

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER AXIOM HEALTHCARE OF MOUNT VERNON				STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WHITE STREET , MOUNT VERNON, Illinois, 62864			
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S0000	Initial Comments		S0000			02/11/2026	
	Annual Certification Survey						
S9999	Final Observations		S9999			02/11/2026	
	Statement of Licensure Violations						
	300.610a)						
	300.1010h)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	300.1210d)1)						
	300.1210d)3)						
	300.1610a)1)						
	300.1620a)						
	300.1630d)						
	300.3210a)2)A)B)C)						
	300.3220f)						
	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.						

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 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.		S9999				

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S9999	Continued from page 2 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a	S9999					

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S9999	Continued from page 3 timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. B) A facility shall protect and promote the rights of the resident. C) Residents have the right to reside in and receive services in the facility with reasonable accommodation of their needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to notify the physician of a resident's change in condition for 1 of 3 residents (R49) reviewed for change of condition in a sample of 42. This failure resulted in R49's hospitalization for sepsis and subsequent death. The facility also failed to implement a pain management program that was effective to promote comfort and control pain to promote the most effective recovery and rehabilitation for 1 of 1 resident (R1) reviewed for pain in the sample of 42. This failure resulted in R1 experiencing significant pain daily as evidenced by expressions of persistent pain and tearfulness. Upon interview, R1 describes the pain present almost daily as a 9 out of 10, on a scale of 1-10 with 10 being the worst pain. Findings Include: 1. R49's Admission Record with a print date of 1/22/26 documents R49 was admitted to the facility on 5/30/25 with diagnoses that include chronic obstructive pulmonary disease, simple chronic bronchitis, cirrhosis of liver, ulcerative colitis, major depressive disorder, borderline personality disorder, anemia, and		S9999				

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S9999	Continued from page 4 heart disease. R49's Minimum Data Set dated 9/2/25 documents a Brief Interview for Mental Status score of 15, which indicates R49 was cognitively intact. R49's most recent Care Plan documents a Focus area of, "(R49) has Congestive Heart Failure Date Initiated: 06/10/2025." This Focus area includes the following intervention, "Monitor/document/report PRN (as needed) any signs of s/sx (signs/symptoms) of Congestive Heart Failure...Date Initiated: 06/12/2025..." This same Care Plan documents a Focus area of, "(R49) has an Indwelling Catheter: Neuromuscular dysfunction of bladder. Date Initiated: 06/10/2025..." This Focus area includes the intervention, "Monitor/record/report to MD (physician) for s/sx (signs/symptoms) of UTI (urinary tract infection) ..." R49's progress notes document the following. 10/13/25 1:00 PM, "Residential hospice nurse (name of nurse) and two bath aides here to see pt (patient), bathe her and discharge her from hospice services 10/13/25 due to no longer meeting hospice criteria. Patient aware of this... Patient got a little tearful today with me as she was upset, she was being discharged. Patient conts (continues) to be jaundice. Alert and able to voice needs, meds (medications) given by nurse one at a time with a spoon today. No complaints nausea voiced, appetite fair today, fluids taken fair. Foley patent and draining orange tinged urine. Conts on routine pain meds as ordered. Patient had a BM (bowel movement) today. Conts on neb txs (treatments) as ordered. C/L (call light) in reach." 10/24/25 10:17 AM, "(V7) NP (Nurse Practitioner) in house, assessed resident, reviewed medications. Resident is requesting a "full work up" be done. States she isn't receiving hospice anymore so something should be able to be done with my UTI (urinary tract infection), my jaundice, my mental state, my everything. NP discussed past hospitalizations, dx (diagnosis), and exactly what resident is wanting. NP stated she would request records from (name of regional hospitals), and the other facilities resident has stayed in over the last couple years. Educated resident that these records would need to be reviewed to see what kind of plan can be put in place to provide adequate care. Resident voiced understanding. (V7) NP also made aware by writer that new RX (prescription) of oxycodone is needed as she is out and no Rx on file. Also notified next dose is due @ 1300 (1:00 PM) with NP acknowledging. NOR (new order received) to obtain CBC	S9999					

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S9999	Continued from page 5 (complete blood count), CMP (comprehensive metabolic panel), Ammonia, Amyase (sic), Lipase levels, CT (computed tomography) head w/o (without) contrast, and refer to Ophthalmology for double vision. Lab reqs (requisitions) completed and order left for (name) of scheduler/transport. "Signed by V3 (LPN). 10/27/25 4:33 PM, "Resident Foley leaking. Removed old Foley #18Fr (French)30cc (cubic centimeter) balloon deflated and intact upon removing. Per sterile technique, inserted #18Fr 30cc Foley without difficulty. Immediate return of orange tinged urine r/t (related to) pyridium. No sediment, foul odor noted. UA (urinalysis) specimen obtained and awaiting lab pick up in AM." Signed by V3 (LPN). 10/30/25 4:04 PM, "UA results received back from (V7) NP and NP said no new orders at this time, waiting on culture results, pt has a Foley and takes pyridium. patient aware that we are waiting on culture results." Signed by V3 (LPN). 11/02/25 8:29 PM, "partial UA and partial culture results were faxed to NP by (initials) RN (Registered Nurse) and orders came back that said culture pending NNO (no new orders) at this time. The Final UA and final culture came back 11-2 and cx (culture) said probably contamination greater than or equal to 3 organisms isolated. Contact the lab within 48 hours if identification is clinically indicated. Patient aware of this and I also gave ON call NP (name) update that it came back probable contamination. NP said if we need to redo the UA we can. Will call lab Monday am and then go from there." Signed by V10 (LPN). 11/04/25 10:40 AM, "(V7) NP in house. Assessed resident with NOR to obtain CXR (chest x-ray), decrease Oxycodone from 20mg 2 tabs p.o. (by mouth) q (every) 4hrs (hours) routine to Oxycodone 30mg (milligrams) p.o. q 6hrs PRN (as needed). d/c (discontinue) PRN Oxycodone 20mg p.o. q 2hrs when new dosage of Oxycodone arrives. Keep original orders in place until new dosage of Oxycodone arrives. Start Benadryl 25mg p.o. TID (three times a day) PRN r/t (related to) itching, start Mary's Magic Mouthwash QID (four times a day) x (times) 14 days r/t sores on tongue. Order air mattress to prevent further breakdown. Start MVI (multi vitamin) w/ minerals, ProHeal 30mL (milliliters) BID (twice daily). Have		S9999				

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S9999	Continued from page 6 dietary assess, pt (patient) would benefit from increase protein. Biotech notified of CXR needed. (name of previous Director of Nurses) notified of wound consult order and order for air mattress. (V7) DM (Dietary Manager) notified of dietary consult." Signed by V3 (LPN). 11/5/25 5:44 PM, "Resident slept most of the day. Jaundice increasing daily. Fluid intake not as good as it usually is, very little eaten @ (at) meals. O2 (oxygen) on @ 3lpm (liters per minute) per n/c (nasal cannula). Foley cath (catheter) patent and draining dark amber urine." Signed by V3 LPN. 11/6/25 6:00 AM, "Spoke to CNAs (Certified Nursing Assistant) regarding this resident's health status. CNA stated that resident had been like this all day yesterday and continues today. VS- 102.6 (forehead), 93% on RA (room air), 78/60 (blood pressure), 28 (respirations), 149 P (pulse). Breathing is very shallow and abdominal. Pupils area (sic) dilated the right side is larger than the left side pupils. Barely any response when vitals taken. Barely drinking any liquids and only had a scant amount of urine 250 cc of urine all night long. Is very jaundiced to skin and eyes. Said "Help Me". Attempted to call (name of physician group) OnCall did not pick up so called (name of ambulance service) @ 0610 (6:10 AM) and (name of local hospital) ER (emergency room) @ 615. 0625 (6:25 AM) Left with (name of ambulance service) to the ER. Called (name of physician group) and got a hold of (name of physician) who was fine sending out after nurse gave her report. ADMIN (administrator) was called at 0635 (6:35 AM)." Signed by V6 RN. 11/06/25 9:40 AM, "pts (patients) brother called and said the hospital had called and let him know patient was in the ER and he called me to see what she had going on that she was sent to ER and I told him what I received in report as to why they sent her. Brother said he was at work but when I got an update could I call him and let him know and if he couldn't answer then I could leave a message and I told him I would." Signed by V10 LPN. 11/06/25 11:50 AM, "I received a call from (name of nurse) at (initials of local hospital) ER and she was calling to let me know that patient had passed away and they called the time of death 1135am. I asked (name of nurse) if doctor said what he thought happened and nurse said she wasn't sure but said probably sepsis as her urine in Foley was really awful and even when they pulled some urine out it was awful. (name of nurse) said they didn't do any labs, basically comfort care as	S9999					

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S9999	Continued from page 7 she was not doing real good there at the hospital. The nurse said she was with patient when she was passing and held patients hand and the doctor was on the other side of patient. The nurse asked if I knew what funeral home patient had wanted and I couldn't find in the chart and so I went and asked social services (name) and she found that pt wanted (name of local funeral home) in Salem. I asked (name of nurse) if she had called patients brother (name of brother) yet and she said no and I told her he wanted me to call him back when I heard something, so I said I would try to call as he was at work. I notified pts brother (name) at 1218pm and gave emotional support over phone. 1221 social services (name) attempted to notify the other brother (name) but got no answer. 1225pm I called (name of pharmacy) spoke with (name) and let her know that patient had passed away so we didn't need to worry about doing anything with the MVI order/allergy they had sent and needed to talk to us about....notified ADON (Assistant Director of Nursing) (V2) and Admin (Administrator) (V1) of patients passing." Signed by V10 LPN. R49's facility medical record documents under the Weights and Vitals Summary the following vital signs on 11/2/25 at 9:27 AM, blood pressure 112/60, temperature 97.6 Fahrenheit, pulse 68. There are no respirations or oxygen saturations documented on this date and time. This same report documents oxygen saturation of 97% on 11/2, 11/3, 11/4 and 11/05/25. This indicates R49's vital signs were not monitored after she began declining in condition on 11/5/26. R49's hospital records dated 11/06/25 documents under History, "54yo (year old) woman on comfort care brought by EMS (Emergency Medical Services) from nursing home for end of life distress, presumed infection with septic shock, patient altered, lethargic in hypoactive delirium, febrile, tachycardic, tachypneic. POLST (Physician Order for Life Sustaining treatment) form reviewed, and NH (nursing home) nurse confirms patient is on comfort care status. Analgesia, anxiolysis, antipyresis, and supplemental oxygen given for comfort. Patient has a Foley catheter in place that is the likely source of infection, so will discontinue due to likelihood of foreign body in inflamed organ causing significant pain." R49's hospital records documents under Physical Exam, "BP (blood pressure) 104/58, Pulse 176, Temp (temperature) 102.9 ° (degrees) F (Fahrenheit), Resp (respirations) 46..." Under Procedures Critical Care R49's hospital record documents, "Patient suffering with septic shock in end of life distress. Comfort-focused medications and interventions initiated. Making arrangements for hospital admission	S9999					

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S9999	Continued from page 8 although hospital is at peak census, so patient will likely need to be triaged to remain in ED (Emergency Department) until hospital can better accommodate transfer upstairs. Will continue interventions to alleviate distress here in ED. The hospital record documents under Progress Notes, "Pt (patient) remains tachypneic despite Fentanyl, PO (by mouth) Lorazepam. I placed peripheral IV (intravenous) under ultrasound guidance to better facilitate pt's comfort care meds. Pt given IV Acetaminophen for fever. Foley catheter discontinued. Will plan for intermittent straight caths to avoid indwelling catheter which would likely be more painful to keep in place. IV hydromorphone and diazepam ordered for continued tachypnea not responding thus far to medications already given. Rn (Registered Nurse) contacted pt's brother, who states that he is still at work but can come after 2:30 pm to visit. On reassessment, pt is no longer breathing rapidly. Breaths nonlabored, shallow and gradually slowing. Patient shows no sign of distress. RN (name of nurse) and I sat at bedside with patient as her breathing ceased, HR (heart rate) slowed and then became asystolic. Time of death noted at 1135." The hospital records document under Clinical Impressions, "Septic Shock...Urinary tract infection associated with indwelling urethral catheter...end of life care, Do not resuscitate, chronic liver failure with hepatic coma..." On 1/20/26 at 10:48 AM, V25 (hospital RN) stated she wasn't working when R49 arrived at the hospital, but she took over her care shortly after she arrived. V25 stated R49 was disoriented, had a super high temperature and a fast heart rate. V25 stated, "she was real sick." V25 stated they started her on oxygen and gave her medication to slow her heart rate down. V25 stated the facility sent paperwork documenting R49 was comfort care only. When asked if the treatment would have been different had she been a full code versus comfort care, V25 stated the treatment would have probably been the same since she was so bad when she arrived at the hospital. V25 stated she was extremely sick, and treatment probably wouldn't have changed the outcome. R49's Certificate of Death Worksheet documents R49 expired on 11/06/2025 with cause of death listed as sepsis and liver failure. R49's Hospice Visit Note Report dated 5/17/25 documents R49 was admitted to hospice on 5/17/25 with diagnoses of COPD. R49's Hospice Visit Note Report dated 10/13/25 documents R49 was discharged from hospice with reason	S9999					

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S9999	Continued from page 9 for discharge documented as "No longer terminally ill." This same report documents hospice shared the discharge summary with V10 (RN) and V1 (Administrator). On 1/13/26 at 1:40 PM, V26 (Senior Hospice Clinical Supervisor) stated R49 was discharged from hospice because she didn't meet the terminal status requirement per symptomology. V26 stated she didn't meet the guidelines to continue for COPD (chronic obstructive pulmonary disease). V26 stated they had been told R49 had liver failure so they ran labs to determine if she would meet the guidelines under a different diagnosis. V26 stated her lab results did not indicate she was terminal by clinical standards. V26 stated R49 did have some jaundice while she was on hospice. V26 stated she was surprised to hear R49 had passed away. R49's POLST form dated 5/17/25 documents a check next to "Comfort-focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death. Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting." On 1/25/26 at 2:06 PM, V1 (Administrator) confirmed via email R49 did not have a new/updated POLST after she discharged from hospice. V1 stated in the email she did not have a conversation with R49 when she came off hospice so she couldn't confirm what advance directives R49 wanted. On 1/15/26 at 11:44 AM, V7 (Nurse Practitioner/NP) stated she saw R49 a couple of times. V7 stated R49 came off hospice because she no longer had a qualifying diagnosis. V7 stated she was trying to catch up with R49's overall health since she was no longer on hospice. V7 stated R49 was chronically ill but she didn't remember her being acutely ill. When asked about the contaminated urine, V7 stated if she had been made aware R49 was having symptoms she would have had them repeat the urinalysis. V7 stated she ordered the chest x-ray because R49 had a cough but her vital signs were ok so she did not order it stat, and it could take a few days to get the x-ray and the results back. V7 stated they were weaning R49 off the pain medication since she was no longer on hospice and wanted treatment. V7 stated R49 was not on comfort care. V7 stated orange colored urine is normal with the medications R49 was taking but dark urine would have been a concern. V7 stated if she had been notified of R49's change in condition, she would have had them		S9999				

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NAME OF PROVIDER OR SUPPLIER AXIOM HEALTHCARE OF MOUNT VERNON				STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WHITE STREET , MOUNT VERNON, Illinois, 62864			
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S9999	Continued from page 10 monitor her vital signs and send her to the hospital for evaluation since she didn't have the laboratory results, she had ordered. V7 stated R49 was off hospice and had not verbalized to her she wanted to be placed on comfort care. V7 stated R49 wanted treatment. V7 stated she couldn't say for sure the outcome would have been different if R49 had received treatment earlier but the sooner she received treatment the better chance she would have had. On 1/14/26 at 3:33 PM, V14 (CNA/Certified Nursing Assistant) stated she provided care to R49 the day before she was sent to the hospital. V14 stated R49 was not herself. V14 stated they told the (unknown) nurse but she wasn't sure what she did. V14 stated she couldn't understand what R49 was saying and normally she could. V14 stated R49's skin color was yellow, and urine was dark but they were told that was because of a medication she was taking. V14 stated she was concerned about R49, but she told the nurse and when she reports information it only goes so far. V14 stated she thought the nurse working was V3, but she wasn't sure. On 1/14/26 at 1:41 PM, V3 (LPN) stated she remembered R49 but couldn't remember specific details. This surveyor reviewed her progress note dated 11/05/25 with V3 and she stated that was normal for R49. V3 stated the normal for R49 was alert and "giving everybody hell." V3 stated R49 knew she was dying and had voiced that for a couple of weeks. V3 stated hospice staff discussed sending R49 to the hospital and she declined. When asked if she was aware R49 had been discharged from hospice, V3 stated she thought R49 was picked back up by hospice for liver failure. V3 stated, "No, I knew they had talked about discharging her but could keep her on for liver failure." This surveyor reviewed R49's progress note dated 10/24/25 where it documents R49 was evaluated by V7 (Nurse Practitioner) and they discussed pursuing treatment since she was no longer under hospice care, V3 stated, "That is not good." V3 was unable to remember if R49's physician was notified of her condition or if there were any labs done. V3 stated R49 told her she was dying. When asked how they communicate a change in treatment, such as someone being discharged from hospice, V3 stated the communication is "horrible." V3 stated they used to just give verbal report, then they had a notebook they would write information in. V3 stated she started at the facility as an agency nurse and there was no way to know anything. V3 stated she just hoped she could figure things out. V3 stated then they got the electronic records system, and they did their report on a communications board and that worked well when they could access it. V3 stated she hadn't been able to	S9999					

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S9999	Continued from page 11 access it for months and had gone back to using a notebook. On 1/14/26 at 3:01 PM, V4 (LPN) stated she took care of R49 the first few nights (11/4 and 11/5/25) she worked at the facility. V4 stated it was her third night working, and she was supposed to be training but the other nurse called in. V4 stated V24 (RN) was working on the other hall but had to leave for a family emergency around 3 am. V4 stated after she left, she was responsible for passing morning medications to all of the residents in the facility. V4 stated she had been given report by the day shift nurse (V3) who told her R49 didn't want to go to the emergency room but her urine "was bad." V4 stated she assessed R49, and she had a pulse and was breathing but wouldn't wake up to take her medication. V4 stated R49's urine looked bad, but she didn't remember the specific details. V4 stated she thought R49 was still under hospice care, so she didn't notify the physician or send her to the hospital for evaluation. V4 stated she didn't know what to do with R49 so when the day shift nurse came in on the morning of 11/6/25 she reported the change to her. V4 stated when V6 saw R49 she "freaked out," and sent R49 to the hospital for evaluation. On 1/14/26 at 11:46 AM, V6 (RN/Registered Nurse) stated she returned to work on 11/6/25 day shift after being off for a couple of days. V6 stated V4 (LPN) gave her report and told her R49 looked "terrible." V6 stated she went to R49's room and immediately said that was not acceptable. V6 asked how long R49 had looked like that and V4 told her a couple of days. V6 stated R49 was greenish in color, her eyes were not responding, and she had shallow breaths. V6 stated, "I looked at her and I was not happy." V6 stated R49 passed away about four hours after she got to the hospital. V6 stated, "I was just shocked she hadn't been sent out already." V6 stated she discussed her concerns with V1 (Administrator) and she didn't really say much about it. On 1/14/26 at 4:20 PM, V10 (LPN) stated she provided care to R49 but couldn't remember if she took care of her in the days leading up to her hospitalization. V10 stated she remembered R49 had some issues, and they did a urinalysis, but the lab said it was contaminated because it had more than three "bugs" in it. V10 stated she remembered R49's urine looked "nasty" and remembered thinking she could very well have three "bugs" growing in it. V10 stated she didn't think R49 was treated with antibiotics. V10 stated R49 would say she didn't want to be treated for them. When asked where that would be documented V10 stated in the	S9999					

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S9999	Continued from page 12 progress notes. V10 stated she knew she didn't want to be treated because she told hospice R49 didn't want treatment. This surveyor asked V10 if she spoke with hospice when R49 began to decline and V10 stated she did. V10 then stated R49 went off hospice. V10 stated R49 would tell hospice about issues, and they would tell her if she wanted treatment, she would have to go off hospice. On 1/15/26 at 8:36 AM, V11 (CNA) stated they took R49 off hospice, and she didn't feel like she should have been. V11 stated R49 was jaundice, not feeling good, and not acting right. V11 stated those symptoms started with in two days of her going to the hospital. On 1/15/26 at 10:36 AM, V5 (CNA) stated she took care of R49 prior to her hospitalization. V5 stated she told them something wasn't right. V5 stated she reported it to unknown nurses, and they would "put it off." V5 stated she didn't remember if R49 had any urinary complaints, but her urine looked like there was blood in it. V5 stated the nurses told her it was a medication she was on, but it didn't look like anything she had ever seen from medications. V5 stated the CNA's tried to meet her needs but she felt like the nursing care was "pushed off," and when she would report something to them, they would say they had checked it and R49 was ok. On 1/21/26 at 8:57 AM, V2 (Assistant Director of Nurses) stated she was not aware of the change in condition for R49. V2 stated if she had been notified, she would have had them notify the physician. The facility Physician-Family Notification-Change in Condition dated 10/1/15 documents, "Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner....Guidelines: the facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is:...A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); Life-threatening conditions are such things as heart attack or stroke. Clinical complications are such things as development of stage II pressure ulcer, onset or recurrent periods of delirium, recurrent urinary tract infections, or onset of depression..."		S9999				

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S9999	Continued from page 13 2. R1's admission record printed 1/21/26 documents an admission date of 11/27/25. R1's admission record documents diagnoses including but not limited to fibromyalgia, chronic pancreatitis, scoliosis, gastroparesis, type II Diabetes and chronic pain syndrome. R1's minimum data set (MDS) dated 12/18/25 documents R1 has a brief interview for mental status (BIMS) score of 15 indicating resident is cognitively intact. R1's MDS documents R1 has pain almost constantly. This MDS documents R1's pain affects her sleep almost constantly. R1's MDS documents pain interferes with R1's day to day activities almost constantly. R1's Order Summary Report dated 1/21/26 documents orders including but not limited to for Lyrica 50 milligram (mg) capsule (cap) – give 1 cap by mouth one time a day related to fibromyalgia (start date 12/17/25); Lyrica 50mg cap – take 1 cap by mouth at bedtime (start date 11/28/25) ; gabapentin 600mg tablet – take tablet by mouth three times per day for pain related to fibromyalgia (start date 12/10/25); ibuprofen 800mg tablet – take one tablet by mouth every eight hours as needed for pain related to chronic pain syndrome (start date 11/28/25); lidocaine external patch 4% - apply to area of pain topically one time a day for pain related to chronic pain syndrome (start date 1/4/26); oxycodone-acetaminophen 10/325mg tablet – take one tablet by mouth every four hours as needed for pain related to chronic pain syndrome (start date 11/28/25); tizanidine 4mg tablet – take one tablet by mouth four times per day for pain related to chronic pain syndrome (start date 12/10/25). R1's current Care Plan documents R1 has a focus area for chronic pain related to fibromyalgia dated 11/27/25. The same care plan documents interventions for this focus area include but are not limited to monitor/document for side effects of pain medication dated 11/27/25; Other interventions added to the care plan after this investigation was started was to identify and record previous pain history and management of that pain and impact on functions dated 1/16/26; notify physician if interventions are unsuccessful or if current complaints is a significant changed from resident's past experience of pain dated 1/16/26; referral to pain management dated 1/16/26. R1's December 2025 medication administration record (MAR) documents a pain level for the Lidocaine external patch 5%. R1's MAR documents that 17 days out of 31 days R1's pain level was rated at an 8 or higher on a scale of 1-10 with 10 being the worst pain. R1's	S9999					

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S9999	Continued from page 14 December MAR documents R1 took her oxycodone/acetaminophen 10/325mg as needed pain medication 21 days out of 31 days at least once per day and frequently more than once per day. Of those 21 days R1 had 19 days of a pain scale rated 8 or higher. R1's January 2026 MAR documents R1 took her oxycodone/acetaminophen 10/325mg as needed pain medication 9 out of the first 12 days of January at least once per day and frequently more often than that. 4 out of those first 12 days R1 rated her pain as an 8 or higher on a scale of 1-10 with 10 being the worst pain. R1's MAR for the month of January 2026 documents on the 9th, 10th, 11th, 12th, and 14th at the 8 P.M. medication administration time Lyrica was not administered. R1's MAR documents Lyrica was also not administered on the 7th, 9th, 12th, and 14th at the 8 A.M. medication administration time. R1's MAR documents R1 received Lyrica on dates 7th, 8th, and 13th at 8 P.M. medication administration time when Lyrica was reportedly not in stock. R1's MAR documents R1 received Lyrica on the 8th, 10th, and 11th at the 8 A.M. medication administration time when Lyrica was reportedly not in stock. R1's narcotics reconciliation record (narcotics sign out sheet) documents R1 received a dose of Lyrica on 1/6/26 at 8:00 P.M. The next dose of Lyrica signed out as administered for R1 is not documented until 1/15/26 at 7:30 A.M. R1's progress notes dated 1/7/26, 1/9/26, 1/10/26, 1/11/26, 1/12/26, 1/13/26, 1/14/26 documents R1's Lyrica was out of stock and not administered as ordered. R1's weights and vitals summary form printed 1/21/26 for the month of December documents R1 had pain at an 8 or above 21 out of 31 days. Same form documents for the month of January R1 had pain she rated at an 8 or higher 4 out of the first 12 days in the month. On 1/13/26 at 8:48 A.M., R1 stated she has pain related to chronic pancreatitis, severe scoliosis, and Diabetes type 3. R1 stated her back and ribs hurt all the time. R1 stated, "On average my pain is 7-8 on a scale of 1-10. On the outside I used oxycodone, oxycontin, muscle relaxers, and ibuprofen to control my pain. I've also been out of my Lyrica for several weeks while being in this facility." R1 stated she usually takes her pain pill (oxycodone/acetaminophen) every four hours routinely. R1 stated she does not have a heat pad or anything alternative to use for pain. R1 stated the			S9999			

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S9999	Continued from page 15 facility took her heating pad and hasn't offered her any alternatives. R1 stated her pain prevents her from doing many things like being able to be more active and do things for herself. While conducting interview R1 was observed lying very rigid in bed, unmoving. R1 appeared to be afraid to move due to the pain it would cause her. On 1/14/26 9:33 A.M., R1 stated, "Doing anything like showering, walking, standing causes pain." R1 stated, "My pain meds takes the edge off but never takes it away. The number one thing that helps me the most is my heat pad." On 1/20/26 at 10:28 A.M., R1 stated she was admitted the last part of November 2025. R1 stated, "I've had pain every day since I've been here. I have constant pain in my back and ribs and periodic pain in other joints. I don't know what it's like to not be in pain. I would describe my pain as stabbing, aching, and sharp pains, and it varies in different regions at different times. My cause of pain is bursitis and arthritis, scoliosis, herniated discs, and past injuries involving multiple broken bones. I have pain every day all day long. At its worst it's above 10. On average it's about an 8. Everything makes it worse. Bending over, walking causes shooting pain in my legs. The only thing that took my pain away was Dilaudid. Nothing else ever has. My pain has stopped me from doing everything. I've been stuck in bed on a heating pad for two years when I was at home. My goal for pain management would be for it to be below a 5 on a regular basis. No, I'm not satisfied with my current level of pain now. I need something stronger. I'm currently on oxycodone. It takes the edge off a little bit where I can barely function, but it doesn't take it below a 5. It may take me to a 7. I also take Ibuprofen occasionally as well. When you're in pain so often it is exhausting." Resident was tearful at times talking about her pain levels. R1 stated, "I do report my pain to the nurses. They give me my oxycodone when it's due but if it's not time for it they tell me there's nothing they can do and to go back to my room. They don't call the doctor that I know of to report my pain. I've talked to the doctor and nurse practitioner, and they have told me I am already on pain medicine. They haven't tried to put me on anything stronger. The doctor did write down some notes about my pain but has never followed through with what we discussed. We discussed the fact I'm in so much pain, and I'm not getting enough pain meds. That it's not working, and I would like something stronger. I also discussed this with the nurse practitioner. The nurse practitioner told me I was already taking the max dose for oxycodone and that she wouldn't increase it."			S9999			

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S9999	Continued from page 16 On 1/14/26 at 2:56 P.M., V4, Licensed Practical Nurse (LPN) stated R1 frequently tells her she's hurting very badly. V4 stated R1 describes her pain as very generalized pain in the back and abdomen. V4 stated R1 rates her pain frequently at an 8-10 on a scale of 1-10. V4 stated R1 asks for her as needed pain medication every 4 hours routinely. On 1/15/25 at 3:41P.M., V14, Certified Nurse's Aide (CNA) stated R1 frequently states she hurts all over and she reports pain daily. V14 stated she does notify the nurse when she tells her she has pain but is not sure if the nurse gives her something for the pain. V14 stated the facility doesn't have hot or cold packs that would be helpful to relieve some pain. On 1/20/26 at 3:27 P.M., V6, Registered Nurse (RN) stated R1 mentions frequent pain. V6 stated every time R1 can have a pain pill she asks for one and V6 gives her one. V6 stated sometimes even after she gives R1 the pain medication she says it doesn't relieve the pain. V6 stated if she says the pain medication isn't relieving the pain V6 will try to get her to do some relaxation techniques. V6 stated she has never thought to call the doctor or nurse practitioner when R1's pain appears to be unrelieved with the current medication. V6 states R1 also takes as needed ibuprofen and a daily lidocaine patch. V6 stated R1 describes her pain as constant. V6 stated R1 told her the pain doesn't come and go but remains all the time. V6 stated R1's pain appears to be at its worst in the morning from 6 A.M. to 9 A.M. On 1/21/26 at 11:27 A.M., V35, Agency LPN stated R1 describes her pain as usually present in her back and normally rates it a 10 out of 10. V35 stated R1 knows exactly when she can have another pain pill and usually wants it right at that time. V35 stated she has never thought to notify the doctor or nurse practitioner of R1's pain because she can have oxycodone every four hours and ibuprofen as needed as well as a daily lidocaine patch, gabapentin and Lyrica. V35 stated she knows R1 is telling the staff what her pain is, but R1 is not showing that objectively because she can walk unassisted with a walker, she's independent with showering, eating and all other activities of daily living as far as V35 is aware. V35 stated R1 takes care of all her own needs. V35 stated these are the reasons she hadn't reached out to the doctor for R1's reports of her pain not being controlled. On 1/21/26 at 12:06 P.M., V3, LPN stated R1 frequently complains her pain in the morning is when it's at its		S9999				

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S9999	Continued from page 17 worst. V3 stated she will give her an oxycodone/acetaminophen tablet at 8 A.M. medication administration time and then another one around noon. V3 stated after the second dose at noon is when R1 tells her she can finally get up and do something. V3 stated R1 describes her pain as "excruciating pain". V3 stated R1 usually rates her pain 10 out of 10 on scale of 1-10 with 10 being the worst. V3 stated R1 describes the effectiveness of her pain medication as "helping some." V3 stated R1 usually rates her pain about 6-7 on scale of 1-10 after the first dose of oxycodone/acetaminophen and then maybe a 3-4 after the second one administered at noon. V3 stated she talked to R1 when she first got here about getting something different for her pain, and she said she's not interested in changing anything. V3 stated R1 told her this is what worked best for her. V3 stated that's why she had never talked to the doctor or nurse practitioner about changing anything. On 1/21/26 at 12:37 P.M., R1 stated she had never said she didn't want her pain medication regimen changed. R1 stated she had told the doctor and nurse practitioner she would like to try Dilaudid, but one of the nurses here (R1 couldn't remember who) told her they wouldn't prescribe it. R1 stated she has never mentioned it to the doctor personally because she only saw him once for approximately 2 minutes and didn't have time to mention it. On 1/21/26 at 2:37 P.M., V4, LPN stated R1 tells her the Lyrica and Oxycodone don't touch her pain and that she needs something stronger. V4 stated she had not called the doctor or nurse practitioner in relation to her pain especially when they are already aware of it and treating it. On 1/21/26 at 11:53 A.M., V30, Certified Nurse's Aide (CNA) stated R1 had only complained of pain to her a few times since R1's arrival to the facility. V30 stated R1 has reported to her that her pain meds aren't enough. V30 stated R1 will ask for ibuprofen 30-45 minutes after taking her oxycodone. V30 stated she reports R1's complaints of pain or need for a medication for pain to the nurse. V30 stated regarding CNAs aiding in pain relief about the only thing they can do is reposition the resident. V30 stated they had also tried a rice heating pad for R1 but it ended up coming apart. V30 stated R1 only used it for about a day. On 1/22/26 at 12:32 P.M., V2, Assistant Director of Nurses/LPN stated she was not familiar with R1's pain levels. V2 stated R1 told her last week that her Lyrica	S9999					

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S9999	Continued from page 18 she was out of doesn't do a lot for her except to the enhance the effects of her gabapentin. V2 stated Lyrica was primarily used as a medication to help control neuropathic pain related to diabetes and pain related to fibromyalgia, two of R1's diagnoses On 1/22/26 at 3:34 P.M., V1, Administrator stated she had not talked to R1 about her pain. V1 agreed pain is subjective but believes R1 maybe manipulating to obtain more medications or medication seeking. V1 stated 6-7 days was completely uncalled for to be out of a person's medication including pain medication. V1 stated if a person were in uncontrolled pain, it would potentially slow their rehabilitation and recovery time down. On 1/26/26 at 10:05 A.M. V7, Nurse Practitioner (NP) stated R1 has a lot of health problems. V7 stated R1 is on a substantial number of medications for her nerve pain and anxiety and her other multiple diagnoses. V7 stated R1 is a complex medical case. V7 stated R1's vitals have been stable since her arrival to the facility except an occasional low blood pressure due to her diagnosis of hypotension. V7 stated R1 hasn't voiced any localized areas of specific pain to her, R1 reports her pain as generalized pain that is uncontrolled. V7 stated she would be concerned about giving R1 any more pain medications due to her multiple significant doses of medication including oxycodone, valium, and Seroquel to name a few. V7 stated a medical professional can only prescribe a person only so much pain medication safely. V7 stated R1's reports of her pain she's experiencing and her assessment of R1 do not always tell the same story in relation to R1's pain levels she's reporting. V7 stated though R1 does report a lot of nerve pain, R1 doesn't appear to be in the distress she reports. V7 stated however, uncontrolled pain in any person could affect recovery time, blood flow, bowel movements, depression or increase in, and failure to thrive to name a few possible adverse outcomes. V7 stated though, she does not believe this is happening with R1. V7 stated R1 appears to be at her baseline with her pain. V7 stated she wouldn't have a problem discharging R1 to home if she had some place to go to. V7 stated her overall assessment of R1 would be she is not as in much significant or uncontrolled pain as R1 reports according to her general demeanor and her vital signs. Facility's pain management policy dated 11/28/12 documents its purpose is to, "To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain	S9999					

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
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S9999	Continued from page 19 management plan to enhance healing and promote physiological and psychological wellness. Same policy documents the "Goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement." It further documents, "Pharmacological and non-pharmacological interventions will be included in the care plan and addressed in direct and indirect care assignments... e. Determination of the resident's acceptable level of pain...11. The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications. (A)		S9999				