

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145692	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of Flora		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions to prevent falls were implemented for 3 of 3 (R1, R2, and R3) residents reviewed for falls in the sample of 12. Findings Include: 1. R1's Transfer/Discharge Report with a print date of 6/15/26 documents R1 was admitted to the facility on [DATE] with diagnoses that include kidney failure, heart failure, atrial fibrillation, diabetes, and anxiety disorder. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's Fall Risk assessment dated [DATE] documents a score of 21.0, which indicates R1 is at high risk for falls. R1's current Care Plan documents a Focus area of, I am at risk for fall/injury from weakness and tiredness: Date Initiated: 05/07/2026 Revision on 06/10/2026. This Focus area includes the following interventions, .Fall Intervention: Staff not to leave resident unattended in bathroom. Date Initiated: 05/19/2026. Reeducate resident to ask for assistance/help when needed. Date Initiated: 05/07/2026. Observed for increased weakness and tiredness and encourage rest periods as needed. Date Initiated: 05/07/2026. R1's Alleged Fall reports document R1 had falls in the facility on 5/5, 5/18, 5/30, and 6/5/26. R1's current Care Plan does not document a new fall intervention for the falls on 5/30 and 6/5/26. On 6/15/26 at 3:13 PM, V8 (Registered Nurse/RN) stated she didn't take care of R1 very often but was working on 6/5/26 when he fell. V8 stated she implemented the intervention of a pressure pad alarm to prevent future falls. On 6/15/26 at 11:36 AM, V9 (Power of Attorney/POA) stated after R1's fall on 6/5/26, the facility implemented a bed/chair alarm but she thought they should have implemented it before that fall. On 6/15/26 at 2:19 PM, V3 (Certified Nursing Assistant/CNA) stated R1's fall interventions include using a gait belt, side rails, and a chair/bed alarm. On 6/15/26 at 2:17 PM, V4 (CNA) stated she thought R1's fall interventions were to use a gait belt, side rails, and a bed/chair alarm. R1's Alleged Fall report dated 5/30/26 documents R1 was found on the floor in bathroom and documents R1 stated he was trying to use the bathroom and slipped on his bottom. The report documents there were no injuries noted. Under Notes the report documents, Resident hospitalized r/t (related to) increased confusion, CHF (congestive heart failure), abnormal labs. Will re-evaluate resident upon return to facility. On 6/15/26 at 3:48 PM, V2 (Director of Nurses/DON) stated R1 had a fall on 5/30/26. This surveyor reviewed R1's Care Plan with V2 and she stated there was no new fall intervention implemented after the fall on 5/30/26. V2 reviewed R1's Alleged Fall report dated 5/30/26 and stated it documents R1 was sent to the hospital on 6/1/26 and that was the fall intervention. When asked if that was an appropriate intervention to prevent falls, V2 stated it was not. 2. R2's Transfer/Discharge Report with a print date of 6/15/26 documents R2 was admitted to the facility on [DATE] with diagnoses that include dementia, hypertension, lack of coordination, and polyneuropathy. R2's MDS dated [DATE] documents a BIMS score of 13, indicating R2 is cognitively intact. R2's Fall Risk assessment dated [DATE] documents a score of 14.0, indicating R2 is at high risk of falls. R2's current Care Plan documents a Focus area of I have had an actual fall. Date Initiated: 03/10/2026. This Focus area includes the following interventions. 12/27/25 educate to use call light before ambulating and refer to therapy 1/12/26 educate staff to ensure (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 - Minimal harm or potential for actual harm Residents Affected - Few	walker is within reach at all times, 1/20/26 offer a later bedtime with staff assistance, 2/8/26 ensure walker is within reach, 2/22/26 pressure alarm while in bed and up in recliner, 5/19/26 signage up to remind resident to ask for assistance.R2's Alleged Fall report documents the following:1/12/26 R1 was yelling for assistance and was found on his floor right outside of the bathroom and stated he couldn't find his walker, needed to go to the bathroom, and lost his balance after leaving the bathroom.1/20/26 R1 was found on the floor and was unable to give a description of how he fell.2/8/26 R1 was found on the floor by an unnamed CNA and was unable to describe how he fell.2/22/26 R1 was found lying on his floor just outside the bathroom. R1 stated he was trying to get back to bed and slipped.On 6/15/26 at 1:35 PM, R2 was sitting in his recliner which is situated near the head of his bed. R2's over the bed table was sitting in front of him and his walker was sitting against the opposite wall approximately three feet from the foot of R2's recliner. There was no pressure alarm visible under R2. The pressure alarm was sitting on R2's bedside table on the other side of the bed, not within R2's reach.On 6/15/26 at 2:11 PM, R2's walker was in the same position approximately three feet from his recliner, where he was sitting and his pressure alarm was still on the bedside table on the other side of the bed.On 6/15/26 at 2:40 PM, V10 (Vice President of Operations) walked with this surveyor to R2's room. R2's walker remained in the same position approximately three feet from his recliner where he was sitting and the pressure alarm was still on the bedside table on the other side of the bed. When asked if he went to the bathroom independently, R2 stated he did. When asked how he got to the bathroom when his walker was not within reach, R2 stated he finagled it around. R2 stated he doesn't use the call light for assistance.On 6/15/26 at 2:48 PM, V6 (Licensed Practical Nurse/LPN) stated she had taken care of R2 a couple of times and didn't know what his fall interventions were.On 6/15/26 at 3:04 PM, V7 (Certified Nursing Assistant/CNA) stated R2's fall interventions were to use a gait belt and walker. V7 stated she didn't know if R2 had a bed/chair alarm. V7 stated R2's walker was usually sitting by his dresser (where it was located during this surveyor's observations on 6/15/26) or in his closet. When asked if R2 used the walker, V7 stated he used it to go to the bathroom. V7 stated R2's walker was usually in reach but sometimes they moved it when they transferred R2's roommate.On 6/15/26 at 2:17 PM, V4 (CNA) stated R2 was at risk of falls, and his fall interventions were to use a walker with a gait belt and a staff member to assist as needed. V4 stated R2 also had side rails, and they left his door and privacy curtain open so they could check on him frequently when they walked by his room. V4 stated R2 did not have a bed/chair alarm as a fall intervention.On 6/15/26 at 2:19 PM, V3 (CNA) stated R2 was a fall risk and listed his fall interventions as side rails, walker, gait belt, open door and privacy curtain with frequent checks. V3 denied R2 having a bed/chair alarm as a fall intervention.On 6/15/26 at 3:48 PM, V2 (Director of Nurses) stated R2's fall interventions included a call don't fall sign, keep walker in reach, and a pressure alarm. When this surveyor asked V2 why R2 had the same intervention of keep walker in reach implemented after his falls on 1/12 and 2/8/26, V2 stated she wasn't an employee at the facility at that time, but she wouldn't have implemented the same intervention twice. This surveyor reviewed the observation of the pressure alarm being on R2's nightstand and not under him when sitting in his recliner, V2 stated sometimes he takes off the alarm, but he wouldn't have been able to get it off and then get it to the bedside table on the other side of the bed. V2 stated she would expect new and appropriate interventions to be initiated after a fall and would expect the interventions to be implemented.3. R3's admission Record with a print date of 6/17/26 documents R3 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of bone, heart disease, and diabetes.R3's MDS dated documents a BIMS score of 15, indicating R3 is cognitively intact.R3's Fall Risk assessment dated [DATE] documents a score of 3.0, indicating R3 is not at risk for falls. R3's current Care Plan does not document a Focus area or interventions to prevent falls.R3's Alleged Fall report dated 4/23/26 documents R3 was found sitting on the floor and reported her walker tipped over and she fell against the door frame and slid to the floor. There is no fall intervention documented in this report.On 6/15/26 at 10:32 AM, R3 stated she hadn't had any falls while in the facility.On 6/15/26 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:08 PM, V10 (Vice President of Operations) stated R3 did not have a fall Focus area or interventions to prevent falls on her current care plan. On 6/15/26 at 3:13 PM, V2 (Director of Nursing) stated R3 had one or two falls since being at the facility. V2 reviewed R3's current Care Plan and stated there was no Focus area or interventions in place to prevent falls and she would expect there to be. The facility Fall Prevention Program dated 11/28/12 documents, Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.		