STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. BUILDING B. WING	**08/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXIOM GARDENS OF MOUNT VERNON	**#5 DOCTORS PARK , MOUNT VERNON, Illinois, 62864**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	INITIAL COMMENTS Facility Reported Incident of 8/1/25- 2583991	F0000		09/02/2025
S9999	FINAL OBSERVATIONS Statement of Licensure violations: 300.610a) 300.1210b) Section 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		09/02/2025

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 reverse for further 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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S9999	Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: 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	S9999		

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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

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

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S9999	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 housekeeping and was on the unit the day of the incident with R1 and R2. V7 stated he saw R1 walk up to the nurse's station and saw his nose bleeding. V7 stated R1 then stated, "He hit me and broke my nose." V7 stated R2 was walking up the hall behind R1. V7 stated when R1 saw R2 he went to him and hit him in the chest. V7 stated the nurse was there and we separated the two residents. On 8/8/2025 at 12:33PM, via phone interview V9 (LPN) stated he was the nurse working the unit the evening that R1 and R2 had a peer-to-peer incident. V9 stated R1 came up to the nurse's station and his nose was bleeding and crooked. V9 said the next thing that happened was R2 came walking up behind R1 and when R1 saw R2 he went towards him. V9 stated he did not see R1 hit R2 as he was trying to get to them to separate them. V9 stated he did not see R2 hit R1 either but R2 had blood on his hand and in between fingers. V9 stated he assessed both residents and made notifications. V9 stated both residents were sent to separate hospitals.V9 stated R1 was sent to the Emergency Room to get checked for his injury to his nose and R2 was sent to a different hospital for a Psychiatric Evaluation. V9 stated he was off shift when the residents returned from the hospital.	S9999		

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S9999	On 8/8/2025 at 1:05PM, V2 (Director of Nursing) stated she was in the facility the evening the incident occurred between R1 and R2. V2 stated she came over immediately and helped send both residents out to the hospital. V2 stated both residents ambulate independently. V2 stated sometimes R2 wanders into other residents' room but he is monitored to redirect when he does go into other rooms. V2 stated R2 doesn't talk much and when he does, he mumbles. V2 stated R1 talks but uses curse words a lot. On 8/8/2025 at 10:25AM, R2 was noted to be resting in bed with his eyes open. R2 was asked how he was doing and he mumbled something but not understandable. R2 would not answer any questions. On 8/8/2025 at 12:15PM, R2 was observed in his room walking around with only underwear on. R2 was asked a couple questions with no answers given. R2's Psychiatry Note dated 8/5/2025 documents the type of visit is an acute visit. Chief Complaints shows recent peer altercation. The history of present illness shows R2 is a 74-year-old male with a history of insomnia and dementia. The staff request due to recent altercation in which R2 ended up hitting another resident on the memory unit. At present R2 is pleasantly confused and a poor historian due to dementia. R2's speech described as word salad/mumbled. No medication changes were made at this time. R1 Psychiatry Note dated 8/5/2025 documents the type of visit is an acute visit. Chief complaint shows recent peer altercation. History of present illness shows R1 is a 56-year-old male with history of dementia, seen per staff request due to recent altercation in which another resident on the memory unit hit him. Will continue current regimen for now. Policy titled "Abuse Prevention and Reporting-Illinois dated 10/24/2022, documents, the facility affirms the right of our resident to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services y staff or mistreatment. This will be done by establishing an environment that remotes resident sensitivity, resident security and prevention of mistreatment. Abuse definition means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury. (B)	S9999		