

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  03/04/2026
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)		
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure effective pain management and treatment was provided in a timely manner for 1 (R1) of 3 residents reviewed for pain management in the sample of 5. This failure resulted in R1, who was admitted to the facility with a right femur fracture, and displaced trimalleolar and bimalleolar fractures of the right lower leg, experiencing prolonged, significant pain due to necessary pain medication not being available. The findings include: R1's admission Record documented an admission date of 02/14/26 and included diagnoses of fracture of unspecified part of neck of right femur, cellulitis of right lower limb, displaced Tri malleolar fracture of right lower leg, displaced bimalleolar fracture of right lower leg and end stage renal disease. R1's Discharge Minimum Data Set (MDS) dated [DATE] documented R1's short term memory was ok and cognitive skills for daily decision making regarding tasks of daily life was marked as independent. In the Functional Abilities and Goals section, this MDS documented R1 was dependent for toileting, rolling left to right, sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to chair transfer, toilet transfers, and tub/shower transfers. In the section titled Health Conditions, R1 was documented as receiving scheduled pain medications and was offered and/or declined PRN (as needed) pain medications. In the section titled Medications, the MDS documented R1 had an indication for and was taking opioid medication. R1's Care Plan was incomplete but in progress due to the recent admission. However, R1's Admission/re-admission Observation assessment dated [DATE] at 9:47PM documents under the section titled Neurological, R1 is oriented to person, place, time and situation. Under the section titled Pain, the following is documented: The Numeric Rating Scale for pain documents a pain level of 8 on a scale of 00 to 10 with the location specifying R1's right leg. Under coping it documents that R1 has PRN oxycodone to alleviate the pain. The question asking what makes the pain worse is left blank. Under lifestyle it documents R1's pain affects sleep by keeping her awake and affects her mood by feeling depressed. Under the section titled Treatments the medications oxycodone and acetaminophen are listed. In the section for Pain Care Planning, it documents a focus area of I have pain with a goal of I will not have an interruption in normal activities due to pain through the review date. Interventions selected document to administer analgesia as per orders. Give 1/2 hour before treatments or care, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/record pain characteristics PRN: Quality (e.g. sharp, burning), Severity (1-10 scale) Anatomical location; Onset; Duration (e.g., continuous, intermittent); Aggravating factors, Relieving factors, and Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. On 02/26/26 at 11:48AM, V15 (Family Member) stated that R1 arrived at the facility on (Saturday) 02/14/26 later in the evening after being discharged from a local hospital. V15 said that R1 had been in the hospital due to sustaining several fractures from a fall at her previous nursing home placement and was in horrible pain. V15 said that the facility did not get R1's oxycodone until around 2 days later. V15 stated that R1 was alert and could state that she was in pain the whole time until they were able to get her oxycodone. V15 said that they did give R1 some Tylenol but that didn't work at all for her pain. V15 said that she doesn't understand why it would take so long to get R1 pain (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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F 0697  Level of Harm - Actual harm  Residents Affected - Few	<p>medication. V15 verified that R1 was no longer at this facility as she wanted to discharge and go to another facility with in house dialysis so that she didn't have to be transported back and forth to dialysis due to the pain it would cause. R1's Order Summary Report documents an order for oxycodone Hcl (Hydrochloride) oral tablet 5mg (Milligrams) give 1 tablet by mouth every 4 hours as needed for pain take 1 tablet po (Orally) every 4 hours as needed with an order date of 02/14/26. The Order Summary Report also documents an order for Tylenol 325mg give 2 tablets by mouth every 4 hours as needed for mild pain with a start date of 02/15/26. R1's Order Summary Report documents an order for pain monitoring -ask resident pain level every shift with an order date of 02/16/26. R1's Medication Administration Record (MAR) for 02/01/26 to 02/28/26 documents oxycodone Hcl oral tablet given on 02/19/26 at 11:29AM with a pain level of 7 and 02/19/26 at 4:26PM with a pain level of 3. R1's Progress Notes dated 02/16/26 at 4:27PM document Have called pharmacy 3 times today to check if oxy (Oxycodone) rx (prescription) is in. Not in yet. Called (Physician Provider Company) x (times) 3 and on the last call they mentioned that the request was sent to (Nurse Practitioner) at 3:35PM. Informed the (Nurse Practitioner) that the cutoff for the pharmacy is at 6:00PM R1's MAR for 02/01/26 to 02/28/26 documents Tylenol 325mg (milligrams) give 2 tablet by mouth every 4 hours as needed for mild pain as administered on 02/15/26 at 2:22PM with a pain level of 3, on 02/16/26 at 12:27PM with a pain level of 5, on 02/19/26 at 6:43AM with a pain level of 5, and on 02/19/26 at 2:23Pm with a pain level of 4. R1's Vital Records document the following Pain Level</p> <p>Summaries:02/14/26 at 9:49PM a pain level of 502/15/26 at 2:22PM pain level of 3, 3:35PM pain level of 0, 4:35PM pain level of 0, 5:15PM pain level of 0, 11:03PM pain level of 002/16/26 at 9:22AM pain level of 5, 12:27PM pain level of 5, 3:15PM pain level of 1, 10:51PM pain level of 002/17/26 at 4:46AM pain level of 0, 9:27AM pain level of 4, 9:28AM pain level of 3, 10:55AM pain level of 0, 7:54PM pain level of 402/18/26 at 8:41PM pain level of 002/19/26 at 4:55AM pain level of 0, 6:43AM pain level of 5, 7:16AM pain level of 5, 8:37AM pain level of 3, 11:29AM pain level of 7, 2:15PM pain level of 4, 2:23PM pain level of 4, 4:24PM pain level of 3, 4:24PM pain level of 3, 4:25PM pain level of 3, 4:26PM pain level of 3, 5:28PM pain level of 3, 5:30PM pain level of 0, 7:05PM pain level of 0, 8:08PM pain level of 002/20/26 at 8:04AM pain level of 1. On 02/26/26 at 10:04AM, V2 (Director of Nursing/DON) stated that their new pharmacy is terrible. V2 said that their pharmacy has an emergency medication bank at the facility that does have narcotic pain medication, but oxycodone is not one of the medications in the emergency medication bank kit. V2 said that if they did have oxycodone in the emergency medication bank, they would have had to get a script then call the pharmacy and get a code and it can take up to 4 hours to call back with the code to get into the emergency medication bank kit. V2 said that R1 arrived at the facility on 02/14/26 after 5:00PM, so R1's medications would have missed the cut off to be delivered on Sunday morning. V2 said the bad thing about this is, if the nurses were having a problem with getting R1's oxycodone V2 doesn't know why they didn't call her. V2 said that she doesn't know for sure what day R1's oxycodone finally came in. V2 said that she knows the facility contacted the pharmacy several times trying to get R1's oxycodone pain medication. On 02/26/26 at 10:10AM, V3 (Assistant Director of Nursing/ADON) stated they tried to get ahold of the pharmacy about R1's oxycodone to see if they could get it since they didn't have it in the emergency medication bank kit. V3 said she thinks the reason why they didn't call and get an order for some other kind of pain medication that was in the emergency medication bank was because R1 was allergic to hydrocodone and that is mainly what they have in the emergency medication bank kit. On 02/26/26 at 10:24AM, V1 (Administrator) stated R1 came from an outside hospital and arrived on 02/14/26 later in the evening. V1 said if the facility gets a new resident and they have a controlled substance like oxycodone and don't have a prescription for the it, they can request it from the physician. V1 said they have several physicians they can call and they always have an on-call physician as well. V1 said they have an emergency medication bank kit at the facility they can pull from if it is past the cut off for the pharmacy delivery date. V1 said they also have emergency runs for medications, although they generally don't have to use it but they could have had R1's oxycodone (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>delivered via emergency run. V1 said she doesn't think R1 came with a script for the oxycodone. V1 said the nurses should have gotten a hold of another provider to get a script for the oxycodone so they could have gotten the medication. On 02/26/26 at 10:34AM, V4 (Vice President of Operations) stated that the nurses should have gotten a hold of a physician and gotten a script for R1's oxycodone. V4 said that R1 should have come with a script from the hospital for the oxycodone. On 03/02/26 at 9:52AM, V5 (Registered Nurse) stated she took care of R1 for one day. V5 said she did call the pharmacy several times on 02/16/26. V5 said she doesn't like the new pharmacy and the pharmacy was acting like they didn't have a prescription for R1's oxycodone, but they did have a prescription for the oxycodone. V5 said she was calling the nurse practitioner and on-call physician trying to get a script and the pharmacy already had a prescription for it. V5 said the pharmacy told her they did find the prescription. V5 said R1 was in a lot of pain and V5 gave R1 some Tylenol because that is all she had to give R1 for pain. V5 said R1 did not get her oxycodone on 02/16/26. V5 said she did request an emergency run for R1's oxycodone, but the pharmacy did not do one. V5 said whoever put a 0 down on R1's pain level scale was not telling the truth because R1 was always having pain. V5 said there is no excuse why they didn't try to get R1 pain medication over the weekend. V5 said it was probably agency that was working. V5 said she doesn't know why the pharmacy did not bring R1's oxycodone when she requested the emergency run either. V5 stated they do have oxycodone 5mg in the emergency medication bank kit. V5 said she doesn't know why the hospital didn't send a script for the oxycodone when they discharged R1 to the facility. V5 said when she calls the physician or the on-call doctor they are usually pretty good about getting the prescription sent right away. V5 said R1 was crying when she worked and had a 10 out of 10 on the pain scale. V5 said she was trying everything she could to try to get R1's pain under control. V5 said she thought she took an oxycodone 5mg out of the emergency medication bank kit to give to R1. On 03/02/26 at 10:04AM, V2 (DON) was at the emergency medication bank and tried to log in to see if she could pull up the screen for oxycodone. V2 was able to pull up the screen on the emergency medication bank that showed oxycodone 5mg IR (Immediate release), however the quantity showed blind, which means the machine will not disclose the amount of medication in the bank. On 03/02/26 at 10:05AM, V2 stated she doesn't know if R1's oxycodone was IR or not. V2 stated if it wasn't, the nurses could have gotten a script for it to give R1 one until her oxycodone came in. V2 said she knew they dropped the ball on getting R1's oxycodone. V2 said to find out how many controlled substances they have in the emergency medication bank, they have to call V12 (Emergency Medication Bank Representative) and he will provide a code when there is an active script to be able to get the medication out of the emergency medication bank. On 03/02/26 at 10:19AM, V11 (Pharmacy Customer Service) stated R1 did not receive her oxycodone until 02/17/26 (three days after admission). V11 said they did not receive an active prescription for the oxycodone 5mg until 02/16/26 (two days after admission). V11 said no staff from the facility requested an emergency run of R1's oxycodone. V11 said the nurses at the facility could have requested to get the oxycodone out of the emergency medication bank. V11 stated she doesn't see where anyone from the facility requested to get oxycodone out of the emergency medication bank. V11 said the emergency medication bank should have oxycodone 5mg in it. On 03/02/26 at 10:29AM, V12 (Emergency Medication Bank Representative) stated he is the person who the facility would contact to access any medications out of the emergency medication bank. V12 stated the emergency medication bank does contain oxycodone 5mg IR at the facility. V12 stated no staff at the facility requested to get any oxycodone out of the emergency medication bank from 02/14/26 until now. V12 said if they had a prescription for the oxycodone, he could have given the facility a code and they would have had the oxycodone to give to R1. On 03/02/26 at 10:57AM, V7 (Agency Licensed Practical Nurse/LPN) stated she took care of R1 on 02/15/26. V7 stated she talked to V3 (ADON) about R1's oxycodone not being available. V7 said V3 told her R1's medication could be pulled from the emergency medication bank. V7 said she doesn't have access to the emergency medication bank because she is an agency nurse. V7 said she didn't get much report from (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to obtain and provide necessary controlled prescription pain medication in a timely manner for 1 (R1) of 3 residents reviewed for pharmacy services in the sample of 5. The findings include: R1's admission Record documented an admission date of 02/14/26 and included diagnoses of fracture of unspecified part of neck of right femur, displaced Tri malleolar and bimalleolar fractures of right lower leg, cellulitis of right lower limb, and end stage renal disease. R1's Discharge Minimum Data Set (MDS) dated [DATE] documented R1's short term memory was ok and cognitive skills for daily decision making regarding tasks of daily life was marked as independent. In the Functional Abilities and Goals section, this MDS documented R1 was dependent for toileting, rolling left to right, sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to chair transfer, toilet transfers, and tub/shower transfers. In the section titled Health Conditions, R1 was documented as receiving scheduled pain medications and was offered and/or declined PRN (as needed) pain medications. In the section titled Medications, the MDS documented R1 had an indication for and was taking opioid medication. R1's Care Plan was incomplete but in progress due to the recent admission. However, R1's Admission/re-admission Observation assessment dated [DATE] at 9:47PM documents under the section titled Neurological, R1 is oriented to person, place, time and situation. Under the section titled Pain, the following is documented: The Numeric Rating Scale for pain documents a pain level of 8 on a scale of 00 to 10 with the location specifying R1's right leg. Under coping it documents that R1 has PRN oxycodone to alleviate the pain. The question asking what makes the pain worse is left blank. Under lifestyle it documents R1's pain affects sleep by keeping her awake and affects her mood by feeling depressed. Under the section titled Treatments the medications oxycodone and acetaminophen are listed. In the section for Pain Care Planning, it documents a focus area of I have pain with a goal of I will not have an interruption in normal activities due to pain through the review date. Interventions selected document to administer analgesia as per orders. Give 1/2 hour before treatments or care, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/record pain characteristics PRN: Quality (e.g. sharp, burning), Severity (1-10 scale) Anatomical location; Onset; Duration (e.g., continuous, intermittent); Aggravating factors, Relieving factors, and Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. R1's Medication Administration Record (MAR) for 02/01/26 to 02/28/26 documents oxycodone Hcl oral tablet given on 02/19/26 at 11:29AM with a pain level of 7 and 02/19/26 at 4:26PM with a pain level of 3. R1's Progress Notes dated 02/16/26 at 4:27PM document Have called pharmacy 3 times today to check if oxy (Oxycodone) rx (prescription) is in. Not in yet. Called (Physician Provider Company) x (times) 3 and on the last call they mentioned that the request was sent to (Nurse Practitioner) at 3:35PM. Informed the (Nurse Practitioner) that the cutoff for the pharmacy is at 6:00PM R1's Care Plan was incomplete but in progress due to the recent admission. However, R1's Admission/re-admission Observation assessment dated [DATE] at 9:47PM documents under the section titled Neurological, R1 is oriented to person, place, time and situation. Under the section titled Pain, the following is documented: The Numeric Rating Scale for pain documents a pain level of 8 on a scale of 00 to 10 with the location specifying R1's right leg. Under coping it documents that R1 has PRN oxycodone to alleviate the pain. The question asking what makes the pain worse is left blank. Under lifestyle it documents R1's pain affects sleep by keeping her awake and affects her mood by feeling depressed. Under the section titled Treatments the medications oxycodone and acetaminophen are listed. In the section for Pain Care Planning, it documents a focus area of I have pain with a goal of I will not have an interruption in normal activities due to pain through the review date. Interventions selected document to administer analgesia as per orders. Give 1/2 hour before (continued on next page)</p>		

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V2 said that if they did have oxycodone in the emergency medication bank, they would have had to get a script then call the pharmacy and get a code and it can take up to 4 hours to call back with the code to get into the emergency medication bank kit. V2 said that R1 arrived at the facility on 02/14/26 after 5:00PM, so R1's medications would have missed the cut off to be delivered on Sunday morning. V2 said the bad thing about this is, if the nurses were having a problem with getting R1's oxycodone V2 doesn't know why they didn't call her. V2 said that she doesn't know for sure what day R1's oxycodone finally came in. V2 said that she knows the facility contacted the pharmacy several times trying to get R1's oxycodone pain medication. On 02/26/26 at 10:10AM, V3 (Assistant Director of Nursing/ADON) stated they tried to get ahold of the pharmacy about R1's oxycodone to see if they could get it since they didn't have it in the emergency medication bank kit. V3 said she thinks the reason why they didn't call and get an order for some other kind of pain medication that was in the emergency medication bank was because R1 was allergic to hydrocodone and that is mainly what they have in the emergency medication bank kit. On 02/26/26 at 10:24AM, V1 (Administrator) stated R1 came from an outside hospital and arrived on 02/14/26 later in the evening. V1 said if the facility gets a new resident and they have a controlled substance like oxycodone and don't have a prescription for the it, they can request it from the physician. V1 said they have several physicians they can call and they always have an on-call physician as well. V1 said they have an emergency medication bank kit at the facility they can pull from if it is past the cut off for the pharmacy delivery date. V1 said they also have emergency runs for medications, although they generally don't have to use it but they could have had R1's oxycodone delivered via emergency run. V1 said she doesn't think R1 came with a script for the oxycodone. V1 said the nurses should have gotten a hold of another provider to get a script for the oxycodone so they could have gotten the medication. On 02/26/26 at 10:34AM, V4 (Vice President of Operations) stated that the nurses should have gotten a hold of a physician and gotten a script for R1's oxycodone. V4 said that R1 should have come with a script from the hospital for the oxycodone. On 02/26/26 at 11:48AM, V15 (Family Member) stated that R1 arrived at the facility on (Saturday) 02/14/26 later in the evening after being discharged from a local hospital. V15 said that R1 had been in the hospital due to sustaining several fractures from a fall at her previous nursing home placement and was in horrible pain. V15 said that the facility did not get R1's oxycodone until around 2 days later. V15 stated that R1 was alert and could state that she was in pain the whole time until they were able to get her oxycodone. V15 said that they did give R1 some Tylenol but that didn't work at all for her pain. V15 said that she doesn't understand why it would take so long to get R1 pain medication. V15 verified that R1 was no longer at this facility as she wanted to discharge and go to another facility with in house dialysis so that she didn't have to be transported back and forth to dialysis due to the pain it would cause. On 02/26/26 at 1:36PM V8 (Licensed Practical Nurse/LPN) stated that they do have a problem at times with getting controlled prescription pain medications from the pharmacy. V8 said that since they have had the new pharmacy this has been a problem. V8 said that when a new resident comes into the facility, sometimes the pharmacy will deliver the new residents' medications on time and other times they do not. V8 said that it is not a problem with the provider writing the prescriptions, they are always good at writing the prescriptions, it is the pharmacy. On 03/02/26 at 9:52AM, V5 (Registered Nurse) stated she took care of R1 for one day. V5 said she did call the pharmacy several times on 02/16/26. V5 said she doesn't like the new pharmacy (continued on next page)</p>		

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  03/04/2026
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and the pharmacy was acting like they didn't have a prescription for R1's oxycodone, but they did have a prescription for the oxycodone. V5 said she was calling the nurse practitioner and on-call physician trying to get a script and the pharmacy already had a prescription for it. V5 said the pharmacy told her they did find the prescription. V5 said R1 was in a lot of pain and V5 gave R1 some Tylenol because that is all she had to give R1 for pain. V5 said R1 did not get her oxycodone on 02/16/26. V5 said she did request an emergency run for R1's oxycodone, but the pharmacy did not do one. V5 said whoever put a 0 down on R1's pain level scale was not telling the truth because R1 was always having pain. V5 said there is no excuse why they didn't try to get R1 pain medication over the weekend. V5 said it was probably agency that was working. V5 said she doesn't know why the pharmacy did not bring R1's oxycodone when she requested the emergency run either. V5 stated they do have oxycodone 5mg in the emergency medication bank kit. V5 said she doesn't know why the hospital didn't send a script for the oxycodone when they discharged R1 to the facility. V5 said when she calls the physician or the on-call doctor they are usually pretty good about getting the prescription sent right away. V5 said R1 was crying when she worked and had a 10 out of 10 on the pain scale. V5 said she was trying everything she could to try to get R1's pain under control. V5 said she thought she took an oxycodone 5mg out of the emergency medication bank kit to give to R1. On 03/02/26 at 10:04AM, V2 (DON) was at the emergency medication bank and tried to log in to see if she could pull up the screen for oxycodone. V2 was able to pull up the screen on the emergency medication bank that showed oxycodone 5mg IR (Immediate release), however the quantity showed blind, which means the machine will not disclose the amount of medication in the bank. On 03/02/26 at 10:05AM, V2 stated she doesn't know if R1's oxycodone was IR or not. V2 stated if it wasn't, the nurses could have gotten a script for it to give R1 one until her oxycodone came in. V2 said she knew they dropped the ball on getting R1's oxycodone. V2 said to find out how many controlled substances they have in the emergency medication bank, they have to call V12 (Emergency Medication Bank Representative) and he will provide a code when there is an active script to be able to get the medication out of the emergency medication bank. On 03/02/26 at 10:19AM, V11 (Pharmacy Customer Service) stated R1 did not receive her oxycodone until 02/17/26 (three days after admission). V11 said they did not receive an active prescription for the oxycodone 5mg until 02/16/26 (two days after admission). V11 said no staff from the facility requested an emergency run of R1's oxycodone. V11 said the nurses at the facility could have requested to get the oxycodone out of the emergency medication bank. V11 stated she doesn't see where anyone from the facility requested to get oxycodone out of the emergency medication bank. V11 said the emergency medication bank should have oxycodone 5mg in it. On 03/02/26 at 10:29AM, V12 (Emergency Medication Bank Representative) stated he is the person who the facility would contact to access any medications out of the emergency medication bank. V12 stated the emergency medication bank does contain oxycodone 5mg IR at the facility. V12 stated no staff at the facility requested to get any oxycodone out of the emergency medication bank from 02/14/26 until now. V12 said if they had a prescription for the oxycodone, he could have given the facility a code and they would have had the oxycodone to give to R1. On 03/02/26 at 10:57AM, V7 (Agency Licensed Practical Nurse/LPN) stated she took care of R1 on 02/15/26. V7 stated she talked to V3 (ADON) about R1's oxycodone not being available. V7 said V3 told her R1's medication could be pulled from the emergency medication bank. V7 said she doesn't have access to the emergency medication bank because she is an agency nurse. V7 said she didn't get much report from the nurse working before her about R1. V7 said she did give R1 some Tylenol because she was really hurting. V7 said she called the pharmacy and tried to get R1's oxycodone and she let the night shift nurse know she called the pharmacy and requested R1's oxycodone. V7 said she feels like Tylenol did help manage R1's pain some. V7 said she talked to V3 about R1's oxycodone and V3 is who showed V7 the standing orders they had for Tylenol, so V7 was able to write an order for the Tylenol to be able to give R1 some. V7 said she thought they had oxycodone in the emergency medication bank but wouldn't have been able to pull it. V7 said even after she called the pharmacy (continued on next page)</p>		

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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.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and requested the oxycodone they still did not bring R1's oxycodone. On 03/02/26 at 11:24AM, V3 (ADON) stated she doesn't remember talking to V7 about R1's oxycodone. V3 said she does remember talking to V17 (LPN) on 02/14/26 about R1's medications. V3 said R1 arrived late on 02/14/26 and the orders wouldn't make it until the next day because R1 got to the facility too late. V3 said she told V17 to get a hold of the pharmacy for an emergency run to get R1's medications. V3 said she thought V17 told her they didn't have oxycodone in the emergency medication bank. V3 said when R1 was admitted to the facility V3 had only been in her position for about 2 weeks. V3 said evidently, they did not do an emergency run on R1's medications. On 03/04/26 at 1:20PM, V18 (V16's Nurse) stated the first time anyone from the facility requested a script for R1's oxycodone was on 02/16/26 at 3:49PM. V18 stated a prescription was sent over to the pharmacy at 4:47PM by one of their providers. V18 said they do not have record of any other request from the facility for a script for R1's oxycodone other than on 02/16/26. V18 said the facility also sent a pulse which is a communication system the facility uses, on 02/16/26 notifying the providers of a new admission for R1. The facility policy titled Medication Administration undated documents under Procedures, #21 - If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Like medications are not to be Borrowed from one resident for another. The Pharmacy policy titled Medication Orders Controlled substance prescriptions documents under policy: Medications included in the Drug Enforcement Administration (DEA) classifications as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription to ensure delivery of medication. The director of nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications. The Pharmacy policy titled Medication ordering and Receiving from Pharmacy #4 Stat and emergency medications are ordered as follows: during regular pharmacy hours, the pharmacy is notified of the emergency or stat order; the order is then phoned, sent electronically, or faxed to the pharmacy. The nurse must call the pharmacy to request a STAT order. STAT medications are delivered within 4 hours of verbal order by nurse for a STAT order, unless extenuating circumstances arise and facility is notified. If available, the initial dose is obtained from the emergency kit, when necessary. B. if after hours, medications should be ordered as outlined in the emergency pharmacy service and kits policy.</p>		