

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of Rosiclare		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 Fairview Rd Rosiclare, IL 62982	
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 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. Based on interview and record review, the facility failed to ensure that direct resident care staffing was adequate to meet the needs of residents in the facility. The failure has the potential to affect all 29 residents residing in the facility. Findings include: On 7/8/2026 at 8:22AM, V10 (Certified Nurse Assistant/CNA) stated there is usually always 3 CNAs on the dayshift and she feels like with 3 CNAs the residents get good care, and showers can get done as scheduled. V10 was asked if she was working on 6/28/2026. V10 stated she came in at 6:00AM on 6/28/2026 and there were only 2 CNAs scheduled for that shift, so the night shift CNA had to stay over 4 hours because he was the dot for that day. The dot means if there is not enough staff for on oncoming shift then the person with the dot by their name must stay over. V10 stated so from 6:00AM-7:00AM there were 3 CNAs until the other dayshift CNA (V8) started vomiting and was sick, so she had to go home. V10 stated the nightshift CNA that had to stay over had to leave at 10:00AM because he had already worked 12 hours before staying over. V10 stated so between 10AM and 1:00PM she was the only CNA working on the floor. V10 stated the lunch meal was a little tough but the nurses helped feed and pass trays. V10 stated the nurses tried to help as much as they could but they had their own jobs to do as well. V10 stated she knows the nurses helped give a few showers. V10 was asked if any showers were missed due to low staffing and V10 stated yes I know there were some missed, and I know for sure 2 residents did not get their showers and there may have been more. V10 was asked if she felt like resident care was affected by the low staffing and V10 stated yes it was but I did the best I could do. V10 stated I know the DON (Director of Nursing) was notified but she never came in to help. V10 stated it was the first and only time that I have ever been the only CNA on the floor. On 7/8/2026 at 2:56PM, V8 (CNA) stated she was scheduled for dayshift on 6/28/2026. V8 stated she came in sick, and she vomited at the nurse's station, and the nurses sent her home. V8 stated that at the time she left there were 2 CNAs left on the floor and one of those had stayed over from the night shift. V8 stated she left at 7:00AM. V8 stated we normally have 3 CNAs on dayshift and with 3 CNAs we are able to provide good patient care and get all the showers completed. V8 stated some days are harder than others but we manage to get everything done. On 7/8/2026 at 12:01PM, V7 (Licensed Practical Nurse/LPN) stated she was working on 6/28/2026. V7 stated at 6AM there were 2 CNAs at the facility for dayshift. V7 stated V8 (CNA) became sick and started vomiting so V8 had to leave so this left 1 CNA for dayshift. V7 stated a nightshift CNA stayed over until 10AM to help on the floor. V7 stated from 10AM to shortly before 2PM there was only 1 CNA on the floor, but the nurses did try to help on the floor in between medication passes and other duties. V7 stated she was able to help with 3 showers on that day. V7 stated she and the other nurse also helped feed residents on that day. V7 stated that staffing is rough and when someone has to go home sick when you are already short is a problem. V7 stated she was texting V2 (DON) but V2 would not come in because she had plans for the day. V2 stated we did the (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	best we could for the residents. On 7/7/2026 at 11:22AM R1 was observed sitting up in her wheelchair in her room. R1 was alert and oriented. R1 stated she feels like there are days when there are not enough staff. R1 stated she remembers a Sunday when there was only one CNA working for part of that day. R1 stated that 1 CNA was trying but there are just too many for one person. R1 stated she had an episode of incontinence because they just could not get to her in time. Call lights were going off for quite a while. Residents needing assistance were having to wait to include myself. R1 stated she had the night shift CNA who stayed over a little while, get her up that morning before he left. R1 stated even though when there are 3 CNAs it is sometimes 8:00AM before she is getting up out of bed. R1 stated her showers are supposed to be on Wednesdays and Saturdays and she did not get a shower either day last week but it is because they did not have time. On 7/9/2026 at 2:40PM reviewed R1's shower sheets and the electronic medical record documentation and documents show R1 received showers twice a week from 6/1/2026- 7/1/2026. R1 was scheduled for a shower on 7/8/2026 but decided to wait until 7/9/2026 because it was storming per interview with R1 on 7/8/2026 at 2:50PM. On 7/7/2026 at 11:38AM, R2 who was alert and oriented stated she is not happy with her care. R2 stated she does not get showers like she is supposed to. R2 stated her dirty clothes had been lying on the other bed for over a week. R2 stated they do not have enough staff, and it takes a long time for the staff to answer call lights. R2 was asked if there has ever been a time when staffing was low and she felt like she didn't get the help she needed. R2 stated, yes there was one day recently that there was not hardly any staff here and we did not get the help we needed. The staff that were here were trying but there was just not enough help. R2 could not recall the exact day. R2 stated she does require assistance with showers and sometimes with cleaning herself after using the bathroom. On 7/7/2026 at 11:47AM, R3 who was alert and oriented, stated quiet often they only have 2 CNAs on dayshift and 2 CNAs on evenings and nights. R3 stated there are usually 2 nurses on days, 1 nurse on evenings, and 1 nurse on night shift. R3 stated she knows that recently there was a day that there was only one CNA and at least the night shift stayed until around 10AM and then someone else came in before 2:00PM. R3 stated she could hear call lights going off for a while waiting for help that day. R3 stated she is dependent on staff to turn and reposition her and she does not get turned or checked on every 2 hours. R3 stated she may get turned once during the evening shift. R3 stated she has never been turned every 2 hours on any shift. R3 stated she is paralyzed from the waist down and she can't use her hands and arms to help because they have very little use. On 7/7/2026 at 1:02PM, V12 (Assistant Director of Nursing/MDS Coordinator) stated she was unsure of who the manager on duty was for 6/28/2026. V12 was shown the manager on duty schedule that was provided, and it documented V12 was manager on duty on 6/28/26. V12 stated she was unable to do that shift because of family plans. V12 stated she was not sure who actually took her spot on 6/28/2026. V12 was asked who was on call for nursing for 6/28/2026. V12 stated we are all basically on call all the time and this included V2 (Director of Nursing). V12 stated she was notified by the facility that staffing was low so she tried to call people in to work without success and she was unable to come in due to family plans. V12 stated she does know that the nurses were trying to help. V12 was asked if one or two CNAs on the dayshift was acceptable, V12 stated no and we normally always run 3 CNAs on the dayshift. On 7/7/2026 at 1:08PM, V2 (DON) stated she was made aware of the staffing circumstances that occurred on 6/28/2026. V2 stated she was made aware but she was unable to come to the facility and help because she had made arrangements with her family. V2 stated she knew V6 (CNA) did come in to help at some point. V2 was asked if she felt like 1 CNA and 2 nurses could provide the care the residents need. V2 stated they did work together but there should always be 3 CNAs on the dayshift. V2 stated 1 CNA is not enough to provide care for the residents. On (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7/8/2026 at 3:00PM, V1 (Administrator) stated she was not made aware of the staffing issues on 6/28/2026 until later in the morning and she immediately started calling staff and had a CNA to come to the building as soon as possible which that CNA got to the building around 1:00PM. V1 stated this was not a good situation and she has already put corrective measures in place and the nurse managers that are on call will be expected to come to the facility and fill the void for nurse staffing until the issue is resolved. V1 stated they have the dot system in place and that helps cover so the residents' care is adequate, but there may need to be some changes to that system to have another back-up in place as well. V1 stated she has been at the facility for about 15 months, and she has never had this type of staffing issue, and it will not happen again because they will have staff back up in place. Certified Nursing Assistance (CNA) schedules for the period of 6/1/2026 through 7/9/2026 were reviewed. The schedule reflects 3 CNAs for day shift (6AM-2PM) scheduled regularly, 3 CNAs for evening shift (2PM-10PM) and 2 CNAs for night shift (10PM-2PM). The schedule does reflect that on 6/28/2026 there were only 2 CNAs scheduled for the dayshift with 1 open spot. V8 (CNA) was scheduled for 6AM-2PM but was marked as 6AM-7AM. Time sheets reviewed for 6/28/2026 document V8 had 1 hour worked and 7 hours sick. V9 (night shift CNA) worked until 10AM and V10 (CNA) worked 8.30 hours starting at 6:00AM. V6 (CNA) worked 1.3 hours starting at 12:45PM. Policy titled Nurse Staffing with no date documents, it is the policy of facility to provide sufficient licensed and unlicensed staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well being of each resident. Nurse staffing shall be based on resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health. Facility Census sheet dated 7/7/26 documents there are 29 residents living in the facility.		

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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 interview, and record review the facility failed to ensure they used the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. This failure has the potential to affect all 29 residents living in the facility. Findings include: The Facility Assessment dated 9/16/2025 documents current census average of 31-36 residents. The assessment documents there are 3 wings all double occupancy. The staffing plan on this Facility Assessment documents Licensed Nurses providing direct care total number needed or average or range is 6AM-6PM 1RN and 1LPN or 2 LPNs, and 6PM-6AM 1 RN or LPN. On 7/7/2026 at 11:00AM, V1 (Administrator) was asked if the Director of Nursing is usually in the building 8 hours a day throughout the week. V1 stated well usually she is but sometimes she is weekend manager, so she is off a day through the week. V1 stated V2 does take vacation days sometimes and has most holidays off. Requested the working schedules for 6/1/2026-7/31/2026. Schedules presented. On 7/7/2026 at 1:08PM, V2 (Director of Nursing/DON) was asked if she understood the facility assessment and the need for 8 hours of RN coverage per day, V2 stated she understood some of it. V2 stated she does come in when she can if needed for coverage. On 7/1/2026 the schedule documents no RN scheduled. V2's payroll sheet documents a clock in at 9:18 ([NAME])-4:30PM. Only 6.75 hours of RN coverage. On 7/6/2026 the schedule documents no RN scheduled. V2's payroll sheet documents absent/holiday. Leaving the facility with 0 RN hours. Reviewed Nurses schedules dated 6/1/2026- 7/9/2026. The schedule documents the DON is scheduled Monday through Fridays 8:00AM-4:30PM. On 6/1/2026 the schedule documents there were not 8 consecutive hours of RN coverage. Only 7.5 hours of RN coverage. No RN scheduled and DON [NAME] at 8:36AM-4:30PM. On 6/9/2026 the schedule documents there were 0 RN hours. DON absent/vacation and no RN scheduled. On 6/19/2026 the schedule documents there were not 8 consecutive hours of RN coverage. Only 7.75 hours. No RN scheduled and DON clock in was 8:11AM ([NAME])- 4:30PM. Facility Census Sheet dated 7/7/26 documents there are 29 residents living in the facility. Policy titled Nurse Staffing with no date documents, it is the policy of facility to provide sufficient licensed and unlicensed staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well being of each resident. Nurse staffing shall be based on resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health.		