	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6004881	B. WING		12/19/2024	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
хюм н	EALTHCARE OF MO		IITE STREET VERNON, IL 6	2864		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 000	Initial Comments		S 000			
	Annual Licensure a	and Certification Survey				
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations 1 of 4				
	300.615e) 300.615f)					
		etermination of Need quest for Resident Criminal prmation				
	Section 2-201.5(a) facility shall, within resident, request a check pursuant to Information Act for admission to the fa check was initiated Hospital Licensing be based on the re and other identifier	he screening required by of the Act and this Section, a 24 hours after admission of a criminal history background the Uniform Conviction all persons 18 or older seeking icility, unless a background I by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, s as required by the te Police. (Section 2-201.5(b)	3			
	on the Illinois Sex (at www.isp.state.il. of Corrections sex	check for the individual's name Offender Registration website us and the Illinois Department registrant search page at s to determine if the individual ered sex offender.	3			
	This REQUIREME	NT is not met as evidenced by	:			
		and record review the facility criminal history background				
is Depart DRATORY	tment of Public Health ′ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE

	epartment of Public	Kaith (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	ESURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
		IL6004881	B. WING		12/	19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AXIOM H	IEALTHCARE OF MO			20004		
			VERNON, IL 6	PROVIDER'S PLAN OF ((XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
S9999	Continued From pa	age 1	S9999			
	admission, includir Offender Registrat Department of Cor page for 4 of 6 resi R197) reviewed for sample of 24.	ted within 24 hours after ng checking the Illinois Sex ion website and the Illinois rections sex registrant search idents (R97, R98, R99, and r criminal history records in a				
	Findings include:					
	1. R97's Face She date of 11/6/24.	et documented an admission				
	Offenders Program includes R97 as ar CHIRP (Criminal H Process) report wa	ment of Public Health Identified Facility report for this facility in identified offender. R97's listory Information Response is dated 11/6/24 with the result s a "hit" on the criminal history				
	of the Illinois Sex C Illinois Department facility provided do were not complete	acility was asked for evidence Offender Registry check, and of Corrections check. This cuments showed these checks d until 12/12/24, therefore were in 24 hours of admission.				
	2. R98's Face She date of 12/02/24.	et documented an admission				
	therefore was not of admission. In addit CHIRP documenta transposed R98's f	mentation was dated 12/10/24 completed within 24 hours of ion, it was also noted on the tion that the facility mistakenly irst and last name when eck, therefore not completing porrect individual.				
. –		et documented an admission				
ois Depar ATE FORI	tment of Public Health M		6899 2	44Q11	lf continua	tion sheet 2 c

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		IL6004881	B. WING		- 12/19/2024	
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		12/	19/2024
	EALTHCARE OF MO	1700 WF				
		MOUNT	VERNON, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	date of 12/03/24.					
		mentation was dated 12/10/24 completed within 24 hours of	.,			
	4. R197's Face She date of 11/25/24.	eet documented an admission				
	there was a "hit" or convictions and wa	umented a result indicating the criminal history with s dated 12/02/24, therefore within 24 hours of admission.				
	Manager/BOM) sta not been received to corporate office. V2	2:42 PM, V20 (Business Office ted R197's documentation had until 12/12/2024 from the 20 stated, she notified the Program via email on				
	documentation on I (Regional Director) residents' CHIRPs not completed time requirements. Whe responsible for con stated that they did completing these c	DPM, when shown the R97, R98, R99, and R197, V23 confirmed that these and/or registry checks were ly in accordance with the m asked who in the facility is ppleting these tasks, V23 n't have anyone in house hecks at the current time and aff complete this task.	3			
		(C)				
	Statement of Licen	sure Violations 2 of 4				
	300.625a) 300.625c)1)2) 300.625f)1)					

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		IL6004881	B. WING		12/19/2024	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 12/	
АХІОМ Н	EALTHCARE OF MO	UNT VERNON	IITE STREET VERNON, IL	62864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	age 3	S9999			
	300.625g)					
	Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks.					
	background check identified offender a	resident's criminal history reveal that the resident is an as defined in Section 1-114.01 ty shall do the following:				
	Police, in the form a	fy the Department of State and manner required by the e Police, that the resident is ar	ı			
		arrange for a riminal history record inquiry to e identified offender resident.				
		ders are residents of a facility, nply with all of the following				
	county and local lavidentity of identified	Il inform the appropriate w enforcement offices of the l offenders who are registered are residents of the facility.				
	0/	nall maintain written compliance with Section t.				
	This requirement is	not met by:				
	failed to ensure tim background check	and record review, the facility ely review of criminal history results, arrange for				
ois Depar	tment of Public Health		6899 2	244Q11	If continua	tion sheet 4 d

	epartment of Public		()(0) 1			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		IL6004881	B. WING		12/19/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	EALTHCARE OF MO	UNT VERNON 1700 WH	IITE STREET			
		MOUNT	VERNON, IL 6	52864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 4	S9999			
	within 72 hours, an identified offenders program for 2 (R97	riminal history record inquiry d ensure timely reporting of to the Identified Offender and R197) of 6 residents round checks in the sample of	F			
	Findings Include:					
	1. R97 Face Sheet date of 11/6/24.	documented an admission				
	Offenders Program includes R97 as an CHIRP (Criminal H Process) report wa	ment of Public Health Identified a Facility report for this facility a identified offender. R97's istory Information Response s dated 11/6/24 with the result s a "hit" on the criminal history				
		ne Resident Applicant at Form dated 11/11/2024.				
	Manager/BOM) sta documentation of s orders within the 72 she only had R97 s	1:15 PM, V20 (Business Office ated she is unable to produce scheduling R97's fingerprint 2-hour timeframe. V20 stated sign the consent prior to the p complete his fingerprints.				
	2. R197's Face Sho date of 11/25/24.	eet documented an admission				
	12/02/24, therefore documented a resu	umentation was dated was not completed timely and ult indicating there was a "hit" ory with convictions.	Ŀ			
	Fingerprint Conser	me Resident Applicant at Form dated 12/13/2024.				
ois Depar	tment_of Public Health M		6899 2	44Q11	lf continua	tion sheet 5 d

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6004881	B. WING		12/	19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
АХІОМ Н	EALTHCARE OF MO		TE STREET /ERNON, IL 6	2864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 5	S9999			
	Manager/BOM) sta documentation of s orders within the 72 she only had R97 s company arriving to On 12/12/24 at 3:30 confirmed that R19 timely. When asked responsible for com stated that they did completing these c offsite corporate sta On 12/17/2024 at 2 Manager/BOM) sta not been received to corporate office. V2	:17 PM, V20 (Business Office ted she is unable to produce cheduling R197's fingerprint 2-hour timeframe. V20 stated, igned the consent prior to the p complete his fingerprints. OPM, V23 (Regional Director) 7's CHIRP was not completed d who in the facility is npleting these tasks, V23 n't have anyone in house hecks at the current time and aff complete this task. 2:42 PM, V20 (Business Office ted R197's documentation had until 12/12/2024 from the 20 stated, she notified the Program via email on (C)				
	Statement of Licen	sure Violations 3 of 4				
	300.650d) 300.661					
		ersonnel Policies I check the status of all Health Care Worker Registry				
	Section 300.661 He Check	ealth Care Worker Background				
	A facility shall comp					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6004881	B. WING		12/19/2024	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IEALTHCARE OF MO		IITE STREET VERNON, IL 6	2864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ige 6	S9999			
		d Check Act and the Health ground Check Code.				
	These REQUIREM evidenced by:	ENTs are not met as				
	failed to ensure the and all required bac checked for employ	and record review the facility Healthcare Worker Registry ckground check websites were yees. This has the potential to nts residing at the facility.	•			
	Findings Include:					
	Application for Med	ng-Term Care Facility licare and Medicare" dated ented 48 residents reside in the	•			
	employee roster wi (Cook) date of hire status as active. V1 Registry check doc V12's work eligibilit not able to provide current documents Worker Registry, III the Department of the Department of Wanted Fugitive we	ded untitled, undated th hire dates documents V12's as 11/25/24 and employment 12's Healthcare Worker uments dated 6/25/2020, y as eligible. The facility was reproducible evidence of of checking the Healthcare inois Sex Offender Registry, Corrections Inmate Search, Corrections Sex Offender and ebsite, and/or the Office of s website for V12 prior to				
	employee roster wi (Certified Nursing A 11/1/24 and employ facility was not able	ded untitled, undated th hire dates documents V13's Assistant) date of hire as (ment status as active. The e to provide reproducible ng the Healthcare Worker				

INDIS DEPARTMENT OF PU ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	IL6004881	B. WING		12/19/2024	
ME OF PROVIDER OR SUPPL	.IER STREET A	ADDRESS, CITY, S	TATE, ZIP CODE	•	
XIOM HEALTHCARE OF	MOUNT VERNON	HITE STREET VERNON, IL 6	52864		
REFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
S9999 Continued From	n page 7	S9999			
Department of Wanted Fugitiv	Sex Offender Registry, the Corrections Sex Offender and e website, and/or the Office of ral's website for V13 prior to				
employee roste (Certified Nursi 11/11/24 and er facility was not evidence of che Registry, Illinois Department of Wanted Fugitive	rovided untitled, undated r with hire dates documents V14's ng Assistant) date of hire as nployment status as active. The able to provide reproducible ecking the Healthcare Worker s Sex Offender Registry, the Corrections Sex Offender and e website, and/or the Office of ral's website for V14 prior to	5			
employee roste (Certified Nursi 11/4/24 and em facility was not evidence of che Registry, Illinois Department of Wanted Fugitive	rovided untitled, undated r with hire dates documents V15's ng Assistant) date of hire as ployment status as active. The able to provide reproducible ecking the Healthcare Worker a Sex Offender Registry, the Corrections Sex Offender and e website, and/or the Office of ral's website for V15 prior to	5			
employee roste (Certified Nursi and employmer not able to prov checking the D	rovided untitled, undated r with hire dates documents V16's ng Assistant) date of hire as 7/2/2 nt status as active. The facility wa ide reproducible evidence of epartment of Corrections Sex te for V15 prior to 12/10/2024.	4			
	rovided untitled, undated r with hire dates documents V17's	S			

OF CORRECTION	IDENTIFICATION NUMBER:			1 0014	
		A. BUILDING:	·····	СОМ	PLETED
	IL6004881	B. WING		12/	19/2024
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IEALTHCARE OF MO		-	2864		
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 8	S9999			
employment status able to provide repr the Healthcare Wor Offender Registry, f Sex and Wanted Fu Office of Inspector prior to 12/10/2024 at 9 stated she had not worker background V15, V16 and V17 stated, she verified V12, V13, V14, V15 V1 stated, the facili healthcare worker background	as active. The facility was not roducible evidence of checking rker Registry, Illinois Sex the Department of Corrections ugitive website, and/or the General's website for V17 :53 AM, V1 (Administrator) completed the healthcare checks for V12, V13, V14, prior to their date of hire. V1 and printed all documents for 5, V16 and V17 on 12/10/2024 ty does not have a policy for background checks but, they				
do follow the health regulations.	(C)				
Statement of Licens	sure Violations 4 of 4				
300.1210a) 300.1210b) 300.1210c) 300.1210d)5)					
facility, with the par the resident's guard applicable, must de comprehensive car includes measurab meet the resident's and psychosocial n	ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (Housekeeper) data employment status able to provide reprise the Healthcare Word Offender Registry, Sex and Wanted Field Office of Inspector prior to 12/10/2024 On 12/11/2024 at 9 stated she had not worker background V15, V16 and V17 stated, she verified V12, V13, V14, V15 V1 stated, the facili healthcare worker b do follow the health regulations. Statement of Licens 300.1210a) 300.1210b) 300.1210c) 300.1210d)5) Section 300.1210 (Nursing and Person a) Comprehen- facility, with the par the resident's guard applicable, must de comprehensive car includes measurab meet the resident's	HEALTHCARE OF MOUNT VERNON 1700 WH MOUNT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 (Housekeeper) date of hire as 12/3/24 and employment status as active. The facility was not able to provide reproducible evidence of checking the Healthcare Worker Registry, Illinois Sex Offender Registry, the Department of Corrections Sex and Wanted Fugitive website, and/or the Office of Inspector General's website for V17 prior to 12/10/2024. On 12/11/2024 at 9:53 AM, V1 (Administrator) stated she had not completed the healthcare worker background checks for V12, V13, V14, V15, V16 and V17 prior to their date of hire. V1 stated, she verified and printed all documents for V12, V13, V14, V15, V16 and V17 on 12/10/2024 V1 stated, the facility does not have a policy for healthcare worker background checks but, they do follow the healthcare worker guidelines state regulations. (C) Statement of Licensure Violations 4 of 4 300.1210a) 300.1210b) 300.1210b) 300.1210c) 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	TOO WHITE STREET MOUNT VERNON, IL 6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 8 S9999 (Housekeeper) date of hire as 12/3/24 and employment status as active. The facility was not able to provide reproducible evidence of checking the Healthcare Worker Registry, Illinois Sex Offender Registry, the Department of Corrections Sex and Wanted Fugitive website, and/or the Office of Inspector General's website for V17 prior to 12/10/2024. S9999 On 12/11/2024 at 9:53 AM, V1 (Administrator) stated she had not completed the healthcare worker background checks for V12, V13, V14, V15, V16 and V17 prior to their date of hire. V1 stated, she verified and printed all documents for V12, V13, V14, V15, V16 and V17 on 12/10/2024. (C) Statement of Licensure Violations 4 of 4 300.1210a) 300.1210b) 300.1210b) 300.1210c) 300.1210c) 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	1700 WHITE STREET MOUNT VERNON, IL 62864 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF OF (EACH CORRECTIVE ACT) Continued From page 8 S9999 (Housekeeper) date of hire as 12/3/24 and employment status as active. The facility was not able to provide reproducible evidence of checking the Healthcare Worker Registry, Illinois Sex Offender Registry, the Department of Corrections Sex and Wanted Fugitive website, and/or the Office of Inspector General's website for V17 prior to 12/10/2024. Sey and Wanted Fugitive website, and/or the Office of Inspector General's website for V17 prior to 12/10/2024. In 12/10/2024. ON 12/10/2024. ON 12/10/2024. (C) Stated she had not completed the healthcare worker background checks but, they do follow the healthcare worker guidelines state regulations. (C) Statement of Licensure Violations 4 of 4 300.1210 General Requirements for Nursing and Personal Care (Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the In	1700 WHITE STREET MOUNT VERNON. IL 62364 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISCIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDENTS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 S9999 (Housekeeper) date of hire as 12/3/24 and employment status as active. The facility was not able to provide reproducible evidence of checking the Healthcare Worker Registry, the Department of Corrections Sex and Wanted Fugitive website for V17 prior to 12/10/2024. S9999 Office of Inspector General's website for V17 prior to 12/10/2024. On 12/11/2024 at 9:53 AM, V1 (Administrator) stated she had not completed the healthcare worker background checks for V12, V13, V14, V12, V13, V14, V15, V16 and V17 or 12/10/2024. V12, V13, V14, V15, V16 and V17 on 12/10/2024. V12, V13, V14, V15, V16 and V17 on 12/10/2024. V12, V13, V14, V15, V16 and V17 on 12/10/2024. V12, V13, V14, V15, V16 and V17 on 12/10/2024. V12, V13, V14, V15, V16 and V17 on 12/10/2024. (C) Statement of Licensure Violations 4 of 4 300.12100, 300.12100

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		11 000 4994	B. WING		401	10/10/2020	
	PROVIDER OR SUPPLIER	IL6004881	DDRESS, CITY, ST		12/	19/2024	
		1700 WH	ITE STREET	IATE, ZIP CODE			
AXIOM H	IEALTHCARE OF MO		VERNON, IL 6	2864			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLETI DATE	
S9999	Continued From pa	age 9	S9999				
	allow the resident to practicable level of provide for discharg restrictive setting b needs. The assess the active participal resident's guardian applicable. (Section b) The facility care and services to practicable physical well-being of the re each resident's corr plan. Adequate and care and personal	ensive assessment, which o attain or maintain the highes independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as n 3-202.2a of the Act) shall provide the necessary o attain or maintain the highes al, mental, and psychological usident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident.	t				
		care-giving staff shall review able about his or her residents' care plan.					
	nursing care shall i	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:					
	pressure sores, he breakdown shall be seven-day-a-week enters the facility w develop pressure s clinical condition de	rogram to prevent and treat at rashes or other skin e practiced on a 24-hour, basis so that a resident who vithout pressure sores does no cores unless the individual's emonstrates that the pressure dable. A resident having	t				
	pressure sores sha services to promote	all receive treatment and e healing, prevent infection, ressure sores from developing					

ND PLAN (OF OODDEOTION	(X1) PROVIDER/SUPPLIER/CLIA	(XZ) MULTIPLE	CONSTRUCTION		SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		IL6004881	B. WING		12/19/2024	
AME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ХІОМ Н	EALTHCARE OF MO					
			VERNON, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	age 10	S9999			
	These requirement by:	s were not met as evidenced				
	review the facility fa implement interven ulcers for 2 of 3 (R3 reviewed for pressu This failure resulted pressure ulcer to his	ion, interview, and record ailed to assess, treat, and tions to prevent pressure 33 and R18) residents ure ulcers in the sample of 24. d in R33 developing a Stage 3 is right Ischium and R18's left nd worsening/declining.				
	The Findings Includ	de:				
	admission date of 7 includes the following	record documents an 7/17/22. This same document ng diagnosis: Parkinsonism, ype 2, Dementia, and other I deficiencies.				
	11/15/24 Section C short term and long conducted by staff. documents that R3 toileting, hygiene an M0100 of this MDS developing pressur has unhealed press this assessment. S	nimum Data Set (MDS) dated 0700 documents R33 has a g term memory problem This same MDS Section GG 3 is dependent on staff for nd bed mobility. Section 6 documents R33 is at risk for re ulcers/injuries and that he sure ulcer/injury at the time of ection H, Bladder and Bowel, 3 always has urinary and				
		e dated 8/16/24 documents a indicates R33 is at high risk of				
		as a focus area with an 11/24, that R33 has potential				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		IL6004881	B. WING		12/19/2024	
	PROVIDER OR SUPPLIER		DRESS, CITY, S			
	FROVIDER OR SUFFLIER		TE STREET	IATE, ZIF CODE		
AXIOM H	IEALTHCARE OF MO		ERNON, IL 6	2864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	age 11	S9999	DEHOLNOT		
29999	impairment to skin of bowel and bladd area, with an initiati that R33 will maintar review date. Docum focus area include: lotion on dry skin P relief device for w/or risk assessment: B upon admission or quarterly and PRN, with documentation documents a focus 7/11/24 of "the reside mobility related to F arthritis." The goal, 11/21/24 for this focus will remain free of or immobility, including formation, skin breat through the next ref for this focus area i resident request ref restoratives as order bearing and up as r R33's Wound Asse date 11/4/24, docum Practitioner) lists a injury with an onset wound that is in the treatment. The treat includedpreventa air mattress and pro cushion, and to offi- assessment also do Stage 3 pressure in	integrity relate to incontinence er. The goal for this focus ion date of 7/11/24, documents ain clean and intact skin by the nented interventions for this Keep skin clean and dry, use RN (as needed), pressure c (wheelchair) and bed, skin raden Scale weekly x 4 weeks readmission and then and weekly skin assessment n. R33's Care Plan also area with a revision date of dent has limited physical Parkinson's, weakness, and with a revision date of cus area, is that "the resident complications related to g contractures, thrombus akdown, fall related injury view date." The interventions includes: 1/2 side rails per lated to safety, nursing ered, the resident is weight needed with one assist. essment and Plan, with a visit mented by V24 (Nurse left ischium Stage 3 pressure t date of 10/21/24 for the e Active/initial phase of atment order ative wound recommendations: essure reduction chair oad as tolerated. The same ocuments a right ischium hjury with an onset date of ad measurements of 2.1 cm.				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IL6004881 STREET A		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IL6004881	B. WING		12/	12/19/2024	
		STREET AI	L DDRESS, CITY, STATE, ZIP CODE		• • •		
хюм н	EALTHCARE OF MO		ITE STREET VERNON, IL 6	2864			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From page 12		S9999				
	wound recommendations of air mattress and pressure reduction cushion.						
	of 11/19/24, docum ischium Stage 3 pro- date of 10/17/24. To preventative wound air mattress and a cushion. The same a left ischium Stage onset date of 10/21 for preventative wo	ent and Plan, with a visit date nented by V24 that a right essure injury with an onset Treatment order for d recommendations include an chair pressure reduction assessment also documents e 3 pressure injury with an 1/24 is healed. Treatment order ound recommendations include d chair pressure reduction					
	of 11/26/24, docum ischium Stage 3 pro date of 10/17/24 is preventative wound	ent and Plan, with a visit date bented by V24 that a right essure injury with an onset healing. Treatment order for d recommendation includes an hair pressure reduction					
	of 12/3/24, docume Assistant) that a rig right Ischium with a stable with measur 2cm. Width x 0.1 c for preventative wo	ent and Plan, with a visit date ented by V18 (Physician ght Stage 3 pressure injury to an onset date of 10/17/24 is ements of 3.3cm. Length x m. Depth. Treatment ordure ound recommendation includes hair pressure reduction					
	stated that the wou leaves their progres in the chart. V2 we	0 PM, V2 (Director of Nursing) nd group that comes in weekly ss notes and orders to be filed ent on to state that those are sician orders and are to be					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ILE0004881		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6004881	B. WING		12/19/20	24
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IEALTHCARE OF MO		IITE STREET VERNON, IL 6	2864		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	MPLET DATE
S9999	Continued From pa	age 13	S9999			
	seen on a mattress air mattress. On 12 (Registered Nurse) air mattress nor did relieving cushion of on to state that she	/24, R33 was observed to be s that was scooped but not an 2/11/24 at 11:30AM, V4) confirmed that this was not ar d R33 have an extra pressure n his wheelchair seat. V4 went e has not seen a cushion in nd this is the scoop mattress				
	made of R33 at: 8 2:30 PM and 3:30P	nittent observations were :30AM, 11:00 AM, 12:00 PM, PM in his wheelchair with no cushion in his wheelchair.				
	made of R33 at: 8: eating breakfast in his chair, 8:58AM in the wheelchair with 9:30 am in his roon wheelchair with no AM in his room in f	nittent observations were 05 am in the dining room his wheelchair with no pad in n the hallway by his room in n no pressure reduction pad, n in front of the television in his pressure reduction pad, 9:51 ront of television in his				
	AM in his room in f wheelchair with no AM in room in front with no pressure re dining room in his v	pressure reduction pad, 10:40 ront of television in his pressure reduction pad, 11:05 t of television in his wheelchair eduction pad, 12:50 PM in wheelchair with no pressure ble, 1:20 PM by his room in				
	hallway in his whee reduction pad, 1:40 his wheelchair with 1:53 PM by room in	 PM by his room in hallway in PM by his room in hallway in no pressure reduction pad, n hallway in his wheelchair eduction pad stated that he was 	5			
	got up at 5 am and the bathroom and b took to bingo still in	that is the last time he went to been out of this chair, 2:06 PM o chair, 2:47pm still in bingo or of Nursing) that R33 had				

Illinois D	epartment of Public	Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IL6004881	B. WING		12/1	9/2024		
NAME OF PROVIDER OR SUPPLIER STREET AU			DDRESS, CITY, STATE, ZIP CODE					
		1700 WH	ITE STREET					
	IEALTHCARE OF MO	MOUNT VERNON	/ERNON, IL	62864				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
S9999	Continued From page 14		S9999					
	repositioning, and 3	nce 5 AM with no peri care or 3:03 PM R33 was transferred o bed and peri care was						
	Assistant) stated th did not have the red the mattress to pro stated that these in weight and aide in	OPM, V18 (Wound Physician hat she was not aware that R33 commended seat cushion or mote wound healing. V18 terventions help off load the wound healing. V18 stated at l expect them to follow the doctor orders.						
	that she found a ge	0PM, V1 (Administrator) stated I pad that fits the wheelchair tart using that for R33 when he vheelchair.						
		(B)						
Illinois Department of Public Health STATE FORM		6899	244Q11	If continuatior	n sheet 15 of 15			