the facility was actively seeking to hire a Director of Nursing to fill the open position. V3 said the facility did not have a specific policy concerning Registered Nurse coverage or on having a Director of Nursing.The facility's matrix dated 4/12/26 documents a total of 46 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. The Facility assessment dated [DATE] documents the following in part: Staffing Plan-Describe your general staffing plan to ensure sufficient staff to meet the needs of the residents at any given time. 1 (one) DON (Director of Nursing) RN full time days; if has other responsibilities add more RN as Asst. (Assistant) DON to equal one FTE (full time employee).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on interview, observation, and record review the facility failed to maintain an effective pest control program to rid the facility of gnats. This failure has the potential to affect all 46 resident currently residing in the facility. The findings include:On 04/12/26 at 8:50AM, R29, who was alert and oriented, stated that the facility does have a problem with gnats. R29 stated that they are all over the building. On 04/12/26 at 8:51AM, R29's room was observed with 2 gnats flying over R29's bed. 04/12/26 at 9:03AM, gnats were observed on R2's food tray that was sitting on R2's bedside table in his room.On 04/12/26 at 9:09AM, R3, who was alert and oriented, stated that the facility has a problem with gnats. R3 said that the gnats are in the dining room and in all the bedrooms. R3 said she has one gnat that has been in her room for a while and won't leave her food or stuff alone. R3 said that she has one gnat that has gotten pretty big in her room, and her and the gnat are becoming friends now. On 04/12/26 at 9:17AM, R24, who was alert and orientated, stated that the facility has a terrible problem with gnats. R24 said that they are in the bedrooms and in the dining room. On 04/12/26 at 9:20AM, R21, who was alert and oriented, stated that the facility has a problem with gnats all over the building. R21 said when he is trying to eat in the dining room, he is having to swat at them to get them away from his food The facility policy dated 09/01/22 titled, Pest Control documents: 3. the pest control program will be conducted on a regular and as needed basis and 10. the facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects or rodents.The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 4/13/26 documents there are 46 residents living in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for 5 of 5 residents (R15, R22, R23, R32 and R38) reviewed for call light response times in a sample of 46.Findings include:1. R23's admission record documents an admission date of 10/20/2023 with diagnoses of chronic pulmonary edema, mild intellectual disability, morbid obesity and need for assistance with personal care. R23's MDS (minimum data set) dated 1/15/26 documented R23 with a BIMS (brief interview for mental status) score of 15 out of 15 total, which indicates R23 is without cognitive impairment. This same MDS documented R23 has impairment to both lower legs, uses a wheelchair and is dependent on staff for transfers and toileting care.On 4/12/2026 at 9:10am, R23 said he had to wait 3 hours the previous night (4/11/2026) for his call light to be answered by staff because there are only two staff working on the night shift. R23 said this is how it is every night. R23 said he turned the call light on around 12:00am and the staff did not answer the call light until around 3:00am. R23 said most nights there are only two staff on the night shift and he must wait for staff to provide him toileting care. 2. R22's admission record documents an admission date of 3/31/2025 with diagnoses of peripheral vascular disease, muscle wasting/atrophy and chronic congestive heart failure. R22's MDS dated [DATE] documented R22 with a BIMS score of 15 out of 15 total, with indicates R22 is cognitively intact. This same MDS documented R22 has impairment in both legs, uses a wheelchair and is dependent on staff for toileting and personal hygiene care.On 4/12/2026 at 10:07am, R22 said on the night of 4/11/2026, he had to wait two hours for his call light to be answered by staff. R22 said the facility needs more staff and only had two CNA's (Certified Nursing Assistants) on staff at night. R22 said he turned on his call light around 1:00am and staff did not answer the call light until 3:10am.3. R32's admission record documents an admission date of 6/6/2025 with diagnoses of pulmonary fibrosis, atrial fibrillation, muscle wasting/atrophy and chronic congestive heart failure. R32's MDS dated [DATE] documents R32 with a BIMS score of 13 out of 15 total which indicates R32 is without cognitive impairment. This same MDS documented R32 uses a walker for ambulation and needs supervision/touch assistance for toileting and personal hygiene care.On 4/12/2026 at 11:10am, R32 said at night the facility only had two staff for all these people. R32 said it takes 30-45 minutes for the staff to answer her call light for help to the bathroom. R32 said she doesn't want to fall and get hurt. R32 said the facility needs more workers to care for the people who live here. 4. R15's admission record documents and admission date of 12/12/2025 with diagnoses of emphysema, chronic obstructive pulmonary disease, seizures and need for assistance with personal care. R15's MDS dated [DATE] documents R15 with a BIMS score of 14 out of 15 total which indicates R15 is without cognitive impairment. This same MDS documents R15 has impairment to both legs, uses a wheelchair and is dependent on staff for toileting care.On 4/14/2026 at 12:04pm, R15 turned on her call light for assistance. At 12:15pm, two staff were observed walking past R15's activated call light and did not answer the call light. At 12:21pm, staff answered R15's call light. 5. R38's admission record documents an admission date of 4/4/2025 with diagnoses of chronic obstructive pulmonary disease, hypertension, need for assistance with personal care and dependence on supplemental oxygen. R38's MDS, dated [DATE], documents a BIMS score of 15 out of 15 total, which indicates R38 is without cognitive impairment. This same MDS documents R38 has impairment to both legs, uses a wheelchair and needs partial moderate assistance with toileting from staff.On 4/14/2026 at 3:35pm, R38 stated he had turned on his call light about 15 minutes ago to get assistance with his oxygen concentrator and oxygen tubing. At 3:49pm staff answered R38's call light and assisted R38.On 4/12/2026 at 9:30am, V14 (Certified Nursing Assistant) said the facility does not have enough help. V14 said she has trouble getting all the needs of the residents met in a timely manner due to the lack of staff. V14 said call lights are especially hard to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	answer in a timely manner. V14 said residents must wait as long as 30-45 minutes until she can get to them. V14 said we do the best we can, but we need more help.On 4/15/2026 at 12:05pm, V1 (Administrator) said she handles the nursing scheduling for this facility since they don't have a Director of Nursing. V1 reviewed the current CNA schedule (4/5/26-4/18/26) which revealed only two CNAs worked 10:00pm-6:00am and said, I really don't know if two CNAs are enough staff to provide adequate resident care in a timely manner. I'd have to review our facility policy to see what it said. And then stated, I really don't know. Only having two CNA on the nightshift is how we have always done it, so that is what I schedule, I really wouldn't know if two are enough staff or not.The facility's CNA (Certified Nursing Assistant) schedule titled April 5-April18, 2026, documents two CNAs scheduled from 10:00pm-6:00am for 4/5, 4/6, 4/7, 4/9, 4/10, 4/11, 4/12, 4/13. Only one CNA was scheduled 10:00pm-6:00am for 4/8/2026.Facility policy titled Call Light (revision date of 2/2/18) documented the following in part: Purpose: To respond to residents' requests and needs in a timely and courteous manner.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on interview, observation, and record review the facility failed to provide a method to call for assistance from the toilets and shower rooms for 36 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R17, R19, R21, R22, R24, R25, R26, R28, R29, R30, R31, R32, R33, R36, R38, R39, R40, R41, R42, R43, R45, and R46) of 36 residents reviewed for accommodations of needs in a sample of 46.Findings include: On 04/12/26 at 9:15 AM the shower room on the north hall had no call light in the shower stall. On 04/12/26 at 9:16 AM on the north hall, the first bathroom on the left side of the hall had no call light accessible from the floor, the first bathroom on the right side of the hall had no call light accessible from the floor, and the second bathroom on the right side of the hall had no call light accessible from the floor. On 04/12/26 at 9:24 AM on the south hall, the first bathroom had no call light accessible from the floor near the toilet. The second bathroom had no call light accessible from the floor near the toilet. On 04/16/26 at 3:46 PM V1 (Administrator) stated, all restrooms, shower rooms, and toilets should have call lights and should be able to be activated from the floor if a resident was to fall. The room roster dated 03/23/26 presented on 04/12/26 documents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R17, R19, R21, R22, R24, R25, R26, R28, R29, R30, R31, R32, R33, R36, R38, R39, R40, R41, R42, R43, R45, and R46 reside on the north and south halls. The undated facility policy titled, Physical Plant & Environmental Policy & Guidelines documents: 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: nurse call light systems and door signaling systems/wander guard systems.

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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 maintain repairs to windows, floors, and radiators and keep resident floors, bathrooms, and shower areas clean for 36 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R17, R19, R21, R22, R24, R25, R26, R28, R29, R30, R31, R32, R33, R36, R38, R39, R40, R41, R42, R43, R45, and R46) of 36 resident reviewed for safe clean, comfortable environment in a sample of 46.Findings include: 1. On 04/12/26 8:41AM, R5 who was alert and oriented, stated that he has the insides of his incontinent brief from last night all over his floor. R5 said that his incontinent brief exploded last night, and no one would clean it up for him. On 04/12/26 at 8:42AM, there was a white polymer substance all of the floor next to R5's bed. 2. On 04/13/26 at 11:50AM, R28's room had two ceiling tiles that were pushed up into the ceiling and had what appeared to be some kind of insulation hanging around the ceiling tile track that was pushed up. The area where the ceiling tiles were pushed up is located above R28's nightstand and head of bed area. On 04/13/26 at 3:10PM observed what appeared to be the insulation that was hanging from the ceiling tile tracks now laying on R28's nightstand and floor. 3. On 04/12/26 at 9:18AM R24's room observed which had a very strong urine smell to the room. On 04/12/26 at 2:20 PM there was urine under R24's bed, the puddle of urine was covering an area of approximately four by three feet. There are two tiles missing under R24's bed and the space where the tiles should be appeared very saturated, there were brown marks around the edges of tiles spanning an area of approximately five foot by five foot. On 04/13/26 at 3:17 PM there was urine under R24's bed, the puddle of urine was covering an area of approximately four by three feet. There are two tiles missing under R24's bed and the space where the tiles should be appeared very saturated, there were brown marks around the edges of tiles spanning an area of approximately five foot by five foot. On 04/14/26 at 10:00 AM R24's bed had urine under his bed, the urine covered an area of approximately one foot by two foot. 4. On 04/12/26 at 8:47AM went into R5's room. There was a urine smell. Observed a cushion R5's wheelchair that appeared to have some liquid on cushion that had no cover and appeared to be some kind of foam. On 04/12/26 at 8:48AM, R5 who was alert and oriented, stated that his room does sometimes smell like urine. 5. On 04/12/26 at 8:51AM observed strong urine smell in R29's room 6. On 04/12/26 at 8:56AM observed a strong urine smell in R45's room. (continued on next page)

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	145664	A. Building B. Wing	04/16/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 04/12/26 at 9:03AM observed R2's room which had a strong smelled of urine and old indwelling catheter bag with urine in it observed in a trash can on top of R2's nightstand. 8. On 04/12/26 at 9:15 AM the bathroom next to the shower room on the north hall had a build-up of dirt and debris around the base of the toilet, on the north hall. The first restroom on the left side of the hall had a build-up of a dark substance around the base of the toilet. The second bathroom had a build up of a dark substance around the base of the toilet. The first bathroom on the right side of the hall had a build up of a dark substance around the base of the toilet. 9. On 04/12/26 at 9:20 AM the 2nd bathroom on the south hall had two cracked tiles to the left of the toilet, there was a buildup of dirt and debris around the base of the toilet, and there was a missing baseboard on the wall on the right side of the room and half the wall on the adjacent wall. 10. On 04/12/26 at 11:05 AM in R22's room there was broken window that measured 10 inches by 25 inches, it had a large crack that was taped, with the glass pieces offset by approximately 0.5 inches from each other. There was cardboard covering the window, there is what appears to be water damage at the bottom of the cardboard. 11. On 04/12/26 at 2:25 PM there was no covering over the baseboard radiator exposing sharp metal pieces along the radiator in R9 and R36's room. On 04/16/26 at 4:04 PM, V1 (Administrator) stated the bathrooms should not have any accumulation of dirt or debris in them. V1 stated they are working on an intervention for under R24's bed to be able to keep that area clean. V1 stated, the building should be maintained in good repair. The room roster dated 03/23/26 presented on 04/12/26 documents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R17, R19, R21, R22, R24, R25, R26, R28, R29, R30, R31, R32, R33, R36, R38, R39, R40, R41, R42, R43, R45, and R46 live on the north and the south halls. The undated facility policy titled, Physical Plant & Environmental Policy & Guidelines documents: 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. 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide supplements as ordered to underweight residents for 4 (R1, R2, R3, and R15) of 6 residents reviewed for nutritional status in a sample of 46.Findings include:1.R15's admission Record documents an admission date of 12/12/25 with diagnoses including: pan lobular emphysema, chronic obstructive pulmonary disease, conversion disorder with seizures or convulsions, chronic kidney disease, anemia, dementia, gastro-esophageal reflux disease, depression, and anorexia. R15's Care Plan documents a focus area of R15 has a potential nutritional problem dated 03/01/26 with interventions including: provide and serve supplements as ordered dated 03/01/26 and RD (Registered Dietitian) to evaluate and make diet change recommendations dated 12/15/25.R15's Order Summary Sheet documents a dietary order of regular diet, regular texture with super cereal at breakfast, whole milk in place of menu milk and fortified pudding at lunch and supper dated 01/28/26. On 04/12/26 during lunch service at approximately 12:07 PM, R15 did not receive any fortified pudding. R15 received Italian marinated pork loin, stuffing roasted broccoli, and apple pie. R15's dietary ticket dated lunch 04/11/26 given on 04/12/26 at lunch documents: fortified pudding 1 serving and nutritional ice cream.On 04/14/26 during the lunch service at 12:07 PM, R15 did not receive any fortified pudding. R15 received ranch baked chicken, potato wedges, buttered carrots, dinner roll, and mixed fruit dump cake.On 04/15/26 during the lunch service at 12:06 PM, R15 did not receive any fortified pudding with her lunch. R15 received hamburger stroganoff, buttered peas, pineapple, and a beverage.R15's Registered Dietician note dated 03/20/26 at 3:13 AM documents R15's March weight was 106.2 pounds with a significant weight loss noted for 3 months at 7.65% with a BMI of 18.8 which is considered underweight. R15's diet is regular diet with thin liquids, super cereal at breakfast, whole milk in place of menu milk and fortified pudding at lunch and supper. Weight is noted as up 1/11/26 - 03/09/26 (99.3, 104.5, 106.2 pounds respectively), but remains below admission weight of 115 pounds. V9 (Registered Dietician) recommends to offer 60 cc of 2.0 calorie supplement two times a day to provide additional nutrition. 2.R2's admission Record documents an admission date of 11/06/25 with diagnoses including: Parkinson's disease, severe protein-calorie malnutrition, vitamin D deficiency, anemia, hyperlipidemia, muscle wasting and atrophy, anxiety disorder, depression, dementia, and schizoaffective disorder.R2's care plan documents a focus area of R2 has a nutritional problem dated 11/24/25 with interventions including: provide and serve supplements per Dr. (doctor) order dated 11/24/25 and RD to evaluate and make diet change recommendations dated 11/06/25.R2's Order Summary Report documents a dietary order dated 11/21/25 of a regular diet with regular texture. R2 has a dietary order dated 12/18/25 of nutritional ice cream one time a day at lunch with an order status of active. R2's Order Summary report documents a dietary order dated 12/17/25 documents an order stating: continue with 100cc (cubic centimeter) water G-tube flush three times a day to keep tube patent after checking placement. Bolus feedings discontinued as of 12/17/25 per dietitian recommendations three times a day for hydration with no end date.R2's Nutrition/Dietary Note dated 12/16/25 at 6:44 AM documents: RD note, R2's December weight is 122.6 pounds with a significant weight gain noted for one month at 10.65% with a BMI of 18.5% which is considered underweight for his age. The current oral diet meets/exceeds estimated nutritional needs with appetite noted as generally good and weight up significantly for one month. R2's overall weight gain is acceptable as BMI remains underweight for age, however at this time will recommend to hold bolus feedings of 250 ml (milliliters) isosource 1.5 twice a day, continue 100 cc water flush three times a day to keep the tube patent and will recommend to add nutritional ice cream one time a day to support continued good PO (oral) intake/nutrition.R2's weight and vital sheet documents weights on 03/15/26 at 10:01 AM of 123.1 pounds, 03/22/26 at 11:27 AM of 128.2 pounds, 03/29/26 at 11:27 AM of 128.2 pounds, on 04/05/26 at 2:05 PM of 122.3 pounds, and on 04/12/26 at 1:31 PM of 122.4 pounds.On 04/12/26 during lunch (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service at 12:07 PM, R2 did not receive a nutritional ice cream with his lunch. R2 received Italian marinated pork loin, stuffing roasted broccoli, and apple pie. R2's meal ticket dated lunch 04/13/26 does not document a nutritional ice cream should be given.On 04/13/26 during lunch service at 12:11 PM, R2 did not receive a nutritional ice cream with his lunch. R2 received spaghetti with meat sauce, Italian blend vegetables, garlic bread, and gelatin with whipped topping.On 04/14/26 during lunch service at 12:18 PM, R2 did not receive a nutritional ice cream with his lunch. R2 received ranch baked chicken, potato wedges, buttered carrots, dinner roll, mixed fruit cake, tea, and water. On 04/15/26 during lunch service at 12:20 PM, R2 did not receive a nutritional ice cream with his lunch. R2 received hamburger stroganoff, buttered peas, pineapple, and a beverage.3. R1's admission Record documents an admission date of 02/28/25 with diagnoses including: severe protein calorie malnutrition, chronic obstructive pulmonary disease, supraventricular tachycardia, Alzheimer's disease, pan lobular emphysema, cervical disc degeneration, hypothyroidism, bilateral primary osteoarthritis of the knee, are related osteoporosis, iron deficiency, depression, major depressive disorder, spondylosis, cognitive communication deficit.R1's significant change in status Minimum Data Set assessment dated [DATE] documents a brief interview of mental status of 05 indicating severe cognitive impairment. Section K, Swallowing/Nutritional Status documents R1's weight is 89 pounds and R1 has had a loss of 5% or more in the last month or 10% or more in the last 6 months.R1's care plan documents a focus area of at risk for malnutrition dated 03/04/25 with interventions including: consult a dietician per order dated 03/04/25 and supplements per Dr. (doctor) order dated 03/25/26.R1's Order Summary Report documents the following orders: regular diet, regular texture with super cereal at breakfast, nutritional shake at all meals, whole milk three times a day with meals, and add fortified pudding at lunch and supper with an order status of active dated 4/3/26; 2.0 calorie supplement three times a day for weight loss give 150 ml (milliliters), may substitute with house supplement when not available dated 2/28/25; refer to residential hospice dated 3/13/26; Mitrazapine oral tablet 15 mg, give 1 tablet by mouth at bedtime for appetite stimulant.On 04/12/26 during lunch service at approximately 12:03 PM, R1 did not receive any fortified pudding or whole milk with her lunch. R1 received Italian marinated pork loin, stuffing roasted broccoli, apple pie and a nutritional shake. On 04/13/26 during breakfast service at approximately 7:35 AM, R1 did not receive any super cereal with her breakfast. R1 received scrambled eggs, sausage, toast with jelly, milk, and nutritional shake.On 04/14/26 during lunch service at 12:17 PM, R1 did not receive any fortified pudding or whole milk with her lunch. R1 received ranch baked chicken, potato wedges, buttered carrots, dinner roll, mixed fruit cake, tea, water and nutritional shake. On 04/15/26 at 12:12 PM, R1 did not receive any fortified pudding with her lunch. R1 received hamburger stroganoff, buttered peas, pineapple, a nutritional ice cream, a nutritional shake and a beverage.R1's Nutrition/Dietary Note dated 02/20/26 at 11:54 AM documents: R1's February weight was 88.4 pounds with a significant weight loss noted for 1 month of 7.05% with a BMI of 16.17% which is considered underweight. R1's diet is regular diet with thin liquids, encourage fluids, super cereal at breakfast, whole milk at all meals, nutritional ice cream and nutritional shake at all meals and 120 cc 2.0 calorie supplement three times a day. R1 has multiple supplements in place, will recommend to refer to MD (Medical Doctor) to review for possible dose increase of mirtazapine to 15 mg (milligrams) to better stimulate appetite and will additionally recommend to increase 2.0 calorie supplement to 150 cc three times a day as nursing reports good acceptance.4. R3's admission Record documents diagnoses including: severe protein-calorie malnutrition, muscle wasting and atrophy, anxiety disorder, post-traumatic stress disorder, major depressive disorder, polyarthritis, dementia, acute duodenal ulcer with perforation, anemia, amnestic disorder, vitamin D deficiency, and frontotemporal neurocognitive disorder.R3's Order Summary Report documents a dietary order of: regular diet, regular texture with fortified mashed potatoes at lunch dated 02/20/26.R3's order summary report documents an order dated 04/07/26 documenting: cleanse g-tube removal site, pat dry, apply dry dressing/non adherent and tape to affected area until healed.R3's Care Plan documents a focus area of I have a potential (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nutritional problem dated 01/05/26 with interventions including: provide and serve supplements as ordered dated 01/02/26 and RD to evaluate and make diet change recommendations dated 12/02/25.On 04/12/26 during lunch service at approximately 12:12 PM, R3 did not receive any fortified mashed potatoes with her lunch. R3 received Italian marinated pork loin, stuffing roasted broccoli, and apple pie. On 04/15/26 at 12:26 PM, R3 did not receive any fortified mashed potatoes with her lunch. R3 received hamburger stroganoff, buttered peas, pineapple, and a beverage.On 04/15/26 at 12:26 PM, R3 stated she is supposed to get fortified mashed potatoes with lunch, sometimes they will give her fortified pudding instead, today she did not get either.R3's RD Note dated 03/20/26/ at 3:49 AM documents: J-tube remains in place at this time with resident only receiving 100 cc (cubic centimeters) water flush three times a day to keep patent. R3's March weight was 97.4 pounds with a BMI (Body Mass Index) of 18.4 which is underweight for her age. R3's most recent weight dated 03/15/26 is up slightly at 103 pounds. R3's diet is a regular diet (upgraded 02/03/26) with thin liquids (lactose intolerance noted) and fortified mashed potatoes at lunch. Per discussion with V2 (Assistant Director of Nursing) resident has an appointment next month to review for possible tube removal.On 04/16/26 at 2:16 PM, V9 (Registered Dietician) stated, she expects all the residents including R1, R2, R3, and R15 to receive the supplements she has ordered to maintain weight or increase weight.On 04/16/26 at 2:50 PM, V8 (Dietary Manager) stated the residents should receive the supplements, the meal tickets should be reviewed more closely. V8 stated, he does not know why R2's supplement is not on his meal ticket.On 04/16/26 at 3:46 PM, V1 (Administrator) stated the residents that have supplements ordered should receive those supplements. The facility policy dated 2022 titled, Unintentional Weight Loss documents: unintentional weight loss can be rapid or sometimes slow and insidious. It is important that systems are in place to detect, assess and develop and individualized plan of care for persons with unintentional weight loss.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview, observation, and record review the facility failed to follow the menu provided for the residents receiving the mechanical soft diet for 6 (R9, R13, R16, R28, R31, and R37) of 6 residents reviewed portion sizes in a sample of 46.Findings include:The document titled, Diet type report documents R9, R13, R16, R28, R31, and R37 receive the mechanical soft diet.On 04/12/26 during lunch service starting at 11:50 AM R9, R13, R16, R28, R31, and R37 received 2 ounces of the ground marinated pork loin with gravy and 4 ounces of soft chopped broccoli with pieces of the broccoli being over one inch in size.The Diet Spreadsheet dated week 3, day 13 documents: mechanical soft ground meat diet: ground marinated pork loin with gravy #8 scoop (0.5 cup/3.75 fluid ounces) and soft chopped broccoli 4 ounce spoodle.On 04/12/26 during lunch service V17 (Dietary staff) served the blue scoop (2 ounces) of the ground pork with gravy to R9, R13, R16, R28, R31, and R37 on the mechanical soft diet. On 04/12/26 at 12:37 PM, V8 (Dietary Manager) stated the blue scoop, the one used to serve the mechanical soft meat, was 2 ounces. On 04/16/26 at 2:16 PM, V9 (Registered Dietician) stated she would expect the soft and chopped broccoli would be pieces smaller than an inch in size and she would expect the residents to receive the portions as directed by the diet spreadsheet. On 04/16/26 at 2:35 PM, V8 stated two scoops of the two ounce scoop should have been served, so 4 ounces of the ground pork loin should have been served to those receiving the mechanical soft diet.The recipe for the ground marinated pork loin with gravy documents portion size #8 scoop (4 ounces). 7. Portion #8 scoop of moist, ground meat and ladle an additional 1-2 ounces gravy over the top. The facility policy dated 2020 titled, Menu Planning and Requirements documents: menus are planned to provide nourishing, palatable attractive meals that meet the nutritional needs of residents served, (based on age, size, gender, physical activity, and state of health), in accordance with the dietary reference intakes/recommended dietary allowances as issues by the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, unless otherwise contraindicated by medical conditions and needs.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on interview, observation and record review the facility failed to provide the mechanical soft diet as directed by the recipe for 6 (R9, R13, R16, R28, R31, and R37) of 6 resident reviewed for mechanical soft diets in a sample of 46.Findings include:The document titled, Diet type report documents R9, R13, R16, R28, R31, and R37 receive the mechanical soft diet.On 04/12/26 during lunch service starting at 11:50 AM V17 (Dietary staff) served 4 ounces of broccoli with pieces over one inch in size to R9, R13, R16, R28, R31, and R37 on the mechanical soft diet.On 04/12/26 during lunch service starting at 11:50 AM R9, R13, R16, R28, R31, and R37 received 4 ounces of soft chopped broccoli with pieces of the broccoli being over one inch in size.The Diet Spreadsheet dated week 3, day 13 documents: soft chopped broccoli 4 ounce spoodle.The recipe titled, soft chopped broccoli documents: 4. chop broccoli into bite-sized pieces (1/2 or less). Transfer to steam table pans. Cover and hold until ready to serve. On 04/16/26 at 2:16 PM, V9 (Registered Dietician) stated she would expect the soft and chopped broccoli would be pieces smaller than an inch in size and she would expect the residents to receive the portions as directed by the diet spreadsheet. The facility policy dated 2020 titled, Diet Summary documents: dental soft (mechanical soft) diet: this consistency modified diet is for individuals with limited or difficulty in chewing regular textured foods. This diet follows the regular diet planned and provides food that can be easily chewed. The diet consists of food of nearly regular textures but eliminates very hard, sticky, crunchy or hard to chew foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review the facility failed to follow and maintain proper infection control practice for indwelling catheters and while providing indwelling catheter care and proper sanitation for glucometers for 6 (R2, R5, R19, R29, R31, and R34) of 12 residents reviewed for infection control in a sample of 46. The findings include: 1. R2's admission Record documents an admission date of 11/06/25 with diagnoses in part of obstructive and reflux uropathy. R2's MDS (Minimum Data Set) documents in Section C a BIMS (Brief Interview for Mental Status) score of 13 which indicates R2 is cognitively intact. Section GG document toileting as dependent and transfers as partial/moderate assistance. Section H documents indwelling catheter as yes. R2's Care Plan documents a focus area of enhanced barrier precautions r/t (related to) indwelling urinary catheter with a revision date of 04/01/26. Another focus area of I have indwelling catheter with a revision date of 11/24/25 documents interventions in part of 1. check tubing for kinks PRN (as needed) each shift. 2. The resident has 16 FR (French) 5 cc (Cubic Centimeters) foley (Indwelling catheter). Positioning catheter bag and tubing below the level of the bladder. R2's Progress Notes dated 04/08/26 at 3:04AM documents in part Infection Type: Type of infection: Urinary Tract Infection. Treatment/orders: (R2) is receiving Bactrim DS (Double Strength) oral tablet 800-160MG (Milligram) 1 tablet by mouth every 12 hours. Interventions: (R2) is receiving receives [sic] oral antibiotic. Head of bed elevated. Additional fluids offered and accepted. Evaluation/Notifications: Condition is stable, no distress noted . Contact isolation maintained related to ESBL (Extended-Spectrum Beta-Lactamases)/urine. R2's Progress Note dated 04/13/2 at 6:47AM documents New order per (Infectious disease physician) d/c (discontinue) contact isolation r/t (related to) completion of abt (antibiotic therapy). Resume EBP (Enhanced Barrier Precautions) R2's Order Summary Report documents an order for contact isolation d/t ESBL with a start date of 04/01/26 and an end date of 04/12/26 and an order for Bactrim DS Oral tablet 800-160mg give 1 tablet by mouth every 12 hours for ECOLI/ESBL for 10 days with a start date of 03/29/26 and an end date of 04/08/26. On 04/12/26 at 9:03AM, a 3 drawer bin containing PPE (Personal Protective Equipment) was observed outside of R2's room and contact isolation signage was observed on R2's door. R2 was observed lying in bed with his indwelling catheter bag lying on the floor under R2's bed. There was no cover over the indwelling catheter bag. There were no isolation bins for trash or linens observed in R2's room. A small trash can with a regular liner was sitting on a nightstand that had an old indwelling catheter bag in it with urine still in the bag. There were no isolation barrels in room to throw away PPE that was removed. R2's room smelled of urine. On 4/13/26 at 1:30pm, V5 (CNA) and V6 (CNA) performed urinary catheter care on R2. Prior to beginning the procedure, V5 and V6 washed their hands and donned clean gloves. Throughout the urinary catheter care procedure, V5 changed his gloves but did not perform any hand hygiene between the glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/13/26 at 2:20pm, V5 (CNA) said he should have used alcohol-based hand rub to cleanse his hands between glove changes, but he was nervous and forgot. 2. R5's admission Record documents an admission date of 02/6/24 with diagnoses in part of obstructive and reflux uropathy. R5's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicated R5 is cognitively intact. Section GG documents toileting as dependent. Section H documents indwelling catheter as yes. R5's Care Plan documents a focus area of: I have a foley (Indwelling) catheter with a revision date of 03/02/26 with interventions of 1. Monitor and document intake and output as per facility policy. 2. Monitor/document for pain/discomfort due to catheter. On 04/12/26 at 8:47AM, R5 was observed in bed with indwelling catheter laying on the floor under his bed. There was no indwelling catheter cover bag observed to the side of R5's bed. On 04/12/26 at 8:49AM, R5 stated that they always throw his indwelling catheter bag on the floor under his bed when they put him to bed or sometimes, they leave it in the bed with him. On 4/13/26 at 2:00pm, V5 and V6 performed urinary catheter care for R5. Prior to starting the procedure, V6 washed her hands and applied clean gloves. Throughout the procedure, V6 changed gloves, but failed to perform hand hygiene between the glove changes. 3. R19's admission Record documents an admission date of 07/27/2018 with diagnoses of generalized (acute) peritonitis, malignant neoplasm of prostate, benign prostatic hyperplasia without lower urinary tract symptoms, and obstructive and reflux uropathy. R19's MDS (Minimum Data Set) dated 02/19/26 documents in Section C a BIMS score of 12 indicating that R19 has moderately impaired cognition. Section GG documents toileting as dependent. Section H documents indwelling catheter as yes. R19's Care Plan documents a focus area of Enhanced Barrier Precautions r/t (related to) indwelling urinary catheter with a revision date of 01/28/26. Another focus area of I have a indwelling catheter r/t obstructive uropathy with a revision date of 01/28/26 interventions include in part: 1. The resident has foley (indwelling) catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. 2. Check tubing for kinks PRN (as needed) each shift. On 04/12/26 at 8:43AM, R19 was observed lying in bed with the indwelling catheter bag lying on the ground under R19's bed. There was no bag observed for R19's indwelling catheter bag to keep off the ground. On 04/12/26 at 8:45AM, R19 stated that he always keeps his indwelling catheter bag on the floor or in the bed next to him. R19 stated where else I'm I going to put it? On 04/12/26 at 12:20PM, R19 was observed in the dining room with his indwelling catheter bag sitting next to him in his wheelchair with the bag 1/4 full of urine and the bag sticking out from under the right wheelchair arm. When R19 is propelling in his wheelchair, the wheel of wheelchair keeps hitting the indwelling catheter with the urine in it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/13/26 at 12:30PM, R19's indwelling catheter bag was observed lying in his wheelchair on R19's right side. An indwelling catheter bag holder was observed under R19's chair, but indwelling catheter bag was not in it. 4. R29's admission Record documents an admission date of 11/29/25 with diagnoses including obstructive and reflux uropathy. R29's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R29 is cognitively intact. Section GG documents toileting as supervision and touching assistance. Section H documents indwelling catheter as yes. R29's Care Plan document a focus area of: I have indwelling catheter with a revision date of 01/07/26 with interventions in part of 1. change indwelling catheter per Dr. (doctor) orders, 2. Check tubing for kinks PRN (as needed). 3. Position catheter bag and tubing below the level of the bladder and away from entrance door. On 04/12/26 at 8:50AM, R29's indwelling catheter bag was observed lying on ground under R29's bed with no bag to place catheter bag in. On 04/13/26 at 11:00AM, R29's indwelling catheter bag was observed in a covered bag that was connected to the bed frame. On 04/13/26 at 11:05AM, R29 stated that usually his indwelling catheter bag lays on the floor, but he said that yesterday evening he went and got a indwelling catheter bag holder and put it on his bed frame to hold his catheter bag off of the floor. R29 said that he does have problems with frequent Urinary Tract infections, but he currently does not have a Urinary Tract Infection. 5. R31's admission Record documents an admission date of 03/20/26 with diagnoses in part of overactive bladder and neuromuscular dysfunction of bladder. R31's MDS dated [DATE] documents in Section C a BIMS score of 14 which indicates R31 is cognitively intact. Section GG documents toileting as dependent. Section H documents indwelling catheter as yes. R31's Care Plan documents no focus area regarding indwelling catheter. R31's care plan is in review and update at this time. On 04/12/26 at 9:05AM, R31 was observed lying in bed with her indwelling catheter laying on the floor under her bed. There was no indwelling catheter cover bag observed to R31's bed. On 04/14/26 at 1:35PM, V14 (Certified Nurse Assistant) stated that all indwelling catheter bags should be in a cover on the resident bed and not on the floor. V14 stated that she thinks that all of the indwelling catheters are in bags either on their bed or under their wheelchair. V14 stated that she didn't know if on 04/12/26 if the indwelling catheter bags were in covers or not and off the floor. V14 said all catheters need to be below the bladder to drain. On 04/14/26 at 1:37PM, V6 (Certified Nurse Assistant) stated she worked on 04/11/26 and thought that all of the indwelling catheters were in covers and bag to the wheelchairs and bed and not on the floor. V6 said that she only worked 4 hours on 04/11/26 so she isn't sure if all the indwelling (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheters were for sure or not in a bag cover to wheelchair and beds and not on the floor. V6 stated that all indwelling catheters need to be below the bladder to drain. On 04/14/26 at 1:38PM, V4 (Licensed Practical Nurse) stated that R2 came off contact isolation yesterday on 04/13/26. V4 stated V2 (Assistant Director of Nursing) called the Infectious disease doctor, and they gave V2 orders to discontinue the contact isolation and switch over to EBP (Enhanced Barrier Precautions) on R2. On 04/14/26 1:40PM, V2 (Assistant Director of Nursing) stated that she did call the Infectious disease doctor yesterday on R2 about him being on contact isolation because of ESBL (Extended Spectrum Beta Lactamases). V2 stated all indwelling catheters should not be on the floor and they should be in a protective bag that is attached to the bed or the wheelchair to make sure that the indwelling catheter is not dragging on the floor. V2 said that all indwelling catheters should also be below the bladder to help them drain. V2 stated that R2's old indwelling catheter drainage bag should not have been in a regular trash bag in R2's room when he was on isolation. V2 said the old indwelling catheter bag should have been placed in a biohazard bag and thrown in the biohazard bin. On 4/15/2026 at 2:15pm, V2 (Assistant Director of Nursing) said all staff should be performing hand hygiene between glove changes when providing resident care. The facility policy titled Hand Hygiene/Handwashing (revision date of 12/5/24) documents the following in part: Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare workers. Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing) -After glove removal. The facility policy titled Urinary Catheter Care with a revision date of 2/14/19 documents Purpose: To establish guidelines to reduce the risk of or prevent infection in resident with an indwelling catheter. #6. Catheters shall be positioned to maintain a downhill flow of urine to prevent a back flow of urine into the bladder or tubing, during transfer, ambulation and body positioning. #7. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly. May place drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with floor or other surfaces. 6. On 4/13/2026 at 11:50am, V10 (Licensed Practical Nurse) performed a blood sugar test using the facility's portable glucometer machine. V10 donned clean gloves, but did not use alcohol based hand rub or wash her hands with soap and water prior to donning the clean gloves. V10 gathered the needed supplies and entered R31's bedroom and placed them on R34's bed on top of R34's bottom sheet, as the bed was not made. V10 then performed the test and exited the room. V10 set the facility's portable glucometer on top of her medication cart. V10 removed her gloves, gathered insulin administration supplies and reapplied clean gloves. V10 did not perform hand hygiene prior to donning the clean gloves. V10 entered R34's room and administered the insulin to R34. V10 returned to her medications cart, removed her gloves and did not perform hand hygiene. Next, V10 took an alcohol wipe and wiped it on the facility's portable glucometer and placed the glucometer back into the medication cart drawer. On 4/13/2026 at 11:55am, V10 said she works at this facility often and this is how she cleanses the facility's portable glucometer machine when she works. V10 said she doesn't like to use bleach wipes because it makes her fingers hurt, so she uses the alcohol wipes instead. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Glucometer Cleaning dated 11/1/2024 documents the following in part: Purpose: to prevent the growth and spread of microorganisms and bloodborne pathogens. The blood glucose monitor should be cleaned and disinfected between each resident test. Procedure: To clean and disinfect the meter, use pre-moistened wipe/towel of 1 ml (milliliter) or 5-6% sodium Hypochlorlorite solution (household bleach) and 9ml water to achieve a 1:10 dilution final concentration of 0/5-0.6% sodium hypochlorite. Wipe meter with 1:10 solution bleach wipe/towel until all surfaces of the glucometer are visibly wet. Discard bleach wipe/towel. Place glucometer on a clean surface such as a paper towel and allow to air dry for no less than 3 minutes. Remove gloves and wash hands.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to respond to a grievance in a timely manner for one (R3) of one resident reviewed for grievance responses in a sample of 46.Findings include: R3's admission record documents diagnoses including: severe protein-calorie malnutrition, muscle wasting and atrophy, anxiety disorder, post-traumatic stress disorder, major depressive disorder, polyarthritis, dementia, acute duodenal ulcer with perforation, anemia, amnestic disorder, vitamin D deficiency, and frontotemporal neurocognitive disorder. R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental status (BIMS) score of 15 indicating R3 is cognitively intact. On 04/15/26 at 9:53 AM, R3 stated the facility has not responded to her grievance that she turned in and she would like to know what they are doing. R3 stated, she filed the original grievance she thinks about three weeks ago and has told them about other concerns she has had with another resident on the weekends every Monday morning after V1 (Administrator) arrived. R3's concern/compliment form dated 03/17/26 documents a complaint R3 made against another resident. The grievance form does not document anything under the section to be completed by grievance official. This would include Steps taken, pertinent findings correction actions taken or follow up with the person filing the complaint. The form was signed at the bottom by V1 and V20 (Social Service Director). On 04/16/26 at 1:34 PM, V1 (Administrator) stated, they addressed the concern in the grievance with R3. V1 stated, theoretically they should have filled out whether the grievance was substantiated or not and they should have filled in the corrective action and filled in when they talked to R3. The resident council minutes dated 01/21/26 at 10:00 AM documents: residents had concerns on how complaints were being delt with, explained that we would bring grievances from the prior month's council meeting and review them each meeting. The facility policy dated 01/04/19 titled, Resident Rights documents: notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: voice grievances and have the facility respond to those grievances.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a level II Preadmission screening and Resident review (PASRR) was completed for a resident with a diagnosed mental disorder for 1 (R4) of 2 residents reviewed for PASRR screening in a sample of 46.The findings include: R4's admission record documents an admission date of 04/30/24 with diagnoses in part of major depressive disorder recurrent, unspecified psychosis, anxiety, and insomnia.R4's MDS (Minimum Data Set) dated 02/06/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 07 which indicates severely impaired cognition.A documents titled Illinois PASRR summary of findings Preadmission Screening and Resident Review report date 05/03/24 with R4's name documents under, why this preadmission screening and resident review occurred: We gathered the information in this report through: No clinical documentation submitted by facility. Interview with you. Interview with nurse. We learned that: Your health is declining. You feel week. You need support to manage your care. A review needed to be completed for your continued care. A PASRR needed to be completed. Level II outcome documents- Level II excluded from PASRR no diagnosis-No LOC (Level of Conciseness).On 04/13/26 at 12:30pm, V21 (Regional Administrator) stated that she doesn't know why R4's PASRR doesn't have any diagnosis or information on the original screen done on 05/03/24. V21 stated that they are going to be doing a new level I PASRR screen on R4 and make sure all the information is in the screen.On 04/13/26 at 1:10PM, V1 (Administrator) stated that V22 (Regional Financial Administrator) will be submitting a new PASRR today.On 04/13/26 at 3:13PM, V22 stated that she completed a new PASRR level I screen today for R4 and it did trigger for R4 to have a level II. V22 said that they have a level II scheduled.A document titled Notice of PASRR Level I Screen Outcome with R4's name as individual evaluated dated 4/13/26 documents under PASRR level I determination as refer for level II onsite.The facility policy titled Preadmission Screening and Annual resident review (PASARR) documents under Guideline: It is the policy to screen all potential admissions on a individual basis. As part of the preadmission process, the facility participates in the Preadmission screening and Resident Review (PASRR) screening process (LEVELI) for all new and readmission per requirement to determine if the individual meets the criterion for mental disorder (SMI (Severely Mental Illness)/SMD (Severe mental disorder), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until the level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen. r objective: The objective of the PASARR policy is to ensure that individuals with mental illness and intellectual disabilities receives the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to follow the dietary preferences for 2 (R10 and R40) of 12 residents reviewed for dietary preferences in a sample of 46.Findings include:1.R10's admission Record documents an admission date of 07/28/25. R10's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 13 indicating R10 is cognitively intact. R10's Dietary Initial/Quarterly/Annual assessment dated [DATE] documents: food preference 3. dislikes: fish, Brussel sprouts, broccoli, coleslaw, cottage cheese, crabmeat, oranges, pineapple, cucumber.The Diet Spreadsheet dated week 3 day 13 documents for lunch: Italian marinated pork loin, stuffing, roasted broccoli, apple pie, and beverage.On 04/12/26 at 12:06 PM, R10 was served Italian marinated pork loin, stuffing, roasted broccoli, apple pie, and a beverage.On 04/12/26 at 12:40 PM, R10 did not eat any of his broccoli on his plate. When asked, R10 stated, he does not like broccoli.On 04/15/26 at 12:25 PM, R10 received his lunch of hamburger stroganoff, buttered peas, pineapple, and a beverage.On 04/15/26 at 12:25 PM, R10 did not eat any of his pineapple. When asked, R10 stated, he does not like pineapple.2. R40's admission Record documents an admission date of 06/24/21. R40's MDS dated [DATE] documents a BIMS score of 09 indicating R40 has moderate cognitive impairment. R40's Dietary Initial/Quarterly/Annual assessment dated [DATE] documents: food preference 3. dislikes: mushrooms, cucumber, broccoli, carrots, cauliflower, coleslaw, spinach, and green pepper.The Diet Spreadsheet dated week 3 day 13 documents for lunch: Italian marinated pork loin, stuffing, roasted broccoli, apple pie, and beverage.On 04/12/26 at 12:10 PM, R40 was served broccoli with his lunch.On 04/12/26 at 12:38 PM, R40 did not eat any of his broccoli on his plate. When asked, R10 stated, he does not like broccoli.On 04/16/26 at 2:45 PM, V8 (Dietary Manager) stated the dietary staff should follow the dietary cards and the residents should not receive items that have listed as dislikes, they should receive a nutritionally equivalent substitution. The facility policy dated 2022 titled, Menu Planning and Requirements: documents: 6. deviations from the planned menu allow for individualized nutrition based on nutritional or medical needs and/or resident requests. These deviations are indicated on a meal card or other communication tool for the serving staff.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide influenza and pneumococcal vaccinations after consent forms had been signed for 2 (R2 and R15) 5 residents reviewed for immunization in a sample of 46.Findings include:1.R15's admission Record documents a date of birth indicating R15 is [AGE] years of age and diagnoses including: pan lobular emphysema, chronic obstructive pulmonary disease, conversion disorder with seizures or convulsions, chronic kidney disease, anemia, dementia, gastro-esophageal reflux disease, depression, and anorexia. R15's undated consent documents: the question: has the resident received the PCV 13 (pneumococcal conjugate vaccine 13) vaccine in the past with unknown checked and the statement I consent to receive the PCV13 if not previously given or if unknown checked. 2. R2's admission Record documents an admission date of 11/06/25, a date of birth indicating R2 is [AGE] years of age, and diagnoses including: Parkinson's disease, severe protein-calorie malnutrition, vitamin D deficiency, anemia, hyperlipidemia, muscle wasting and atrophy, anxiety disorder, depression, dementia, and schizoaffective disorder.R2's undated Authorization and Release for Pneumococcal Vaccine (PCV12 & PPSV23) (pneumococcal conjugate vaccine 12 & Pneumovax 23) form documents the question has the resident received the PCV13 vaccine in the past with the answer unknown checked with the box checked for I consent to receive the PCV13 if not previously given or if unknown signed by R2.On 04/13/26 at 11:20 AM, V2 (Assistant Director of Nursing) stated, R15 did not receive the influenza or pneumococcal vaccinations and R2 did not receive the pneumococcal vaccination. They have them ordered and they will get them administered. The facility policy dated 04/21/22 titled, Influenza and Pneumococcal Immunizations documents: Influenza immunizations: on admission, each resident or the resident's representative will be provided education regarding the benefits and potential side effects of the immunization. Once a consent is signed indicating they wish to receive the influenza vaccine, this consent is valid for the duration of the stay and the influenza vaccine will automatically be given annually. Each resident is offered an influenza immunization October 1 through March 31 annually unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The resident's medical record includes documentation that indicates, at a minimum, the following: that the resident either received or did not receive the influenza immunization due to medical contraindications or refusal. Pneumococcal immunization: each resident is offered a pneumococcal immunization per CDC recommendations (see CDC Pneumococcal Vaccine Timing for Adults reference table) unless the immunizations medically contraindicated or the resident has already been immunized; a second pneumococcal vaccine will be offered only when necessary according to the CDC guidelines. The resident's medical record includes documentation that indicates, at a minimum, the following: that the resident either received or did not receive the pneumococcal immunization due to medical contraindications or refusal. The Centers for Disease Control Pneumonia Vaccination Recommendations website (updated 2/25/26) documents: Administer PCV15, PCV20, or PCV21 for all adults 50 years or older: Who have never received any pneumococcal conjugate vaccine, Whose previous vaccination history is unknown.