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	03/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent sexual abuse to a resident by an employee and failed to prevent physical abuse of a resident from another resident for 2 of 3 residents (R7, R22) reviewed for abuse in the sample of 42.Findings Include:1.R22's admission Record print date of 3/18/26 documents R22 has diagnoses including vascular dementia with behavioral disturbance, peripheral vascular disease, anxiety, supraventricular tachycardia, heart disease, and osteoarthritis. R22's MDS (Minimum Data Set) dated 1/31/26 documents R22 is severely cognitively impaired and requires substantial to maximal assistance with transfers. The Facility's undated Preliminary 24-hour Abuse Investigation Report documents an offense was alleged against R22 by an employee. The Facility's undated Final Abuse Investigation Report documents name of resident abuse: (R22). The original allegation: unknown date and time. Allegedly this incident happened in her room. This was reported to Administrator by Activity Director. Unit Aide (V19) did kiss this resident on the mouth/lips. No injuries noted. The Unit Aide in his statement stated he did kiss her only once on the mouth. Through thorough investigation, talking to staff and residents, this incident did occur. Based on the known facts, the following conclusions have been determined about the original allegation: This incident was substantiated. The Facility's Human Resource Notice of Corrective Action for V19 and dated 1/15/26 documents Employee Explanation: He stated he did kiss (R22) on the lips like he would for his grandma.2. R7's admission Record with print date of 3/19/27 documents R7 has diagnoses including end stage renal disease, chronic obstructive pulmonary disease, major depressive disorder, hyperkalemia, type 2 diabetes mellitus, and anxiety disorder. R7's MDS dated [DATE] documents R7 is cognitively intact and independent with ADLS (activities of daily living). R7's progress note dated 12/12/25 at 2:27 PM documents R7 was outside smoking, R33 came outside and began yelling at R7. R33 then came back into the facility and went to his own room. As R7 was coming into the facility and passed R33's room, R33 opened the door and threw a cup of coffee on R7. Residents were separated immediately and assessed for injuries. No injuries were noted at this time. R7 states that he was outside smoking and R33 came out and started harassing him. He stated this is not the first time. He then said he came into the facility and walked past R33's room where he threw a cup of coffee at him. The facility's Report to IDPH (Illinois Department of Public Health) dated 12/12/25 documents this writer continued investigation with interviewing staff and residents, this was witnessed incident. During thorough investigation, this writer concluded that R7 was outside and R33 went outside and started yelling at R7 on 200 hall. R33 went back in his room. When R7 came back in from smoking outside, R33 threw coffee on R7 and R7 pushed R33 in the chest, pushed him away with open hands. The pushing happened in the doorway of R33's room. On 3/19/26 at 11:41 AM V14 [NAME] President of Operations stated the abuse to R22 by V9 and the abuse between R33 and R7 did occur.On 3/19/26 at 12:58 PM R7 stated R33 did throw coffee on him and he did not have any injuries. The facility's Abuse and Retaliation Prevention and Reporting policy dated 1/8/26 documents 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 facility therefore prohibits (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident-secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment of residents. This will be done by conducting pre-employment screening of employees and pre-admission screening of residents, orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, retaliation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. It continues, abuse means any physical or mental injury, retaliation, or sexual assault inflicted upon a resident other than by accidental means.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide safe transfers for 3 of 14 residents (R1, R12, R50), to initiate fall interventions for a high fall risk resident for 1 of 14 residents (R2) resulting in R2 falling and fracturing her hip, to implement fall interventions for 1 of 14 residents (R22), and to keep door alarms activated, all reviewed for resident safety in the sample of 42. The findings include:1. R2's Face Sheet, admission date of 12/05/25, documents that R2 has diagnoses of but not limited to bilateral primary osteoarthritis of knee and dementia other diseases classified elsewhere, severe, with psychotic disturbance. R2's Minimum Data Set (MDS), dated [DATE], documents thatR2 is severely cognitively impaired, and she is dependent or requires substantial/maximal assistance with her activities of daily living (ADLs). Walking was not attempted due to medical conditions or safety concerns. R2's Electronic Medical Record, (EMR) was reviewed and no documentation was found that an admission fall risk assessment was completed. R2's Care Plan, admission date of 12/05/25, documents R2 is at risk for falls (date initiated: 01/04/26), interventions include but are not limited to evaluate fall risk on admission and as needed (PRN) and if resident is a fall risk, initiate fall risk precautions. It also documents that R2 is at risk for fall/injury related to (R/T) wandering/poor safety awareness (created date of 12/22/25). R2's Post Acute Care Transfer Report, dated 12/05/25 at 10:07 AM, documents Behavioral Interventions: 1:1 observation Safety High risk for falls, Physical aggression, Risk for elopement. R2's Progress Notes, dated 12/20/25 at 02:59 AM, documents that the nurse was notified by the Certified Nursing Assistant (CNA) the resident was found on the floor in her room. The nurse assessed R2 and helped the CNA assist her back to bed. There were no visible signs of injuries noted, and her vital signs (v/s) were within normal limits (WNL). R2 stated her right hip was sore. The physician and resident's sister was notified. R2's Fall-Initial Occurrence Note, dated 12/20/25 at 2:40 AM, documents that R2 had an unwitnessed fall in her room, she had taken off her tread socks, and she was trying to go to the bathroom. R2's Progress Notes, dated 12/20/25 at 04:23 AM, documents that R2 complained of (c/o) pain in her right hip of a 10 out of 10. The physician was notified and gave orders to send R2 to the local hospital. R2's Alleged Fall-Unattended report, dated 12/20/25 at 02:40 AM, documents that R2 was found on the floor in her room by the CNA. The nurse witnessed R2 on the floor with her tread socks sitting beside her. R2 said she was attempting to go to the bathroom. The nurse assessed R2 and helped the CNA assist R2 back to bed. There are no visible injuries and v/s are WNL. R2 complained of right hip soreness. R2 c/o worsening right hip pain, the physician was notified, and R2 was sent out to the hospital. R2's Report to Illinois Department of Public Health (IDPH) Regional Office Final Report, dated 12/26/25, documents that R2 has diagnoses of dementia, bilateral primary osteoporosis of knee, and hyperlipidemia. Description of occurrence: Alleged fall with injury, injuries: Right hip fracture, actions (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	taken: Nurse assessed, neurological evaluation initiated, sent to local hospital emergency room department for evaluation and treatment, R2 then transferred and admitted to higher level of care hospital and received surgical repair of right hip fracture. Follow up/Final Report Summary: The was an unwitnessed fall in resident's room. Resident observed on floor on her buttocks after attempting to ambulate independently to the toilet. Prior to ambulation, resident had removed her non-skid socks resulting in inadequate traction. R2 resident, was readmitted on [DATE] from the hospital with intact staples to surgical site and post-surgical orders in place. Safety signage posted as a reminder to call for assistance. Staff to monitor to ensure appropriate footwear and/or non-skid socks and provide toileting assistance. Care plan updated to reflect current status. R2's Progress Notes, dated 12/22/25 at 10:44 AM, documents that R2 continues follow up (f/u) for recent fall and right hip fracture. R2 has staples to surgical site and are intact. R2's progress Notes, dated 12/31/25 at 02:10 PM, documents that R2 noted sitting on floor in front of wheelchair (w/c) in hallway. R2 stated she tried to get up and sat down on the floor. R2 was assisted back into her w/c. On 03/18/2026 at 2:35 PM, the facility was unable to provide R2's initial admission fall risk assessment. On 03/19/2026 at 7:25 AM, R2 is lying on her back in bed with her eyes closed. Her call light is attached to the sheet at the head of her bed off the side and out of reach of R2. 2. R22's Face Sheet, admission date of 06/19/24, documents that R22 has diagnoses of but are not limited to Vascular Dementia, unspecified severity, with other behavioral disturbance, peripheral vascular disease, hypertension (HTN), history of falling. R22's MDS, dated [DATE], documents she is severely cognitively impaired, and she requires substantial/maximal assistance with bed mobility and with transferring. R22 is frequently incontinent of bladder and always incontinent of bowel. R22's Care Plan, admission date of 06/19/24, documents R22 is at risk for fall and has had an actual fall r/t (related to) history of falling, dementia, fractures, restlessness/agitation, arthritis. Interventions include but not limited to bed pad alarm, keep in visual of staff when up in wheelchair, Batteries replaced on chair alarm, ensure alarm in place, resident placed near nurse's station, and Pressure pad alarm added to chair. R22's Fall Initial Occurrence note, dated 01/10/26 at 08:10 AM, documents R22 had an unwitnessed fall in the common bathroom. She fell from her w/c to the floor. R22 has a laceration above her right (R) eye. Resident was assessed for injury, assisted back into w/c, and then sent to the local ER for evaluation and treatment. R22's Local Hospital emergency room report, dated 01/10/26 at 9:51 AM, documents R2 is a [AGE] year-old female patient with extensive medical history (hx) including dementia who resides at the local nursing home and who reportedly sustained an unwitnessed fall this AM from her wheelchair. She was found to be lying on the floor, having hit her head. No loss of conscious (LOC) and she is not on any blood thinners. Last tetanus shot was 2020. Patient (Pt) appears to be at her baseline which is alert and oriented (A&O) times 1-2. She does have two lacerations along the right upper eye orbit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	There are no other complaints of pain or any other distress noted. It further documents the laceration to R2's right eyebrow is 2.5 centimeters (cm) in length and 2 millimeters (mm) in depth. Laceration repaired with tissue adhesive. R22's Fall Initial Occurrence note, dated 02/03/26AM, documents R22 had an unwitnessed fall in the dining room on the 300 hallway. It also documents resident fell forward from her wheelchair (w/c), struck her head on the ground, loss of consciousness noted, three lacerations noted to resident's forehead. Resident was sent to the local emergency room (ER) via ambulance. Precipitating and contributing factors include but are not limited to recent fall, incontinence, and she is confused. She was brought to the nurse's station to monitor. R22's Local Hospital emergency room report, dated 02/03/26 at 9:09 AM, documents that R2 is a [AGE] year-old female that presents from local nursing home after sustaining a fall from her wheelchair. Emergency medical services (EMS) state the patient fell forward and hit her head on the floor. Patient had 60 minutes of LOC. Patient has multiple lacerations and hematoma to her forehead. The patient has a hx of dementia with multiple falls in the past. Patient cries out in pain with movement. No obvious injury besides her forehead. R2's lacerations were repaired with six (6) Steri-Strips and tissue adhesive. During observations on 03/17/26 from 9:30 AM through 12:39 PM, with 15-minute intervals R22 was seen without safety interventions in place or being followed. R22's chair/bed pull alarm monitor was not connected to the pull cord on her chair while she was in her chair. On 03/17/26 at 11:30 AM, R22 was placed in her room by self and wasn't in view of staff and her alarm wasn't in place. On 03/17/26 at 12:44 PM, V29, Certified Nursing Assistant (CNA) said R22's chair alarm was put on her because her daughter (V17) comes and helps her with her lunch, so she really doesn't need it when V17 is here. On 03/17/26 at 12:48 PM, V17, (R22's family member) was asked if she had removed the chair alarm when she came to the facility and she responded No. On 03/19/2026 at 7:20 AM, R22 is up and in her w/c and being taken down to the dining room for breakfast. The alarm device monitor was still attached to the head of R22's bed. The pull cord was seen on the back of R22's w/c. On 03/18/2026 at 12:05 PM V14, [NAME] President (VP) of Operations said she would expect fall interventions to be in place. On 03/20/2026 at 10:47 AM, V30, Medical Director said just because someone has dementia, wanders, and is now multiple psychotropic medications doesn't necessarily make them a fall risk. He said a fall risk assessment should be completed and he believes it's part of the initial assessment when someone is admitted . He said he would expect the staff to be aware of it if someone is a fall risk and he would expect fall interventions to be put in place to prevent future falls. 3. R12's admission Record, dated 3/19/26, documents R1 was originally admitted to the facility on [DATE] with diagnosis of acquired absence of left and right above knee amputation (AKA), Peripheral venous insufficiency, hypertension (HTN), chronic obstructive pulmonary disease (COPD), overactive (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bladder, congestive heart failure (CHF), major depressive disorder, peripheral vascular disease (PVD), Arteriosclerotic heart disease (ASHD), morbid obesity, nicotine dependence (cigarettes), falls, and polyneuropathy. R12's Care Plan, dated 3/2/26, documents: R12 is a smoker of cigarettes. Interventions: Instruct resident about the facility policy on smoking: locations, times, safety, medications, per MD (medical doctor) order, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, resident will keep smoking materials in a secured location. 2/20/26: R12 can be rude to other residents at times, history of smoking used cigarettes out of disposer concerns. R12's MDS, dated [DATE], documents R12 is cognitively intact and is dependent on staff for bathing, toileting, and personal hygiene. R12's Smoking Safety Risk Assessment, dated 12/6/25, documents Does the resident currently smoke or use electronic smoking device? No. R12's Smoking Safety Risk Assessment, dated 3/4/26, documents Does the resident currently smoke or use electronic smoking device? No. This resident (R12) is safe to smoke unsupervised. On 3/16/26 at 9:34 AM, R12 was observed being placed in her wheelchair by V20, Certified Nursing Assistant (CNA), and V12, CNA. R12 is a bilateral AKA, requested her camouflage pull over gown to go out and smoke. V20 brought it to her and put it on R12. the gown had several burn marks noted on the front of her hood/gown from smoking. V12 then handed R12 her cigarette from her side table, mentioning that is her only one left, R12 asked for her lighter and V12 gave it to her from her side table also. On 3/17/26 at 9:33 AM, R12 stated there is no smoking times and she can go out and smoke whenever she wants and there is usually no staff outside with them. R12 stated she is waiting on someone to bring her some more cigarettes so she can go smoke. On 3/17/26 at 11:20 AM, The door leading to the smoking area at the end of the 200-Hall was opened, alarm sounding with V5, CNA, answering the alarm. When asked about the door alarm being on, and residents stating they can smoke anytime they want without the alarm sounding, V5 stated I think it depends on who is working if it's armed or not. On 3/17/26 at 11:25 AM, V26, Registered Nurse (RN), stated We shut the alarm off during smoking time so the residents can go smoke. When I'm here, I make sure the alarm is on when it's not smoke times. I don't know why we can't leave it off all the time so the residents can go outside, it is a fenced in area. 4. R1 admission record, dated 3/19/26, documents R1 was originally admitted to the facility on [DATE] with diagnosis of COVID, pneumonia, dysphagia, degenerative disease of nervous system, lumbar scoliosis, major depressive disorder, epilepsy, hypothyroidism, anxiety disorder, polyosteoarthritis, diverticulosis, cardiomegaly, falls, and osteoporosis. R1's Care Plan, dated 2/5/26, documents R1 requires restorative assistance with bathing, grooming, dressing related to immobility. 3/6/25: R1 requires assist with ADL's related to weakness, history of Ilieopubic fracture, rib fractures, history of falls, resident refuses foot board and foot pedals most times. Interventions: requires two staff participation with transfers per full body mechanical lift (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	device, keep call light within reach and encourage use, answer promptly. 3/6/25: R1 is at risk for falls related to weakness, current fractures, neuropathy, osteoporosis. Interventions: Fall mat, high fall risk, keep call light within reach at all times and answer timely, assist with ADL's, follow facility fall protocol, review past falls and attempt to determine cause, anticipate needs, promote physical activity for strengthening, keep furniture in locked position, provide a safe environment: floors free of spills and/or clutter, adequate, glare free light, bed in low position at HS (hours sleep), assistive devices in place, personal/needed items within reach. R1's MDS, dated [DATE], documents R1 is cognitively intact and is dependent on staff for ADLs and transfers. R1 is always incontinent of both bowel and bladder. R1's last Fall Risk Assessment completed, dated 1/23/24, documents R1 is a High Fall Risk. On 3/16/26 at 1:20 PM, R1 was observed being transferred from her wheelchair to her bed. V20, CNA, and V12, CNA, used a full body mechanical lift device and lifted R1 off her wheelchair with the wheelchair unlocked, held R1 to her bed, and then lowered to the bed and detached from device. Both CNAs left the room with no placement of a fall mat and no fall mat seen in the room. 5. R50's admission Record, dated 3/19/26, documents R50 was originally admitted to the facility on [DATE], with diagnosis of Vascular dementia, Alzheimer's disease, major depressive disorder, irritable bowel syndrome (IBS), HTN, osteoporosis, generalized anxiety disorder, dysphagia, COPD, psychosis, COVID, contracture left and right hand, chronic respiratory. failure, and emphysema. R50's Care Plan, dated 4/16/25, documents R50 requires assist with ADL's r/t dementia, Alzheimer's, weakness. Intervention: Toileting Schedule: Every 2 hours and PRN (as needed). R50 wears adult undergarments r/t incontinence of bowel and bladder. Interventions: Assist with incontinence Q (every) 2H (hours) and PRN, keep clean, dry, free of irritating substances. R50 is at risk for falls r/t weakness, dementia. Interventions: Assist with ADL's, quarterly fall assessment, review past falls and attempt to determine cause, anticipate needs, promote physical activity for strengthening, keep furniture in locked position, provide a safe environment: even floors free of spills and/or clutter, adequate, glare free light, bed in low position at HS, assistive devices in place, personal/needed items within reach. R50's MDS, dated [DATE], documents R50 has a severe cognitive impairment and is dependent on staff for all ADLs and transfers. R50 is always incontinent of both bowel and bladder. R50's last Fall Risk Assessment completed, dated 8/6/21, documents R50 is a High Fall Risk. On 3/16/26 at 1:30 PM, R50 observed in geriatric chair with legs/arms slightly contracted, the full body mechanical lift device sling placed underneath her and was attached to the device. R50's wheelchair was unlocked while lifting R50 off her wheelchair to her bed and then lowered. The Facility's Fall Prevention Program Policy, dated 11/21/17, documents in part To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Fall Prevention Program includes the following components: Methods to identify risk factors, methods to identify residents at risk, Assessment time frames, Use and implementation of professional standards of practice, Adherence to manufacturer's recommendation in use of alarm and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	medical devices and special care equipment, Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk. The Facility's Smoking Safety Policy, dated 10/24/22, documents in part To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate [NAME] each resident that they are responsible for following each rule and on-going compliance with this policy. A Smoking Safety Assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store smoking materials, and if a smoking apron is indicated. The plan of care shall reflect the results of this assessment. This assessment will be completed upon admission, quarterly and with significant change. The following behaviors and/or conditions will jeopardize and/or cause revocation of the person's independent privileges: Self-harmful behaviors, such as burning clothing, hands, fingers, face or lips. This category includes residents who are generally careless while smoking and may present a significant risk of fire setting. 6.On 3/16/26 at 8:43 AM Surveyor tested the 200 hall exit door by opening it and the door alarm did not sound. Surveyor asked V5 CNA (Certified Nurse Assistant) why the exit alarm did not function and V5 replied because residents go out when they want for fresh air and it is a restraint if we keep the door alarm on. V5 then returned to the exit door with a key and used the key to activate the door alarm. V5 stated a key must be used to activate and deactivate the door exit alarms. On 3/18/26 at 7:50 AM Surveyor noted an exit door alarm sounding on the 100 hallway. On 3/18/26 at 7:51 AM V1 Administrator stated she expects all exit door alarms to always be on. On 3/18/26 at 8:01 AM Surveyor noted the exit door continued to alarm on 100 unit. Surveyor asked V1 Administrator what exit door alarm was sounding as the alarm on the 100 unit has been ringing for over 10 minutes. V1 stated she thinks it is from people entering the front door without putting the door alarm code in, but she would have to find out for sure. Surveyor asked how employees in other areas of the facility could hear the low buzzing exit alarm sounding. V1 stated she has an alarm company coming out to assess and repair the exit alarms as needed. V1 stated she is aware of the issues with the door alarms including the 300 hall/Memory Care Unit exit alarm not functioning properly and an alarm company is coming to make all necessary repairs. The Facility's Elopement Device policy dated 8/23/17 documents Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders, and to ensure the security system is inspected to identify malfunctions should they occur. Equipment includes exit door keypads. Responsibility: all facility staff. Procedures: Elopement alert devices will be used as an interventional tool to prevent resident elopements. It continues, the inspection and status of the test will be recorded on a facility approved log located at the front desk. Maintenance staff and manager on duty will be responsible for maintaining this log. In the event testing reveals a malfunctioning in the exit door security system, maintenance personnel will be notified and a staff member placed at the door to prevent unauthorized exits. The facility's CMS 761, dated 03/16/26, documented there are 56 residents residing at the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to perform catheter and complete incontinent care for 4 of 4 (R4, R11, R44, R50) residents reviewed for toileting in a sample of 42.Findings include: 1 R4's Care plan, dated 12/17/2025, documents that (R4) has a Hx (history) of UTI (urinary tract infection) and is At Risk for Recurrent/Chronic Urinary Tract Infection 12/3/25 Foley cath (catheter) placed due to pressure ulcers. 12/3/25 Indwelling urine cath care, peri care, and change per MD (doctor)orders. Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas. R4's Minimum Data Set (MDS), dated [DATE], documents that R4 is cognitively impaired, always incontinent of bowel, has an indwelling catheter, and dependent on staff for toileting. On 3/16/2026 at 1:00 PM observed V9, Certified Nurses Assistance (CNA) and V11, CNA, performed incontinent of care. R4 was incontinent of bowel. V9 and V11 assisted R4 onto her left side. V9 using wet wash clothes wiped the anal area. V9 and V11 then assisted R4 onto her back. Pulled down R4's gown and applied covers. V9 and V11 did not cleanse R4's entire buttock or perform incontinent care. 2. R55's Care Plan, dated 2/10/26, documents that (R11) wears adult undergarments r/t incontinence. It also documents Assist to toilet q2h and PRN (as needed). R55's MDS, dated [DATE], documents that R55 is cognitively intact, frequently incontinent of urine, always incontinent of bowel, and dependent on staff for toileting. On 3/16/2026 at 1:27 PM observed V9 and V11 toileting R55. V9 and V11 assisted R55 from the wheelchair to the free-standing commode in room. V9 and V11 assisted R55 with pulling pants down revealing a heavily soiled urine soak incontinent brief. V9 and V11 assisted R55 onto the toilet. At 1:43 PM V11 applied R55's clean brief. V9 and V11 then assisted R55 into a standing position. V9 then using a wet washcloth cleansed R55's buttocks. V11 and V9 then pulled up R55's brief and pants. V9 and V11 did not cleanse R55's entire buttocks, peri area, groin, inner thighs, and labia. 3. R44's admission Record, dated 3/19/26, documents R12 was originally admitted to the facility on [DATE], with diagnosis of Type 2 Diabetes Mellitus (DM), Congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), Benign prostatic hyperplasia (BPH), Dysphagia, Malnutrition, Lumbar disc degeneration, first degree Atrial-Ventricular block, chronic kidney disease (CKD), Anemia, Polyosteoarthritis, Spinal stenosis, Dorsalgia, Trans Ischemic Attach (TIA)/Cerebral infarction without residual deficits, osteoarthritis, Hypertension (HTN). R44's Care Plan, dated 4/7/25, documents R12 is provided extensive assist with activities of daily living (ADL's) related to weakness. Interventions: R44 is non-ambulatory, requires assistance of 1-2 with hygiene, clothing adjustment, transfers, keep call light within reach and encourage use, answer promptly. 9/19/25: R44 has a history of urinary tract infections (UTI) and is at risk for recurrent/chronic UTIs. Interventions: Check at least every two hours for incontinence. Wash, rinse and dry soiled areas. R44's MDS, dated [DATE], documents R44 has a moderate cognitive impairment and is dependent on staff for ADLs and transfers. R44 is frequently incontinent of both bowel and bladder. (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	03/20/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/26 at 10:13 AM, V23, CNA, and V24, CNA, entered to provide incontinent care for R44 while sitting in wheelchair. Both CNAs donned gloves with no HH seen done, a sit-to-stand device placed in front of R44, sling applied around R44 and then attached to the device. R44 was lifted off his wheelchair, incontinent brief removed and was wet with urine, V23 changed gloves with no hand hygiene done, then got a wet washcloth from sink, no soap or cleaning spray used, and while R44 was bent over standing, briefly wiped R44's front side, penis and testicles, then got another wet cloth and wiped R44's buttocks. V21, LPN, in room and applied cream to R44's buttocks which appeared to have slight rash. V24 applied clean brief to R44 and then pulled pants up. V23 continued to use soiled gloves she used to clean R44's buttocks to pull up R44's pants and lower him to his wheelchair, then controlled the device and wheelchair with same gloves on. There was no soap or peri-cleaner used, R44's anal area was never cleaned, and no hand hygiene done between the one glove change with soiled gloves. 4. R50's admission Record, dated 3/19/26, documents R50 was originally admitted to the facility on [DATE], with diagnosis of Vascular Dementia, Alzheimer's disease, Major depressive disorder, IBS, HTN, Osteoporosis, Generalized anxiety disorder, Dysphagia, COPD, Psychosis, COVID, Contracture left and right hand, chronic resp. failure, Emphysema. R50's Care Plan, dated 4/16/25, documents R50 requires assist with ADL's r/t dementia, Alzheimer's, weakness. Intervention: Toileting Schedule: Every 2 hours & PRN. R50 wears adult undergarments r/t incontinence of bowel and bladder. Interventions: Assist with incontinence q2h and PRN, Keep clean, dry, free of irritating substances. R50 is at risk for falls r/t weakness, Dementia. Interventions: Assist with ADL's, Quarterly fall assessment, Review past falls and attempt to determine cause, Anticipate needs, promote physical activity for strengthening, keep furniture in locked position, Provide a safe environment: even floors free of spills and/or clutter, adequate, glare free light, bed in low position at HS, assistive devices in place, personal/needed items within reach. R50's MDS, dated [DATE], documents R50 has a severe cognitive impairment and is dependent on staff for all ADLs and transfers. R50 is always incontinent of both bowel and bladder. On 3/16/26 at 1:30 PM, V12, CNA, and V20, CNA, were observed performing peri-care on R50. R50's pants pulled down and brief unfastened and removed which appeared to be saturated in urine with strong urine smell. V20 used same soiled gloves she took off the saturated brief with, then got wet cloth from a basin of water and wiped R50's vagina, then with same gloves on, got another cloth from basin of water and wiped R50's left buttock while turned to her right, R50 rolled over to her left side and wiped R50's right buttock. V20 got a dry washcloth and wiped R50's buttocks and anal area using the same soiled gloves. V20 then touched R50's pillows, sheet, and pulled the blanket over R50. No was no hand hygiene or glove changes done between soiled to clean areas. The Facility's Incontinence Care Policy, dated 4/20/21, documents in part, Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. 2. Perform hand hygiene and put on non-sterilegloves. 4. Soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe. b) Rinse with remaining cloth using clean surfaces for all surface areas. Do not place soiled soapy cloths back in clean basin water until procedure completed. May drape soiled cloths over the side of the wash basin, or place directly in soiled linen plastic bag. c) Clean/rinse inner/upper thigh areas to remove urine moisture. 6. Gently pat area dry with a towel from anterior to posterior. 8. Using the final rinse cloth, from frontwashing, wash and rinse the peri-anal area. Pat dry. 9. Change gloves and perform hand hygiene. 12. Remove gloves and perform hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Glove Use - Nursing Policy, dated 12/5/24, documents in part, This facility will provide gloves of appropriate quality and size for nursing personnel and use appropriate type of gloves based on medical or surgical aseptic technique and in accordance with Universal/Standard Precautions and Transmission Based Precautions. Non-sterile gloves shall be worn for procedures involving contact with mucous membranes and for other resident care or diagnostic procedures requiring a sense of touch or that require contact with blood or body fluids that are visibly contaminated with blood. Examples include but are not limited to: Incontinence. 5. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface. care. 7. Hand hygiene will be performed after removing gloves. When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting. Soap and water are recommended for cleaning visibly dirty hands. The Facility's Hand Hygiene/Handwashing Policy, dated 12/5/24, documents in part Hand Hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). Examples of When to Perform Hand Hygiene (Either Alcohol Based Hand Sanitizer or Handwashing): Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed), after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient, if hands will be moving from a contaminated-body site to a clean-body site during patient care, after glove removal.