

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000360		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2026	
NAME OF PROVIDER OR SUPPLIER AXIOM HEALTHCARE OF HARRISBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WEST SLOAN STREET , HARRISBURG, Illinois, 62946			
(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		S0000			02/23/2026	
	Complaint Investigation 2651270/2730539						
S9999	Final Observations		S9999			02/23/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.690c)						
	300.3210t)						
	300.3240c)						
	300.3240e)						
	300.3240g)						
	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 300.690 Incidents and Accidents						
	c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 4 (R1, R2, R3, and R4) of 7 residents reviewed for abuse out of a sample of 7. This failure would result in a reasonable person such as R3 and R4 feeling vulnerable, threatened, fearful or distressed due to R2's presence in the facility and not receiving adequate protection from aggressive behaviors. Findings include: R2's Admission Record documented an admission date of 11/10/25 and included diagnoses of anxiety disorder, depression, and dementia. R2's MDS dated 1/13/26		S9999				

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S9999	Continued from page 2 documented a BIMS score of 6, indicating R2 was severely cognitively impaired. R2's Care Plan included a Focus Area of "Potential for aggressive behavior r/t (related to) dementia" initiated on 11/17/25, with corresponding interventions that included to encourage participation in activities, monitor labs as ordered, observe residents location and change in aggression level, remove from area when resident shows increased aggression, and resident moved to different room on 11/17/25. All interventions have a date initiated of 11/17/25 with no further additions noted after that date. 1. A Report to IDPH (Illinois Department of Public Health(Regional Office marked as "Final" documents a Date of Incident/Accident as 11/17/2025 with at time of 1:00 AM and names R3 and R2 as the residents involved. Under Description of Occurrence is documented "Alleged Resident to Resident Physical Altercation." No injuries were noted, and the report indicates Residents Immediately Separated and an investigation was initiated. Under Follow Up/Final Report Summary, the report documented "Allegation of resident to resident altercation was substantiated. (R2) woke up confused, he walked across the room and grabbed roommates (R3's) legs and was accusing (R3) of sleeping with (R2's) sister. (R3) awoke to his legs being grabbed (R2) (sic). (R2) then slipped landing on (R2's) knees while he still had a hold on (R3's) legs. (R3) yelled for help staff arrived as (R3) struck (R2) in the back of head to get (R2) to release (R3's) legs. Staff immediately separated residents and completed full body assessments on both residents. No injuries noted on either resident... Staff initiated an intervention of moving residents to separated rooms away from each other." The report documents it was completed by V1 (Administrator) on 11/21/25. R3's Admission Record documented an admission date of 11/27/24 and included diagnoses of vascular dementia, bipolar disorder, depressive disorder, and anxiety disorder. R3's MDS dated 12/4/25 documented a BIMS score of 11, indicating R3 was moderately cognitively impaired. Additional facility investigation documentation labeled "#128 Res/Res Altercation" dated 11/17/25 at 1:00 AM documents the incident location as Resident's Room and V14 (Licensed Practical Nurse/LPN) prepared the report. V14's statement documents "Staff heard yelling from residents room. Upon entering room, observed resident (R2) on the floor holding onto foot of roommate (R3) and (R3) hitting (R2) in the head." R3's statement		S9999				

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S9999	Continued from page 3 documents "Resident stated upon entering the room that 'He (referring to R2) came over here and started attacking me.' This nurse asked him (R3) to clarify what he meant by 'attack' to which the resident (R3) stated 'He grabbed by foot and wouldn't let go.' (R3) also stated that he no longer wanted to be roomed with the resident (R2) anymore." This report documented no injuries observed post incident. 2. A Report to IDPH Regional Office marked as "Final" documents a Date of Incident/Accident as 12/15/2025 with at time of 3:25 AM and names R4 and R2 as the residents involved. Under Description of Occurrence is documented "Alleged Resident to Resident Physical Altercation." No injuries were noted, and the report indicates Residents Separated, Police called and an investigation was initiated. Under Follow Up/Final Report Summary, the report documented: "(R2) was found to have hit (R4) in back of her head, resident confused at time not understanding what he (R2) had done. (R4) was not injured and stated it did not hurt her just stunned her and she (R4) is not afraid. (R2) has followed up with psychiatrist and has had a medication change." The report documents it was completed by V1 (Administrator) on 12/17/25. R4's Admission Record documented an admission date of 11/5/24 and included diagnoses of schizoaffective disorder, anxiety disorder, dementia, and depressive disorder. R4's MDS dated 11/14/25 documented a BIMS score of 12, indicating R4 was moderately cognitively impaired. Additional facility investigation documentation labeled "#152 Res/Res Altercation" dated 12/15/2025 at 3:30 AM documents the incident location was the dining room and V14 (LPN) prepared the report. The incident description documents "CNA (Certified Nursing Assistant) staff stated that agitated resident hit this resident on the top of the head with facility signage that was removed from the wall." Resident description documents "Resident (R4) didn't state much about the incident but said 'it was a shock more than anything, he does crazy things.' This nurse asked resident if she was in any pain to which she stated no." Under Injuries observed at time of incident documents injury location as top of scalp. Mental status is documented as alert and oriented to person, situation, place and time. The injuries report post incident documents No Injuries Observed Post Incident. Under Statements, V14 (LPN) documented "I did not personally see this incident occur but after talking with this resident (R4), she seemed more shaken up than anything. Residents vitals and neuro assessments were all within normal limits. No	S9999					

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S9999	Continued from page 4 visible injuries were noted to residents face or scalp." V15's (CNA) statement documents "(V16/CNA) got me from (room number) to come to dining room to help with an agitated resident that was combative. Resident was sitting on piano bench and began hitting me, swinging with fists and a board off the wall. He hit me in right ribs and breast. He grabbed a heavy Christmas decoration and threw it at me. He got up chasing mr on foot at me, I got the w/c (wheelchair) and got him to sit." V16's (CNA) statement documents "Client in dining room, became combative with staff by standing up and swinging upper body and arms with closed hands resulting between contact between staff and patient. 1:1 given client redirected, no injuries noted. On the way back from nurses desk another client approached the same area resulting in an altercation between said aggressive patient and other client. Top of patient's head smacked at contact made 1:1 give, nurse notified. No injuries noted." 3. A Report to IDPH (Illinois Department of Public Health) Regional Office marked as "Initial & Final" documents a Date of Incident/Accident as 02/03/2026 with no time documented and names R1 and R2 as the residents involved. Under Description of Occurrence is documented "Alleged resident to resident altercation." No injuries were noted and the report indicates an investigation was initiated. Under Follow Up/Final Report Summary, the report documented: "(Name of R1's) daughter reported to the Administrator that on December 16, 2025 that resident (name of R2) grabbed her father's blanket and hit his back. The daughter reported this to Admin weeks after the incident occurred. The daughter spoke to the nurse on duty at the time of the incident and stated that (name of R2) was bothering her and her father (R1) and asked if he (R2) could be moved. At the time of the incident resident's daughter did not mention any hitting. By the time the incident was reported (name of R2) had been sent to inpatient psychiatric care. (Name of R2) has since returned to the facility with no further incidents. Residents and staff interviewed with no concerns identified..." The report documents it was completed by V1 (Administrator) on 02/03/2026. R1's Admission Record documented an admission date of 3/25/25 and included diagnoses of chronic obstructive pulmonary disease, panlobular emphysema, and dysphasia. R1's Minimum Data Set (MDS) dated 1/25/26 documented a Brief Interview of Mental Status (BIMS) score of 15, indicating R1 was cognitively intact. On 2/4/26 at 10:29 AM, V3 (Licensed Practical Nurse/LPN) said she was working on 12/16/25. V3 said		S9999				

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S9999	Continued from page 5 she was down the hall with the medication cart administering medications to other residents when V9 approached her and told her R2 was yelling at V9 (Family Member). V3 said she told V9 she would take care of it and went to the dining room. V3 said when she got to the dining room R2 was sitting in his wheelchair about 3 tables away from R1 and was yelling at V9. V3 said she assisted R2 to the other side of the dining room away from R1. V3 said V9 did not report any physical incident to her at the time. V3 said V9 had only told V3 that R2 was being verbally abusive to V9. V3 said about a month after this incident, V1 came to V3 asking when V9 had reported to V3 on the date of this incident. V3 said she did not tell V9 to report what had happened on 12/16/25 to V1. On 2/4/26 at 3:20 PM, R1 was alert and oriented to self, time, and place. R1 said he was not sure of the exact date of the incident with R2. R1 said he was sitting in the dining room after the evening meal talking to V9 (Family Member) when R2 came up behind R1 and rammed R2's wheelchair into R1's wheelchair and R2 started punching R1 in the back. R1 said he told R2 to stop and get away from R1. R1 said another male resident sitting in the dining room yelled at R2 to stop. R1 said he thought the other resident yelling scared R2 and caused R2 to stop and roll away from R1. R1 said he was not sure of the other male resident's name. R1 said V9 immediately went to get a nurse, so R1 assumed the facility was aware of the incident. R1 said a nurse came to the dining room and assisted R2 back to R2's room. On 2/4/26 at 3:39 PM, V9 said she had been told by various staff R2 could become physically aggressive. V9 said on 12/16/25, V9 and R1 were sitting in the dining room when R2 came up behind R1 and hit R1's wheelchair with R2's wheelchair. V9 said R1 told R2 to stop when R2 started punching R1 in the back and started pulling on R1's blanket. V9 said R7 was sitting at a table on the far side of the dining room and used a stern voice to tell R2 to stop. V9 said R2 stopped punching R1 and R2 rolled his wheelchair back away from R1. V9 said after the incident, V9 went to get V3 (LPN) and informed V3 of what had happened. V9 said V3 came to the dining room and R2 was still close to R1 sitting in his wheelchair. V9 said V3 assisted R2 back to R2's room. V9 said V3 told V9 to report what happened to V1 (Administrator) and V9 sent V1 an email describing the events. V9 said after she sent V1 the email on 12/16/25, V9 returned to the facility the next day and did not see R2. V9 said she thought R2 was no longer in the building due to the email V9 had sent to V1 and "thought it was taken care of." V9 then said on 1/6/26,		S9999				

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S9999	Continued from page 6 she visited the facility and saw R2 had returned to the facility. V9 said she spoke with V2 (Director of Nursing/DON) on 1/6/26 regarding her concerns with R2 being back in the facility after R1 and R2's physical altercation and the need for R1 and R2 to be kept apart. V9 said later that day on 1/6/26, V1 (Administrator) called V9 and yelled at V9 for about 20 minutes saying V1 only had 24 hours to report the incident and asking why V9 didn't report this to V1. V9 said she told V1 she had sent V1 an email on the day the incident had happened. V9 said V1 said she had not received any email from V9 about this incident so V9 told V1 she would forward the previously sent email. On 2/5/26 at 10:12 AM, V7 (Certified Nursing Assistant/CNA) said he could not recall a specific date with any incident between R1 and R2. V7 said he did recall an incident when R2 grabbed R1's wheelchair and R2 had to be redirected away from R1. V7 said R2 "had a lot of conflict with a lot of residents." V7 said he had seen R2 raise his fist like he was going to hit another resident, but staff had intervened prior to R2 making contact. V7 said he had not witnessed the event between R1 and R2 on 12/16/25 but had come to the dining room after V9 spoke with V3. V7 said he did not recall what V9 said at that time. V7 said "later on" V9 had asked staff to keep R2 away from R1 because R2 had hit R1 in the past. On 2/5/26 at 10:23 AM, V8 (CNA) said she did not witness the incident between R1 and R2. V8 said in the past she had seen R2 get physically aggressive with other residents and "it was common for (R2) to get aggressive." On 2/5/26 at 1:42 PM, V1 (Administrator) said she was not aware of the incident occurring on 12/16/25 between R1 and R2 until 1/6/26 when V9 came to speak with V1. V1 said she did not report the incident at that time because V1 thought it was unfounded. V1 said she reported the 12/16/25 incident on 2/3/26 after V9 sent a letter to corporate. R7, who was determined to be present in the dining room at the time of the 12/16/26 incident between R1 and R2, was unable to be interviewed due to being discharged prior to this investigation and did not answer the phone or return a phone call. An email communication dated 1/6/26 at 3:53 PM from V9 to V1 documented in part "...Here's my original email. (CC'ing (V2/DON) since I talked to her about it today.) It never registered that you didn't receive my email since everything in this email was resolved the next		S9999				

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S9999	Continued from page 7 day and hasn't been an issue since. I just assumed you took care of it!..." This email chain also contained the original email from V9 to V1 dated 12/16/25 at 9:55 PM documenting in part "... you probably will get a report on this in the morning from the nursing staff but the nurse tonight (V3's name) asked me to report directly to you. The first two incidents are related: (R1) was "attacked" or "harassed" by (name of R2) twice today. The first instance happened earlier in the day when I wasn't there. (R1) said that (name of V7) intervened. The second happened at dinnertime, when I was there. First, (name of R2) rolled up to the table, invading his (R1's) personal space. When (R1) didn't move (he was actively eating his dinner) (name of R2) started pushing his chair and I asked (name of R2) to move away from (R1). (Name of R2) them (sic) hit him (R1) in the back and started yelling at him. (Name of R2) pushed him (R1), slapped/hit him, yelled at him, and yanked his blanket. (Name of R7) yelled at (Name of R2) very loudly and I went to get a nurse or a CNA to help. (Name of V3) responded. For the last month or so, I have been actively trying to keep (R1) as far away from (Name of R2) as possible: ensuring CNAs do not put them at the same table and making sure they are as far away from each other in the dining room as possible, as I have been told by multiple nurses and CNAs that (name of R2) is combative, aggressive, and dangerous. One told me one day that it was inevitable that someone was going to get hurt with (name of R2) in the building. I want to make sure that (name of R2) never touches (R1) ever again. If he (R2) threatens or touches (R1) in an aggressive way ever again, I will file a report against him (R2)..." The facility presented a letter dated 1/31/26 from V9 documenting in part "... I am writing to formally address two major issues that require immediate action... 1. Resident-to-Resident Assault (Unreported and Mishandled)... On December 16, 2025 (R1) was assaulted by another resident during dinnertime. I witnessed the incident. The resident approached (R1), invaded (R1's) space, pushed (R1's) wheelchair, hit (R1) yelled at (R1), and pulled (R1's) blanket. Another resident intervened verbally, and I immediately sought staff assistance. (V3) responded promptly, and I was instructed to email the Site Administrator, (V1), with a full account, which I did that same evening. I received no response, but when the aggressor was absent from the facility the following days, I reasonably assumed the incident had been addressed. On January 6, 2026, I learned from (V1) that the resident had been temporarily away for treatment related to aggression and had returned with what was described as a "clean slate." Upon seeing this resident back in the facility,			S9999			

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S9999	Continued from page 8 I alerted department heads to keep (R2) away from (R1). I was repeatedly told to speak with (V1). I subsequently forwarded the original email, complete with timestamp, proving the report was made the night of the assault. To my knowledge, no formal report has been filed by the facility, and no meaningful safeguards have been implemented..." On 2/6/26 at 2:45 PM, V1 (Administrator) said the resident to resident abuse allegation investigations between R2 and R3 and R2 and R4 were substantiated because they were found to have happened. V1 said the intervention put in place for R3 was R2 was moved out of R3's room. V1 said the intervention put in place for R4 was R2 was referred to psychiatry for a medication change. The facility's revised 10/24/22 Abuse Prevention and Reporting-Illinois policy documented in part "... This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services be staff or mistreatment... This will be done by... Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment... Identifying occurrences and patterns of potential mistreatment... Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences... Filing accurate and timely reports... Definitions:.. Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means... Abuse is a willful infliction of injury... with resulting physical harm, pain, or mental anguish to a resident... Physical Abuse... Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment..." (B)		S9999				