

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 06/24/2026
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 interview, observation and record review, the facility failed to investigate a fall for 1 of 3 residents (R1) reviewed for accidents in a sample of 6. Findings include: R1's admission Record documents an admission date of 05/28/2025 with diagnoses including primary insomnia, major depressive disorder, recurrent, mild, vascular dementia, severe without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R1's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 3, indicating that R1 is severely cognitively impaired. R1's Care Plan documents a focus area of My preferences are: I prefer to put myself on the floor and lay/sleep with a blanket at times. This focus area includes the following interventions: utilize fall mat on the floor next to bed with an initiation date of 6/12/26 and promote preferences of choice r/t (related to) putting self in floor to lay/sleep with blanket with an initiation date of 8/11/25. R1's Care Plan documents a focus area of I am at increased risk for falls with interventions including utilize fall mat on the floor next to bed with an initiation date of 6/12/26 and If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol with an initiation date of 9/4/25. R1's Progress Notes document on 6/6/2026 at 11:30pm, Resident was noted to be laying on the floor outside his room. CNA (Certified Nursing Assistant) x 2 went to assist resident back to bed. No injuries were noted to resident. R1's Progress Notes document on 6/10/2026 at 4:00pm, It was reported to me that resident had a bruise on his right buttock that was noticed during his shower. I assessed resident and noted bruising to coccyx, sacrum, right buttock/gluteal fold, right posterior thigh, and right hip. No complaints of pain. Resident is unable to tell me what happened, he replies I don't know. Measurements are 23cm (centimeters) x 35cm in total. On 6/23/26 at 1:35pm, with V6 (CNA) present, R1 was observed to have dark purple bruising at various stages of healing across his entire lower back that wrapped around to his right thigh and into his groin. R1 was also observed to have a large knot, approximately the size of a tennis ball on the right side of his lower back just above his buttocks. There was no new bruising noted to this area and R1 did not indicate that he was in pain when V6 palpated the area. On 6/22/26 at 1:30pm, V4 (Registered Nurse/RN) stated R1 has a history of putting himself on the floor and they don't write it up as a fall, it is in his care plan. V4 stated R1 was found in the hallway on 6/6/26 by staff and she assessed him for injuries, and he had none. V4 stated she had staff put R1 back to bed. V4 stated she did not classify it as a fall since he most likely intentionally put himself on the floor and does it often. On 6/22/26 at 2:12pm, V3 (Registered Nurse/RN) stated that if someone has an unwitnessed fall, they will immediately assess the resident get vitals, range of motion, skin assessment, do a risk management assessment and investigation and notify family, the resident's doctor and managers. V3 stated the process is similar for injuries/bruises of unknown origin. V3 stated if the fall was not witnessed, they would also initiate neuro checks on the resident and send them out right away if any injury is suspected. V3 stated R1 does have a history of putting himself on the floor and was care planned for it. V3 stated she would initiate a fall investigation for any resident found on the floor in the hallway. On 6/22/26 at 2:12pm, V2 (Assistant Director of Nursing) stated that R1 has a behavior of crawling out of bed and on the floor. (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	V2 stated he used to sleep on the floor at home all the time, V2 stated he is care planned for it. V2 stated she did not do an injury of unknown origin investigation because she is convinced it was from R1 crawling out of bed. V2 stated she did the fall risk management, and they got a fall mat just in case. V2 stated it was hard for her to say whether or not she would classify it as a fall because it is technically an intentional change in plane and she feels like it is more normal. V2 stated she did ask for clarification from corporate and they advised her to treat it as a fall moving forward. V2 stated if a resident was found on the floor in the hallway by staff and no one witnessed how they got there, it would be written up as a fall and staff are always to do neuro checks. On 6/22/26 at 2:23pm, V5 (Certified Nursing Assistant) stated she was changing R1 when they noticed the bruise on him. V5 stated they got the nurse immediately and they measured it and called the doctor and got some x-rays. V5 stated R1 did have a history of crawling out of bed but she has never seen him have bruising like that. On 6/23/26 at 2:12pm, V6 (Certified Nursing Assistant) stated that she takes care of R1 at times. V6 stated she took care of R1 at the previous facility he was at and he does have a history of crawling out of bed, he did it at the other facility. V6 stated he will get on his buttocks and kind of scoot. V6 stated he will scoot across the floor. V6 stated the day the bruising was noticed, it was very dark and all across his lower back, all down his right thigh and into his groin. V6 stated she has never seen any bruise like this from him crawling out of bed and she does not feel like that could have caused an injury like this. On 6/23/26 at 2:27pm, V1 (Administrator) stated there was no investigation into the progress note of R1 being found on the floor outside his room on 6/6/26. V1 stated when the bruise was discovered on R1's buttocks, V2 (Assistant Director of Nursing) was working the floor and assessed R1. V1 stated that V2 stated she talked to the floor staff, and it was discussed by IDT (Interdisciplinary Team), but she did not have a formal investigation. V1 stated if a resident was found on the floor outside their room, she would expect a fall investigation to be done. The facility policy titled Incident and Accident Report with a revision date of 4/7/2019 under policy it states The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury. Procedure step 5 documents All incident/accident reports are reviewed, signed, and investigated by: a. The Administrator; and b. The Director of Nursing or the Assistant Director of Nursing.		