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	05/27/2025

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 - Few	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** 49714 Based on interview and record review, the facility failed to ensure residents were free from resident to resident physical abuse for 2 (R3 and R4) of 3 residents reviewed for abuse in the sample of 4. Findings Include: R3's Admission Record documented R3 was admitted to the facility on [DATE] and included diagnoses of unspecified dementia, essential hypertension, unspecified protein-calorie malnutrition, atrial fibrillation, osteoarthritis of knee, adult failure to thrive, and unspecified macular degeneration. R3's Minimum Data Set (MDS) assessment dated [DATE], documented that R1 has a Brief Interview for Mental Status (BIMS) score of 11, indicating R3 is moderately impaired. R3's Care Plan with a date of 05/01/2025 included a focus area of I have a behavior problem (Physical altercation with roommate.) The interventions listed are administer meds as ordered, anticipate and meet residents needs, arrange placement with compatible roommate, and monitor for evidence of agitation. R4's Admission Record documented R4 was admitted to the facility on [DATE] and included diagnoses of vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and primary insomnia. R4's MDS assessment dated [DATE], documented a BIMS score of 99 indicating that R4 was unable to complete the interview. R4's Care Plan with a date of 03/25/2025, included a focus area of I have impaired cognitive function/dementia or impaired thought processes related to a diagnosis of vascular dementia. The interventions listed are use the residents preferred name, identify yourself, face the resident when speaking, engage the resident with simple, structured activities that avoid overly demanding tasks, monitor and report any changes in cognitive function, and review medications. (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 - Few	The facility's Final Abuse Investigation Report with no date documented on 05/01/2025 at 5:00 A.M, V15 (Certified Nurse Assistant/CNA) was walking in the hall and witnessed R4 and R3 entangled on the floor of their room. R3 was observed having skin tears on the outer side of both hands and R4 had a swollen nose. R3 and R4 were separated immediately. R3 reported that he was sleeping and that a man jumped on top of him. R4 did not have a recollection of the event. Residents are no longer roommates and there have been no further incidents. On 05/23/2025 at 9:35AM, V13 (Licensed Practical Nurse/LPN) stated that he was the nurse that came on shift on 05/01/2025 at 6:00 AM and the incident occurred before he arrived. V13 stated that R3 and R4 were sharing a room at the time of the incident. V13 stated that R3 was always stating that people were stealing his stuff, and everyone was out to get him. V13 stated it is very rare for R4 to have behaviors. V13 stated R4 gets frustrated because he is not able to make his needs known. V13 stated that he feels that R3 was the aggressor in the incident. V13 stated that R3 always talks about being a [NAME] and whipping people. V13 stated he feels that R4 sat on the edge of R3's bed causing R3 to become agitated and that is when the incident occurred. V13 stated that neither resident was sent out to seek treatment. V13 stated that R3 was moved to the non-locked side of the facility in a room by himself. V13 stated that R4 has had no behaviors since the incident with R3. On 05/23/2025 at 9:50AM, R3 was alone in his room in bed and stated he was in an altercation about a year and a half ago. R3 stated he does not remember being in an altercation with anyone the last couple of months. R3 stated that someone tried to beat up on him but he handled it. R3 stated I worked him over. On 05/23/2025 at 9:57 AM, V1 (Administrator) stated that after the incident with R3 and R4, R4 was evaluated by psych and medications were adjusted. V1 stated that after the incident the residents were immediately separated and R3 was moved off the locked dementia side of the facility. V1 stated that R3 can be territorial and would get upset when residents would wonder in his room. On 05/23/2025 at 10:36 AM, V14 (CNA) stated that R4 is a pleasant resident and does not cause any trouble. V14 stated that R4 gets frustrated when you have to wake him up but other than that he will allow staff to provide care for him. V14 stated she has never witnessed R4 be aggressive with any other resident. V14 stated that after the incident, R3 stated he worked (R4) over real good. On 05/23/2025 at11:13 AM, V15 (CNA) stated that she was the aide working on the locked dementia unit the night the altercation occurred between R3 and R4. V15 stated she was doing bed checks on the middle hall and heard someone yelling help. V15 stated that she could tell it was coming from the front hall so she went to the front hall. V15 stated she entered R3 and R4's room and observed R3 and R4 entangled on the floor in an altercation. V15 stated she removed R4 from on top off R3. V15 stated she and R4 left the room and went to the nurses station. V15 stated that she has never observed R4 being combative with anyone. V15 stated that R3 did not like R4 in his room because R4 would rummage through his personal belongings. V15 stated that before the incident occurred, R3 had voiced that he would like a different room because he did not like R4 in there and was going to kick R4 out of the room. V15 stated she is not sure if the nurses reported this to V1 or not. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2025 at 3:19 PM, V16 (LPN) stated she was the nurse the night the incident occurred between R3 and R4. V16 stated it was reported to her by V15 (CNA) that R3 and R4 had been entangled together on the floor. V16 stated that R3 explained that R4 kept coming over to his bed and R3 told him to quit. R4 explained to V16 that they just went at it. V16 stated that R3 always thinks someone is out to get him and does not like having roommates. V16 stated that R3 didn't like that R4 would rummage through his things. Facility policy titled Abuse Prevention and Reporting - Illinois with a revision date of 10/24/2022, documented under section titled Guidelines - 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Protection of Residents: Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including but not limited to, the separation of residents.