STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000368	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA , WEST FRANKFORT, Illinois, 62896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2558380/2607026	S0000		10/01/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		10/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were not met as evidenced by: Based on observation, interview, record review the facility failed to provide supervision during smoking to prevent an accident and failed to provide an appropriate intervention to prevent future falls for 1 of 15 residents (R27) reviewed for accidents in a sample of 48. This failure resulted in R27 falling outside in the designated smoking area and then having to be sent out to the emergency room for laceration on her left and right arm and having to be seen by a wound care specialist. R27’s Admission Record dated 09/10/25 documents an admission date of 06/06/25 with diagnoses of history of falling, tobacco use, type 2 diabetes mellitus with diabetic neuropathy, unspecified sequelae of nontraumatic intracerebral hemorrhage. R27’s MDS (Minimum Data Set) dated 08/18/25 documents	S9999		

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S9999	Continued from page 2 in Section C a BIMS (Brief Interview for Mental Status) score of 13 which indicates R27 is cognitively intact. Section GG documents walk 10 feet as supervision and touching assistance, walk 50 feet with two turns as supervision and touching assistance, and walk 150 feet as supervision and touching assistance. R27's Care Plan with a revision date of 06/10/25 with a focus area of Risk for falls which has a goal of resident will be free of falls. Interventions for this focus include 08/04/25 Fall intervention updated to include maintenance supervisor to fix concrete in courtyard, 06/06/25 determine residents' ability to transfer, 06/06/25 ensure call light is available to resident, 06/06/25 evaluate fall risk on admission and PRN (as needed), 06/06/25 if fall occurs, alert provider, and 06/06/25 if fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. R27's witnessed fall report dated 08/03/25 document's incident location: Outside, Nursing Description: Nurse visualized pt (Patient) laying on back outside on floor, skin tear to the left wrist, left forearm, right forearm with blood present applied pressure to the skin tear to stop bleeding. Pt voiced no pain in lower extremities, no inverting turn to feet. VS (Vital Signs) obtained other nurse called appropriate persons. Pt sent to (Local Hospital) with bed hold policy. Resident Description: Patient stated she was trying to get out of the way of another pt when she tripped and lost her balance. Pt stated she did not have pain in lower extremities, but her arms were a 10/10. Injuries observed at time of incident: laceration left forearm, skin tear left wrist, and skin tear right forearm. A statement taken by V2 (Director of Nursing) from V24 (Certified Nurse Assistant/CNA) dated 08/03/25 documents under statement: "I was passing cigarettes to the residents and heard yelling. I saw (R27) on the concrete next to the railing holding her arm saying I was trying to get out of his way." R27's hospital discharge records from local hospital dated 08/03/25 documents her diagnosis as other skin changes- large skin tears bil (Bilateral) forearm left greater than right. Special notes document leaves covered, until you can get an appt (appointment) with pcp (Primary Care Physician) or wound care. R27's hospital records document that R27 was sent back to the facility with a prescription for Doxycyline Hyclate (antibiotic) every 12 hours and Hydrocodone-Acetaminophen (pain medication) every 6 hours for pain control.	S9999		

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S9999	Continued from page 3 R27's hospital records for a visit on 8/5/25 document, "Pt (patient) states, "I was trying to move away from somebody yesterday and I was kind of knocked over and I fell and I hit the concrete my body and scraped my arms real bad. They sent me to (Name of local ER). Today my arm just won't stop bleeding so they sent me back in." These records document Final diagnoses as skin tear of left upper extremity and hand swelling. R27's wound assessment and plan from the wound care doctor dated 08/05/25 documents right forearm wound measurement 4 cm (centimeter) length X 5 cm width X 0.1cm depth and left forearm wound measurement: 10 cm length X 6.5 cm width X 0.1cm depth. On 09/09/25 at 9:40AM, R27 stated on 08/03/25 that she was walking outside down the ramp to go smoke with all the smokers. R27 said she had her rolling walker and was holding on to the rail to go down the ramp. R27 stated she was trying to go down that ramp when she saw R10 who had already gone down the ramp and was coming back her way, R27 said she was trying to get out of his way because he doesn't pay attention, and he will run you down. R27 said that she was trying to get out of his way and tried to back up, but his walker bumped into her walker, and she went back and fell. R27 said that R10 didn't stop he just kind of bumped her as he went past, and she was on the ground bleeding. R27 said that she had large skin tears to both of her arms from the fall and that there was blood all over. R27 said that she was yelling out in pain. R27 said that the staff had her sit up on her wheeled walker and was trying to get the bleeding to stop. R27 stated that she did not trip or fall over any cracks or broken concrete. R27 stated she heard that R10 bumped into another resident the next day she didn't know who it was. R27 said that her wounds on her arms were so bad she had to have a wound doctor take care of them and they talked about a wound graft to the left arm, but they didn't have to do a graft. R27 said that the wounds to her arms are just now starting to heal. R27 stated that she doesn't feel safe around R10 when they go out to smoke. R10's Admission Record dated 09/10/25, documents an admission date of 05/11/21 with diagnoses schizophrenia, need for assistance with personal care, anxiety, depression and nicotine dependence. R10's MDS dated 07/21/25 documents in Section C a BIMS score of 11 which indicates R10 has moderately impaired cognition. Section GG documents walk 10 feet as supervision or touching assistance, walk 50 feet as	S9999		

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S9999	Continued from page 4 supervision and touching assistance, and walk 150 feet as supervision and touching assistance. R10's Care Plan has a focus area of Tobacco use with a revision date of 04/24/25 with a intervention in part of: The resident requires supervision while smoking with a date initiated of 05/10/25. Another focus is: The resident has a history of being impatient during smoke breaks when he is waiting in line to enter/exit building r/t (related to) poor impulse control with a revision date of 09/09/25 with interventions in part of: The resident's triggers for impatience are during smoke breaks when entering/exiting the building d/t (due to) becoming impatient with peers. Resident is educated on single file line with peers wanting to enter/exit also and that cutting in line is not allowed. Resident educated at each smoke break time to reduce aggression revision on 09/09/25, Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of resident posing danger to self and other with a date initiated of 08/20/24, and when the resident becomes agitated: Intervene before agitation escalates: Guide away from source of distress: Engage calmly in conversation: If response is aggressive, staff to walk calmly away, and approach later revision on 09/09/25. On 09/09/25 at 10:58AM, R10 stated he has bumped into several residents before when going outside for his designated smoke break. R10 stated that it is his fault sometimes when he bumps into other residents and other times it is the other resident fault. R10 stated he remembers R27 falling outside on one of their designated smoke breaks. R10 said that the resident doesn't get out of his way. R10 said that when R27 fell she was yelling and bleeding all over. R10 said that he doesn't know who all he has bumped into at the facility. R10 said that when he goes out to smoke, they try to make him last in the line. R10 said that he doesn't know why he must be last that is just what they told him at the facility. On 09/09/25 at 11:30AM observed R27 right and left arm. R27 had an area to her left forearm which appeared to be approximately 10cm long and around 7 cm wide with some redness noted, along with areas that appeared to be scar tissue and raised. R27's right forearm arm had an area which appeared to be scar tissue no open area noted areas appears to be approximately around 5cm in length. On 09/08/25 at 3:00PM, R26 who was alert and oriented stated she is a smoker, and she was outside on the designated smoke break when R10 fell. R26 stated R10	S9999		

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S9999	Continued from page 5 was trying to hurry up and get his cigarette and R27 was coming down the ramp and that R27 was trying to get out of the way of R10 and R27 backed up and fell. R26 stated that R10 just went over and bumped R27 as she was laying on the ground. R26 stated that a nurse has her write a statement about what happened on 08/03/25 with R27's fall. R26 stated that R10 is always in a hurry and doesn't look where he is going and bumps into everyone. R26 said R10 has bumped into her before. On 09/09/25 at 10:38AM, R3 who was alert and oriented stated that she is a smoker and that she was outside on 08/03/25 when R27 fell. R3 stated that R27 was coming down the ramp to go outside to smoke and that R10 was going to run over R27 with his rolling walker so R27 was trying to get out of the way and fell. R3 said after R27 fell that R10 plowed right over her. R3 stated that R10 has bumped into her with his rolling walker and caused a skin tear to her leg. R3 said that R10 is always in a hurry to be the first out to smoke and he wants to get his cigarettes first. R3 said that she thought he has bumped into another resident legs and caused a skin tear. On 09/09/25 at 10:46AM, R28 who was alert and orientated stated that she is a smoker and goes out for the designated smoke breaks. R28 stated she remembers when R27 had her fall outside on 08/03/25. R28 stated R27 was trying to get out of the way of R10 so he didn't run her over. R28 stated she is not sure if R10 bumped her or pushed her causing the fall. R28 said R10 is always in a hurry to get outside to smoke and will pass all the residents up on the ramp and try to get outside first. R28 stated that she knows that R10 has bumped into a couple of residents while trying to get outside to smoke. R28 could not remember who all R10 has bumped into. On 09/09/25 at 2:25PM, R4 who was alert and oriented at that time stated that she does go outside to smoke. R4 stated that she thought a guy bumped into her when she was outside smoking but couldn't remember who it was. R4 stated that she didn't know if she got a skin tear or not from the guy bumping into her. On 09/08/25 at 3:00PM, V16 (Licensed Practical Nurse/LPN) stated that R27 fell on 08/03/25. V16 said that she wasn't outside when R27 fell but that she heard that R27 was trying to get out of the way of R10 and that R27 fell and received skin tears to both arms. V16 said that she was taking witness statements to help the agency nurse out because residents were saying R10 bumped into R27.	S9999		

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S9999	Continued from page 6 On 09/08/25 at 3:13PM, V1 (Administrator) stated that R27's accident on 08/03/25 when R27 fell outside on the designated smoking break was because R27 was trying to back up out of R10's way and then she fell. On 09/08/25 at 3:31PM, V22 (Agency LPN) stated that R27 fell outside on her designated smoke break on 8/3/25. V22 stated that when R27 fell outside she caused skin tears to both arms that were bleeding bad and that she had to send R27 out to the local hospital. On 09/09/25 at 11:55AM, V25 (Social Service Director) stated that she has only worked at the facility for around month. V25 said that R10 must go last in the line when they are going out on the designated smoke breaks. V25 stated that when she started working at the facility that is what they told her, she didn't remember who told her. V25 said she doesn't know why they didn't make him the first person to go out because he is always in a hurry to get outside and smoke. V25 said that R10 gets in hurry and tries to get down the ramp as fast as he can. V25 stated that when she takes the residents outside for their designated smoke breaks, she has heard several residents talking about how R10 has bumped into them, but she has never had any of those residents come to her complaining about it. V25 said she tries to wait to pass out the cigarettes to the residents until all the residents are outside so she can make sure all the residents get outside first safely. On 09/09/25 at 2:33PM, V28 (MDS/Care Plan Nurse) stated that R10 use to have a focus area on the Care Plan about his impulse control of getting in a hurry to go outside and smoke. V28 stated that she resolved that focus area on the care plan because she went back and looked at the social service notes and nurses' notes and did not see any more concerns with R10 rushing to get outside to smoke. V28 stated the last incident that R10 had with getting into a hurry was back on 03/11/25 when R10 was in a hurry to get out and bumped someone with his rolling walker. V28 said that she was putting the focus area back on R10's care plan today about him having impulse control and getting in a hurry to smoke. V28 said that the reason she was putting the focus area back on his care plan is because she was told today that R10 was rushing and getting in front of people to get outside. On 09/09/25 at 3:46PM, V21 (Maintenance Director) stated that he did repair some concrete out in the designated smoking area. V21 stated that he didn't know why he must repair the area. V21 said that the concrete around the smoking area did have a few cracks, and it	S9999		

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S9999	Continued from page 7 had a dip in one of the areas and he filled it the best he could. V21 said that he didn't know if some of the wheels on the wheelchairs were getting stuck on the cracks or what. V21 said that the cracks and the dip are on the patio part not by the handrail. V21 said that he doesn't remember if he got a work order about it or if he was just told about the cracks. On 09/09/25 at 3:51PM, V1 stated that when R27 fell outside in the designated smoking area they talked about her fall in their daily meeting. V1 said they were trying to figure out how R27 fell so they went outside to the designated smoking area and found some cracks in the concrete, and they thought those could be a fall hazard, so they had V21 repair the cracks. V1 said that she doesn't know why R10 is last coming when they take the residents out on their designated smoke breaks, but she is currently doing an in-service with staff about taking residents out to smoke and monitoring for behaviors when they are outside smoking along with being mindful about what is going on outside when the residents are smoking. On 09/10/25 at 11:02AM, V2 (Director of Nursing) stated on 08/03/25 R27 was trying to get out of the way of R10 when she fell. V2 stated that the staff member who was outside supervising when R27 was R24. V2 said that R24 said in her statement that she was passing out cigarettes when R27 fell, and she heard her yelling. V2 said that R24 should not have passed out any cigarettes until she had made sure that all the residents made it out to the smoking area and was able to observe all resident when they smoked. V2 said that she thought fixing the cracks in the concrete was an appropriate intervention for R27's fall, because she thought it said somewhere that R27 fell because of the cracks. On 09/09/25 at 3:45 PM there were six residents outside smoking with nine residents lined up making their way out the door to the smoking area. R10 was in line to go out to the smoking area. R10 would shuffle his feet pushing his walker forward coming within approximately an inch of hitting the resident in front of him and then would move backwards almost stepping into the resident behind him. This action continued until R10 was in the outside area. The facility policy titled "Fall Prevention Program" with a revision date of 11-21-17 documents the purpose as: 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	S9999		

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S9999	Continued from page 8 necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines include in part: Methods to identify risk factors. The facility policy titled 'Safe Smoking and Vaping Policy/Procedure" with a last update date of 09/10/25 documents under policy: The facility works to provide appropriate care for residents, keeping safe and comfort in mind. Residents may have the desire to smoke/vape, and accommodations will be provided as the facility deems appropriate. The facility treats the use of vaping products the same as traditional smoking products. Procedure documents in part: 3. The rules are as followed # 3. Conduct while smoking must promote safety. #4. No negative behaviors related to smoking are permitted. B. The timeframes above are the only times smoking materials may be distributed. Continued disruption of resident care responsibilities over smoking break times constitutes a violation of the "No negative behaviors related to smoking are permitted." (B)	S9999		