STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Flora	**232 GIVEN STREET , FLORA, Illinois, 62839**

(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 Investigation of Facility Reported Incident of 07-28-2025/2583088	S0000		08/22/2025
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1210b) 300.1210d)6) 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. 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:	S9999		08/22/2025

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

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S9999	Continued from page 1 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. These Regulations are not met as evidenced by: Based on interview, and record review the facility failed to prevent a fall from a wheelchair for 1 (R1) of 3 residents reviewed for accidents in the sample of 3. This failure resulted in R1 falling forward out of the wheelchair onto the floor resulting in an acute comminuted fracture of the distal left clavicle. The findings include: R1's "Admission Record" documents an admission date of 6/20/2025 and included diagnoses of cardiac arrhythmia, essential hypertension, personal history of transient ischemic attack, hyperlipidemia, unspecified atrial fibrillation, gastro-esophageal reflux disease, gastritis, and age-related osteoporosis. R1's admission Minimum Data Set (MDS) assessment dated 07/07/2025 documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 has moderate cognitive impairment. This same MDS under Functional Abilities and Goals documented R1 has no physical impairments on upper or lower body extremities and uses a wheelchair for mobility. This section also documents R1 needs supervision / touch assistance to wheel 50 feet with two turns once seated in wheelchair and R1 needs partial / moderate assistance to wheel 150 feet once seated in wheelchair. R1's Care Plan dated 07/28/2025 documented a Focus Area of "I have had an actual fall with serious injury fractured left clavicle." Interventions listed include therapy evaluation for wheelchair positioning, and foot pedals related to the fall, continue interventions on the at-risk plan and physical therapy consult for strength and mobility. The facility's "Report to Illinois Department of Public Health Regional Office" with a date of 07/28/2025 documented "Description of Occurrence: fall from wheelchair." Under "Follow Up/Final Report Summary" it is documented that R1 fell out of the wheelchair after toe caught on the floor while being pushed by staff. R1 had been holding her feet up and dropped her feet when the toe caught on the floor. R1 received a fracture to the left clavicle and orthopedics are following. There	S9999		

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S9999	Continued from page 2 was no surgery required; R1 has to wear an immobilizer to the left shoulder as tolerated. R1 is working with therapy, and therapy will address wheelchair positioning. R1's Progress Note authored by V3 (Licensed Practical Nurse/LPN) dated 07/28/2025 with at time of 9:52 AM documented R1 had a fall "this morning." V4 (Certified Nurse Assistant/CNA) was pushing R1 to the bathroom to get R1 changed and ready for the day. R1 dropped her feet she had lifted while V4 was pushing her and caught them under the wheelchair a little bit causing her to fall onto her knees out of the wheelchair and then fell onto her left side. R1 did not hit head as witnessed by this nurse. ROM (Range of Motion) is WNL (Within Normal Limits), denied pain, VS (Vital Signs) WNL, small, reddened area L (left) knee. R1's Progress Note authored by V3 dated 07/28/2025 with a time of 2:15 PM documented R1 complained of pain to this nurse of left shoulder. Tylenol administered and portable STAT 2 view L shoulder et (and) L arm x-ray called and ordered per physician. R1's Progress Note authored by V6 (LPN) dated 07/29/2025 with a time of 3:18 AM documented X-Ray company called to report possible fracture of left clavicle. V2 (Director of Nursing/DON) and nurse practitioner notified. New order received to send resident to local emergency department for evaluation and treatment. R1's Progress Note authored by V3 dated 07/29/2025 with a time of 10:20 AM documented in part, R1 arrived back from local hospital emergency department with fracture of left clavicle. New order for left arm sling to be worn at all times besides showering until follow up appointment with orthopedics. R1's Progress Note authored by V2 (DON) dated 07/29/2025 with a time of 11:19 AM documented, this note is a summary of the IDT (Interdisciplinary Team) Fall Committee Meeting Note. Please see assessment for full details. Summary of incident: CNA was pushing resident down the hallway to take her to the restroom. Resident dropped her feet and got them caught and she fell forward onto her knees out of the wheelchair and then fell on her left side. Did not hit her head. Root cause of fall determined by IDT: (this section is left blank). New interventions and/or changes suggested by the IDT at this time: refer to OT (Occupational Therapy) for wheelchair positioning and foot pedals for w/c (wheelchair).	S9999		

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S9999	Continued from page 3 R1's "Patient Report" with a date of 07/28/2025 and a time of 8:35 PM documented under impression, (R1) has a deformity of the distal left clavicle, consistent with nondisplaced fracture. R1's "Witnessed Fall" report dated 07/28/2025 documented under "Incident Description - CNA was pushing resident down the hallway to take her to the restroom. Resident dropped her feet and got them caught and she fell forward onto her knees out of the wheelchair and then fell to her left side. Did not hit her head." On 08/07/2025 at 11:44 AM, R1 was sitting in the dining room with a sling in place to her left arm. There were no wheelchair pedals noted to R1's wheelchair. R1 stated that she fell out of her wheelchair about two weeks ago. R1 stated her pain is ok and not a problem. R1 stated "the girl was pushing her too fast in the wheelchair." R1 stated "I told her to slow down, my knees don't work, and I couldn't hold up my legs any longer." R1 stated her legs got heavy and dropped down causing her to fall out of the wheelchair. R1 stated she has fallen a few times and fears getting hurt from falling. R1 stated she wheels the wheelchair with her hands and doesn't always use her feet. R1 stated that therapy gave her this new wheelchair after the fall. R1 stated that her old wheelchair was too heavy. R1 stated that the facility has never placed foot pedals on her wheelchair. On 08/07/2025 at 12:03 PM, V3 (LPN) stated on the morning of 07/28/2025, she was receiving report on the hall and saw R1 being pushed by V4 (CNA) in a wheelchair to the shower room. V3 stated that R1 had her feet up and then they dropped. V3 stated R1's feet went under the wheelchair and R1 fell forward onto the ground. V3 stated that V4 did not see R1's feet drop because she was pushing her from behind. V3 stated that R1 has never used foot pedals on her wheelchair because R1 uses her feet to self-propel around the facility. V3 stated that V4 was pushing R1's wheelchair at a normal pace. V3 stated she did not hear R1 tell V4 to slow down. V3 stated that after the fall, she immediately assessed R1 for injuries and her range of motion was within normal limits. V3 stated several hours later R1 complained about pain in the shoulder area. V3 stated she gave her Tylenol and called the doctor to get an order for an X-ray. V3 stated that R1 doesn't complain of pain and is doing ok with the sling on. On 08/07/2025 at 12:42 PM, V5 (Therapy Director) stated that she does not recommend or use wheelchair pedals because they are a restraint. V5 stated that if a	S9999		

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S9999	Continued from page 4 resident can self-propel a wheelchair, then you cannot place foot pedals on the wheelchair. V5 stated that R1 moves herself around the facility usually without staff assistance. V5 stated she was never made aware by facility staff that R1 was supposed to be evaluated for foot pedals. V5 stated she was never really told about the incident with R1 falling out of her wheelchair and was not told that the intervention was to have Occupational Therapy evaluate foot pedals. V5 stated she is unsure why staff would be pushing R1's wheelchair. V5 stated that staff are able to get foot pedals anytime they feel the need to. On 08/07/2025 at 12:53 PM, V4 (CNA) stated that she was the CNA that was pushing R1's wheelchair when she fell out of it. V4 stated that R1 was on her way to the bathroom and was having trouble getting there by herself. V4 stated that she decided to help R1 by pushing her since she was struggling. V4 stated suddenly R1's legs dropped, and her foot went under the wheelchair causing her to fall out of the wheelchair. V4 stated that R1 usually propels herself in the wheelchair to the restroom and only needs help with care. V4 stated that she is not sure why R1 dropped her legs and never heard R1 say to slow down. On 08/07/2025 at 12:56 PM, V5 (Therapy Director) stated she looked back in her notes and on 08/06/2025, she started educating staff on proper pushing of residents in wheelchair and wheelchair safety. V5 stated that she put foot pedals in R1's room in case she is sick or too weak to hold her legs up and needing assistance with her wheelchair. V5 stated that even if she would have completed the evaluation, she would not recommend foot pedals for a resident who uses her feet to self-propel around the facility. On 08/07/2025 at 12:59 PM, V2 (DON) stated that if foot pedals are not a restraint, then why in nursing school where we told that if they were on, they had to be down otherwise they could not be on. V2 stated the manufacturer of wheelchairs states that if the foot pedals are on a wheelchair, they have to be down, that foot pedals cannot be on a wheelchair and folded up. On 08/07/2025 at 1:05 PM, V1 (Administrator) stated that she went back to review morning meeting minutes. V1 stated that on 07/28/2025 and again on 07/29/2025, R1's fall was discussed. V1 stated that on 07/29/2025, therapy was told in morning meeting that R1's wheelchair needed to evaluate for foot pedals. On 08/07/2025 at 2:12 PM, R1 was observed to be self-propelling her wheelchair in the hallway. R1 was	S9999		

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S9999	Continued from page 5 scooted up in the wheelchair seat to the edge and was bent forward. R1 would move her feet and rock her upper body at the same time to propel her wheelchair. R1's left foot was observed to be dragging occasionally on the floor while she was self-propelling. R1's left foot would appear to get stuck on the floor while she was self-propelling her wheelchair though the hallway corridor. On 08/07/2025 at 2:46 PM, V1 (Administrator) stated that R1 fell on 07/28/2025 and didn't complain of pain until later in the afternoon. V1 stated that R1 was sent out after the results of the x-rays came back to the facility. V1 stated that on 07/29/2025 in morning meeting, R1's fall was discussed again, and the intervention chosen was to have therapy evaluate R1 related to wheelchair positioning and the need for foot pedals. V1 stated she was not aware until today that therapy had not evaluated R1 for foot pedals. V1 stated that R1 has continued working with therapy after the fall. V1 stated that her understanding of the fall was V4 was pushing R1 to the bathroom and R1's legs dropped. V1 stated that it was explained to her while investigating the fall that R1's toe got caught causing her to fall out of the wheelchair. V1 stated that prior to the fall, R1 rarely asked staff to help her in the wheelchair. V1 stated that staff education started on 07/31/2025 by V2 (DON) and on 08/06/2025 by V5 (Therapy Director). V1 stated that R1 has foot pedals in her room that staff can use when they need too. V1 stated the education that was done was wheelchair positioning, taking your time while pushing a resident in a wheelchair, and use foot pedals when needed. V1 stated that R1 will see the orthopedic doctor on 08/13/2025. On 08/07/2025 at 2:57 PM, V2 (DON) stated that not all staff have been educated on wheelchair safety yet. V2 stated that some staff haven't worked or forgot to sign the education sheet when they were in serviced. V2 stated she was not aware that therapy had not evaluated R1's wheelchair for foot pedals. V2 stated that R1's interventions are making sure staff are more aware of resident's positioning while in wheelchair while transporting and to follow up with therapy. V2 stated the education she completed with staff was on proper wheelchair safety and while pushing a resident in the wheelchair to remind them to keep their feet up. V2 stated that if a resident can't keep their feet elevated while pushing them in a wheelchair, the resident should already have foot pedals on the wheelchair. V2 stated that R1 has had minimal pain since the incident and continues to self-propel herself in the wheelchair throughout the facility.	S9999		

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S9999	Continued from page 6 Facility policy titled “Fall Prevention Program” with a revision date of 11-21-17 documents under 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.” (B)	S9999		