

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 03/19/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for 1 residents of 9 residents (R68) reviewed for call light response in a sample of 51. The findings include: R68's admission Record documents an admission date of 3/13/26 and a discharge date of 3/18/26, with the following diagnoses in part; cerebral atherosclerosis, blindness in right eye category 5, blindness in left eye category 5.R68's Minimum Data Set (MDS) was incomplete due to being a new admission.R68's care plan documents that she is at high risk for falls intervention to include anticipate and meet her needs, be sure her call light in within reach and encourage the resident to use it for assistance as needed, be aware of blindness.03/16/2026 at 10:01AM R68's call light was observed on. V9 (Certified Nursing Assistant/CNA) responded promptly. V12 (Family Member) stated to V9 that R68 needed to use the restroom. V9 stated that she was the only one on the hall, R68 was a two assist and it would be a minute. V9 shut the call light off and left the room without toileting R68. On 3/16/2026 at 10:22am, V10 (CNA) stated that R68 had been toileted after breakfast and then laid down. V10 stated she had not been toileted since then. V10 stated that R68 is technically a one assist, but that morning she was having trouble with her legs, and they were using two. On 3/16/2026 at 10:24am, continuous observations of R68's room began.On 3/16/2026 at 10:41am, R68's call light came on. On 3/16/2026 at 10:42am, V10 answered R68's call light and toileted R68.On 3/19/2026 at 11:08am V9 stated they like to have three aides on the hallway, but there are only two at times. V9 stated there are residents on the hallway that require the assistance of two staff. V9 stated if there is only one available, they can ask the nurse or a staff member from the other side.On 3/19/2026 at 11:21am, V10 stated they should have 3 aides on the hallway, but sometimes they only have two. V10 stated if there are two aides on the hallway and they need assistance with a resident; they can get the nurse or a CNA from the other side depending on who's working.On 3/19/2026 at 1:16pm, V2 (Director of Nursing/DON) stated if a resident put on their call light to use the restroom and staff had to get another staff member to transfer, a 40 min wait time until they are toileted is not acceptable, they should be grabbing the nurse or another qualified staff member. V2 stated staffing should never prevent someone from getting out of bed.The facility policy titled Dignity with a revision date of 4-23-2018 with a guideline that states: The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</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
---	-------	-----------

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 03/19/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide enough staff to supervise and attend to the needs of the residents in a timely manner. This failure has the potential to affect all 70 residents that reside in the facility. Findings include:</p> <p>1. R53's admission record documents an admission date of 9/15/2025 with the following diagnoses in part; Cerebral infarction due to thrombosis of right middle cerebral artery, hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side, age-related physical debility.</p> <p>R53's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 15, indicating that R53 is cognitively intact. Section GG documents R53 has an impairment of lower extremities on both sides, requires substantial to maximum assistance with transfers. R53's MDS documents R53 requires supervision or touching assistance with eating.</p> <p>R53's care plan documents that he requires supervision with meal consumption and has an ADL (Activities of Daily Living) self care deficit. R3's care plan documents R53 needs assistance or is dependent in: transfer, dressing and toilet use.</p> <p>On 3/16/26 at 9:10am, R53 was lying in bed and stated he participates in activities, and they are good when staff allows him to get in his chair. R53 stated if he gets up and, in his chair, he might as well plan on staying in it for the day. R53 stated if he doesn't get out of bed in the morning, he may as well plan on staying in there. R53 stated staff always tells him they need two people to transfer him, and someone is always on break or going on break or they do not have enough staff.</p> <p>On 3/16/26 at 12:50pm, R53 was observed lying in bed eating in his room alone, without supervision.</p> <p>On 3/17/26 at 10:03am R53 was observed lying in bed.</p> <p>On 3/17/26 at 1:07pm, R53 was observed lying in bed eating in his room alone, without supervision.</p> <p>On 3/17/26 at 2:27pm, R53 was lying in bed and stated he asked to get out of bed in the morning, and they told him that it was fine, but don't expect to get back into bed until after lunch.</p> <p>On 3/18/26 at 12:40pm, R53 was lying in bed and stated he did not even ask to get out of bed today. R53 stated what's the point They are just going to make him stay in the chair all day. R53 stated he starts hurting after a couple of hours of being stuck in his chair.</p> <p>On 3/18/26 at 12:47pm, R53 was observed lying in bed eating in his room alone, without supervision.</p> <p>On 3/19/26 at 12:33pm, R53 was observed lying in bed eating in his room alone, without supervision. At that time R53 stated that he always eats in his room alone if he stays in bed. R53 stated he does not have supervision when eating.</p> <p>On 3/19/26 at 2:46pm R53 was lying in bed.</p> <p>2. R68's admission Record documents an admission date of 3/13/26 and a discharge date of 3/18/26, (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 03/19/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>with the following diagnoses in part; cerebral atherosclerosis, blindness in right eye category 5, blindness in left eye category 5.</p> <p>R68's Minimum Data Set (MDS) was incomplete due to being a new admission.</p> <p>R68's care plan documents that she is at high risk for falls intervention to include anticipate and meet her needs, be sure her call light in within reach and encourage the resident to use it for assistance as needed, be aware of blindness.</p> <p>03/16/2026 at 10:01AM R68's call light was observed on. V9 (Certified Nursing Assistant/CNA) responded promptly. V12 (Family Member) stated to V9 that R68 needed to use the restroom. V9 stated that she was the only one on the hall, R68 was a two assist and it would be a minute. V9 shut the call light off and left the room without toileting R68.</p> <p>On 3/16/2026 at 10:22am, V10 (CNA) stated that R68 had been toileted after breakfast and then laid down. V10 stated she had not been toileted since then. V10 stated that R68 is technically a one assist, but that morning she was having trouble with her legs, and they were using two.</p> <p>On 3/16/2026 at 10:24am, continuous observations of R68's room began.</p> <p>On 3/16/2026 at 10:41am, R68's call light came on.</p> <p>On 3/16/2026 at 10:42am, V10 answered R68's call light and toileted R68.</p> <p>On 3/19/2026 at 11:08am V9 stated they like to have three aides on the hallway, but there are only two at times. V9 stated there are residents on the hallway that require the assistance of two staff, if there is only one available, they can ask the nurse or a staff member from the other side. V9 stated R53 is set-up assistance for meals.</p> <p>On 3/19/2026 at 11:21am, V10 stated they should have 3 aides on the hallway, but sometimes they only have two. V10 stated if there are two aides on the hallway and they need assistance with a resident; they can get the nurse or a CNA from the other side depending on who's working.</p> <p>On 3/19/2026 at 1:16pm, V2 (Director of Nursing/DON) stated if a resident put on their call light to use the restroom and staff had to get another staff member to transfer, a 40 min wait time until they are toileted is not acceptable, they should be grabbing the nurse or another qualified staff member. V2 stated staffing should never prevent someone from getting out of bed. V2 stated her expectation for a resident requiring supervision at meals would be for them to be in the dining room if someone could not always be present in the room during the meal.</p> <p>3. R69's admission record documents an admission date of 12/01/25 with diagnoses of unspecified focal traumatic brain injury with loss of consciousness, recurrent depressive disorders, anxiety disorder, personal history of traumatic brain injury, dementia, schizoaffective disorder, and convulsions.</p> <p>R69's MDS (Minimum Data Set) dated 12/10/25 documents in Section C a BIMS (Brief Interview of Mental Status) score of 99, which indicates R69 is severely cognitively impaired. Section GG documents eating as supervision and touching assistance and walking as supervision and touching assistance. (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 03/19/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R69's Care plan documents a focus area of : I am an elopement risk/wanderer related to Traumatic brain injury, date initiated 2/13/26. Interventions include distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television book. Know that he does not stay engaged and will wander off from activity/meal/task. Document wandering behavior and attempted diversional interventions in the behavior log. All initiated 2/16/26. Another focus area includes: I am at risk for fall/injury related to wandering/poor safety awareness, seizure potential. Date initiated 12/12/25. Interventions include staff to observe resident's whereabouts frequently throughout their shift. Date initiated 12/12/25. Another focus area includes: I have a behavior problem, entering other resident rooms and taking other resident items at times with a date initiated as 12/1/25. Interventions include redirect R69 when he is occupying other resident bed in other resident room, redirect R69 when he is wandering into other resident rooms and anticipate and meet the resident's needs. R69's Care plan did not address any concerns related to abuse or potential for abuse or any additional behaviors. R69's Care plan was revised on 3/17/26 to include a focus area of: I have a behavior problem, I take other resident food/resident trays at mealtimes.</p> <p>R69's psychiatry note dated 02/18/26 documents: chief complaint: staff report several concerning behaviors including wondering in and out of others rooms, pacing without rest, inappropriate sexual behaviors, stealing other residents things from there room as well as there (sic) food at mealtimes, digging in and eating things out of the trash. R69 becomes physically aggressive with any attempt a (sic) redirection.</p> <p>On 03/16/26 at 12:53PM observed R69 walking in the dining room. Observed R69 walk over to R14's table where he took R14's brownie off of R14's plate and began eating R14's brownie right in front of R14.</p> <p>On 03/17/26 at 12:06PM observed R69 grab R70's dessert of fruit crisp off the table. Observed R69 eating R70's fruit crisp as staff were trying to take R70's fruit crisp away from R69.</p> <p>On 03/17/26 at 12:10 PM R69 was directed out of the dining room by V6 (Licensed Practical Nurse) and V5 (Certified Nurse Aide/CNA).</p> <p>On 03/17/26 at 12:11 PM R69 left the dining room.</p> <p>On 03/17/26 at 12:11 PM V5 stated, there are no staff on the hallways to supervise R69.</p> <p>On 03/17/26 at 12:11 PM - 12:27 PM there were no staff observed on the hallways.</p> <p>On 03/17/26 at 12:26 PM R69 came out of R70's room with a bag of chips he opened and started eating and a square bottle of fingernail polish remover (that looked very similar to a drink bottle) in his hands.</p> <p>On 03/17/26 at 12:27 PM surveyor was able to convince R69 into giving the bottle of fingernail polish remover to her.</p> <p>On 03/17/26 at 12:31PM observed R69 in the dining room eating off R70's plate and R70 was trying to take the plate back and food was going all over the table. Observed R69 trying to eat the food off the plate and R70 was twisting and shaking his arm.</p> <p>On 03/17/26 at 12:42 PM V6 stated, R69 has come behind the nurses' station grabbed sodas and (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 03/19/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>chips. R69 stated he can open them both and will walk the halls and eat and drink them.</p> <p>On 03/17/26 at 12:43 PM observed R69 in his room eating off a plate that had mashed potatoes and peas on the plate. R69's designated and assigned plate did not have peas and mashed potatoes on it.</p> <p>On 03/17/26 at 12:47 PM, V5 (CNA) stated that some days she will have to remove up to 15 different plates out of R69's room where he has stolen plates off of the table in the dining room or taken some other resident tray.</p> <p>On 03/17/26 at 1:09 PM R69 entered the dining room on the north side entrance, walked part way through the dining room and picked up a plate a resident had eaten off of. R69 then took a few bites off of the plate and walked on. R69 set that plate down, picked up another plate that a different resident had already eaten from started eating from that plate and walked out of the dining room with the plate of food back to his room and ate the rest of the food with no staff present in the dining room.</p> <p>On 03/17/26 at 1:12 PM R69 entered the dining room on the north side entrance, walked part way through the dining room and picked up a plate a resident had eaten from. R69 then took a few bites off of the plate and walked on. R69 then picked up a cup that a resident had already drank from, drank out of the cup and took both items back to his room, drinking out of the cup while walking down the hallway with no staff in the dining room.</p> <p>On 03/18/26 at 11:59AM observed R69 climb over the nurses' station countertop. R69 then got behind the nurse's station and moved the treatment cart away which was in the locked position from a closet door that was located behind the nurse's station. R69 then went inside of the door that had snacks, activity supplies, personal staff items and medical supplies. R69 grabbed a small open bag of potato chips out of the closet and started eating the potato chips. No staff were observed around the nursing station.</p> <p>On 03/18/26 at 12:04PM, V8 (Laundry) stated that she just saw R69 climbing over the countertop at the nurse's desk and she went and got a certified nurse assistant out of the dining room to help R69 since there was no staff around.</p> <p>On 03/18/26 at 12:14PM observed R69 take R14's nutritional ice cream off the table while R14 was eating his food on his plate.</p> <p>On 03/19/26 at 11:29 AM, R69 walked down the hall, stopped at the locked nurses' station, sat down on the counter, turned around on the counter facing into the nurses' station, put his feet on the floor inside the locked nurses' station and entered inside of the locked nurses' station. R69 moved the treatment cart and opened the closet. R69 opened plastic bags, opened boxes and looked through several items in the closet, with no staff in sight.</p> <p>On 03/19/26 at 11:31 AM, V16 (CNA) walked past the nurses' station but did not see R69 in the closet behind the locked nurses' station.</p> <p>On 0/19/26 at 11:32 AM, V5 (CNA) entered the east side unit from the side door, saw R69 behind the nurses' station, went behind the nurses' station, found a small bag of miniature marshmallows, handed R69 the marshmallows and R69 left the nurses' station.</p> <p>On 03/19/26 at 10:48AM, V6 (Licensed Practical Nurse) stated that she has observed R69 on several (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 03/19/2026
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>occasions climbing over the nurse's station and moving the treatment cart and getting into the closet to find himself a snack.</p> <p>On 03/19/26 at 10:35AM, V14 (CNA) stated that R69 has climbed over the nurse station multiple times, and he will move the treatment cart and get into the closet behind the nurse's station. V14 said that R69 will get into the closet and take out all kinds of things that he finds that might be a snack. V14 said that she has heard that he has also climbed into the kitchen window and tried to get food. V14 stated that she has never observed this but has heard about it.</p> <p>On 03/19/26 at 10:43AM, V4 (Dietary Manager) stated that he has observed R69 climbing into the kitchen from the serve out window and from the dirty dish window. V4 said that R69 has gotten into the kitchen and they had to get R69 out of the kitchen. V4 said that they have tried to keep the dirty dish window closed now or just half open so that R69 doesn't get into the window when staff is preparing the meals and doesn't see R69 trying to get into the kitchen. V4 said that R69 has done it several times, the last time was a couple of weeks ago.</p> <p>On 03/19/26 at 10:45AM, V15 (Dietary Aide) state that R69 has come into the kitchen several times when he has been working. V15 said that last time that R69 was in the kitchen was a couple of weeks ago. V15 said that R69 will crawl into the serving window or the dirty dish window.</p> <p>On 03/19/26 at 10:55AM observed the dirty dish window which appeared to be at least 3 feet off the ground as well at the serve out window.</p> <p>On 03/19/26 at 1:45PM, V1 (Administrator) stated that she feels like R69 climbing over the nurse's station and into the kitchen is more a hazard for the staff then the resident. V1 stated that, R69 is very agile and he is very hard to re-direct, so I feel like staff is more at risk with trying to get the resident out of the kitchen or trying to get him away from somewhere.</p> <p>Undated facility policy titled Corporate Compliance Plan, documents the following under the section titled, Quality of Care: The facility strives to consistently and fully comply with the various laws and regulations pertaining to the treatment, services and needs of residents to attain or maintain residents' highest practicable physical, mental and psychosocial well-being. Because they are so integral to maintaining this well-being, the following areas are deemed to be priorities for focus on quality of care . provide adequate staffing levels and sufficiently trained or supervised staff to properly deliver medical, nursing, and related services.</p> <p>Undated facility policy titled, Nurse staffing, documents the following: It is the policy of (Name of Facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well being of each resident.</p> <p>The Long-Term Care Facility Application for Medicare and Medicaid form dated 3/17/26 documents there are 70 residents currently residing in the facility.</p>		