STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2459993/IL182129 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.680d) 300.1210c) 300.1620a) 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. Section 300.680 Restraints d) The use of chemical restraints is prohibited. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 1	S9999		

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 300.3220 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 ensure residents were free from chemical restraints when staff administered an injectable anti-psychotic medication twice within an 8 hour time frame without the resident's consent and without a physician's order to include adequate indications for use, and failed to attempt less restrictive alternative treatments prior to administration of the medication for 1 (R1) of 3 residents reviewed for chemical restraints in the sample of 7. This failure resulted in R1 being sent to the Emergency Room for lethargy, facial swelling, and possible allergic reaction to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 2	S9999		

anti-psychotic medication administered.

This failure resulted in an incident, which was identified to have begun on 12/3/24 at approximately at 10:30 PM when V10 (Licensed Practical Nurse) administered Chlorpromazine (Thorazine) 100mg Intramuscular injection and again on 12/4/2024 at 5:30AM.

The findings include:

R1's "Admission Record" documents an admission date of 9/6/2023 and includes diagnoses of Parkinsonism, Paranoid Schizophrenia, unspecified Psychosis, Heart Failure, Anxiety Disorder, Hypertension, Schizoaffective Disorder and Major Depressive Disorder. R1's "Admission Record" also documents R1's allergies as Clonazepam (Klonopin), Fluphenazine (Prolixin), Haloperidol (Haldol), and Mellaril (Thioridazine).

R1's Minimum Data Set (MDS) dated 9/11/2024 documents in section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 99, indicating that R1 was unable to complete the interview. Section E, Behavior, "Delusions" is marked under potential indication for Psychosis. Section E also documents that verbal behavioral symptoms directed toward others occurred 4 to 6 days, but less than daily, during the 7 day look back period. Physical and other behavioral symptoms directed at others is marked as the "behavior was not exhibited." Section N, Medications, documents that R1 received antipsychotics on a routine basis only.

R1's "Physician Orders" dated 9/6/2023 documents an order for Chlorpromazine 100mg IM every 6 hours as needed for Psychosis. Offer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 3	S9999		

by mouth first give with Benztropine in same syringe. R1's "Physician Orders" for September, October, November, and December 2024 were reviewed with no orders noted for Chlorpromazine (Thorazine). R1's document titled "Medication Administration Record" for December 2024 has no documentation of an order for, or administration of, Chlorpromazine (Thorazine).

On 12/13/2024 at 10:58AM, V18 (Registered Pharmacist) stated R1's order for Chlorpromazine (Thorazine) 100mg IM was ordered on 9/2/2023 and stopped on 9/21/2023 and the reason for that date is because the order was processed on 9/7/2023 and 14 days later it was stopped on 9/21/2023. V18 said that there was not a restart date or updated order date for Chlorpromazine (Thorazine). V14 stated the order was stopped on 9/21/2023 due to being an as needed psychotropic medication and cannot be valid after 14 days so it is stopped by the pharmacy due to regulations.

On 12/11/2024 at 2:40PM, V12 (Certified Nurse Assistant/CNA) stated she worked on the night of 12/3/2024-12/4/2024 from 8PM -6AM and she was the one-on-one sitter for R1. V12 stated when she arrived at work that evening, she was told in report that R1 had thrown a urinal at staff. V12 stated at approximately 9:30PM she was being assisted by another CNA with R1's care and R1 spit on the other CNA. V12 stated V10 came in and told R1 she was going to give him something to calm him down if he didn't stop having behaviors. V12 stated around 10:30PM she and another CNA (V14) was standing R1 up so he could use the urinal, and V10 came in and went behind R1 and gave him a shot in his bottom. V12 stated R1 said "That was a sneaky thing you just did." V12 stated earlier in the shift,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 4	S9999		

V11 (LPN) had come into the room and told R1 she would give him a shot if he had any behaviors. V12 stated after the injection R1 had behaviors for about 15 minutes then he went to sleep and slept like a baby all night. V12 was asked if she witnessed the 2nd Injection that was said to have been given at approximately at 5:30AM on 12/4/2024, V12 stated I did not and I was watching him very closely as I would push a resident just up to the dining room and then went back in to check on R1, not leaving him out of my sight for more than a couple of minutes at a time. V12 stated when she left at 6:00AM, R1 was sleeping soundly. V12 stated V10 told her she had given a second shot, but she didn't witness this and R1 was sleeping.

On 12/11/2024 at 3:28PM, V10 (LPN) stated she was familiar with R1, and she worked on the night shift that started on 12/3/2024 at 10:00PM and ended at 6:00AM on 12/4/2024. V10 stated R1 started having behaviors of biting, spitting, and kicking staff so she pulled 2 ampules of Chlorpromazine (Thorazine) to administer to R1. V10 stated the medication was in a box in the medication cart with R1's name on the box with instructions. V10 stated she went to R1's room and 2 CNA's (V12 and V14) were standing him up with his pants down to either change him or let him use the urinal. V10 stated each CNA had ahold of R1's arms. V10 stated " I sneaked in behind them and jabbed him in the butt with the shot of medication of Chlorpromazine." V10 was asked if she explained to R1 what she was doing and V10 stated "Lord no, he would not have let me do it." V10 was asked what R1's response was when she gave him his injection, V10 stated "well he swung at me and I dodged the hit and R1 stated, that was sneaky and that was not right." V10 was asked if she validated the orders for R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 5	S9999		

before administration and V10 stated "No." V12 stated she gave a second injection on 12/4/24 at 5:30AM.

R1's "Nurse's Note" dated 12/3/2024 at 10:30PM, authored by V10 (LPN), documents "Resident screaming and cursing staff during care spitting on CNA's PRN (as needed) injection given. Remains 1:1."

On 12/12/2024 at 2:45PM, V10 was asked why the injection of Chlorpromazine (Thorazine) was given at 5:30AM on 12/4/2024, V10 stated "he was acting up and starting to get revved up again." V10 stated she can't remember who assisted her with the injection, but she did give him an injection at 5:30AM on 12/4/24. V10 was asked if she explained to R1 what she was administering and V10 stated "No I just jabbed it in his arm." V10 stated " V10 is very strong and can hurt people." V10 was asked why there is no documentation of giving this injection, V10 stated I was busy trying to pass medications and I was helping the CNA's as well. V10 stated she had not had time to check physician orders or the medication administration record prior to administering the medication or even after she administered either dose she had administered.

On 12/12/2024 at 12:10PM, V13 (CNA) stated he was aware R1 received an injection at 10:30PM the night of 12/3/2024. V13 stated he worked 10PM to 6AM on 12/3/204-12/4/2024. V13 stated he was unaware that a second injection was given at 5:30AM on 12/4/2024. V13 stated he went and checked on R1 before he left at 6:00AM and he was really sleeping. V13 stated the reason the injection was given at 10:30PM on 12/3/2024 is R1 was starting to kick us and using obscene language. V13 stated after the injection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 6	S9999		

R1 slept all night.

On 12/12/2024 at 12:52PM, V14 (CNA) stated she worked 10PM-6AM on 12/3/2024-12/4/2024. V14 stated R1 was yelling down the hall and spit on staff around 10PM. V14 stated that R1 was trying to get out of bed. V14 said she was told by V10 to help V12 get R1 in a standing position and pull his pants down so V10 could give him an injection. V14 stated V10 came in the room and got behind us and gave the injection in R1's buttocks, this occurred around 10:30PM. V14 stated R1 swung at V10 and R1 stated " that was sneaky." V14 stated we offered R1 the urinal after the injection and he refused to use the urinal. V14 stated R1 rested the rest of the night, and he was fine throughout the night. V14 stated she was not aware of a second injection being given. V14 stated she checked on R1 before she left at 6:00AM and he was sleeping well.

On 12/12/2024 at 1:17PM, V15 (CNA) stated she came to work on 12/4/2024 at 5:00AM. V15 stated she did not know of any behaviors from R1 and did not get anything in report, but she was assigned to a different hall. V15 stated she did see V10 with a syringe in her hand but did not know who the medication was for and what room V10 went into.

On 12/12/2024 at 1:30PM, V16 (CNA) stated she worked on 12/4/2024 from 5:00AM to 1:00PM. V16 stated when she arrived at work and made some rounds, she did not know of any residents having behaviors. V16 stated she was busy getting residents up and she did see V10 with a syringe in her hand but did not know who it was for. V16 stated she did not witness or assist with any injections being given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 7	S9999		

On 12/12/2024 at 12:15PM, V9 (LPN) stated on 12/4/2024 she was the charge nurse for R1. V9 stated she received report from V10 (LPN) at 6:00AM, V10's report included information that V10 had administered Haldol IM (intramuscular injection) at 10:30PM on 12/3/2024 and 5:30AM on 12/4/2024. V10 reported to V9 that R1 had been aggressive. V9 stated she went to check on R1 before breakfast and R1 was sleeping, and he didn't arouse when she softly called his name. V9 stated R1 did not eat breakfast because he was sleeping. V9 stated I just thought he was tired from the medication. V9 stated she went back to his room to check on him a short time before lunch and she could not get him to wake up, so she asked V7 (LPN) to come help her with him. V9 stated she and V7 went immediately back to R1's room and turned him over a little and noted R1 to arouse a little and he was mumbling with worsened slurred speech, lips swollen, side of his face was red with some edema noted and the top of his head was very red with a rash like appearance. V9 stated she ran and got V3 (LPN/Assistant Director of Nursing), and this is when they called EMS (Emergency Medical Services) to transport R1 to the ER (Emergency Room). V9 stated she then went to investigate what actual medication was given. V9 stated she noted a box of Chlorpromazine with 20 ampules in the box and the box had contained 25 ampules when it was filled.

R1's "Nurse's Note" dated 12/4/2024 at 12:20PM, authored by V9 (LPN), documents that EMS in facility to transport resident to ER.

On 12/11/2024 at 2:22PM, V3 (Licensed Practical Nurse/Assistant Director of Nursing) stated on 12/4/2024 she arrived at work around 11:00AM. V3 stated V7 (Licensed Practical Nurse/LPN) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 8	S9999		

V9 (Licensed Practical Nurse) were working the floor at the time, and reported to V3 that R1 was not acting right, and his eyes were swollen, as well as his mouth. V3 stated she called the ambulance. V3 stated R1 was sent out to the emergency room. V3 stated during her investigation she spoke with V12 (Certified Nurse Assistant/CNA) who was the sitter on the previous night of 12/3/2024, for R1. V3 stated that V12 reported she witnessed an injection being given to R1 by V10 (Licensed Practical Nurse/LPN) the night of 12/3/2024. V3 stated she was under the impression that R1 had to be held for the injection and that is not allowed as that is physically restraining a resident, then giving the medication to calm him down is a chemical restraint.

R1's "Nurse's Note" dated 12/4/2024 at 11:30AM, Medication removed from medication cart Chlorpromazine IM (Intramuscular) vials removed and discarded.

R1's "Nurse's Note" dated 12/4/2024 at 11:59AM, authored by V3 (LPN/Assistant Director of Nursing), documents "Resident noted to have symptoms of allergic reaction. Upon entering residents (R1) room this nurse noted that resident has a swollen face, eyes, and hives. Called (V8-Physician) with symptoms and gave orders to send to ER (Emergency Room) for eval and treat. EMS (Emergency Medical Service) called."

R1's "Nurse's Note" dated 12/4/2024 at 12:45PM, authored by V7 (LPN), documents that report called to local hospital ER.

On 12/12/2024 at 12:31PM, V7 (LPN) stated she was working the day of 12/4/2024. V7 stated she was asked to go with V9 to check on R1. V7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 9	S9999		

stated "we got him aroused, his face/jaw area was swollen, and I remember the top of his head was so red with a rash noted." V9 stated she noted his tongue seemed a little thick and his speech was really slurred. V7 stated when EMS got to the facility R1 was still lethargic and he didn't even resist care as he normally does. V7 stated all R1 did was mumble. V7 stated she has never given R1 any type of injections and she did not know those injections were in the medication cart.

R1's Emergency Department document titled: Physician Documentation dated 12/4/2024 at 1:29PM documents "this 63-year-old white male presents to Emergency Department by EMS (Emergency Medical Service) with complaints of possible allergic reaction. Patient at nursing home was sent in because nurses thought he was having an allergic reaction to some medication. Patient was seen yesterday by this Emergency Department, was found to have emergency medical condition (complaint was abdominal pain). Patient was given Benadryl Intravenously in rout by EMS they felt like his face was flushed and had some swelling, patient knocked out from Benadryl, he does react if you touch him. Will CAT SCAN head." The ER Notes documents allergies of: Fluphenazine, Haldol, Klonopin, Mellaril, Penicillin, Porlixin. The "ER Course" documents at 2:48PM: in lieu of the labs done yesterday that were within normal limits and patient is back to normal limits after IV (Intravenous) Benadryl wore off. Will return to nursing home. There is no allergic reaction to medication because he did not get any yesterday while in this Emergency Department and he did not get any nursing home medications today either.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 10	S9999		

On 12/12/2024 at 7:11PM, V17 (Emergency Room Physician) stated he was working the day of 12/4/2024 and he provided care for R1. V17 pulled the ER visit that occurred on 12/4/2024 and was reading his report to this surveyor. V17 read the report stating R1 had not received any medications the day before (12/3/2024) while in the emergency room and there is no evidence of medications being given in between ER visits. V17 was asked if he was aware R1 had received 2 injections of Chlorpromazine (Thorazine) with one being on 12/3/2024 at 10:30PM and the other one at 5:30AM on 12/4/2024, V17 stated " I was not aware of that at all, and nobody reported this to me." V17 stated "well this changes things because it makes sense why the paramedics administered IV (Intravenous) Benadryl, this patient probably was having an allergic reaction." V17 stated the paramedics would not have administered any medications while in route if it was not deemed necessary for the safety for the patient. V17 stated "I saw (R1) probably at least 30 minutes after the Benadryl was administered and the redness and swelling would have decreased from the Benadryl by that time." V17 stated "(R1) was really lethargic but I thought it was from the Benadryl." V17 stated "No wonder he was so out of it, he had a big dose of Thorazine just a few hours before and one before that 6 hours apart." V17, stated "I reviewed (R1's) medication sheets and those did not even list Thorazine and there sure was no documentation of Thorazine given." V17 was asked if this was a potential for harm to this patient and V17 " Absolutely and not even just the allergic reaction, the fact that this patient had received 2 large doses of Thorazine within hours of coming to the ER and me as the physician not even knowing that, this could have been a bad situation for the patient. I could have ordered a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 11	S9999		

medication that was contraindicated with Thorazine."

Attempts were made on 12/13/2024, 12/16/24, and 12/17/24 to reach the ambulance service for an ambulance report for R1 on 12/4/2024 without success.

On 12/13/2024 at 10:58AM, V8 (Physician) stated he does recall being informed R1 was administered 2 separate doses of Thorazine and was sent to the Emergency Room due to possible reaction. V8 stated he was not notified until R1 was in the Emergency Room. V8 was asked if he was aware the order for Thorazine was discontinued on September 21st, 2023, V8 stated I am not sure I knew that part. V8 stated he recalls the ER did not think it was an allergic reaction for some reason. V8 was informed the ER was unaware of the Thorazine injections. V8 stated "Ok, makes sense." V8 stated "I hope that is now on his allergy list along with other psych medications on his list." V8 stated R1's Psychosis has worsened since November. R1 started refusing his medications and was very paranoid of his medications.

On 12/10/2024 at 1:45PM, V1 (Administrator) stated she was aware of the medication error that was made on R1. V1 stated she had terminated 2 nurses over the incident. V1 stated "one nurse was fired because she intended to give the medication if a behavior would have occurred on her shift and the other nurse (V10) actually gave the medication not once but twice. V1 stated she could not believe a nurse would give a medication without checking the records. V1 stated there is nothing she could have done to stop it unless she was asked prior to administering the medication. V1 stated R1 was sent to the hospital with what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 12	S9999		

looked like an allergic reaction.

An incident report titled "Report to IDPH (Illinois Department of Public Health) Regional Office" dated 12/4/2024, documents the following "Description of Occurrence": On early AM 12/5/2024 (R1) was unable to speak clearly, noted his face and lips are slightly swollen, and some red rashes on his upper torso. (V8-Physician) was called immediately, and the order was received to transport resident to local hospital for further evaluation. It was discovered that a med that was given in the past had been used for (R1) due to behaviors. These injections were discontinued in September of 2023. The medication was good until 3/2025. This medication was accidently given to the resident at 10:30PM and again at 5:30AM for continued behaviors. The "Action Taken" on the incident report documents the following: Patient (R1) transported to (name of local hospital) by ambulance for treatment and observation. Resident was evaluated and a CT (Computed Tomography) was completed with no finding. Resident was returned to the facility with acting behaviors. Resident was placed on 1:1 with a staff member and referrals were sent to several facilities. The" Final Summary" documents the following: (R1) was taken immediately to local hospital, he was gone only a short time and returned to our facility with no findings of medications being the issue. They did perform a CT without contrast, and it came back clear as well.

R1's Care Plan documents a "Focus" area of "the resident is/has potential to be verbally aggressive" with an initiation and revision date of 5/6/2024. Documented interventions for this focus area include the following: Provide positive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 13	S9999		

feedback for good behavior, Emphasize the positive aspects of compliance (5/8/2024); Psychiatric/Psychogeriatric consult as indicated (5/8/2024); the resident tolerates minimal people at a time. The resident needs much amount of personal space. The resident reacts to touch by striking (5/8/2024); When the resident becomes agitated, intervene before agitation escalates. Guide away sources of distress. Engage calmly in conversation, if response is aggressive, staff to walk away calmly and approach later (5/8/2024).

R1's Care Plan also documents a "Focus" area of "the resident is/has potential to be physically aggressive" with an initiation date of 6/10/24. The documented "Goal" of "The resident will not harm self or others thru the next 90 days" with an initiation date of 6/10/2024 and a revision date of 12/5/24. Documented "Interventions" include: administer medications as ordered. Monitor/document for side effects and effectiveness (6/10/2024), assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. (6/10/2024) Communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated (6/10/2024). Give the resident as many choices as possible about care and activities (6/10/2024). Modify environment (6/13/2024). Monitor, document observed behavior and attempted interventions in behavior log (6/13/2024). Monitor/document/report any signs or symptoms of resident posing danger to self and others 6/10/2024). Psychiatric/Psychogeriatric consult as indicated (6/10/2024). When the resident becomes agitated intervene before agitation escalates. Guide away from source of distress. Engage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 14	S9999		

calmly in conversation. If aggressive, staff to walk calmly away and approach later (6/10/2024).

R1's Care Plan also documents a "Focus" are of "The resident uses anti-psychotic medications" with a "Goal" of "The resident will remain free of psychotropic drug related complication, including movement disorder, discomfort, hypotension, gait disturbances, constipation/ impaction, or cognitive/behavioral impairment through review date" with an initiation date of 5/8/2024. Intervention: Administer Psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. (5/6/2024). Review behavior/interventions and alternate therapies attempted and their effectiveness as per facility protocol. Educate the resident/family/ caregivers about risk, benefits and the side effects and toxic symptoms (5/8/2024).

R1's Behavior Tracking was requested from V3 on 12/12/2024 and 12/13/2024 for December 2024 and none was provided. R1's Behavior Tracking was requested again from V1 on 12/19/24 and was received. R1's "Behavior Tacking Records" provided documents the dates of 12/17/24-12/31/24 and do not document any behaviors occurring or need to attempt interventions. There were no "Behavior Tracking Records" for R1 provided for December prior to 12/17/24.

The facility policy titled "Medication Administration" (undated) documents under procedures #2, Review and confirm medication order for each resident on the Medication Administration Record prior o administering medications to each resident. Review medication administration record for any tests or vital signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000194	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM HEALTHCARE OF WEST FRANKFORT	601 NORTH COLUMBIA WEST FRANKFORT, IL 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) COMPLETE DATE
S9999	Continued From page 15 that need to be determined prior to preparing the medications. Number 9 documents, chart medication administration on Medication Administration Record immediately following each resident's medication administration. The facility policy titled "Psychotropic Medication Policy" with a revision date of 11/28/2017, documents "it is the policy of this facility that residents shall not be given unnecessary drug." Definition of Chemical Restraint documents "any medication that is administered with the intent of altering consciousness, responsiveness, or to modify behavior, convenience, punishment, or discipline. The section titled "procedure" documents #1. Attempt to rule our social and environmental factors as causative agents of maladapted behavior. 2. Psychotropic medications shall not be prescribed prior to attempted non-pharmacological interventions to decrease behaviors. 5. Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. (B)	S9999		