STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Harrisburg	1000 West Sloan Street Harrisburg, IL 62946

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to thoroughly assess, follow physician orders, and implement interventions to prevent and/or treat pressure ulcers for 1 of 1 (R78) residents reviewed for pressure ulcers in the sample of 26. This failure resulted in R78's Stage 4 pressure ulcer not being treated as ordered by the physician from 3/11/25 to 3/20/25 (nine days) and unstageable pressure ulcers to bilateral heels not being assessed and/or treated from 3/11/25 to 3/20/25 (9 days). Findings Include: R78's Admission Record with a print date of 3/20/25 documents R78 was admitted to the facility on [DATE] with diagnoses that include hypertension, benign neoplasm of prostate, and vascular dementia with a diagnosis of muscle wasting and atrophy identified on 2/15/25. R78's Minimum Data Set (MDS) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 13, which indicates a moderate cognitive deficit. This same MDS documents R78 is at risk of developing pressure ulcers and documents R78 has one Stage 1 pressure ulcer and two unstageable pressure ulcers. The Skin and Ulcer/Injury Treatments on this MDS are documented as, Pressure reducing device for bed, Turning/repositioning program, Pressure ulcer/injury care, Application of nonsurgical dressings, Applications of ointments/medications, and Application of dressings to feet. R78's Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] documents a score of 16, which indicates R78 is not at risk of developing pressure ulcers. (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 0686 Level of Harm - Actual harm Residents Affected - Few	R78's current Care Plan documents a Focus area of I have pressure ulcer to coccyx, r/t (related to) Immobility Date Initiated: 02/15/2025. This Focus area includes the following interventions implemented on 2/15/25, Administer medications as ordered. Monitor/document for side effects and effectiveness Administer treatments as ordered and monitor for effectiveness Assess/record/monitor wound healing Weekly Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declined to MD (physician) .Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning .Follow facility policies/protocols for the prevention/treatment of skin breakdown .Inform the resident/family/caregivers of any new area of skin breakdown .Monitor nutritional status. Serve diet as ordered, monitor intake and record . Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage .Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated The resident needs assistance, reminder to turn/reposition at least every 2 hours, more often as needed or requested. Res (resident) will refuse at times Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate R78's Order Recap Report dated 2/1/25 to 3/31/25 includes the following physician orders: Start date 3/11/25 Heel protectors and heels floated when in bed every day and night shift. Start date 2/16/25 and end date 2/28/25.Coccyx 4 x (by) 5 cm (centimeter) shearing. Cleanse with NS (normal saline). Pat dry. Apply zinc barrier cream q (every) shift and PRN (as needed) until healed as needed for shearing and every day and night shift for shearing. Start date 3/14/25. Cleanse site to sacrum with NS or wound cleanser and pat dry. Apply Border gauze daily every day shift for [sic] promote wound healing. Start date 3/11/25 end date 3/13/25. Cleanse site to coccyx with NS or wound cleanser and pat dry. Apply Border gauze daily every day shift. Start date 2/16/25 end date 2/28/25. B/L (bilateral) heels: deep tissue injury: skin prep q shift until healed. every day and night shift for deep tissue injury. Start date of 3/11/25 and end date of 3/13/25. Apply Border gauze dressing to Right hip daily every day shift. Start date of 2/16/25 and end date of 2/28/25. Right ankle; pressure area: skin prep daily and cover with foam dressing daily and PRN until healed. as needed for pressure area. And every day shift for pressure area. Start date 2/16/25 and end date of 2/28/25. Resident to wear B/L heel protectors and float heels when in bed as resident tolerates. Deep tissue injury. every day and night shift for deep tissue injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/17/25 at 9:25 AM, R78 was lying in his bed wearing heel protector boots on bilateral feet, with a sheet covering portions of his body. R78 stated he had a pressure ulcer on his buttocks that he acquired during a recent hospital stay. R78's Skin-Other Skin Condition Report dated 2/15/25 documents an area on coccyx, right buttock, and left buttock with no description, assessment, and/or measurements of the areas. R78's Skin-Pressure/Diabetic/Venous/Arterial Wound Report dated 2/16/25 identifies the report as an admission assessment with the following assessment of the pressure areas documented, 1. unstageable pressure area to coccyx that measures 4 x (by) 5 x 0 cm (centimeters), 2. Stage 1 pressure injury to left hip that measures 7 x 6 x 0 cm, 3. deep tissue injury to bilateral heels with no measurements, described as deep red and mushy. 4. right ankle closed pressure area that measures 5 x 5 cm. R78's Progress Notes document: 2/18/25 .New skin issue. Location: Rear left trochanter (hip) Pressure ulcer/injury. Wound was present on admission. Signs and symptoms of infection: None. Painful: No. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: Measurements not due at this time. Skin Note: admitted with pressure areas to L (left) hip, bilat (bilateral) ankles, bilat heels, coccyx. There is no assessment and/or measurement of the areas documented in this progress note. 2/26/25 .Skin #001: skin issue has not been evaluated. Location: Rear left trochanter (hip) Issue type: Pressure ulcer/injury. Wound was present on admission. #002 Skin issue has not been evaluated. Location: Rear left trochanter (hip) .Issue type: Pressure ulcer/injury. Wound was present on admission. (duplicate of issue#001) #003: New skin issue. Location: Left heel .Reddened Red wound was present on admission. #004: New skin Issue: Location. Right heel .red wound was present on admission. #005: New skin Issue. Location: right plantar foot .Right ankle issue type: Pressure ulcer/injury Unstageable .Wound was present on admission. Measurements not documented as part of this assessment. There is no further assessment or measurements documented in this progress note. 2/27/25 (V6/Wound Specialist) here and seen res (resident) new orders received. 2/27/25 Resident experiencing altered LOC (level of consciousness) .MD (Physician) notified. T.O. (telephone order) Send to ER (emergency room) for eval (evaluation) R78's Order Recap Report dated 2/1/25 to 3/31/25 includes the following physician order with a start date of 2/27/25 and an end date of 2/28/25. Silvadene External Cream 1% (Silver Sulfadiazine) apply to sacrum topically every day shift for wound cleanse with wound cleanser pat dry and apply Silvadene, collagen, calcium alginate and dry dressing to wound on sacrum. R78's Wound Specialist note dated 2/27/25 documents, Patient seen on 2/27/25, however, I couldn't put an official note for lack of vital information on the visit of 2/27/25. The patient had an open area on the buttock that measured 3 x 2 with a treatment of Silvadene, collagen, calcium alginate, and dry dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R78's Admission/Re-Admission Observation dated 3/11/25 documents the following assessment under skin integrity, Right trochanter (hip) 6 x 6 cm Unstageable, Sacrum 3 x 2 cm Stage 1. There is no other skin assessment documented on this report. R78's Wound Specialist Report dated 3/13/25 documents a Stage 4 pressure ulcer to R78's coccyx that measured 2.5 x 1.6 x 0.4 cm with an order for a treatment of calcium alginate, collagen powder, silver Sulfadiazine and a gauze island dressing to be applied daily. R78's Progress Notes document: 3/14/25 .Skin Issue: #001: Skin issue has been evaluated. Location: Left heel .red wound was present on admission .#002: Skin issue has been evaluated. Location: Right heel red wound present on admission . #003: Skin issue has not been evaluated. Location: Right plantar foot Pressure ulcer/injury Unstageable . Wound was present on admission. #004: Skin issue has not been evaluated. Location Rear left trochanter (hip) .Pressure ulcer/injury. Wound was present on admission There are no description/assessment/measurements of the pressure ulcers in this progress note. R78's Progress Notes do not document assessment and/or measurements of R78's pressure ulcers. On 03/19/25 at 11:00 AM, V8 (Licensed Practical Nurse) removed a dirty bandage from R78's sacrum that was dated 3/18/25. V8 changed her gloves and hand sanitized then cleaned the area that was open with red/pink tissue in the center of the wound and surrounding the open area. V8 cleaned the area with wound cleanser and covered with a border foam dressing. V8 stated that was the only treatment R78 had. This surveyor asked to observe R78's hip and heels. R78's left hip was free of obvious skin breakdown. R78's right hip had an approximate softball size discolored area on the bony prominence. V8 touched the area and stated it was blanchable and stated V6 (Wound Specialist) had seen the area and it healed out. R78's right heel was observed, and the skin appeared within normal limits, but it was slightly mushy when touched by V8. V8's right outer ankle was red and irritated looking when V8 touched the area it blanched. V8 lifted R78's left leg up out of the boot. R78's left heel was mushy and not in a normal heel shape. The heel was indented and appeared very soft. V8 pushed on the left heel and the skin and underlying tissue held the indented shape after V8 pushed on it. V8 stated it was mushy and did not blanch. R78 stated he always wears the boots to prevent skin breakdown. On 03/19/25 at 11:40 AM, when asked to see the wound log, V2 (Director of Nurses) stated she was behind on it. When asked if she had seen R78's pressure areas, V2 stated she had once but she was off sick last week, so she didn't see them last week. This surveyor reviewed R78's physician orders with V2 and they do not document an order for treatment to the left heel, right ankle, or right hip since his admission back to the facility on [DATE]. V2 stated she would have to review his record before she could give this surveyor any information related to the pressure areas. On 03/19/25 at 1:52 PM, V8 (LPN) stated R78's heels have been soft since he returned from the hospital on 2/27/25. V8 stated R78 had a treatment to his right hip but it looks better since they discontinued the treatment. This surveyor reviewed V6 (Wound Specialist) note dated 3/13/25 and asked why the new treatment order was not followed. V8 stated she didn't have access to V6's orders and/or progress notes. V8 stated V2 (Director of Nurses) usually prints off V6's progress notes and gives them to the nurse working on the floor so they can process any new orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/19/25 at 4:27 PM, V2 (Director of Nurses) stated she would expect the nurse's to complete thorough assessments and to obtain and follow physician orders. V2 stated she is not normally behind on the wound log but right now she is. V2 stated the treatment V8 administered to R78 was not the most recent physician order. V2 stated she called V10 (Physician) and notified him they had not followed V6's most recent treatment recommendations. When asked if R78's pressure ulcer/injuries had improved or declined, V2 stated she would say the area on R78's coccyx looked more like a pressure and not a shear as it was originally classified, so she would say it had worsened. V2 stated she didn't think the area on his hip had worsened and it was blanchable when she assessed him. V2 stated she also assessed R78's heels. V2 stated they were soft not blanchable and not in good shape. V2 stated the left heel was definitely mushy and could rapidly deteriorate. When asked if R78's heels had improved or declined, V2 stated she wouldn't be able to tell because they did not have a previous thorough assessment. R78's Skin-Other Skin Condition Report dated 3/19/25 documents the following pressure ulcers, Right trochanter (hip)- 6 cm x 6 cm brown discoloration blanchable, not open, no drainage, Right ankle (outer) -2 cm x 1.5 cm reddened area, blanchable, not open, no drainage, Right heel - 6 cm x 5 cm soft, mushy heel, not open non blanchable, Left heel - 2 cm x 2 cm soft, mushy heel, not open, non-blanchable, sacrum- 1.5 cm x 1 cm x 0.1 cm, stage 4 pressure ulcer, scant amt (amount) of drainage, no odor, 100% granulation tissue. Under Treatment/Pain Assessment this report documents, Awaiting treatment orders for areas except coccyx. Coccyx treatment order clarified from (V10/Physician) d/t (due to) unable to contact (V6/Wound Specialist) at this time. (V10) notified of (V6's) order from 3/13/25 but order in place in facility not matching order from (V6). (V10) clarifies order to cleanse coccyx with wound cleanser, pat dry, apply SSD 1%, collagen, calcium alginate, cover with border gauze daily. Order processed. On 3/20/25 at 9:56 AM, V6 (Wound Specialist) stated when he first saw R78 he didn't have access to the electronic records and his notes fell through the crack. V6 stated he saw R78 two weeks later and put a progress note in the system. V6 stated he assessed the pressure area on R78's buttocks and thought he looked at his heels. V6 stated floating his heels would be the treatment for the pressure areas on his heels although if the nurse wanted it, he could prescribe skin prep, although it isn't really advised. V6 stated the facility skin checks only mark when there is an actual open area and not when it is just red. V6 stated he would expect the facility to implement his orders and recommendations for interventions. V6 stated the area would heal much faster if they followed his current treatment orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility Pressure Injury and Skin Condition Assessment policy dated 11/28/12 documents, Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse and documented in the resident's clinical record 7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes .10. Pressure injuries and other ulcers (arterial, diabetic, venous) will be measured at least weekly and recorded in centimeters in the resident's clinical record. 11. A wound assessment for each identified open area (sic) will be completed and will include: a. Site location, b. Size (length x width x depth) c. Stage of pressure ulcer d. Odor e. Drainage f. Description g. Date and initials of the individual performing the assessment 18. A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible will be notified by charge nurse

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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** 32765 Based on observation, interview, and record review the facility failed to implement interventions to prevent falls for 1 of 2 (R7) residents reviewed for accidents in the sample of 26. Findings Include: R7's Admission Record with a print date of 3/20/25 documents R7 was admitted to the facility on [DATE] with diagnoses that include dementia, depression, hypertension, and low back pain. R7's MDS (Minimum Data Set) dated 2/19/25 documents R7 has a severe cognitive impairment. This same MDS documents R7 has a history of falls without serious injury. R7's Investigation Report for Falls documents the following falls. 11/24/24 documents R7 was found lying on her back in the lobby. The intervention implemented was a physical therapy and occupation therapy evaluation and treatment. 12/20/24 documents R7 was found across from her room in the hall sitting on the floor. The intervention implemented was to check her frequently when in bed and to use a pad alarm instead of a tab alarm. 1/25 (did not document full date) documents R7 was found sitting on the floor next to her bed. The area of concern identified was that her room needed to be closer to the nurse's station and the intervention implemented was bed low to floor. 1/3/25 documents R7 was found seated by a vacant bed. The intervention implemented was a later wake up time as she seeks to get into vacant beds when she is gotten up too early. 1/14/25 documents R7 was found lying on her left side on the floor with her head by the head of her bed and her feet by the door. The intervention implemented was to change her trazadone to bedtime, discontinue the valium, Ativan at bedtime and to offer snacks/drinks when restless. R7's current Care Plan documents a Focus Area of I have had an actual fall with minor injury r/t (related to) Poor Balance, Unsteady gait. Date Initiated: 11/24/2024. The interventions for this Focus Area include, New intervention: Fall mats on both side of the bed. Date Initiated: 1/25/25. On 03/17/25 at 1:24 PM, R7 was observed laying in a bed that was low to the floor, with a floor mat on the floor next to the left side of the bed. On 03/20/25 at 10:40 AM, R7 was observed in bed that was low to the floor with no mats on floor next to bed. V5 (Licensed Practical Nurse/Care Plan Coordinator) was present during observation and after reviewing R7's current fall interventions, stated R7 should have fall mats on the floor on both sides of her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Fall Prevention Program policy dated 11/21/17 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 .

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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. 51735 Based on interview and record review, the facility failed to ensure Registered Nurse (RN) coverage for 8 consecutive hours a day, 7 days per week. This failure has the potential to affect all 26 residents living in the facility. Findings include: The Facility schedule for February and March 2025 documents there was no Registered Nurse (RN) coverage on 2/1/2025, 2/8/2025, 2/15/2025, 2/22/2025, 2/28/2025, 3/1/2025, 3/13/2025, 3/14/2025, 3/15/2025, 3/22/2025, and 3/29/2025. On 03/17/2025 at 9:25 AM, R78 states there isn't enough staff at times. On 03/19/2025 at 4:00 PM, V2 (Director of Nursing) stated, they don't have RN coverage for 8 consecutive hours a day, 7 day a week. V2 stated, they usually lack Saturdays, and some Sundays are covered. V2 said they have a RN that works as needed who does every other Sunday. On 03/19/2025 at 4:11 PM, V2 stated, there was no RN coverage on 2/1/2025, 2/8/2025, 2/15/2025, 2/22/2025, 2/28/2025, 3/1/2025, 3/13/2025, 3/14/2025, 3/15/2025, 3/22/2025, and 3/29/2025. The Long-Term Care Facility Application for Medicare and Medicaid dated 03/17/2025 documents the current census is 26.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation and record review, the facility failed to provide at least 80 square feet of living space for 8 of 8 residents (R3, R6, R12, R13, R18, R23, R24, and R80) reviewed for room size in a sample of 26. Findings include: On 3/20/25 at 8:20 AM, V1 (Administrator) measured rooms that are dually certified (Medicare and Medicaid) for 4 beds per room. The 10 rooms measured less than 80 square (sq.) feet (ft.) of living space per bed. The 10 room's measurements are as follows: room [ROOM NUMBER]: 311.5 sq. ft. (77.9 sq. ft. per bed) room [ROOM NUMBER]: 302.8 sq. ft. (75.7 sq. ft. per bed) room [ROOM NUMBER]: 305.7 sq. ft. (76.4 sq. ft. per bed) room [ROOM NUMBER]: 304.4 sq. ft. (76.1 sq. ft. per bed) room [ROOM NUMBER]: 310.2 sq. ft. (77.6 sq. ft. per bed) room [ROOM NUMBER]: 289.6 sq. ft. (72.3 sq. ft. per bed) room [ROOM NUMBER]: 304.1 sq. ft. (76 sq. ft. per bed) room [ROOM NUMBER]: 315.7 sq. ft. (78.9 sq. ft. per bed) room [ROOM NUMBER]: 314.6 sq. ft. (78.7sq. ft. per bed) room [ROOM NUMBER]: 307.1 sq. ft. (76.8 sq. ft. per bed) A Daily Census provided by the facility and dated 3/17/25 documents R3, R6, R12, R13, R18, R23, R24, and R80 reside in the rooms listed above. There were no residents assigned to rooms 105, 109, or 110. (continued on next page)

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During the survey from 3/17/25 to 3/20/25, no residents were observed to reside in rooms 105,109, and 110, confirming these rooms were unoccupied. room [ROOM NUMBER] was equipped with 2 beds, 3 nightstands and 3 dressers (rather than the 4 beds for which that room is certified). room [ROOM NUMBER] was equipped with only 3 beds, an oversized recliner, 4 nightstands, and 2 dressers (rather than the 4 beds for which that room is certified). rooms [ROOM NUMBERS] both included 4 beds and 4 nightstands. rooms [ROOM NUMBERS] were both being utilized as storage. room [ROOM NUMBER] was equipped with 4 beds, 6 nightstands, and 1 recliner. room [ROOM NUMBER] was equipped with 3 beds, 1 recliner, 1 dresser, 5 nightstands, and two mini refrigerators. Observations of the undersized resident rooms found the rooms adequate to meet the medical and personal needs for the residents assigned to these rooms, as they were not currently being utilized as 4-bed rooms. Inquiries regarding the size of these rooms during the survey from 03/17/25 to 03/20/25, found no concerns or negative interviews from residents who reside in the waivered rooms. On 03/20/25 between 9:27 AM and 10:03 AM, R3, R6, R12, R13, R18, R23, R24, and R80 all voiced no concerns with the size of their rooms during interviews. Review of Resident Council meeting minutes from the past 6 months indicated no concerns related to the size of the rooms.