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	05/27/2025

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 0700 Level of Harm - Actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bed rails/side rails were installed in accordance with doctor's orders to prevent injury for 1 of 5 resident (R4, R5, R6, R9, and R10) reviewed for bed rails in the sample of 17. The failure resulted in R4 sustaining a fracture of left humerus bone in left upper arm. Findings include: R4's admission record documented R4 was admitted to the facility on [DATE] and included diagnoses of nondisplaced [NAME] fracture of right tibia, multiple fractures of ribs, left side, multiple fractures of ribs, right side, mood disorder, alcohol abuse, anxiety, insomnia, and chronic obstructive pulmonary disease. R4's Minimum Data Set (MDS) dated [DATE], documents R4 has a Brief Interview for Mental Status score (BIMS) of 14 indicating R4 is cognitively intact. MDS section GG documents R4 has no impairment in upper or lower extremity range of motion. It documents that R4 uses a manual wheelchair for mobility. MDS documents that R4 is dependent for shower/bathing, upper and lower body dressing, and personal hygiene. MDS documents that R4 is dependent for rolling left and right in bed, and for changing positions from lying to sitting to standing and vice versa. MDS documents that R4 is dependent for transfers from bed to wheelchair and back and for toileting. MDS section P (physical restraints) documents that bed rails are not used. R4's care plan dated 3/29/25, documents R4 has a focus area that R4 has been assessed to need bedrails with a date of 4/24/25 initiation. Interventions for this focus area with a date initiation of 4/24/25 are to, Assess quarterly and with change in condition for risks and benefits. Attempt alternatives prior to bed rail utilization. Check bed and bed rail routinely for maintenance and functionality. Consider reduction/removal of rails when appropriate/requested. R4's side rail assessment in her dated 3/29/25, documents that R4 has no conditions that put this person at risk with a rail. Side rail assessment further documents that there are no determined risks for use of side rails. Side rail assessment documents that the least restrictive rail device that was appropriate for R4 is half rail-right and half rail-left. (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 0700 Level of Harm - Actual harm Residents Affected - Few	R4's Electronic Health Record (EHR) documented under Orders tab an order dated 4/9/25 ordered by V5, NP (nurse practitioner) for side rails bilaterally (both sides) to be used for positioning. Size of rails was not specified in the order. R4's Facility Injury report dated 5/13/25 by V12's Licensed Practical Nurse (LPN) documents under description, found resident in bed in supine position with LUE (left upper extremity) in between side rail, very painful to touch, arm easily removed, deformity observed to upper arm, extremely painful, ambulance called. Resident description, I was reaching for something and got stuck. This report documents that side rails were in up position and that R4 was reaching for something with arm through side rail. R4's EInteract Transfer form dated 5/13/25 documents R4 was transferred to local hospital on 5/13/25 from facility for complaint of severe left arm pain. The form documents R4 had a pain level of a 10 at the time. R4's Local hospital's emergency department records dated 5/13/25 documents, Pt (patient) got arm stuck in rails. Emergency department records also documents R4's pain was severe enough she was administered Fentanyl 100mcg (microgram) in route to local hospital from facility. R4's Local hospital emergency room records dated 5/13/25 at 7:50 PM, documents that R4 had a diagnosis of fracture of shaft of left humerus (bone in upper arm). emergency room records documents Pt. (Patient) felt a pop in left arm pulling herself across bed. X-ray report from local hospital records dated 5/13/25 documents fracture of humeral shaft with markedly displaced overlapping ends. R4's Hospital's discharge records document R4 was discharged back to the facility on 5/19/25. On 5/20/25 at 7:50 PM, V15, (Certified Nurse's Aide/CNA) stated that the day R4 had her accident related to the side rails, V15 had just helped R4 with a shower and toileting. V15 stated that she had left the room to assist someone else. Within a few minutes of leaving R4's room she stated she heard someone yelling for help down the hallway. V15 stated that she located the yelling at R4's room went in and found R4 lying in bed with her arm through the side rail. V15 stated, It (left arm) looked disfigured. R4 told me she heard a pop. V15 stated that R4 wiggles and worms a lot in bed. V15 stated that R4 uses her bed rails to help her roll and turn in bed. V15 stated that the nursing staff in coordination with the resident or resident's family makes the decision whether to use bed rails on a resident's bed. V15 stated that the style of bed rails on R4's bed at the time of the incident were quarter rails. On 5/21/25 at 1:05 PM, V15 (CNA) showed this surveyor how R4 had her entire arm between the two top pieces of tubing of the bed rail. V15 stated that R4's arm was easily removed from the rails, and it wasn't wedged or stuck when she found R4. V15 stated that R4 had told her she was reaching for her TV remote when she got her arm stuck in the rail. (continued on next page)

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F 0700 Level of Harm - Actual harm Residents Affected - Few	V1's (Administrator) written statement included in the facility's investigation of incident regarding R4 dated 5/13/25 at 3:45 PM, documents that she was present at the time of R4's injury related to side rails. V1's statement documents that R4 was diagnol (sic) in her bed, her arm through the bed rail @ (at) a 90 (degrees symbol), wrist downward and top of wrist touching inside of rail. V1 documents that she asked R4 what happened and R4 told her that she was reaching for her TV remote on nightstand and heard a pop and felt pain. V1 documents that R4 told her that she hadn't done anything to make her arm pop. V1 documents that R4 told her she had not hit her arm on the side rail to her knowledge. R4's final report via email sent into Illinois Department of Public Health dated 5/20/25 at 7:53 PM documents, On 5/13/25 at 3:45 PM, R4 was found with her arm in compromised position. Injury to left arm. Pain and unable to perform range of motion. R4 was sent to the emergency room for treatment. At the hospital R4 was diagnosed with an displaced overriding mid shaft humerus fracture. This report includes a typed statement from V1's (Administrator) that includes, Intervention put in place to change side rails from ¼ to ½ bilateral side rails to prevent further injury and allow (R4) to have better ROM (range of motion). Care plans (sic) and orders have been updated to reflect current status. On 5/20/25 at 10:33 AM, this surveyor observed R4 rolling herself around in her wheelchair using both arms. Noted that there was a brace/soft cast on hand and forearm of left arm. On 5/20/25 at 10:33, AM R4 stated that she had broken her left upper arm three different times. R4 stated that this time she was playing with the kids and they hit her with a soft ball causing it to break. Another time, also while playing with the kids, they hit her with a bowling ball and broke the same arm. R4 stated that she broke her left arm the first time by getting it caught in the bed rail, but that had happened a couple of years ago. It was observed by this surveyor that R4 is oriented to person and time, but not to place and that R4 is a poor historian. On 5/21/25 at 9:05 AM, V5 (Nurse Practitioner) stated she has only seen R4 a few times. V5 stated she does give orders for bed rails, and she does specify what size to be placed on the resident's bed. V5 stated that she did not remember what size she originally ordered for R4 or if she was the one that had ordered them because she had just started on March 10th of 2025. V5 stated that she thinks residents are assessed three times per year to decide if they still need the rails ordered for them. V5 stated that she sees all the residents in the facility once per month, and at that time she herself would assess resident's need for side rails. V5 stated she was not sure why R4 had quarter rails on her bed instead of half rails (that were recommended in the side rail assessment dated [DATE]) at the time of her injury. V5 stated that she did believe R4 should continue to have side rails because R4 has a history of a stroke that's caused weakness, and she needs them to help her turn and reposition herself in bed. V5 stated that however she's not sure if the benefits outweigh the risks for use of side rails for R4 because of her restlessness at night and her recent fracture of the left arm related to side rails. On 05/15/25 2:07PM, V6 (Maintenance Supervisor) stated that he just removed 1/4 rails off R4's bed today. He said that he was told to take them off and he did it today. He said that they weren't half rails that R4 had they were quarter rails. On 05/15/25 at 2:10PM observed R4's bed and rails that were taken off by V6. Bed rails were quarter rails that raise up and lay down next to bed. V6 said those are the rails that fit the bed. (continued on next page)

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F 0700 Level of Harm - Actual harm Residents Affected - Few	On 05/15/25 at 2:50PM, V1 stated that R4 takes her arms and puts them through the side rails and moves her arms all around in the side rails often. V1 said that she doesn't know if R4 has some psychosis or something going on. V1 said that she does unusual things like this at times. On 5/21/25 at 9:45 AM, V2 (Licensed Practical Nurse (LPN)/MDS Coordinator) stated that R4's MDS section P doesn't list side rails as a restraint because they aren't being used as one but only to promote bed mobility. V2 stated that's the way she was trained to fill out the MDS. If side rails weren't being used as a restraint, they were not listed in section P of the MDS. V2 stated that residents are assessed upon admission, then quarterly, and as needed for need for side rails. V2 stated the nurses do a side rail assessment to determine if residents need them, then notify the practitioner for orders, and maintenance installs them on the bed. V2 stated that she believes R4 does need side rails to help her with her bed mobility and to assist with transfers in and out of bed. V2 stated that when the nurses did the side rail assessment for R4 they did determine she needed half rails, and then passed it onto maintenance that side rails needed installing on R4's bed. V2 stated that she didn't believe the nurses told maintenance specifically what size side rails to put on R4's bed. V2 stated that she isn't sure if the benefits outweigh the risks for R4's side rails. V2 stated that she doesn't believe that changing from quarter side rails to half side rails will decrease the risk of injury to R4 related to side rails due to R4's cognition. V2 stated that R4 is often confused about where she is at. That R4 often yells out at night and bangs on and rattles her side rails when she gets confused. V2 stated that after R4's injury the only new intervention put in place regarding side rails was to change them from quarter size to half size rails. On 5/21/25 at 1:47 PM, V11 (Registered Nurse/RN) stated that she had never had training on how to assess a resident's need for side rails. V11 stated that she goes by the side rail assessment and what the results of that recommend. V11 said that to determine the risks versus benefits for using side rails for a specific resident she would consider the resident's cognition, ability to reposition self, and so on. On 5/21/25 at 1:55 PM, V12 (LPN) stated that she doesn't remember receiving any training on completing side rail assessments. V12 stated that to determine need for side rails for each resident she goes by what the answers to the questions on the side rail assessment recommends. V12 stated they also take into consideration resident's need for side rails by their mobility in bed. If the resident is independent in bed mobility, they install them to assist with bed mobility. On 5/21/25 at 2:00 PM observed R4 lying in bed. She was in a supine position. She was able to use her right arm and hand to grab hold of her side rail on the right side to change position in bed. This surveyor asked her what if she needed to roll to the left side since there is no rail on that side, and she stated that she just hopes she doesn't need or want to. R4 stated that overall, the side rails help her to move in bed and protect her from rolling out of bed. On 5/21/25 at 10:08 AM, V6 (Maintenance Supervisor) stated that the nurses are supposed to fill out a work order when side rails are to be installed on a resident's bed. V6 stated that he didn't know he was supposed to ask what style or size of bed rails to install for a specific resident. He stated that in the past he has put on the bed rails that fit the particular bed frame. (continued on next page)

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F 0700 Level of Harm - Actual harm Residents Affected - Few	On 5/21/25 at 12:35 PM, V6 showed this surveyor the same style and make of bed that R4 was reportedly using at time of her injury. The rails on that bed did have some play in them causing a gap of approximately 1.5 inches with pressure applied by this surveyor. There was only three quarters of an inch gap if not applying pressure to the side rail. V6 stated that installing bed rails are very simple. The rails slide on and then there's two nut and bolts tightened down to secure them. V6 stated that he didn't have instructions to install them, but they are simple to install. On 5/21/25 at 2:05 PM, V6 stated he found the instructions for installation of side rails for the bed R4 was using, but not all the beds. V6 stated that according to the manufacturer's instructions he had been installing them correctly. Facility's bed rail policy dated 4/10/18 documents, The facility shall ensure the bed is appropriate for the resident and that bed rails are properly installed and maintained.