STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Gardens of Mount Vernon	#5 Doctors Park 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 - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview and record review, the facility failed to ensure residents were free from staff to resident physical and verbal abuse for 4 (R1, R2, R3, R11) of 5 residents reviewed for abuse in the sample of 11. Findings include: An undated final report sent to the Illinois Department of Public Health on 2/7/25 documented in part, On 2/7/25 at approximately 10:35 am it was notified to this this administrator from housekeeper (V17) that she witnessed staff to resident abuse in this facility. When asked what she has seen, she stated that she has witnessed (V6, Certified Nurses Assistant/CNA) yelling at residents and shoving them as to move them along. When asked why she has never reported this, she said that she was scared of said CNA . (R1) stated that she has had issues with staff. When asked who, she said (V6), she doesn't let me do anything. Following this, staff was asked if they have witnessed abuse from staff to residents in this facility. SSD (V7-Social Services Director) stated that she has never seen abuse, but has heard that staff can be rough with residents. When asked if she has heard any names specifically, she said (V6). (V8, Occupational Therapy Assistant) from our therapy department stated that she has never seen any residents be punched in the face or anything to that severity, but she has seen residents be treated in a way that she would never want her loved ones treated. When asked of any specific names, she said (V6). Housekeeper (V9) stated that last Sunday, she saw (V6) give resident (R2) a shove from behind to get him out of the dining room, another aide (V10, CNA) was standing there and waved (V9) on as to walk away. She stated that she has also heard her be verbally loud and mean with other residents and staff. Housekeeper (V11) stated that she has seen (V6) raise her voice with residents, as well as shove residents (R3) and (R2) around. CNA (V12) stated that he has never seen any physical abuse but noted that (V6) can be a bully to the residents in the way she talks to them. [NAME] (V13) stated that she heard (V6) tell resident (R1) to get her ass back and then proceeded to tell her that hitting me is not a good idea. She then proceeded to grab (R1's) arm and shove her back . In conclusion, the facility can substantiate that verbal and physical abuse has been committed by CNA (V6). Following this investigation, (V6) has been terminated. 1. R1's admission record notes R1 was admitted to the facility on [DATE]. The same Admission Record notes some of R1's diagnoses as unspecified dementia, severe, with other behavioral disturbances, alcohol use, unspecified with alcohol-induced persistent dementia and personal history of transient ischemic attach (TIA), and cerebral infarction without residual deficits. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's MDS (Minimum Data Set) dated 12/18/24 notes that R1 has a BIMS (Brief Interview of Mental Status) of 05 which indicates severe cognitive impairment. On 2/20/25 at 12:40pm, V13 (Cook) said R1 was at the window to the kitchen, and V6 (CNA/Certified Nurse Assistant) hit R1 and grabbed R1 and told R1 that hitting her (V6) was not a good idea. V13 said that V6 also told R1 to get her (R1) ass back prior to grabbing and shoving her. V13 said she is not sure of the date, but thinks it was on a Sunday about a week or two ago and she V13 said she did not report it to the next day on a Monday. On 2/20/25 at 10:40 am, R1 stated V6 yelled at her, but didn't hit or shove her. Then R1 did not answer questions appropriately after that. 2. R2's admission record notes documents that R2 was admitted to the facility on [DATE]. The same Admission Record documents some of R2's diagnoses as: unspecified dementia, severe, with other behavioral disturbance, cerebral infarction, unspecified, delusional disorders, other hallucinations. R2's MDS dated [DATE] notes that a BIMS should not be completed due to resident rarely/never being understood. On 2/20/25 at 12:20pm, V9 (Housekeeper) stated she witnessed V6 push R2 out of the dining room from behind on 1/26/25. V9 stated she went to V8 (Occupational Therapy Assistant) on 1/28/25 and told her about it but then stated they were scared to report the abuse to V1 due to being scared of V6. 3. R3's Admission Record notes that R3 was admitted to the facility on [DATE]. The same Admission Record documents some of R3's diagnoses as Bipolar disorder, current episode manic severe with psychotic features, other front temporal neurocognitive disorder. R3's MDS dated [DATE] note R3 has a BIMS of 99 which indicates that R3 was unable to complete the interview. On 2/20/25 at 11:55 am, V11 (Housekeeping) said she witnessed V6 push and grab R2 and R3. V11 said that V6 grabbed R3 by the arm and angrily raised her voice. V11 said that V6 also did the same thing to R2. 4. R11's Admission Record notes that R11 was admitted to the facility on [DATE]. R11's MDS dated [DATE] note R11 has a BIMS of 99 which indicates the interview could not be completed. R11 did not answer any questions appropriately. On 2/21/25 at 2:55pm, V18 (Dietary Manager) said that V12 (CNA/Certified Nurse Assistant) walked in the dining room and saw R11 peeing on the floor. V18 said Why the hell are you doing that and being nasty? in a sarcastic manner. V18 said she wrote this on the investigation form she was given on 2/7/25 on the allegation of V12 against R11. V18 said she thinks the incident occurred around 2:00pm but does not remember the exact day it occurred. On 2/21/25 at 9:30am, V1 (Administrator) said she was not informed about the incident until she began the investigation on 2/7/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/25 attempts were made to contact V6 via phone. V6 had been terminated and did not respond to any calls Facility Abuse Prevention and Reporting policy, revised 10/24/22 notes that This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40666 Based on interview and record review, the facility failed to immediately report allegations of abuse to the Administrator for four residents (R1, R2, R3, R11) of 5 residents reviewed for abuse in the sample of 11. The findings include: On 2/20/25 at 12:40pm, V13 (Cook) said R1 was at the window to the kitchen, and V6 (Certified Nurse Assistant/CNA) hit R1 and grabbed R1 and told her (R1) that hitting her (V6) was not a good idea. V13 said that V6 also told R1 to get her ass back prior to grabbing and shoving her. V13 also said that she waited to report it until the next day. V13 said she thinks this occurred on a Sunday and she reported it on Monday but does not remember the exact date. V13 said she did not know she had to report it immediately but does now. V13 said she reported the incident to the administrator on 2/7/25. On 2/20/25 at 9:50am, V9 (Housekeeping) said she witnessed V6 push R2 coming out of the dining room on a Sunday and thinks it was a week or so ago. V9 said she is unsure of the exact date. V9 said she went to V7 (Social Services) first and told her. V9 said she thinks that was on a Friday. V9 said she was off Saturday and Sunday and then was called in to the office by V1(Administrator) on Monday after the investigation began the day before On 2/20/25 at 9:00am, V11 (Housekeeping) said she witnessed V6 push and grab R2 and R3. V11 said that V6 grabbed R3 by the arm and angrily raised her voice. V11 said that V6 also did the same thing to R2. V11 said she did go to the Administrator, but not at the time of the incident. V1 said that V6 grabbing R3 was about a month ago. V11 said she did not report it because she thought it would stop and was afraid if she told, she would lose her job On 2/21/25 at 3:00pm, V7 (Social Services Director) said housekeeping brought the incident of V6 (CNA) yelling and shoving a resident (R3) to her attention. V7 said she asked them if they had went to V1 and they said No. V7 said that someone from the kitchen had went to V1 so she didn't go tell V1. On 2/21/25 at 2:55pm, V18 (Dietary Manager) said that V12 (CNA/Certified Nurse Assistant) walked in the dining room and saw R11 peeing on the floor. V18 said Why the hell are you doing that and being nasty? in a sarcastic manner. V18 said she wrote this on the investigation form she was given on 2/7/25. V18 said she did not report it, but did report it on the Incident Investigation Form. On 2/21/25 at 9:30am, V1(Administrator) said that staff are to report all allegations of abuse to her immediately. V1 said that none of these allegations were reported to her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Abuse Prevent and Reporting policy last revised 10/24/22 documents in part, Internal Reporting Requirements and Identification of Allegation: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview and record review, the facility failed to initiate an investigation into an allegation of abuse for 1 of 5 resident (R11) reviewed for abuse in a sample of 11. Findings include: On 2/21/25 at 2:55pm, V18 (Dietary Manager) said that V12 (CNA/Certified Nurse Assistant) walked in the dining room and saw R11 peeing on the floor. V18 said Why the hell are you doing that and being nasty? in a sarcastic manner. V18 said she wrote this on the investigation form she was given on 2/7/25 on the allegation of V12 against R11. V18 said she thinks the incident occurred around 2:00pm but does not remember the exact day it occurred. On 2/20/25 at 2:57pm, V1 (Administrator) stated she did not complete an abuse investigation for an allegation of abuse between R11 and V12. V1 said she missed the allegation regarding abuse on the Facility Incident Investigation Form. Facility Incident Investigation Form notes that V18 wrote on 2 pm on 2/7/25 she has not ever witnessed abuse. V18 responded to the question Do you see or hear of abuse from staff to resident? V18 replied, Just the loud tall guy that's a CNA. When he walked I and saw a resident peeing on the floor, he said Why the hell are you doing that and being nasty. The form is signed by V18. R1's Admission Record noted that R11 was admitted to the facility on [DATE]. The same Admission Record notes some of R11's diagnoses as: Unspecified dementia, unspecified severity, without behavioral disturbances, Psychotic Disturbance, Mood Disturbance, anxiety, Type 2 Diabetes Mellitus without complications, Presence of Automatic (implantable) Cardiac Defibrillator. R11's MDS (Minimum Data Set) dated 12/24/24 note R11 has a BIMS (Brief Interview of mental status) of 99 which indicates the interview could not be completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Abuse Prevention and Reporting policy revised 10/24/22 documents in part, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property, Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences .Upon learning of the report, the administrator or a designee shall initiate an incident investigation All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.