STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145692	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Flora	232 Given Street Flora, IL 62839

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 5 residents (R1) reviewed for care plans in a sample of 5. Findings include: R1's admission record dated [DATE], documents an admitted [DATE] with diagnoses in part of unspecified dementia, depression, hypertension, polyneuropathy, idiopathic urticaria, and hyperlipidemia. R1's MDS (Minimum Data Set) dated [DATE] documents in Section C a BIMS (brief interview for mental status) score of 7 which indicates severely impaired cognition. Section D - Mood documents no mood indicators present. Section E- Behaviors documents no behavioral indicators. Section GG- Functional Abilities documents toileting as partial/moderate assistance, Shower/bathe as substantial/maximal assistance, personal hygiene as partial/moderate assistance. Sit to stand as substantial/maximal assistance. Section V Care Area Assessment Summary Documents Cognitive loss/Dementia as Care Area triggered, ADL (Activities of Daily Living)/rehabilitation potential care area triggered, Urinary incontinence and indwelling catheter as a care area triggered. Nutritional status as a care area triggered, Pressure ulcers as a care area triggered. R1's current Care Plan documents a Focus area of R1 (I) am a Full Code. Attempt resuscitation, CPR (Cardiopulmonary Resuscitations), including intubation and mechanical ventilation with a date initiated of [DATE]. A focus area of R1 (I) was recently admitted to facility. Has a need to adjust to situation and life changes. Interest includes music, dogs, and going outside with a date initiated [DATE]. A focus area of R1 (I) have expressed a desire to remain for permanent placement with a date initiated of [DATE] and revision date of [DATE]. Another focus area of R1 (I) have had an actual fall with (specify: no injury, minor injury, serious injury) poor balance with a date initiated of [DATE]. No other focus areas noted on care plan. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:45AM, V3 (MDS/Care Plan Coordinator) stated she has not had the time to finish and complete R1's comprehensive care plan. V3 stated she should have had focus areas addressed on the care plan regarding cognition, ADL functions, Urinary Incontinence, Nutrition, and Pressure ulcer risk everything that triggered in Section V of the Admission MDS dated [DATE]. V3 stated that she has been working the floor often and doing other duties and has not had time to work on completing R1's care plan. V3 stated that she did have a care plan meeting with R1 and his power of attorney (POA) on [DATE]. V3 said that her and V5 (Social Service Director) were the ones who had the meeting with the R1 and his POA. On [DATE] at 1:00PM, V8 (Registered Nurse/RN) stated that she has cleaned R1's nails multiple times, but that R1 has a problem with digging in his rectum and trying to dig poop out with his fingers. V8 stated that this has been going on the past couple of weeks. V8 stated that they got a medication for R1 to see if he is constipated. V8 stated that R1 also has a problem with refusing care often. V8 said that R1 will refuse showers at times, refuse to get up to go to the bathroom and refuse to get out of bed. V8 said that they did start R1 on a antidepressant as well to help with his mood. On [DATE] at 2:41PM, V7 (RN) stated that R1 will dig in his rectum often and get feces on his hands. V7 said they try to clean R1's nails often. V7 stated that R1 will refuse care often such as showers, toileting and getting out of bed. V7 said that they did get R1 a medication to help him have bowel movements to see if this helps with him digging in his rectum. V7 said that she is never invited to attend care plan meetings. On [DATE] at 10:50AM, V11 (Certified Nurse Assistant/CNA) stated that R1 will refuse care often. V11 said that R1 will be incontinent of bowel and stick his hands in it. V11 said that R1 will refuse to get out of bed and refuse to go to the bathroom. V11 stated she is never invited to attended care plan meeting. On [DATE] at 11:00AM, V12 (CNA) stated that R1 refuses care often. V12 stated that he knows that R1 will dig in his rectum often and then get feces on his hands. V12 stated that he reports the behavior to his nurse. V12 stated that he has never been invited to attend care plan meetings. On [DATE] at 11:02AM, V13 (CNA) stated that R1 will refuse care often. V13 said that R1 will refuse to get out of bed. On [DATE] at 11:10AM, what V3 (MDS/CPC) stated that she does know that R1 refuses care often. V3 said staff has said that R1 is refusing care. V3 stated that she is going to work on R1's care plan and make sure she addresses all R1's triggered care areas and address his refusal of care and other problem areas such as R1 digging poop out of his rectum and getting BM (bowel movement) under his nails and on his hands. V3 said she was going to start working on R1's care plan right away. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Comprehensive Care Plan with a revision date of [DATE] documents in part under purpose To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines documents in part under A comprehensive care plan must be: developed within 7 days after completion of the comprehensive assessment, Prepared by an interdisciplinary team that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutritional service staff, and to the extent practicable, the participation of the resident and the resident's representative.