

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of Mount Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 White Street Mount Vernon, IL 62864	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from abuse from staff for 1 of 3 residents (R1) reviewed for abuse and neglect in the sample of 11. This failure resulted in a staff member physically forcing a resident in to the residents room and shutting the door causing bruising to R1's chest with vocal complaints of pain. Findings include:R1's admission Record documents an admission date of 11/27/13 with the following diagnoses listed in part; muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, severe intellectual disabilities, abnormal posture, age related osteoporosis without current pathological findings.R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of a 5 indicating R1 is severely cognitively impaired. Section GG - Functional Abilities documents that R1 is dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG documents that R1 is dependent on staff for transfers and uses a wheelchair. She also needs supervision or touching assistance for wheeling 150 feet in her wheelchair.R1's current care plan documents that R1 has impaired cognitive function/dementia or impaired thought processes and has a communication problem. R1's care plan does not document R1 as being at risk for abuse.R1's abuse/neglect screening dated 3/19/26 documents that R1 is at moderate risk for abuse.Facility Final report completed by V1(Administrator), dated 3/31/26 documents there was an incident on 3/24/26 with R1 of an injury on unknown origin with injuries including left index finger bruising. Follow-up/final report summary documents: Investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Resident states that she was knocking on her door in her room, which resulted in bruising to her finger. Abuse substantiated, nurse immediately DNR (Do Not Return) from building. Staff educated about involuntary seclusion .In R1's medical record an event record was opened on 03/25/2026 at 9:34pm by V1. This record documented a bruise on R1's right hand that was 0.7 inches (in) (length), 0.5in (Width), and bruising to R1's left chest that was 5 inches in length, and 5inches in width. With vocal complaints of pain.On 3/31/26 at 10:03am, V6 (Certified Nursing Assistant/CNA) stated she came in the morning of 3/24/26, and the night shift aides grabbed her and stated that the night nurse locked R1 in her room several times that night and they kept having to let her out. V6 stated when she went to R1's room she could hear her barely knocking. V6 stated they opened the door and let R1 out. V6 stated she did not notice any bruising on her finger at that time but did notice it a few days later, along with the bruising to her chest. V6 stated that V7 and V8 were the CNA's that night and they told her that R1 had been up front hollering throughout the night. V6 stated R1 does holler a lot but it is usually when there is something wrong or she is asking for assistance. V6 stated that R1 has continued to point at the bruised areas and say nurse hurt me to basically any staff that will listen. V6 stated she did not think that R1 had the strength to cause the bruise on her chest, and at the time she opened the door for her, she was not knocking hard enough to have caused that. V6 stated R1 does not normally accuse staff of hurting her or fabricating stories.On 3/31/26 at 10:05am, V9 (Certified Nursing (continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Assistant/CNA) stated that R1 has a bruise on her finger as well as a large healing bruise on her chest. V9 stated at one point the bruise looked very painful. V9 stated the first day she saw the bruise, she was with the nurse doing a skin check. V9 stated the nurse told her that a night shift nurse was trying to push her into her room and collided with the door. V9 stated that R1 has bruised herself before but it will be tiny, tiny ones. V9 stated it was nothing like that and R1 is not capable of hitting herself that hard in the chest. V9 stated she did not think that R1 could cause those bruises to herself. V9 stated R1 does not have a history of saying staff hurt her. On 3/31/26 11:07am, R1 stated Nurse hurt me, Nurse hurt me, while pointing to her chest and finger. On 3/31/26 at 1:07pm, a bruise was observed on R1's chest. It started just below her left clavicle, covers most of her breast and extends into her upper abdomen. It was a faint yellow color, and appeared to be in later stages of healing. There was also a faint bruise noted to her left index finger that started just under the cuticle and extended through the first and second joint. On 3/31/26 at 2:45pm, V5 (agency nurse) stated the night that the incident happened with R1, it was just two aides and V3 (agency nurse). V5 stated she worked the following night and discovered the bruise on R1's chest. V5 stated she called V1 to report it at approx. 4am and V1 stated she was not surprised she pokes herself all the time. V5 stated she told V1, no it is not like that, she could not have done this. V5 stated R1 does occasionally leave a tiny fingerprint sized bruise on herself, but she does not have the strength to have caused something like that. V5 stated she was told by the CNA's that R1 was sitting up front being noisy. V5 stated the CNAs told her they saw her up front and went down the hall to get up other residents and saw the nurse pushing her to her room at one point. V5 stated the CNA's reported they went down the hallway and she was in her room with the door shut. V5 stated they said they brought her up front and continued to get residents up, and when dayshift arrived, they found her in her room again with the door shut and mad as could be when they found her. V5 stated that R1 has been consistently saying that nurse did it, nurse hurt me. V5 stated it has been reported to administration by not only her, but other staff as well. On 4/1/26 at 10:51am, R8 (R1's Roommate) who was alert to person, place and time stated R1 can be noisy at times. R8 stated she remembers there was a night where she heard a lot of commotion with R1 with a staff member that she didn't know her name, but knew she was not here anymore after that. R8 stated she could not see what happened because it was at night and she had her curtain pulled, but there was something going on and then the door was closed and R1 was still in the room making a lot of racket. R8 stated that shortly after the commotion some of the other girls opened the door and R1 left. R8 stated the staff member was yelling at R1 and R1 was kind of hollering back, but that's all she could really hear. On 4/1/26 at 11:03am, V7 (Certified Nursing Assistant/CNA) stated R1 was in the lobby hollering during the morning of 3/24/26. V7 stated that she and V8 went down the opposite hallway and continued to get people up. V7 stated when they came back up front, R1 was gone. V7 stated at this time V6, who is on day shift had arrived. V7 stated they started down the hallway R1's room is on and could faintly hear R1 yelling and knocking on the door. V7 stated they let R1 out of her room and she was so mad. V7 stated they brought her up front, and at this time she did not notice any bruises. V7 stated she was telling them that the nurse hurt her, nurse door, nurse my room, nurse hurt. V7 stated R1's hands were moving so fast it was hard to notice if the finger was bruised or not, she stated there was no bruise on her chest, but she continued to poke her chest and repeat everything she was saying about the nurse. V7 stated R1 was not able to open the door, because she has poor upper body strength. V7 stated she did not think the way R1 was poking her chest could have caused the massive bruise she had. On 4/1/26 at 11:48am, V4 (Registered Nurse) stated she came in the morning after the incident happened with R1. V4 stated she was under the impression that the nurse was upset because R1 was making too much noise whenever she was trying to pass meds, she stated that is just what R1 does is make noise. V4 stated if she is being loud, something is probably wrong. V4 stated when R1 saw her that morning she immediately pointed to her finger and chest. V4 stated R1's finger was red and swollen, she stated she pointed to the door and said, Nurse did it. V4 stated there's no way R1 could have caused the bruising on the chest, (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>occasionally she will cause a small bruise, but nothing to the extent of her bruises. V4 stated the night shift CNA's contacted V1, she did not directly contact her that day. V4 stated R1's bruise to her chest was large and looked painful. V4 stated R1 did not complain of pain. V4 stated R1 is not capable of opening the door. V4 stated the bruise on R1's chest was reported to V1 and V11 (Former Director of Nursing) on multiple occasions and nothing was done. On 4/1/26 at 1:11pm, V11 (Former Director of Nursing) stated on the morning of the incident involving R1, she was very angry and pointing to her chest saying her did it. V11 stated they were told by night shift staff that V3 took R1 to her room and closed the door. V11 stated as soon as administration was made aware, they started an investigation. V11 stated V7 and V8, the night shift CNA's, said this happened twice. V11 stated it was confirmed that V3 put R1 in her room and closed her in there. V11 stated R1 was not capable of opening the door, she is not strong enough. On 4/1/26 at 1:24pm, V2 (Social Services Director) stated she came in the morning on 3/24/26 around 7:30am, and R1 was visibly upset. V2 stated that V7 and V8 reported V3 closed R1 in her room more than once that night. V2 stated R1 had a bruise on her finger but did not have bruise on chest at that time. V2 stated that R1 does not have a history of making false allegations towards staff. V2 stated that R1 does have a history of causing bruises to herself. V2 stated R1 could not open door. On 4/1/26 at 3:05pm, V1 (Administrator) stated the incident with R1 was reported to police and the agency V3 worked for. V1 stated R1 would not have been able to open the door. V1 stated V3 was interviewed that day and asked not to come back immediately. An incident report from the local police department with a print date of 4/7/26 documents and incident were reported on 4/11/26 at 10:45AM. This report documents in the section titled, involvement it lists R1 as the victim and V3 as the offender. This report was authored by V14 (Police officer). Facility policy titled Abuse and Retaliation Prevention and Reporting- ILLINOIS with an effective date of 1/8/26 documents under policy; This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment.</p>		

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<p>F 0603</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from involuntary seclusion for 1 of 3 residents (R1) reviewed for abuse and neglect in the sample of 11. This failure resulted in R1 being forced in to R1's room and staff closing the door to keep R1 in R1's room multiple times causing R1 to knock on R1's door in attempts to have door opened. Findings include R1's admission Record documents an admission date of 11/27/13 with the following diagnoses listed in part; muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, severe intellectual disabilities, abnormal posture, age related osteoporosis without current pathological findings. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of a 5 indicating R1 is severely cognitively impaired. Section GG - Functional Abilities documents that R1 is dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG documents that R1 is dependent on staff for transfers and uses a wheelchair. She also needs supervision or touching assistance for wheeling 150 feet in her wheelchair. R1's current care plan documents that R1 has impaired cognitive function/dementia or impaired thought processes and has a communication problem. R1's care plan does not document R1 as being at risk for abuse. R1's abuse/neglect screening dated 3/19/26 documents that R1 is at moderate risk for abuse. Facility Final Report to IDPH (Illinois Department of Public Health) Regional Office completed by V1, dated 3/31/26 documents there was an incident on 3/24/26 with R1 regarding an injury on unknown origin with injuries including left index finger bruising. Follow-up/final report summary documents: Investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Resident states that she was knocking on her door in her room, which resulted in bruising to her finger. Abuse substantiated, nurse immediately DNR (Do Not Return) from building. Staff educated about involuntary seclusion. Included in the facility investigation regarding the injury of unknown origin for R1 was an interview conducted with V1 (Administrator) and R1. This interview did not include a date or time of the interview. In this interview, V1 asked What happen this morning with your nurse? R1 response, My nurse, my room. V1 asked, Your nurse took you to your room? R1 responded Yep. V1 asked, then what? R1 responded, Shut the door. V1 stated, Your nurse put you in your room and shut the door? R1 responded, Yep. V1 asked, Why did she do that? V1 responded, My nurse, my room. On 3/31/26 at 10:03am, V6 (Certified Nursing Assistant/CNA) stated she came in the morning of 3/24/26, and the night shift aides grabbed her and stated that the night nurse locked R1 in her room several times that night and they kept having to let her out. V6 stated when she went to R1's room she could hear her barely knocking. V6 stated they opened the door and let R1 out. V6 stated she did not notice any bruising on her finger at that time but did notice it a few days later, along with the bruising to her chest. V6 stated that V7 and V8 were the CNA's that night and they told her that R1 had been up front hollering throughout the night. V6 stated R1 does holler a lot but it is usually when there is something wrong or she is asking for assistance. V6 stated that R1 has continued to point at the bruised areas and say nurse hurt me to basically any staff that will listen. V6 stated she did not think that R1 had the strength to cause the bruise on her chest, and at the time she opened the door for her, she was not knocking hard enough to have caused that. V6 stated R1 does not normally accuse staff of hurting her or fabricating stories. On 3/31/26 at 2:45pm, V5 (agency nurse) stated the night that the incident happened with R1, it was just two aides and V3 (agency nurse). V5 stated she was told by the CNA's that R1 was sitting up front being noisy. V5 stated the CNA's told her they saw R1 up front hollering and went down the hall to get up other residents and saw V3 pushing R1 to her room at one point. V5 stated the CNA's stated they went down the hallway and R1 was in her room with the door shut. V5 (continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>stated they said they brought R1 up front and continued to get residents up, and when dayshift arrived, they found her in her room again with the door shut and mad as can be when they found her. V5 stated that R1 has been consistently saying that nurse did it, nurse hurt me. On 4/1/26 at 10:51am, R8 (R1's Roommate) who was alert to person, place and time stated R1 can be noisy at times. R8 stated she remembers there was a night where she heard a lot of commotion with R1 with a staff member that she didn't know her name, but knew she was not here anymore after that. R8 stated she could not see what happened because it was at night and she had her curtain pulled, but there was something going on and then the door was closed and R1 was still in the room making a lot of racket. R8 stated shortly after the commotion some of the other girls opened the door and R1 left. R8 stated the staff member was yelling at R1 and R1 was kind of hollering back, but that's all she could really hear. On 4/1/26 at 11:03am, V7 (Certified Nursing Assistant/CNA) stated R1 was in the lobby hollering during the morning of 3/24/26. V7 stated that she and V8 went down the opposite hallway and continued to get people up. V7 stated when they came back up front, R1 was gone. V7 stated at this time V6, who is on day shift had arrived. V7 stated they started down the hallway R1's room is on and could faintly hear R1 yelling and knocking on the door. V7 stated they let R1 out of her room and she was so mad. V7 stated they brought her up front, and at this time she did not notice any bruises. V7 stated she was telling them that the nurse hurt her, nurse door, nurse my room, nurse hurt. V7 stated R1's hands were moving so fast it was hard to notice if the finger was bruised or not, she stated there was no bruise on her chest, but she continued to poke her chest and repeat everything she was saying about the nurse. V7 stated R1 was not able to open the door, because she has poor upper body strength. V7 stated she did not think the way R1 was poking her chest could have caused the massive bruise she had. On 4/1/26 at 11:48am, V4 (Registered Nurse) stated she came in the morning after the incident happened with R1. V4 stated she was under the impression that the nurse was upset because R1 was making too much noise whenever she was trying to pass meds, she stated that is just what R1 does is make noise. V4 stated if she is being loud, something is probably wrong. V4 stated when R1 saw her that morning she immediately pointed to her finger and chest. V4 stated R1's finger was red and swollen, she stated she pointed to the door and said, Nurse did it. V4 stated R1 is not capable of opening the door. On 4/1/26 at 1:11pm, V11 (Former Director of Nursing) stated on the morning of the incident involving R1, she was very angry and pointing to her chest saying her did it. V11 stated they were told by night shift staff that V3 took R1 to her room and closed the door. V11 stated as soon as administration was made aware, they started an investigation. V11 stated V7 and V8, the night shift CNA's, said this happened twice. V11 stated it was confirmed that V3 put R1 in her room and closed her in there. V11 stated R1 was not capable of opening the door, she is not strong enough. On 4/1/26 at 1:24pm, V2 (Social Services Director) stated she came in that morning around 7:30, and R1 was visibly upset. V2 stated that V7 and V8 reported V3 closed R1 in her room more than once that night. V2 stated R1 is not always easy to understand, but if you know her you can communicate easily with her. V2 stated she was not sure whether or not R1 was strong enough to leave the bruise, but R1 was poking herself pretty persistently saying nurse hurt, she stated she did not believe R1 could not open door. On 4/1/26 at 3:05pm, V1 (Administrator) stated that R1 is known to make bruises on herself. V1 stated when she got here R1 was poking herself in the chest saying, she did it. V1 stated R1 could not open the door. V1 stated V3 was interviewed that day and asked not to come back immediately. An incident report from the local police department with a print date of 4/7/26 states this incident was reported on 4/11/26 at 10:45am. In the section titled, involvement it lists R1 as the victim and V3 as the offender. Facility policy titled Abuse and Retaliation Prevention and Reporting- ILLINOIS with an effective date of 1/8/26 documents under policy; This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This policy documents under the section titled definitions documents Unreasonable confinement or Involuntary seclusion means the separation of a resident from other residents or from her/his room or (continued on next page)</p>		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative.		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to notify law enforcement in a timely manner of an alleged staff to resident abuse incident for 1 of 3 residents (R1) reviewed for abuse and neglect in the sample of 11. Findings include R1's admission Record documents an admission date of 11/27/13 with the following diagnoses listed in part; muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, severe intellectual disabilities, abnormal posture, age related osteoporosis without current pathological findings. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of a 5 indicating R1 is severely cognitively impaired. Section GG - Functional Abilities documents that R1 is dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. R1's abuse/neglect screening dated 3/19/26 documents that R1 is at moderate risk for abuse. Facility Final Report to IDPH (Illinois Department of Public Health) Regional Office completed by V1, dated 3/31/26 documents there was an incident on 3/24/26 with R1 regarding an injury on unknown origin with injuries including left index finger bruising. Follow-up/final report summary documents: Investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Resident states that she was knocking on her door in her room, which resulted in bruising her finger. Abuse substantiated, nurse immediately DNR (Do Not Return) from building. Staff educated about involuntary seclusion. On 4/6/26 at 11:29am, V14 (Police Officer) stated a report was made on 4/1/26. V14 stated V1 told him they could not file a police report until the Department of Public Health had been in to investigate. V14 stated he was finishing up the report and would have it finished by the end of the day. On 4/6/26 at 2:46pm, V1 (Administrator) stated she reported the abuse to the police on Wednesday 4/1/26 or Thursday 4/2/26 of last week. V1 stated truthfully in the midst of the investigation it slipped her mind, and one of the corporate employees reminded her that she needed to do it, she reported it right after. An incident report from the local police department with a print date of 4/7/26 documents an incident was reported on 4/11/26 at 10:45AM. This report documents in the section titled, involvement lists R1 as the victim and V3 (Agency Nurse) as the offender. This report was completed by V14 (Police Officer). Facility policy titled Abuse and Retaliation Prevention and Reporting- ILLINOIS with an effective date of 1/8/26 documents under the section titled External Reporting, The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations . When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to thoroughly investigate bruising from potential staff to resident abuse for 1 of 3 residents (R1) reviewed for abuse and neglect in a sample of 11. Findings include R1's admission Record documents an admission date of 11/27/13 with the following diagnoses listed in part; muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, severe intellectual disabilities, abnormal posture, age related osteoporosis without current pathological findings. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of a 5 indicating R1 is severely cognitively impaired. Section GG - Functional Abilities documents that R1 is dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG documents that R1 is dependent on staff for transfers and uses a wheelchair. She also needs supervision or touching assistance for wheeling 150 feet in her wheelchair. R1's current care plan documents that R1 has impaired cognitive function/dementia or impaired thought processes and has a communication problem. R1's care plan does not document R1 as being at risk for abuse. R1's abuse/neglect screening dated 3/19/26 documents that R1 is at moderate risk for abuse. Facility Final report completed by V1 (Administrator), dated 3/31/26 documents there was an incident on 3/24/26 with R1 of an injury on unknown origin with injuries including left index finger bruising. Follow-up/final report summary documents: Investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Resident states that she was knocking on her door in her room, which resulted in bruising to her finger. Abuse substantiated, nurse immediately DNR (Do Not Return) from building. Staff educated about involuntary seclusion. In R1's medical record an event record was opened on 03/25/2026 at 9:34pm by V1. This record documented a bruise on R1's right hand that was 0.7 inches (in) (length), 0.5in (Width), and bruising to R1's left chest that was 5 inches in length, and 5inches in width. With vocal complaints of pain. On 3/31/26 at 10:03am, V6 (Certified Nursing Assistant/CNA) stated she came in that morning, and the night shift aides grabbed her and stated that the night nurse locked R1 in her room several times that night and they kept having to let her out. V6 stated when she went to R1's room she could hear her barely knocking. V6 stated they opened the door and let R1 out. V6 stated she did not notice any bruising on her finger at that time but did notice it a few days later, along with the bruising to her chest. V6 stated that V7 and V8 were the CNAs that night and they told her that R1 had been up front hollering throughout the night. V6 stated R1 does holler a lot but it is usually when there is something wrong or she is asking for assistance. V6 stated that R1 has continued to point at the bruised areas and say Nurse hurt me to basically any staff that will listen. V6 stated she was not interviewed. V6 stated she did not think that R1 had the strength to cause the bruise on her chest, and at the time she opened the door for her, she was not knocking hard enough to have caused that. V6 stated R1 does not normally accuse staff of hurting her or fabricating stories. On 3/31/26 at 10:05am, V9 (Certified Nursing Assistant/CNA) stated that R1 has a bruise on her finger as well as a large healing bruise on her chest. V9 stated at one point the bruise looked very painful. V9 stated the first day she saw the bruise, she was with the nurse doing a skin check. V9 stated the nurse told her that a night shift nurse was trying to push her into her room and collided with the door. V9 stated that R1 has bruised herself before but it will be tiny, tiny ones. V9 stated it was nothing like that and R1 is not capable of hitting herself that hard in the chest. V9 stated she did not think that R1 could cause those bruises to herself. V9 stated R1 does not have a history of saying staff hurt her. On 3/31/26 at 11:07am, R1 stated Nurse hurt me. Nurse hurt me. while pointing to her chest and finger. On 3/31/26 at 1:07pm, a bruise was observed on R1's chest. It started just below her left clavicle, covers most of her breast and extends into her upper abdomen. It was a faint yellow color, and appeared to be in later stages of healing. There was also a faint bruise (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
NAME OF PROVIDER OR SUPPLIER Axiom Healthcare of Mount Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 White Street Mount Vernon, IL 62864	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>noted to her left index finger that started just under the cuticle and extended through the first and second joint. On 3/31/26 at 2:45pm, V5 (agency nurse) stated the night that the incident happened with R1, it was just two aides and V3 (agency nurse). V5 stated she worked the following night and discovered the bruise on R1's chest. V5 stated she called V1 to report it at approx. 4am and V1 stated she was not surprised she pokes herself all the time. V5 stated she told V1, no it is not like that, she could not have done this. V5 stated R1 does occasionally leave a tiny fingerprint sized bruise on herself, but she does not have the strength to have caused something like that. V5 stated she was told by the CNA's that R1 was sitting up front being noisy. V5 stated the CNAs told her they saw her up front and went down the hall to get up other residents and saw the nurse pushing her to her room at one point. V5 stated the CNA's reported they went down the hallway and she was in her room with the door shut. V5 stated they said they brought her up front and continued to get residents up, and when dayshift arrived, they found her in her room again with the door shut and mad as could be when they found her. V5 stated that R1 has been consistently saying that nurse did it, nurse hurt me. V5 stated it has been reported to administration by not only her, but other staff as well. On 4/1/26 at 10:51am, R8 (R1's Roommate) who was alert to person, place and time stated R1 can be noisy at times. R8 stated she remembers there was a night where she heard a lot of commotion with R1 with a staff member that she didn't know her name, but knew she was not here anymore after that. R8 stated she could not see what happened because it was at night and she had her curtain pulled, but there was something going on and then the door was closed and R1 was still in the room making a lot of racket. R8 stated that shortly after the commotion some of the other girls opened the door and R1 left. R8 stated the staff member was yelling at R1 and R1 was kind of hollering back, but that's all she could really hear. On 4/1/26 at 11:03am, V7 (Certified Nursing Assistant/CNA) stated R1 was in the lobby hollering during the morning of 3/24/26. V7 stated that she and V8 went down the opposite hallway and continued to get people up. V7 stated when they came back up front, R1 was gone. V7 stated at this time V6, who is on day shift had arrived. V7 stated they started down the hallway R1's room is on and could faintly hear R1 yelling and knocking on the door. V7 stated they let R1 out of her room and she was so mad. V7 stated they brought her up front, and at this time she did not notice any bruises. V7 stated she was telling them that the nurse hurt her, nurse door, nurse my room, nurse hurt. V7 stated R1's hands were moving so fast it was hard to notice if the finger was bruised or not, she stated there was no bruise on her chest, but she continued to poke her chest and repeat everything she was saying about the nurse. V7 stated R1 was not able to open the door, because she has poor upper body strength. V7 stated she did not think the way R1 was poking her chest could have caused the massive bruise she had. On 4/1/26 at 11:48am, V4 (Registered Nurse) stated she came in the morning after the incident happened with R1. V4 stated she was under the impression that the nurse was upset because R1 was making too much noise whenever she was trying to pass meds, she stated that is just what R1 does is make noise. V4 stated if she is being loud, something is probably wrong. V4 stated when R1 saw her that morning she immediately pointed to her finger and chest. V4 stated R1's finger was red and swollen, she stated she pointed to the door and said, Nurse did it. V4 stated there's no way R1 could have caused the bruising on the chest, occasionally she will cause a small bruise, but nothing to the extent of her bruises. V4 stated the night shift CNA's contacted V1, she did not directly contact her that day. V4 stated R1's bruise to her chest was large and looked painful. V4 stated R1 did not complain of pain. V4 stated R1 is not capable of opening the door. V4 stated the bruise on R1's chest was reported to V1 and V11 (Former Director of Nursing) on multiple occasions and nothing was done. On 4/1/26 at 1:11pm, V10 (Former Director of Nursing) stated on the morning of the incident involving R1, she was very angry and pointed to her chest saying her did it. V10 stated they were told by night shift staff that V3 took R1 to her room and closed the door. V10 stated as soon as administration was made aware, they started an investigation. V10 stated V7 and V8 the night shift CNAs said it happened twice. V10 stated V3 put her in her room and closed her in there. V10 stated a complete skin assessment should be done at the beginning of an (continued on next page)</p>		

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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, IL 62864	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>investigation. V10 stated V1 handled all the investigation, but the bruise on R1's chest should have been documented and investigated. V10 stated R1 does not have a history of making false accusations against staff. V10 stated R1 statements nurse do it and nurse hurt me should have been taken seriously. V10 stated R1 was not capable of opening the door. On 4/1/26 at 1:24pm, V2 (Social Services Director) stated she came in that morning around 7:30, and R1 was visibly upset. V2 stated her first question was had anyone called V1, call was made to V1 immediately. V2 stated R1 had a bruise on her finger but did not have bruise on chest at that time. V2 stated that R1 does not have a history of making false allegations towards staff. V2 stated that R1 does have a history of causing bruises to herself. V2 stated the reason why R8 was not interviewed was because she was under the impression R8 was not in the room at the time it happened. V2 stated that V7 and V8 stated V3 closed R1 in her room more than once that night. V2 stated she was not sure whether R1 was strong enough to leave the bruise, but R1 was poking herself persistently saying nurse hurt. V2 stated R1 could not open door. On 4/1/26 at 3:05pm, V1 (Administrator) stated that R1 is known to make bruises on herself. V1 stated when she got here R1 was poking herself in the chest saying see did it, V1 stated she told R1 to stop poking herself in the chest she was going to leave a bruise. V1 stated R1 does not have a history of making false allegations against staff. V1 stated R1 had a bruise on her hand that was later determined was from knocking on the door. V1 stated she did not investigate the bruise on the chest because it was initially not there. V1 stated she was not sure why the bruise wasn't investigated after it was discovered, but that was a good question. V1 stated an incident was opened about it in R1's chart. V1 stated it was reported to police and the agency V3 worked for. V1 stated R1 could not open the door involuntary seclusion was substantiated. V1 stated V3 was interviewed that day and asked not to come back immediately. V1 stated staff was educated on involuntary seclusion. V1 stated V6 was not interviewed because she was not there the whole night, just when they opened her door. Facility initial investigation of an injury of unknown origin to R1's left index finger documents an undated and untimed interview performed by V1 with R1. In this interview, V1 asked, Your nurse took you to your room? R1 responded Yep V1 asked, then what? R1 responded, Shut the door. V1 stated, Your nurse put you in your room and shut the door? R1 responded, Yep. In R1's medical record an event record was opened on 03/25/2026 at 9:34pm by V1. This record documented a bruise on R1's right hand that was 0.7 inches (in) (length), 0.5in (Width), and bruising to R1's left chest that was 5 inches in length, and 5 inches in width. With vocal complaints of pain. Facility Final report completed by V1, dated 3/31/26 documents under the section follow-up/final report summary; investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Abuse substantiated, nurse immediately DNR from building. Staff educated about involuntary seclusion. The facility was unable to produce any evidence that the bruise on R1's chest or the statements made by R1 were thoroughly investigated. Facility policy titled Abuse and Retaliation Prevention and Reporting- ILLINOIS with an effective date of 1/8/26 documents under policy; This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. In the section titled, Internal investigation it documents; Any incident or allegation involving abuse, neglect, exploitation, retaliation, mistreatment, or misappropriation of resident property will result in an investigation. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time.</p>		