

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/01/2026
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services in a manner which prevented elopement for 2 of 3 residents (R2 and R3) reviewed for safety/elopement in a sample of 12. This failure resulted in R2 exiting the locked memory care unit and observed outside the facility for an undetermined amount of time on 04/26/26 and R3 leaving the designated outdoor smoking area with no staff knowledge or supervision, walking a couple of blocks up the road and out of sight of the facility on 04/28/26. The Immediate Jeopardy began on 04/26/26 when the facility failed to provide services in a manner to prevent elopement for R2 and R3. This failure resulted in 1) R2 exiting the locked memory care unit and being observed outside the facility, unknown to staff; 2) R3 leaving the designated outside smoking area and found walking a couple of blocks away, without staff knowledge, in an area observed as being an active residential neighborhood with vehicles utilizing the roadway and no sidewalks. R3 was walking in the road, putting him at risk for preventable injuries and heading toward the main highway (a heavily trafficked roadway about 0.5 miles away). V1, Administrator, V2, Director of Nursing (DON), and V8, Social Services, were notified of the Immediate Jeopardy on 05/28/26 at 1:30 PM. The immediate jeopardy that began on 04/26/26 was not removed at the time of the survey exit because the facility failed to ensure R3 did not have access to the code for the 500-hall patio door and R3 was seen unsupervised by staff while outside on 06/01/26 from 1:00 PM-1:30 PM. Findings Include: 1. R2's Face Sheet, admission date of 10/15/25, documents R2 has diagnoses of but not limited to Wernicke's Encephalopathy and alcohol dependence with alcohol induced persisting dementia. R2's Minimum Data Set (MDS), dated [DATE], documents R2 is severely cognitively impaired (resident is rarely/never understood) and she requires substantial/maximal assistance or is dependent on staff for most of her activities of daily living (ADLs). R2's Care Plan, admission date of 10/15/25, documents R2 is an elopement risk/wanderer. She requires a wander guard r/t (related to) exit seeking, history of attempts to leave facility unattended, Impaired safety awareness, Resident wanders aimlessly, significantly intrudes on privacy or activities. Interventions include but are not limited to Staff to monitor location. Redirect R3 away from doors and from going outside of the facility. Report to hall nurse, DON (Director of Nursing), and administrator if resident leaves facility through a door. It also documents R2 has a Cognitive deficit- forgetful, difficulty with decisions, can say a few words, dementia, Communication deficit r/t dementia, aphasic (impaired ability to speak) at times. It also documents that R2 is at risk for personal injury r/t lack of regard for own safety. R2's Elopement Risk Assessment, dated 01/22/26, documents R2 is not sufficiently alert, oriented, coherent, or knowledgeable allowing him/her to be considered for independent outside privileges. R2 is not able to verbalize how to move/navigate/negotiate safely on community streets, she doesn't know the facility name in case of an emergency, doesn't know how to ask for/seek help in an emergent or problematic situation, is unable to verbalize understanding of potentially dangerous situations, such as walking alone after dark, straying into an alley, accepting rides from strangers, and she can't safely maneuver in community and isn't without debilitating physical impairment making her unsafe. It also documents that R2 has safety risks. R2 is at risk of eloping and should be placed (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on the elopement risk protocol. Rational for decisions: R2 was placed on the locked unit on 11/25/25 and has been doing well in that hall. R2 will attempt to exit seek off that hall but is easily re-directed. R2's Progress Notes, dated 4/26/2026 at 8:06 PM, documents R2 has had increased pacing and has escaped several times from the lockdown unit. The staff get her as soon as she breaches the door as the alarm sounds. She will not stay in bed and keeps pacing wanting to go down the hall to the doors. Her wandering behavior has increased over the last several days. R2's Progress Notes, dated 4/26/2026 8:07 PM, documents: Addendum: Clarification to previous note: R2 has increased pacing and exit seeking noted, staff redirects with success. Activities provided and effective for short periods. R2's Progress Notes, dated 4/28/2026 04:50 AM, documents R2 has been up all night. She has not been asleep at all. She is not able to be redirected. As needed (PRN) medication was given and not effective at all. She has been wandering all over the unit and into other residents' rooms, yelling loudly, clapping her hands, and being very disruptive to other residents on the unit. On 05/19/26 at 9:45 AM, R2 is pacing/walking up and down the hallway and she is wandering in and out of other resident's rooms and the bathroom. On 05/20/26 at 08:30 AM, R2 is up and walking/pacing in the hallway on the memory unit. She is walking in and out of other residents' rooms and was seen opening the main door on the memory unit. Housekeeping/Laundry and other staff were seen coming in and out of that door. On 05/19/26 at 1:45 PM, V11, Certified Nursing Assistant (CNA) said she was working back on the memory unit on April 26th, and she was the only CNA working on this day and the nurse that day was V17, Registered Nurse (RN). V11 said she was in a room with another resident changing and cleaning them up and V17 must have left the unit without letting her know. V11 said when she came out of the dirty utility room she just so happened to look up and see R2 out the window across the hall from the dirty utility room. She said there were no door alarms going off. V11 said she called the 200 hall to inform V17 of R2 being outside and no one answered the phone so she ran down to the 200 hallway and seen V17 standing at the nurses station and she told V17 R2 was out in the yard and V17 didn't do anything about it. She said she then ran outside and got R2 and took her back to the locked memory unit. V11 said she also reported it to V1, Administrator and V1 said to her I'm going to act like I didn't hear that. V11 said She thinks R2 left out the doors following the nurse, went down the 200 hallway and went out the door down at the end of that hallway because it's usually never locked or alarm on. V11 said R2 was walking back over to the memory unit from the 200 hallway outside. She said if she hadn't looked out the window when she did, she doesn't know what would have happened to R2 and she isn't sure how long R2 was even outside. V11 said there was another time she followed someone out the main doors to the memory unit and kitchen staff had to bring her back. On 05/27/26 at 2:30 PM, V1 Administrator said they have been doing a lot of different training and in-services. She said they had training in documentation due to staff not wording things the correct way and she had to have staff go in and correct what they had written. On 05/28/26 at 1:45 PM, V1, Administrator said no one informed her R2 had gotten out of the facility, and she thinks the staff let R2 out on purpose to try and set her up. She said she doesn't understand how she can be held responsible for this if she didn't know it had happened. On 06/01/26 at 12:38 PM, V16, Anonymous said she had documented in R2's chart and V9, Regional [NAME] President of Operations, and V32, Corporate told her she had to change the wording. She said V1 also stated that it is a reportable and the wording needed to be changed. V16 said V1 was made aware of R2 getting out of the facility on 04/26/26. 2. R3's Face Sheet, admission date of 10/28/19, documents R3 has diagnoses of but not limited to non-traumatic chronic subdural hemorrhage, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, aphasia following cerebral infarction, alcohol dependence, and unspecified convulsions. R3's MDS, dated [DATE], documents R3 is severely cognitively impaired, and he is rarely/never understood. He requires supervision or touching assistance with ambulation of 10, 50, 150 feet, and he uses a wheelchair as a mobility device. R3's Care Plan, admission date of 10/28/19, documents R3 is an elopement risk/wanderer r/t impaired safety awareness was initiated on 04/29/26. Physical/verbal (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aggression. 04/28/26 resident pushed wheelchair ambulating away from facility. Interventions include but are not limited to on 04/28/26 elopement risk, staff to accompany R3 outside when he wants to sit on patio. It also documents R3 has a communication deficit r/t CVA (Cerebrovascular Accident) with aphasia (a language disorder caused by damage to the brain, usually from a stroke, head injury, or tumor and impairs a person's ability to speak) (can say help and unhuh), resident uses gestures, points, mumbles, and becomes agitated at times. It further documents R3 is at risk for falls r/t history of falls, psych med use, poor recovery balance, CVA, weakness. Interventions include but are not limited to Provide a safe environment: even floors free of spills and/or clutter, and adequate, glare free light. R3's Elopement Risk Assessment, dated 11/25/25, documents R3 cannot safely maneuver in the community has some physical impairment making it unsafe for R3. It also documents he appears to be capable of outside supervised pass privileges. A care plan for outside pass privileges including risk factors for non-compliance for adhering to pass policies and parameters is indicated. R3's Elopement Risk Assessment, dated 01/22/26, documents R3 cannot safely maneuver in the community has some physical impairment making it unsafe for R3. It also documents that he appears to be capable of outside supervised pass privileges and a care plan for outside pass privileges is indicated. R3's Progress Notes, dated 04/28/26 at 4:21 PM, documents R3 left the designated area while smoking. V8, Social Service Director (SSD) was able to provide supervision and attempted to prevent R3 from walking further and obtained assistance from V1, Administrator. R3's Progress Notes, dated 04/29/26 at 4:21 PM, documents intervention was implemented immediately to mitigate the risk of R3 potentially leaving designated areas. A staff member is to always be with resident while outside. R3's Elopement Risk Assessment, dated 04/29/26, documents R3 responds poorly to staff re-direction when roaming into areas that are off limits or unauthorized, he becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e., would not be able to safely care for him/herself outside of the facility), he isn't sufficiently alert, oriented, coherent, and knowledgeable allowing him/her to be considered for independent outside pass privileges, he is not able to verbalize how to move/navigate/negotiate safely on community streets (cross safely, maintain a safe distance from cars, uses sidewalks, in a wheelchair, propels safely/carefully ect.). It also documents that R3 is at risk for elopement and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. On 06/01/26 at 1:00 PM, R3 was seen sitting out on the 500-hall patio by himself with no staff supervision noted. On 06/01/26 at 1:15 PM, R3 remains outside with no staff supervision. On 06/01/26 at 1:30 PM, R3 continues to sit outside by himself with no staff supervision. On 05/19/26 at 8:06 AM, This surveyor went down the independent hall to the exit door that leads to outside, this surveyor opened the door and no alarm sounded when the door was opened. On 05/27/26 at 9:28 AM- This surveyor asked V22, Licensed Practical Nurse (LPN) if she could put in the code for the 500-patio door. She said the code to get out the back door is 2020* she took this surveyor to the back door and pointed out the code is also written on a note that is posted by the keypad to turn off the alarm before going out and said the code for the door is right here. On 05/27/26 at 9:15 AM, V21, Dietary Aide said he was working the day R3 was out of the facility. He said he was leaving the facility for the day and he seen R3 a couple of blocks up the road (in an observed active residential neighborhood with vehicles utilizing the roadway, and no sidewalks which required R3 to walk in the road putting him at risk for preventable injuries) and there was no staff with the resident. He said he turned his car around and came back to the facility and asked V8, Social Services what R3's limit was and if he was supposed to be up the road. V21 said R3 wasn't on the main road (which is approximately 0.5 miles away from the facility and is a heavily trafficked roadway), but he was heading in that direction. On 05/27/26 at 9:50 AM, follow up interview with V21. He said when he came and got V8 to let her know R3 was up the road a couple of blocks V8 was in her office inside the building. On 05/27/26 at 9:22 AM, R1, who is cognitively intact with a Brief Interview of Mental Status (BIMS) of 14 out of 15 said he was sitting out on the patio and seen when R3 left the facility and walked up the street and around the corner. He said R3 didn't have any staff (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with him when he left, and he was not able to see R3 from the facility after he turned the corner. On 05/27/26 at 3:40 PM, V26, Medical Director said when it comes to the doors being locked/alarmed he would expect the alarms on the doors to be on. He said when it comes to the locked dementia unit residents being safe outside alone, he said not without staff being with them. He said as a general rule it wouldn't be a good idea unless they had family with them and staff need to know they are with family. V26 said he isn't sure if there is a policy for residents who leave the facility independently. He said the staff need to keep track of the residents and it's the facility's responsibility if something happens to the residents. He said with R3 and the change in his supervision he doesn't think it's a good idea for him to just wander off and hope that he comes back. He said R3 should have been accompanied by staff, and it makes him nervous R3 wasn't able to be seen from the facility. He said R3 could have been in grave danger with getting that far and that's not good. The facility's Code Pink-Missing Resident/Elopement policy, revision/review date of 11/15/18, documents 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: 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. (1) Examples of interventions may include but are not limited to: (a) Wander guard bracelet (b) Increased monitoring such as 15-minute visual checks, 1:1 supervision (c) Evaluate for secured unit if available and appropriate. Review and update Elopement Risk binder as appropriate.		