STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Gardens of Nashville	485 South Friendship Drive Nashville, IL 62263

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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident representative after the resident was found outside of the facility for 1 of 3 residents (R4) reviewed for representative notification in a sample of 10. Findings Include: R4's Face Sheet, print date of 12/02/25, documented R4 has diagnoses of but not limited to Alcohol dependence with alcohol induced persisting dementia, Wernicke's encephalopathy, and chronic kidney disease, stage3.R4's Minimum Data Set (MDS), dated [DATE], documented R4 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of two out of 15 and is independent with ambulation. R4's Progress Notes, dated 10/16/2025 at 8:15 PM, documented Nurses Note Text: Around 1815 (6:15 PM), resident was found by CNA (Certified Nursing Assistant) outside by the dumpster. Door alarm and (electronic monitoring device) were sounding. CNA heard the alarm and immediately went to check on alarm. Alarm sounded until this nurse turned it off. Doors at the top of (specified hall) were closed to help resident stay on the hall while meds were being passed and residents were being put to bed. Another CNA has walked around with resident. Snacks and fluids have been offered, taken well.R4's Progress Notes, dated 11/17/25 at 5:41 PM, documented R4 was noted to be walking outside of building on (specified) patio doors. Noted resident was sitting in visitor van. Resident taken out of van and taken back to room. No injuries noted. Does have code alert on. R4's Progress Notes, dated 11/28/2025 at 04:24 AM, documented Note Text: Resident was walking up and down the hallway was in and out of other's rooms. As this nurse was up the hall passing medications, heard the door to the outside close and when this nurse and CNA looked over resident was out the back door, were able to redirect resident back in without any difficulties. Door alarm did not sound attempted to lock door and lock is broken at this time. CNA on another hall also tried to lock door with no success. DON (Director of Nursing) aware of door.R4's Electronic Medical Record was reviewed and there was no documentation of the resident's representative (V14) was notified of R4 getting out of the facility.On 11/24/25 at 2:35 PM, V14, R4's family member said she was not aware of R4 getting out of the facility and no one ever called her and notified her of this. She said there was one day when her sister was at the facility to visit and asked how R4 was doing, and they told her sister oh by the way she got out of the facility. She said then the next day her sister contacted her and let her know but she is R4's guardian. She said she has never been notified of anything when it comes to R4 not even at her old facility. V14 said she would like to be notified about a lot of things. On 12/23/25 at 10:20 AM, V1, Administrator said if a resident were to get out of the facility, she would expect for the staff to contact her immediately either a call or text and to notify the DON. She said she would expect them to document it, and she would start an investigation and report it. V1 said she would expect the maintenance department to keep equipment in good working condition.The facility's policy Physician-Family Notification-Change in Condition, revision date of 11/13/18, documented Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner.The facility's Code Pink-Missing Resident/Elopement, reviewed date of 11/15/2018, documented the following: Guidelines: 1) All personnel are responsible for reporting a cognitively resident attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. 2) Should an employee observe a cognitively impaired resident leaving the premises or attempting to exit the premises, he or she should: Attempt to prevent the departure without use of force. Obtain assistance from other staff members in the immediate vicinity, if necessary. Instruct another staff member to inform the Charge Nurse or Director of Nursing services of the resident's attempt to leave the premises. Be courteous in preventing the departure and returning the resident to the facility Notify the attending physician of the resident's attempt to leave the facility Contact legal representative/responsibility party and inform him/her of the incident. Make appropriate notations in the resident's medical record. Complete a new Elopement Risk Assessment and update the plan of care with appropriate interventions as indicated.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Wound Nurse Practitioner (NP) orders were followed and implemented in a timely manner, failed to ensure low air loss mattress was maintained in well working order, and failed to ensure wound dressings were changed per NP orders for 1 of 3 residents (R2) in a sample of 9. This failure resulted in R2 having worsening of wounds which became infected leading to R2 being hospitalized several times, requiring surgical debridement and Intravenous (IV) antibiotics due to infections of Methicillin-resistant Staphylococcus aureus (MRSA), Pseudomonas, Enterococcus faecalis and Extended-Spectrum Beta-Lactamase (ESBL) Escherichia (E) coli.This failure resulted in R2's wounds worsening and becoming infected. R2 was hospitalized several times, during which R2's wounds required surgical debridement and Intravenous (IV) antibiotics due to multiple infections with Methicillin-resistant Staphylococcus aureus (MRSA), Pseudomonas, Enterococcus faecalis and Extended-Spectrum Beta-Lactamase (ESBL) Escherichia (E) coli.The Immediate Jeopardy began on 08/21/25 when the facility failed to ensure Wound Nurse Practitioner (NP) orders were followed and implemented in a timely manner, failed to ensure low air loss mattress was maintained in proper working order, and wound dressings were changed per NP orders. V1, Administrator, and V2, Director of Nursing (DON) were notified of the Immediate Jeopardy on 12/05/25 at 8:30 AM. Abatement number one on 12/05/25 was accepted. The Immediate Jeopardy was removed on 12/05/25, but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of the in-service trainings.Finding Include:R2's Face Sheet, print date of 12/04/25, document R2's admission date was 05/15/2023 and that R2's diagnoses include a pressure ulcer of right buttock, stage 3, dependence on renal dialysis, chronic kidney disease, stage 4 (severe), and chronic combined systolic and diastolic (congestive) heart failure. Note the State Survey Agency survey event PGW811 exit 7/17/2025 cites an Immediate Jeopardy on current resident, R2 for failing to timely identify, assess and monitor, and provide treatment to prevent the worsening of pressure ulcers. R2's Minimum Data Set (MDS), dated [DATE], section M documents R2 did not have any pressure ulcers/injuries at that time.R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she requires substantial/maximal assistance for rolling left to right, sitting to lying and lying to sitting. R2's Care Plan, admission date of 08/18/25, documented Potential for skin breakdown r/t (related to) incontinence, Hx (history) weeping L/E's (lower extremities), ace wraps for edema, morbid obesity, OAB (overactive bladder), resident is at increased risk for unavoidable skin breakdown r/t autoimmune disease pyoderma gangrenosumStage 3 R (right) buttockStage 3 R posterior thighStage 3 L (left) buttockStage 3 L posterior thighStage 3 L proximal buttockR lateral calf skin tearGoal: R2's will have wounds show improvement through next review and Interventions included but are not limited to Low Air Loss Bariatric Mattress for pressure reduction Per wound clinic/V13, Nurse Practitioner (date initiated 10/15/25), monitor for redness or discoloration to skin, keep skin dry and well lubricated, and weekly skin checks.R2's Hospital Visit records dated 08/13/25, document Assessment and Plan: Active Problems: Decubitus ulcer of right buttock, stage 3 and Infected decubitus ulcer, stage III. 1. Infected decubitus ulcer stage 3/ulcer right buttock stage 3- consult to wound nurse, cultures wound. It further documented R2 was admitted with multiple diagnoses which give rise to active medical issues or baseline comorbidities. Given the complexity of the situation, pending testing, follow-up labs, and ongoing medical interventions it is anticipated the patient will require admission as an impatient spending at least two midnight(s) in the hospital.R2's Wound Care report, dated 08/21/25, documented the following History of Present Illness (HPI). R2 has pressure ulcers to her buttocks; hematoma/trauma to her right lateral calf; abrasion to her left knee; and avulsion of nail to her left 5th toe. It also documented R2 had developed pressure ulcers to the bilateral buttocks and thighs and on 08/13/25 she was admitted into the hospital due to worsening infection of the wounds. She received IV vancomycin and had a wound culture done during her hospitalization which was positive for Methicillin-resistant Staphylococcus aureus (MRSA- is a type of staph bacteria resistant to several common antibiotics making infections harder to treat.). Wound #2 pressure ulcer was located on her right buttock and posterior thigh. Initial wound measurements were 20 centimeters (cm) length x 12cm width x 0.2cm depth. Post debridement measurements were 20cm x 12cm x 8cm depth. Wound #6 Left buttock was a chronic pressure injury/pressure ulcer. Initial wound measurements were 16cm x 8cm x 0.3cm. Post debridement measurements were 16cm x 8cm x 8cm. Wound orders: for Wound #2

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	146043	A. Building B. Wing	12/24/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	146043	A. Building B. Wing	12/24/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure new care plan interventions were implemented to prevent new/worsening pressure ulcers. The facility failed to ensure skin assessments were completed, ensure supplies for wound care were available, and complete wound treatments as ordered for 1 of 3 residents (R1) reviewed for wounds in a sample of 10. This failure resulted in R1 developing a stage II pressure ulcer to her right buttock on 11/25/25, a stage III pressure ulcer to her left buttock on 12/02/25, and worsening/decline to the wound on R1's right heel resulting in R1 requiring antibiotic treatment. The Immediate Jeopardy began on 11/25/25 due to the facility's failure to assess, treat, and complete skin assessments to prevent and/or treat pressure wounds for R1. This failure resulted when V47 (Nurse Practitioner) discovered a Stage II pressure wound to R1's right buttock, which the facility was not aware of. Additionally, on 12/2/25, V47 discovered a Stage III pressure wound to R1's left buttock that the facility was not aware of. V1, Administrator and V2, Director of Nursing (DON) were notified of the Immediate Jeopardy on 12/11/25 at 1:55 PM. Abatement number one and two were not accepted. Abatement number three on 12/12/25 was accepted. The Immediate Jeopardy was removed on 12/12/25, but noncompliance remains at Level Two as additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings Include:On 12/09/25 at 8:15 AM, R1 was up in the day area in her wheelchair, and she was observed in 15-minute intervals from 8:15 AM to 1:25 PM until she was laid down in bed. During this time R1 did have her float boots on and she was cooperative with care. At 9:45 R1 was leaning forward in her wheelchair. At 10:00 AM the certified nursing assistant (CNA) was going to take R1 and lay her down in bed but due to her having physical therapy they decided to leave her up in her wheelchair. R1 was then taken down to physical therapy at 10:17 AM. After therapy was completed, she was brought back to the day area on the 500 hallways and left in her chair due to it being so close to mealtime. At 11:45 AM, V7, Licensed Practical Nurse (LPN) said R1 eats better when she is up in her wheelchair, so she needed to stay up for lunch. 1:15 PM R1 remained in her wheelchair leaning forward in the day area on the 500 halls. At 1:25 PM V26, CNA and V45, CNA assisted R1 back to bed via mechanical lift. On 12/09/25 at 1:25 PM, Once R1 was placed in bed they removed R1 pants and then unfastened R1's incontinent brief and R1's brief was full of bowel movement (BM), V45 did incontinent care and cleaned R1 up. While R1 was on her left side a red area was noted on R1's right hip. When R1 was rolled over onto her right side there was another reddened area seen on R1's left hip. V26 said the area to R1's right side is where she had an open area at one time, but it has healed up. She said it could also be red because R1 had been sitting up in her chair and it's over a bony area. During incontinent care there was an indention on R1's right labia from sitting on the indwelling catheter and then an indention on back of R1's right leg/thigh from where R1 had been sitting on the indwelling catheter bag tubing. V26 said R1 was gotten up between 7:00 AM and 7:30 AM. She said she likes to make R1 a priority and get her laid down as soon as she can because of her wounds.R1's Face Sheet, print date of 12/11/25, documented diagnoses including type II diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, pressure ulcer of right heel stage II, pressure ulcer of sacral region, stage 4, peripheral vascular disease. R1's Minimum Data Set (MDS), dated [DATE], documented she is moderately cognitively impaired with a BIMS of 09 out of 15 and she requires substantial/maximal assistance with rolling left and right and is dependent on staff for sit to lying and lying to sitting. R1 is always incontinent of bowel and bladder. R1's Care Plan, admission date of 11/20/24, documented Potential for skin breakdown r/t (related to) incontinence, decreased mobility, DM (diabetes mellites), PVD (peripheral vascular disease), frequently refuses to lay down, excoriated at times, right foot drop, left great toe amputation, tendon repair left ankle, arterial ulcer right hallux, Refuses vascular studies. R1 will develop no further break down thru next review. Goals include but are not limited to Air mattress, monitor for redness or discoloration to skin, local wound care management consult and tx (treat) weekly, and Weekly skin checks.11/24/25 update: Enhanced Barrier PrecautionsStage 2 Right (R) lateral footStage 3 R heel - History (Hx) Methicillin-resistant Staphylococcus aureus (MRSA)Stage 4 Coccyx Revision on: 11/24/25R1's Behavioral Tracking for November 2025 and December 2025 were reviewed and R1 had no behaviors documented refusing to lay down or refusing treatments/care. R1's Wound Management Notes, dated 11/04/25, documented a wound culture was completed to R1's right heel on 10/14/25 and showed pseudomonas aeruginosa. R1's 10/2025 Treatment Administration Record (TAR), documented on 10/27/25-

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	146043	A. Building B. Wing	12/24/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	146043	A. Building B. Wing	12/24/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure R4 was adequately supervised, failed to ensure door alarms were turned on, and respond in a timely manner to alarms to prevent elopement for 2 of 4 residents (R4, R9) reviewed for safety in a sample of 9. These failures resulted in a severely cognitive impaired resident (R4) repeatedly eloping from the facility despite being identified as an elopement risk, and multiple failures of disabling of door alarms and delayed responses contribute to R4's elopements into unknown and unsafe conditions that include walking in middle of road and getting in a strangers vehicle.The Immediate Jeopardy began on 10/16/25 when the facility failed to properly supervise a resident (R4) to prevent an elopement from the facility. V1, Administrator, and V2, Director of Nursing (DON) were notified of the Immediate Jeopardy on 11/25/2025 at 12:58 PM. Abatement number one on 11/25/25 was not accepted. Abatement number two was accepted on 11/26/25 at 10:27 AM. The Immediate Jeopardy was removed on 11/26/25, but noncompliance remained at a Level Two at that time as additional time is needed to evaluate the implementation and effectiveness of the in-service training. On 12/01/25 at 12:02 PM, V1 Administrator was made aware the immediacy removal had been rescinded due to additional elopement incidents for R4 and R9. Abatement one through four on 12/01/25 were not accepted. Abatement number five was accepted on 12/01/25. The Immediacy was removed on 12/02/25 but the facility noncompliance remains at level two as additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings Include:The facility's daily census roster dated 11/17/25, documented the facility had 59 total residents.On 11/24/25 at 8:00 AM, when coming into the facility and coming down the 100 hallway the alarm was going off.On 11/24/25 at 8:10 AM, V1, Administrator went down and turned/reset the alarm off at this time.On 11/24/25 at 8:46 AM, R4 was seen walking up the 100 hallway then turned around and came back. On 11/24/25 at 8:50 AM, R4 went up the 100 hallway. She came back down the hallway at 8:55 AM. No staff were seen checking on her. On 11/24/25 at 10:00 AM, the door in the day area at the end of the 100 hallway that led to the outside was cracked a little. This surveyor opened the door up and no alarm sounded when the door was opened.On 11/24/25 at 10:05 AM, R4 was seen being taken by 500 hallway staff back towards the 200 hallway.On 11/24/25 at 11:39 AM, the door to the outside on the 100 hallway remains cracked open and two residents are outside smoking. On 11/24/25 at 1:58 PM, R6 and R7 were seen going out the 200-hallway door to the outside and when they opened the door there was no alarm that sounded. R4's Face Sheet, print date of 12/02/25, documented R4 has diagnoses including Alcohol dependence with alcohol induced persisting dementia, Wernicke's encephalopathy, and chronic kidney disease, stage3.R4's Minimum Data Set (MDS), dated [DATE], documented R4 is severely cognitively impaired and is independent with ambulation. R4's Progress Notes, dated 10/15/2025 at 5:13 PM, documented Social Services Note Text: Resident admitted via family vehicle. Resident admitted from another facility. Resident is ambulatory and wanders all day/night. Resident is on 15-minute checks as the wander guard will be placed 10/16/2025 depending on how resident does overnight. Resident doesn't wear glasses, denture, or hearing aids. Resident is pleasant, but on the go. Resident arrived approx. 4:55pm.R4's Progress Notes, dated 10/15/2025 at 5:23 PM, documented Social Services Note Text: Code Alert was placed on resident by director of nursing (DON) at approx. 5:20pm.R4's Elopement Risk Assessment, dated 10/16/25 at 9:04 AM, documented R4 was an elopement risk, and the following interventions were to be used: Door Alarm Band, Identification (ID) bracelet on, frequent checks, and redirection.R4's Baseline Care Plan, dated 10/16/25 at 12:10 PM, documented R4 was cognitively impaired, uses a wander guard for safety, and is an elopement risk. It further documented R4 was transferred from another facility. She is alert, ambulates independently and frequently throughout facility, wearing code alert for wandering, closely watched by staff, on 15-minute checks, diagnoses included chronic obstructive pulmonary disease (COPD), alcoholic dementia, and bipolar. R4's Progress Notes, dated 10/16/2025 at 8:15 PM, documented Nurses Note Text: Around 1815 (6:15 PM), resident was found by CNA (Certified Nursing Assistant) outside by the dumpster. Door alarm and wander guard were sounding. CNA heard the alarm and immediately went to check on alarm. Alarm sounded until this nurse turned it off. Doors at the top of 500 hall were closed to help resident stay on the hall while meds were being passed and residents were being put to bed. Another CNA has walked around with resident. Snacks and fluids have been offered, taken well.R4's Elopement Risk Assessment, dated 10/28/25 at 10:29 AM, documented R4 was independent with locomotion on and off the unit, was moderately cognitively

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	146043	A. Building B. Wing	12/24/2025

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their facility assessment was updated to include all necessary components per the current standards of practice. This failure has the potential to affect all 60 residents residing in the facility. Findings include:The Facility assessment dated [DATE] did not include the following in the plan: identification of current Administrator nor current DON (Director of Nursing), identifying resources to provide necessary care and services the residents require during both day-to-day operations and emergencies (including nights and weekends) and emergencies; evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs as identified through resident assessments and care plans; pertinent information about the resident population the facility serves may include race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, health literacy or other factors that affect access to care and health outcomes related to health equity; physical environment, assisted technology, individual communication devices, or other material resources that are needed to provide the required care and services to residents; evaluations of the facility's training program to ensure any training needs are met for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment did not include an evaluation of applicable policies and procedures, facility based and community-based risk assessment, utilizing an all-hazards approach that evaluates the facility's ability to maintain continuity of operations and its ability to secure required supplies and resources during an emergency or natural disaster, and contingency plan for events or an all-hazards approach. On 12/2/25 at 10:52 AM Surveyor asked V1 Administrator if she has additional information on the Facility Assessment as the one provided does not address all required components including facility and community risk assessments and resources. V1 stated the Facility Assessment that was provided is all the information she has. On 12/2/25 at 1:47 PM V1 Administrator stated the facility does not have a policy for the Facility Assessment. The facility's daily census report, dated 12/2/25, documented there are 60 residents residing in the facility.

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	146043	A. Building B. Wing	12/24/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146043	A. Building B. Wing	12/24/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure infection control standards of practice for hand hygiene, wound dressing disposal, and contaminated linen disposal were followed for 1 (R10) of 3 reviewed for infection control in the sample of 10.Findings Include:R10's admission Record dated [DATE] documented R10's initial admit date to the facility as [DATE]. This same document lists diagnoses for R10 including but not limited to Asymptomatic Human Immunodeficiency Virus (HIV) Infection Status and Chronic Viral Hepatitis B without Delta-Agent.The Weekly Wound Committee Review Pressure Ulcer Cumulative Report dated [DATE] documented R10 admitted to the facility with an unstageable wound to his coccyx with moderate drainage noted.R10's Plan of Care with a revision date of [DATE] documented, R10 is to have Enhanced Barrier Precautions in relation to coccyx pressure ulcer.On [DATE] at 10:39 AM, R10 is observed as residing in a single occupancy room with a sign posted on the door to his room that stated: Stop, Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities.wound care: any skin opening requiring a dressing.On [DATE] at 11:21 AM, V7, Licensed Practical Nurse (LPN) donned a gown, mask and gloves from the 3-drawer cart located outside of R10's room door. Upon entry, R10 was expressing that he needed to have a bowel movement. R10 assisted V7 in rolling to R10's left side and as he did, began to have a bowel movement into the disposable incontinence brief which was under him. R10 was observed as having an undated dressing in place to his coccyx, which was now visibly soiled with feces. After R10 confirmed he had completed his bowel movement, V7 was observed wiping the feces on R10's skin with the disposable brief, folding the feces into the brief and placing it in the trash bag that was located on the floor by R10's room door. V7, then with her still same gloved hands touched the outside of the trash bag to lift the bag to better contain the contents, touched the room door, door handle, door frame and opened the door asking V45 (CNA) to bring in clean bedding supplies for R10. V7 closed the room door and went to the bathroom located within R10's room, touching the bathroom door, bathroom door handle, sink faucet handles and wet a washcloth. Continuous observation was made of V7 in which she remained donned in the same soiled gloves with no hand hygiene completed. V7 returned to R10's bedside and removed the soiled dressing to R10's coccyx and began wiping the skin around the wound as well as the feces smears which were still visible from R10's buttocks area. The coccyx dressing that was removed from R10, was observed as having a moderate amount of blood-tinged drainage present to the dressing as well as a small amount of blood-tinged drainage which ran from the wound onto R10's skin upon the dressing removal. R10 was rolled from his left side, back to his back with the wound coming directly in contact with the bed linens. V7 then doffed her gown, gloves, mask placing them, as well as the soiled coccyx dressing into the clear trash bag located on the floor by the room door, exiting the room, performing no hand hygiene. V7 was then touched the door frame and door handle upon exiting the room. V7 reached into her shirt pocket for the med cart keys, unlocking the med cart, touching the top, sides, as well as opening the drawers of the cart. V7 closed and locked the cart back up, performing no sanitation to the cart and walked down the hall, then utilizing alcohol-based hand sanitizer, midpoint between R10's room and the nurse's station as she was walking. V7 was observed obtaining wound supplies from the wound cart located at the nurses' station. No isolation bins or red / biohazard labeled bins observed being in R10's room or bathroom adjoined to his room. This surveyor was exiting R10's room and asked V45 (Certified Nurse Assistant, CNA) where I should place my cloth isolation gown that I had worn during this observation. V45 stated, put it in the floor by the trash bag & I'll take care of it.On [DATE] at 12:02 PM, V7 (LPN) stated that she is familiar with R10. V7 stated that R10 is on enhanced barrier precautions for a coccyx wound. V7 stated that R10 is positive for HIV & Hepatitis B, so enhanced barrier precautions would also be used for contact with his blood and body fluids. V7 stated that anything that is visibly soiled with blood should be placed in a red biohazard bag in the dirty utility room.On [DATE] at 12:20 PM, V46 (ADON/Wound/Infection control Nurse) stated that R10 is on enhanced barrier precautions and has been since his admission to the facility in [DATE], due to having a coccyx wound and previously a g-tube as well as being immunocompromised with HIV and Hep B diagnoses. V46 stated her expectations are for staff to follow facility policy for enhanced barrier precautions.On [DATE] at 11:45 AM, V2 (Director of Nursing) stated that she is familiar with R10. V2 stated that R10 should be on enhanced barrier precautions presently due his

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	146043	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Gardens of Nashville	485 South Friendship Drive Nashville, IL 62263

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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F 0908 Level of Harm - Actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a low air loss mattress was in proper working order for 1 of 3 residents (R2) reviewed for essential equipment, safe operating condition in a sample of 10. This resulted in R2 being in extreme pain due to R2 having multiple pressure ulcers/injuries, the mattress not staying properly inflated, and R2 laying on a hard metal bed frame. Findings Include: R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she requires substantial/maximal assistance for rolling left to right, sitting to lying and lying to sitting.R2's Face Sheet, print date of 12/04/25, documented R2 has diagnoses including pressure ulcer of right buttock, stage 3, dependence on renal dialysis, chronic kidney disease, stage 4 (severe), and chronic combined systolic and diastolic (congestive) heart failure. R2's Care Plan, admission date of 08/18/25, documented Potential for skin breakdown r/t (related to) incontinence, Hx (history) weeping L/E's (lower extremities), ace wraps for edema, morbid obesity, OAB (overactive bladder), resident is at increased risk for unavoidable skin breakdown r/t autoimmune disease pyoderma gangrenosumStage 3 R (right) buttockStage 3 R posterior thighStage 3 L (left) buttockStage 3 L posterior thighStage 3 L proximal buttockR lateral calf skin tearGoal: R2's will have wounds show improvement through next review and interventions include but not limited to Low Air Loss Bariatric Mattress for pressure reduction Per wound clinic/V13, Nurse Practitioner (date initiated 10/15/25), monitor for redness or discoloration to skin, keep skin dry and well lubricated, and weekly skin checks.On 11/18/25 at 1:50 PM, V8, Certified Nursing Assistant (CNA) said R2's bed had a connection device that had three tubes on it that would connect to the machine, and it would keep coming off. V8 said sometimes when they would just be walking by R2's room and look in they would see that the tube had come disconnected and they would have to go in the room and hook it back up. V8 said the bed R2 has now she just got it three or four days ago.On 11/18/25 at 2:00 PM, Outside of R2's door lying on the floor was a machine (air pump) that went to an old air loss mattress. The control panel was hanging out of the machine by the wires, and it didn't have any hose connected to it. On 11/18/25 at 2:05 PM, V7, Licensed Practical Nurse (LPN) stated R2 should be on an air loss mattress to help prevent wounds. She said the plug had an issue something about the hose would pop off and the plug was lose.On 11/19/25 at 10:41 AM, V9, R2's family member #1 said her biggest issue is with R2's bed. She said R2 is supposed to have an air loss mattress but the one she had was literally held together with duct tape. V9 said they told the Director of Nursing (DON) about it, and she said they had a piece ordered. V9 said R2 would sink in the mattress, and it would make R2's bed sores hurt because the mattress wasn't properly inflated. V9 said they had to change R2's room because the bed she got was bigger than her original bed and it wouldn't fit in her old room. V9 said she has pictures of where the bed was broke, and she would send them to this surveyor. On 11/24/25 at 10:10 AM, R2 said the wound care nurse at a local facility is the one who recommended switching her to an air loss mattress, but she isn't sure when she did that. She said the mattress she had before she got this one was softer, but they had trouble keeping air in it. R2 said whatever was supposed to be putting air into the bed wasn't working right and it kept coming off. R2 said when the air would go out of the old bed it was just like laying on the floor. She said when the air would go out of the mattress, she couldn't handle it her pain was so bad. She said it was a 10 with 10 being the worst and it was a burning type of pain where her sores are. R2 said she didn't want to be around people because she knew she was a crab-a**, and it hurt too much to sit up in her wheelchair. She said she would just have to grit her teeth and bare it before they got her better pain medication. On 12/02/25 at 10:55 AM, V31, R2's family member #2 said he messaged/sent pictures to the DON about the bed not working. He said he likes to have things in writing when it comes to the facility, so he has proof. He said this didn't start because his mom didn't want to lay down in her bed it was because they put her in a wheelchair that was to small and then sent her to dialysis. He said his mom has always slept in her recliner but now she stays mostly in her bed because of the wounds. V31 said R2 didn't get the low air loss mattress until she came back from the hospital this last time. He said that is why she had to be moved to the (specific hall location). V31 said he isn't sure what day R2 got the bed, but it didn't work. The hose that connected to the mattress would keep coming off and they used duct tape to try and keep it in place. V31 said they have changed R2's pain medication also. He said she is in extreme pain due to (d/t) her wounds and so they started her on morphine and after the dressing changes is when she has the most pain On 11/19/25 at 12:42 PM, This

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure nurse aides completed the required 12 hours of education per year. This has the potential to affect all 60 residents residing in the facility. Findings include:The facility's CNA (Certified Nurse Assistant) hire date list documented the following: V32 CNA hire date of 7/26/2011.V33 CNA hire date of 1/21/2002.V34 CNA hire date of 11/12/2018.V35 CNA hire date of 11/4/1999.V36 CNA hire date of 3/18/2019.V37 CNA hire date of 11/19/2019. The facility's in-service records for 2025 documented the following: V32 had 1 hour of education for the past year.V33 had 2 hours of education for the past year. V34 had 1 hour of education for the past year. V35 had 2 hours of education for the past year. V36 had no education documented for the past year.V37 had 2.5 hours of education for the past year. On 12/2/25 at 12:29 AM V1 Administrator stated I have to be honest, that is all we have for the CNA in-services/education for the past year. V1 stated CNAS are supposed to have 10 or 12 hours of continuing education per year. V1 stated the in-services that were provided to the Surveyor were all 30-minute in-services except the wound care in-service did take 1 hour. V1 stated the CNA list has the original hire date and the date the new company took over on 11/1/25. On 12/2/25 at 1:43 PM Surveyor reviewed the CNA education hours with V1 Administrator and V2 DON (Director of Nursing). V1 and V2 both agreed V32, V33, V34, V35, V36, and V37 did not receive the 12 hours of required education in the past year. On 12/2/25 at 2:17 PM V1 Administrator stated she thinks the facility did do dementia training in February of 2025, but she cannot find the attendance records for it. Surveyor asked if the facility provides dementia training within 60 days of hire as documented in the facility Employee Education policy and V1 stated we are not doing that. The facility's Employee Education policy, dated 10/1/22, documented the facility shall provide a Staff Education Plan in accordance with State and Federal regulations. 1. The facility will develop, implement, and maintain a written staff education plan, which ensures a coordinated program for staff education for all facility employees. 2. The staff education plan will be reviewed at least annually by the quality assurance committee and revised as needed. 3. The facility will ensure the staff education plan includes both pre-service and annual requirements. 4. The staff education plan shall ensure that education is conducted annually for all facility employees, at a minimum, in the following areas: a. Prevention and control of infection; b. Fire prevention, emergency procedures-life safety, and disaster preparedness; c. Abuse, neglect, and exploitation; d. Accident, prevention and safety awareness programs; e. Resident's rights to include Advanced Directives; f. OSHA Training - Biomedical Waste Plan and Bloodborne Pathogens; g. Federal law requirement for long term care facilities, which is incorporated by reference, and state rules and regulations; h. Quality Assurance Performance Improvement (QAPI). 5. The facility will ensure, when employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular in-service education based on the outcome of such reviews. It continues, 8. The facility will ensure that all employees will have training, as required by the State regarding dementia, both at within 60 days of hire and annually thereafter. The facility's daily census report, dated 12/2/25, documented there are 60 residents residing in the facility.