

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/07/2026	
NAME OF PROVIDER OR SUPPLIER AXIOM HEALTHCARE OF MOUNT VERNON				STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WHITE STREET , 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 Complaint Investigations: 2653796/2967960 2653977/2971396		S0000			04/22/2026	
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by:		S9999			04/22/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Based on interview and record review the facility failed to ensure residents were free from abuse from staff for 1 of 3 residents (R1) reviewed for abuse and neglect in the sample of 11. This failure resulted in a staff member physically forcing a resident in to the residents room to keep R1 in R1's room multiple times causing R1 to knock on R1's door in attempts to have door opened and shutting the door causing bruising to R1's chest with vocal complaints of pain. R1's "Admission Record" documents an admission date of 11/27/13 with the following diagnoses listed in part; muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, severe intellectual disabilities, abnormal posture, age related osteoporosis without current pathological findings. R1's Minimum Data Set (MDS) dated 3/19/26 documents a Brief Interview of Mental Status (BIMS) of a 5 indicating R1 is severely cognitively impaired." Section GG – "Functional Abilities" documents that R1 is dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG documents that R1 is dependent on staff for transfers and uses a wheelchair. She also needs supervision or touching assistance for wheeling 150 feet in her wheelchair. R1's current care plan documents that R1 has impaired cognitive function/dementia or impaired thought processes and has a communication problem. R1's care plan does not document R1 as being at risk for abuse. R1's abuse/neglect screening dated 3/19/26 documents that R1 is at moderate risk for abuse. Facility Final report completed by V1(Administrator), dated 3/31/26 documents there was an incident on 3/24/26 with R1 of an injury on unknown origin with injuries including left index finger bruising. Follow-up/final report summary documents: "Investigation reveals that nurse on duty on that night shift had pushed resident into her room and shut the door, because resident was yelling in the lobby as other residents were passing by. Resident states that she was knocking on her door in her room, which resulted in bruising to her finger. Abuse substantiated, nurse immediately DNR (Do Not Return) from building. Staff educated about involuntary seclusion..." In R1's medical record an event record was opened on 03/25/2026 at 9:34pm by V1. This record			S9999			04/22/2026

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S9999	Continued from page 2 documented a bruise on R1's right hand that was 0.7 inches (in) (length), 0.5in (Width), and bruising to R1's left chest that was 5 inches in length, and 5inches in width. With vocal complaints of pain. Included in the facility investigation regarding the injury of unknow origin for R1 was an interview conducted with V1 (Administrator) and R1. This interview did not include a date or time of the interview. In this interview, V1 asked "What happen this morning with your nurse? R1 response, "My nurse, my room." V1 asked, "Your nurse took you to your room?" R1 responded "Yep." V1 asked, "then what?" R1 responded, "Shut the door." V1 stated, "Your nurse put you in your room and shut the door?" R1 responded, "Yep". V1 asked, "Why did she do that?" V1 responded, "My nurse, my room." On 3/31/26 at 10:03am, V6 (Certified Nursing Assistant/CNA) stated she came in the morning of 3/24/26, and the night shift aides grabbed her and stated that the night nurse locked R1 in her room several times that night and they kept having to let her out. V6 stated when she went to R1's room she could hear her barely knocking. V6 stated they opened the door and let R1 out. V6 stated she did not notice any bruising on her finger at that time but did notice it a few days later, along with the bruising to her chest. V6 stated that V7 and V8 were the CNA's that night and they told her that R1 had been up front hollering throughout the night. V6 stated R1 does holler a lot but it is usually when there is something wrong or she is asking for assistance. V6 stated that R1 has continued to point at the bruised areas and say nurse hurt me to basically any staff that will listen. V6 stated she did not think that R1 had the strength to cause the bruise on her chest, and at the time she opened the door for her, she was not knocking hard enough to have caused that. V6 stated R1 does not normally accuse staff of hurting her or fabricating stories. On 3/31/26 at 10:05am, V9 (Certified Nursing Assistant/CNA) stated that R1 has a bruise on her finger as well as a large healing bruise on her chest. V9 stated at one point the bruise looked very painful. V9 stated the first day she saw the bruise, she was with the nurse doing a skin check. V9 stated the nurse told her that a night shift nurse was trying to push her into her room and collided with the door. V9 stated that R1 has bruised herself before but it will be tiny, tiny ones. V9 stated it was nothing like that and R1 is not capable of hitting herself that hard in the chest. V9 stated she did not think that R1 could cause those bruises to herself. V9 stated R1 does not have a history of saying staff			S9999			04/22/2026

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S9999	Continued from page 3 hurt her. On 3/31/26 11:07am, R1 stated "Nurse hurt me," Nurse hurt me," while pointing to her chest and finger. On 3/31/26 at 1:07pm, a bruise was observed on R1's chest. It started just below her left clavicle, covers most of her breast and extends into her upper abdomen. It was a faint yellow color, and appeared to be in later stages of healing. There was also a faint bruise noted to her left index finger that started just under the cuticle and extended through the first and second joint. On 3/31/26 at 2:45pm, V5 (agency nurse) stated the night that the incident happened with R1, it was just two aides and V3 (agency nurse). V5 stated she worked the following night and discovered the bruise on R1's chest. V5 stated she called V1 to report it at approx. 4am and V1 stated she was not surprised she pokes herself all the time. V5 stated she told V1, no it is not like that, she could not have done this. V5 stated R1 does occasionally leave a tiny fingerprint sized bruise on herself, but she does not have the strength to have caused something like that. V5 stated she was told by the CNA's that R1 was sitting up front being noisy. V5 stated the CNAs told her they saw her up front and went down the hall to get up other residents and saw the nurse pushing her to her room at one point. V5 stated the CNA's reported they went down the hallway and she was in her room with the door shut. V5 stated they said they brought her up front and continued to get residents up, and when dayshift arrived, they found her in her room again with the door shut and mad as could be when they found her. V5 stated that R1 has been consistently saying that nurse did it, nurse hurt me. V5 stated it has been reported to administration by not only her, but other staff as well. On 4/1/26 at 10:51am, R8 (R1's Roommate) who was alert to person, place and time stated R1 can be noisy at times. R8 stated she remembers there was a night where she heard a lot of commotion with R1 with a staff member that she didn't know her name, but knew she was not here anymore after that. R8 stated she could not see what happened because it was at night and she had her curtain pulled, but there was something going on and then the door was closed and R1 was still in the room making a lot of racket. R8 stated that shortly after the commotion some of the other girls opened the door and R1 left. R8 stated the staff member was yelling at R1 and R1 was kind of hollering back, but that's all she could			S9999			04/22/2026

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S9999	Continued from page 4 really hear. On 4/1/26 at 11:03am, V7 (Certified Nursing Assistant/CNA) stated R1 was in the lobby hollering during the morning of 3/24/26. V7 stated that she and V8 went down the opposite hallway and continued to get people up. V7 stated when they came back up front, R1 was gone. V7 stated at this time V6, who is on day shift had arrived. V7 stated they started down the hallway R1's room is on and could faintly hear R1 yelling and knocking on the door. V7 stated they let R1 out of her room and she was so mad. V7 stated they brought her up front, and at this time she did not notice any bruises. V7 stated she was telling them that the nurse hurt her, nurse door, nurse my room, nurse hurt. V7 stated R1's hands were moving so fast it was hard to notice if the finger was bruised or not, she stated there was no bruise on her chest, but she continued to poke her chest and repeat everything she was saying about the nurse. V7 stated R1 was not able to open the door, because she has poor upper body strength. V7 stated she did not think the way R1 was poking her chest could have caused the massive bruise she had. On 4/1/26 at 11:48am, V4 (Registered Nurse) stated she came in the morning after the incident happened with R1. V4 stated she was under the impression that the nurse was upset because R1 was making too much noise whenever she was trying to pass meds, she stated that is just what R1 does is make noise. V4 stated if she is being loud, something is probably wrong. V4 stated when R1 saw her that morning she immediately pointed to her finger and chest. V4 stated R1's finger was red and swollen, she stated she pointed to the door and said, "Nurse did it." V4 stated there's no way R1 could have caused the bruising on the chest, occasionally she will cause a small bruise, but nothing to the extent of her bruises. V4 stated the night shift CNA's contacted V1, she did not directly contact her that day. V4 stated R1's bruise to her chest was large and looked painful. V4 stated R1 did not complain of pain. V4 stated R1 is not capable of opening the door. V4 stated the bruise on R1's chest was reported to V1 and V11 (Former Director of Nursing) on multiple occasions and nothing was done. On 4/1/26 at 1:11pm, V11 (Former Director of Nursing) stated on the morning of the incident involving R1, she was very angry and pointing to her chest saying her did it. V11 stated they were told by night shift staff that V3 took R1 to her room and closed the door. V11 stated as soon as administration was made aware, they started an			S9999			04/22/2026

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S9999	Continued from page 5 investigation. V11 stated V7 and V8, the night shift CNA's, said this happened twice. V11 stated it was confirmed that V3 put R1 in her room and closed her in there. V11 stated R1 was not capable of opening the door, she is not strong enough. On 4/1/26 at 1:24pm, V2 (Social Services Director) stated she came in the morning on 3/24/26 around 7:30am, and R1 was visibly upset. V2 stated that V7 and V8 reported V3 closed R1 in her room more than once that night. V2 stated R1 had a bruise on her finger but did not have bruise on chest at that time. V2 stated that R1 does not have a history of making false allegations towards staff. V2 stated that R1 does have a history of causing bruises to herself. V2 stated R1 could not open door. V2 stated R1 is not always easy to understand, but if you know her you can communicate easily with her. V2 stated she was not sure whether or not R1 was strong enough to leave the bruise, but R1 was poking herself pretty persistently saying nurse hurt, she stated she did not believe R1 could not open door On 4/1/26 at 3:05pm, V1 (Administrator) stated the incident with R1 was reported to police and the agency V3 worked for. V1 stated R1 would not have been able to open the door. V1 stated V3 was interviewed that day and asked not to come back immediately. An incident report from the local police department with a print date of 4/7/26 documents and incident were reported on 4/1/26 at 10:45AM. This report documents in the section titled, "involvement" it lists R1 as the victim and V3 as the offender. This report was authored by V14 (Police officer). Facility policy titled "Abuse and Retaliation Prevention and Reporting- ILLINOIS" with an effective date of 1/8/26 documents under policy; "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment." This policy documents under the section titled "definitions" documents "Unreasonable confinement or Involuntary seclusion means the separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative." "B"			S9999			04/22/2026