

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2026
NAME OF PROVIDER OR SUPPLIER  Axiom Gardens of Nashville		STREET ADDRESS, CITY, STATE, ZIP CODE  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 - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure a safe resident environment and protection from physical abuse for 1 of 3 (R2) residents reviewed for resident-to-resident abuse in the sample of 3. This failure resulted in R2 being punched in the face by R1, leaving slight redness to her forehead. A reasonable person getting punched in the face would feel fearful, threatened, and intimidated. Findings include: R1's admission Record documents an admission date of 1/13/26 and a discharge date of 2/25/26 with included diagnoses of psychosis, transient alteration of awareness, cognitive communication deficit, dementia, and altered mental status. R1's Care Plan documents R1 has the potential to be physically aggressive punching/hitting related to dementia and poor impulse control. 1/18/26 R1 altercation with another resident, punched other resident in the shoulder two times. 1/21/26 R1 was rummaging through staff purse and hitting staff with fist. 1/27/26 R1 was grabbing residents and hit another resident. 1/29/26 R1 threw orange juice on another resident, hitting staff. (initiated 1/18/26) Interventions include in part medication review for physical behaviors directed towards other residents (initiated 1/18/26), staff to secure personal belongings in clean utility room or medication room (initiated 1/21/26), staff to redirect R1 away from other residents during grabbing or hitting behaviors (initiated 1/27/26), staff to redirect resident away from confrontations and supervise with visual checks every 30 minutes (initiated 1/27/26). R1's MDS (Minimum Data Set) dated 1/19/26 documents a BIMS (Brief Interview of Mental Status) of 03, indicating severe cognitive impairment. Section E documents under Behavioral Symptoms behaviors including physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others), and other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days. Under Impact on Resident, it documents these behaviors significantly interfered with the resident's participation in activities or social interactions and under Impact on Others, it documents these behaviors significantly intruded on the privacy or activity of others and significantly disrupt care or living environment. R2' admission Record documents an admission date of 7/3/24 with included diagnoses of vascular dementia, delirium due to known physiological condition, major depressive disorder, panic disorder, anxiety disorder. R2's MDS dated [DATE] documents a BIMS of 03, indicating severe cognitive impairment. Reviewed R2's Care Plan and it does not have a focus area for R2 being at risk for abuse. A facility incident document with date of incident 1/27/26 at 4:05 PM documents under Type/Nature of incident: Resident/Resident Altercation. Under Nursing Description, it documents While this nurse was on the 200 hall passing medications, CNA witnessed resident (R2) grabbing another resident (R1) in the doorway of the TV room while calling other resident (R1) a whole [sic], other resident (R1) swung and hit the resident (R2) in the face, knocking residents (R2) glasses to the floor, CNA came between them and separated them. Under Description of Action Taken it documents CNA immediately came between the residents (continued on next page)</p>

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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(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 - Actual harm  Residents Affected - Few	<p>and separated them, 2nd CNA came and alerted this writer of incident, this writer immediately reported this to the administrator. R1's Progress Note dated 1/27/2026 at 17:56, type: Behavior Note, created by V7 documents While this nurse was on the 200 hall passing medications, CNA witnessed another resident grabbing this resident in the doorway of the TV room while being called a whore, this resident swung and hit other resident in the face, knocking residents glasses to the floor, CNA came between them and separated them, this nurse immediately notified Administrator, (Physician), and POA. On 4/29/26 at 11:48 PM, V7 stated she was working when the incident happened between R1 and R2 on 1/27/26. V7 stated R1 hit R2 and knocked her glasses off her face. V7 stated she looked back at her messages to V8 (Physician) and she reported to him that R2 had slight redness to her forehead from R1 punching her. On 4/29/26 at 2:50 PM, V2 (Family Member/Power of Attorney) stated she was told R2 was hit in the face by another resident in January and it knocked her glasses off her face but that is all she knows about it. On 4/29/26 at 9:47 AM, V4 (Certified Nursing Aide/CNA) stated she doesn't remember if she was working when R1 and R2 had their altercation on 1/27/26. V4 looked at the daily schedule for 1/27/26 and her name is down as working, V4 stated she doesn't remember the incident. V4 stated R1 had behaviors a lot and they would try to redirect her, but it didn't always work. V4 stated R1 liked to sing so they would try to take her to sing or take her to play the keyboard that was in her room. On 4/29/26 at 9:50 AM, V5 (Activities Aide) stated she doesn't remember if she was working when R1 and R2 had their incident, but she just remembers that R1 punched R2 in the face. V5 stated R1 was very set in her ways and when she thought something had happened, even if it didn't, they had to go along with it to try and redirect her. V5 stated R1 had a lot of behaviors. On 4/29/26 at 9:55 AM, this surveyor attempted to interview R2 and due to her cognitive level, she was unable to recall the incident. On 4/29/26 at 11:35 AM, V1 (Administrator) stated she just started working at this facility last month and does not know any information regarding the incident between R1 and R2 from 1/27/26. A facility policy titled Abuse and retaliation Prevention and Reporting-ILLINOIS dated 1/8/26 documents under Policy: the 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 abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.</p>		