

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Axiom Gardens of Mount Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE #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 - 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. (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure residents were free from resident to resident physical abuse for 2 of 4 residents (R1 and R2) reviewed for abuse in the sample of 6. This failure resulted in R1 sustaining a nasal fracture during and altercation with R2. R1's admission Record documents an admission date of 7/2/2025 and includes diagnoses of Encephalopathy, Unspecified Dementia with other behavioral disturbances, unspecified dementia with agitation, and convulsions. R1's MDS (Minimum Data Set) dated 7/11/2025 includes a BIMS (Brief Interview for Mental Status) score of 2 suggesting R1 has severe cognition impairment. Section E-Behaviors documents R1 does not hallucinations or delusions. R1 has no behaviors of wandering. Section GG -Functional Abilities documents R1 has no impairment with upper or lower extremities. R1's care plan documents a focus area of: R1 is at risk for abuse with date initiated 7/3/25. Goal: R1 will remain free of abuse, mistreatment or otherwise improper care throughout residency at facility (date initiated 7/3/25). Interventions including, observe resident in the company of peers (date initiated 7/10/25), provide reassurance when negative feelings occur (date initiated 8/4/25), notify abuse coordinator of any abuse immediately (date initiated 7/3/25). R2's admission Record documents an admission date of 3/5/2025 and includes diagnoses of Vascular Dementia without Behavioral Disturbance, Psychotic or Mood Disturbance, Anxiety and Insomnia. R2's MDS (Minimum Data Set) dated 5/26/2025 includes a BIMS (Brief Interview for Mental Status) score of 99 suggesting R2 has severe cognition impairment. Section E- Behaviors documents R2 does not have hallucinations or delusions, and no behaviors exhibited for wandering. Section GG - Functional Abilities documents R2 has no impairment to upper and lower extremities and no assistive devices used for mobility. R2 only requires supervision/ touching assistance with ADLs (Activities of Daily Living). R2's Care Plan documents a focus area of: I have a behavior problem (physical aggression) with date initiated of 5/1/25. Interventions include: Monitor for evidence of agitation (initiated 5/1/25), Monitor when approached by confused residents (initiated 5/1/25), Monitor for entering other residents' room (initiated 8/4/25) and Provide 1:1's as need (no date). A final report sent to IDPH (Illinois Department of Public Health) dated 8/6/25 by V1 (Administrator) documents on 8/1/2025, R1 went to the nurse's station with blood coming from his nose and it appeared crooked. V9 (Licensed Practical Nurse/LPN) stated R1 saw R2 and began charging stating R2 had hit him. Residents were immediately separated and sent to local emergency rooms. Follow up/summary documents R1 sustained a fracture to his nasal bone as a result of the alleged peer to peer incident. According to housekeeper, V7 he saw R2 go into R1's room prior to the altercation. R2 was asked if he had struck R1 and he stated got him back. R2 was also noted with blood on his hand. Both residents reside on our locked dementia unit and have a recent BIMS score of 99 due to not being able to complete assessment. Following return from their respective hospitals, both residents completed and telehealth with psychiatry group. No medication changes were made. Care plans were updated to reflect R2 will be encouraged to participate in 1 on 1 activities. R1's care plan reflects that he was sent to emergency room due to abuse from another resident. Staff will be educated to assure that residents do not enter other rooms. Report was authored by V1 and dated 8/6/2025. On 8/8/2025 at 12:22PM, R1 was observed walking in the hallway outside of his room. Observed R1's nose with slight edema and a light purple bruise noted to the bridge of his nose. R1 was asked what happened to his nose. R1 stated, A man hit me in my f***ing nose. R1 was asked if he knew why the other resident hit him and R1 stated, No. R1 stated he did not know the man's name that hit him either. R1's EMR (Electronic Medical Record) progress notes document on 8/1/2025, R1 appears to have been involved in an altercation with a peer. Event was first noted on 8/1/2025 at 3:20 PM. Just prior to or at the time of the event R1 appears to have been walking down the hall. R1's account of the event is R2 punched him in the face. V7 saw resident come down hall with nosebleed yelling that guy hit me. R1's Hospital Report dated 8/1/25 documents, Patient history obtained from nursing home nurse who is with the patient as well as the patient's self, they gotten to a punch fight, he was punched by another resident. And has deviation and bleeding of the nose. That occurred just prior to arrival. No other injuries appreciated. No other complaints, patient states that the pain is moderate, bleeding controlled, will controlled in the emergency room but there is obvious deformity of the nasal bones. XR (x-ray) Nasal Bones Complete. Impression: 1. Acute appearing transverse fracture through the mid nasal bone with minimal depression at the fracture site. Overlying soft tissue swelling On 8/8/2025 at 12:29PM via phone interview V7 (Housekeeping) stated he works in</p>		