STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus at Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to initiate and continue cardiopulmonary resuscitation (CPR) for one resident (R1) who required resuscitative care until Emergency Medical Services (EMS) assumed resuscitative efforts. This failure has the potential to affect 106 residents that are identified as full code.The Immediate Jeopardy began on [DATE] when facility staff failed to ensure, CPR was conducted after R1 was found to be unresponsive and cold blue called. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 3:45pm. The surveyor confirmed by onsite observation, record review and interview that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings Include:Per the facility's video tapes on [DATE]:At 6:58 AM, V4 CNA (certified nurse aide) was seen entering one south nursing unit, walking directly to R1's room, open the door then immediately shut the door, and exit nursing unit.At 7:17:27 AM, V7 CNA (certified nurse aide) was observed opening R1's door, entering room, then exiting room to get V3 LPN (licensed practical nurse).At 7:17: 53 AM, V3 and V7 look in R1's room. V3 was observed walking away from R1's room while V7 enters R1's room.At 7:18:32 AM, V7 exits R1's room and exits nursing unit.At 7:20:06 AM, V6 CNA was observed entering R1's room.At 7:20:20 AM, V5 LPN was observed standing in R1's doorway looking into R1's room and then returning to nurses' station.At 7:20:34 AM, V6 CNA was observed exiting R1's room and calling for help.At 7:21:08 AM, V3 LPN was observed walking down hallway towards R1's room. V3 enters R1's room briefly then exits room. V8 RN enters R1's room briefly then exits the room and nursing unit.At 7:21:59 AM, V5 LPN was observed walking the emergency cart to R1's room and then walking to the nurses' station. There is no backboard observed on the emergency cart.At 7:23:04 AM, V8 RN (registered nurse) was observed entering R1's room.At 7:23:35 AM, V3 LPN was observed removing towels from linen room across from R1's room and handing to V8 who was standing in R1's doorway.At 7:25:20 AM, V3 was observed entering R1's room.At 7:25:34 AM, V11 CNA was observed bringing several clear large plastic bags to R1's room.At 7:25:44 AM, V3 was observed exiting R1's room with a large clear plastic bag with soiled linens. V3 exited nursing unit to dispose of bag.7:27:15 AM, staff exit R1's room. V3 LPN returns and stands by R1's doorway.7:29:05 AM, EMS crew arrive on unit.Between 7:21:59 until EMS crew arrived at R1's room at 7:29:14 AM, staff did not obtain a backboard. The manual resuscitation bag, oxygen tank, and the automated external defibrillator (AED) remained on the emergency cart. The facility's code blue documentation sheet (attached to crash cart) for [DATE] requested from V1 and V2. This sheet was not provided for review during this survey.On [DATE] at 3:00 PM, V4 CNA (certified nurse aide) stated that she worked [DATE] day shift. V4 stated that while she was rounding on the residents on the one north nursing unit, she heard a code blue announced overhead. V4 stated that she ran to the one south nursing unit. V4 stated that she was instructed to call EMS 911. V4 stated that she called 911 and waited in the main lobby for the ambulance crew to arrive. V4 stated that she did not return to the one south nursing unit to assist with CPR (cardiopulmonary resuscitation) efforts for R1.Per the facility's video surveillance tapes, V4 (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	was seen entering one south nursing unit at 6:58 AM and walking directly to R1's room, open the door then immediately shut the door, and exit nursing unit. At 7:22:49 AM, V4 was observed returning to one south nursing unit with a large clear plastic bag and enter R1's room. At 7:23:26 V4 exits R1's room briefly then re-enters room. At 7:26:30 V4 was observed throwing soiled towels/linens into the large plastic bag then proceed to the nurses' station.On [DATE] at 3:15 PM, V5 LPN (licensed practical nurse) stated that on [DATE] she worked the day shift. V5 stated that as she was coming on shift, she heard a code blue called. V5 stated that she performed chest compressions. V5 stated that she switched off with V3 LPN. V5 denied observing any bowel movement on or around R1's bed.Per the facility's video surveillance tapes, at 7:20 AM, V5 was observed entering the one south nursing unit and walking directly to R1's room, opens door, looks in and then closes door. At 7:21 AM, V5 exits nursing unit. At 7:21:59 AM, V5 walks to R1's room with the emergency cart, places it next to room and walks away. V5 does not return to R1's room until 7:28:43 AM. V5 exits R1's room at 7:29:00 AM. On [DATE] at 2:35 PM, this surveyor attempted to interview V6 CNA, day shift CNA on [DATE], but was unsuccessful. V6's phone disconnected. This surveyor reviewed V6's employee file for additional phone number(s). There was one other phone number listed in V6's file from 2023. This surveyor was unsuccessful, no longer phone number for V6. On [DATE] at 3:10 PM, this surveyor attempted to interview V7 CNA, day shift CNA on [DATE], but was unsuccessful. V7 did not return my call. On [DATE] at 11:25 AM, V7 was interviewed. V7 stated that V7 was informed by the CNA on the previous shift that R1 was not changed during the night. V7 stated that when she went to R1's room at 7:17 AM, she observed R1's brief off and feces and urine in R1's bed.On [DATE] at 5:30 AM, V3 LPN stated that he saw R3 in R1's room. V3 stated that he was giving R1 and R3 private time and did not want to interrupt. V3 stated that at 6:30 AM, R3 was still in R1's bed. V3 stated that at 6:55 AM R3 exited R1's room. V3 stated that at 7:10 AM he went into R1's room, R1 was unresponsive. V3 stated that he called a code blue, initiated CPR, and called EMS 911 from the nurses' station phone. V3 stated that he is not sure who was performing chest compressions, he never went back into R1's room. V3 stated that he did not go into R1's room until the paramedics arrived. V3 stated that the crash cart was in R1's room, the manual resuscitation bag was in room, not sure if it was used. V3 stated that after he called 911, he printed R1's face sheet and e-interact form for the paramedics. V3 stated that the morning shift nurses responded to the code blue, does not know the names of staff. V3 is unable to state with certainty that chest compressions and rescue breathing were done since he did not go back into room.On [DATE] at 7:46 AM, V3 LPN stated that he was instructed to lie regarding this event involving R1. V3 would not state who informed him to lie. When questioned what the truth is, V3 stated that he wants to get his story straight before speaking any further to this surveyor.On [DATE] at 12:45 PM, V3 LPN stated that he went to R1's room at 6:30 AM and instructed R3 to leave R1's room. V3 stated that at 7:00 AM he saw R1 sleeping. V3 stated that at 7:15 AM, R1 was found unresponsive. V3 stated that there was dirty linen in R1's room. V3 stated that he was running around trying to figure out what to do. When questioned about chest compressions during a code blue, V3 responded you are not supposed to stop chest compressions before EMS crew takes over the care of the resident. V3 stated that there was feces on R1's bed and the floor and R1 was wet due to incontinence. V3 stated that towels were placed on the floor so staff would not step in the feces. V3 acknowledged cleaning the resident and/or floor does not take precedence over performing CPR.On [DATE] at 10:33 AM, V8 RN (registered nurse) stated that she worked on the one north nursing unit on [DATE]. V8 stated that when she arrived to work she went to the one north nursing unit to prep the medication cart and receive report from V3 LPN (night shift nurse). V8 stated that she heard staff calling V3 by name and then call a code blue. V8 stated that she ran to R1's room and found R1 unresponsive. V8 stated that the crash cart was brought to R1's room and CPR was initiated. V8 stated that she and another staff were performing CPR, she asked to switch, and left R1's room. V8 stated that she returned to R1's room and continued to perform CPR. V8 stated that she left R1's room because no staff were on the one north nursing unit. V8 stated that she does not know (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	which other staff were present during CPR or performing CPR. V8 stated that she passed the EMS crew in the main lobby as they were entering facility.Per the facility's video surveillance tapes, V8 was observed at 7:21:31 AM entering R1's room; exiting room at 7:21:34 AM, and exiting the nursing unit at 7:21:45 AM. At 7:23:26 AM, V8 was observed standing in the doorway for R1's room. V8 is handed a stack of towels from V3 LPN and re-enters R1's room at 7:23:43 AM. At 7:25:24 AM, V8 exits R1's room. At 7:26:52, V8 obtains a large clear plastic bag and more towels. At 7:27:12 AM, V8 was observed standing in R1's doorway speaking with V3, briefly re-enters R1's room, and exits room at 7:27:50 AM and walks to nurses' station before exiting unit.On [DATE] at 12:52 PM, V9 (EMS paramedic) stated that when the crew arrived at R1's bedside, there was no medical equipment (backboard, manual resuscitation bag, oxygen tank) in room and V3 was the only person in R1 and R2's room and he was speaking with R2. V9 stated that the crew immediately placed backboard under R1 and placed manual resuscitation bag over R1's mouth and nose, CPR was initiated. V9 stated that a mechanical chest compression system was applied to R1 and R1 was placed on stretcher and transported to ambulance then hospital. V9 stated that CPR continued in ambulance and in hospital. V9 stated that there was no return of spontaneous circulation for R1. V9 stated that R1's jaw and right arm showed signs of rigor mortis (stiffening of the muscles) and right arm was cold to touch. V9 stated that R1's torso felt warm to touch so CPR was initiated.The EMS report, dated [DATE], notes dispatch was notified at 7:22:47 AM for a resident with breathing problems. The EMS crew arrived at facility at 7:27:31 AM; at R1's bedside at 7:28:26 AM. The EMS crew left the scene at 7:38 AM. The summary notes crew members were dispatched to the facility for a female resident not breathing. Upon arrival, crew was approached by nursing staff that informed crew that R1 was not breathing and informed crew they were performing CPR prior to EMS arrival. Staff also informed crew of finding R1 in the morning like that. Crew noted no CPR in progress upon arrival to R1. Crew noted R1 laying supine in bed, pulseless, apneic and unresponsive. R1 was alert and oriented x 0/4 with a glasgow coma scale of 3 out of 15. Crew began manually performing compressions. Crew placed the cardiac monitor defibrillation pads on R1. Crew analyzed rhythm and noted asystole (no ventricular contraction) on the monitor. Crew started to assist R1 with manual ventilations via manual resuscitation bag at 15 liters/minute of oxygen. Crew transferred R1 from R1's bed to the stretcher. While R1 was placed on the stretcher, crew placed the mechanical chest compression system on R1 and resumed CPR. Crew secured the patient's arms to the mechanical chest compression system and secured device to R1. Nursing staff gave all patient information to crew member. While moving R1 t to the ambulance, crew had mechanical compressions and ventilations continuing. Once in the ambulance, crew placed a device to maintain R1's airway and continued ventilation. Crew secured airway device and confirmed airway device was appropriately inserted. Crew established an IO (interosseous) catheter in R1's left humeral head with no complications. Crew administered the first round of Epinephrine 1:10 via IO. Crew then paused CPR for a rhythm and pulse check. Crew noted no pulse and R1 to remain in asystole. Crew resumed CPR and ventilations. Crew then secured R1 onto the stretcher and transported R1 to the closest hospital. En route, the hospital was contacted via telemetry and crew alerted the hospital of a cardiac arrest. R1 was transferred to a bed in the emergency department, and a handoff report was given to the primary Physician and primary nurse. R1's hospital record, dated [DATE], notes R1 presented to the emergency room at 7:41 AM, CPR in progress. Asystole noted entire time. Per EMS, R1 was found down at facility, unknown down time. R1 exhibiting rigidity of the right upper extremity and jaw on intubation attempt. R1 warm to touch. Pupils fixed and dilated. En route an airway device was inserted. In the emergency department, CPR continued. R1 was unresponsive, skin was cool and dry, pupils fixed and dilated. A rapid sequence endotracheal intubation was performed. R1 went through three rounds of epinephrine in the emergency room, five rounds total during her resuscitation. R1 remained asystole on the monitor on all pulse checks. On final pulse check, bedside echocardiogram performed which showed cardiac standstill. Time of death called at 7:56 AM.American Heart Association 2025 guidelines for adult CPR (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	notes early high-quality CPR and prompt defibrillation are the most important interventions associated with improved outcomes in adult cardiac arrest. For adult cardiac arrest, rescuers should perform chest compressions with the patient on a firm surface. Start CPR until advanced care arrives. The adult BLS (basic life support) algorithm notes start with compressions, check for visible object in mouth before giving breaths, start CPR, begin bag-mask ventilation with oxygen. High-Quality CPR notes push hard (at least 2 inches [5 cm]), push fast (100-120/min) and allow complete chest recoil, minimize interruptions in compressions, avoid excessive ventilation, change compressor every 2 minutes, if no advanced airway, 30:2 compression-ventilation ratio. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following steps to remove the immediacy.PLAN OF REMOVALF678Affected resident corrective actions.R1 expired at the hospital [DATE].The facility failed to initiate and continue CPR for R1 who required resuscitative care until Emergency Medical services assumed resuscitative efforts.Immediate Actions and Actions to prevent recurrence. (Initiated on [DATE] at 4:45PM and will continue until all staff are in-serviced and trained prior to the start of their shift)The facility took the following immediate actions to address the citation and prevent any additional residents from suffering an adverse outcome. An In-service was conducted on performing CPR on residents who are full codes and in cardiopulmonary arrest/ requiring emergency medical attention, with emphasis on staff recognizing cardiac arrest and initiating CPR without delay, and staff understanding their roles and responsibility during a code event. Staff education has been conducted including documentation of who conducted the training and their title.(This immediate action was initiated and was completed on [DATE] at 4:45)A knowledge check and competency assessment completed immediately for all staff. Staff competence to initiate CPR has been verified utilizing a questionnaire for all nursing staff, competency test was conducted by DON/Designee.All staff currently on duty were educated and verified competent to provide CPR prior to resuming care.An audit of all residents' code status orders has been conducted to ensure they are accurate and readily available to staff.New hires will be in-serviced by the DON, or Designee on the facility's code blue policy.All staff members who are currently on vacation, or are not available, have received education on the facility's code blue policy via telephone, and will also receive the same education upon their return to work by DON/Designee.The facility does not utilize agency staff however the same process of providing education to ensure that Agency staff will receive the same training as the facility staff prior to the start of their shift.A crash cart audit was conducted by DON/ADON/Designee to ensure all resuscitation equipment, including a backboard and manual resuscitation device, is readily available, no concerns identified. (This immediate action was initiated and was completed on [DATE] at 4:45pm)The Medical Director, Administrator, DON and RNC reviewed the facility's policies which include but are not limited to the following. There was no revision required. Procedures on Code blue policy. 2) Emergency Cart Policy(This was initiated, reviewed and completed on [DATE] at 4:45pm)The DON/ designee will conduct code blue drills to identify any potential need for additional training. To ensure compliance, the results of the audit/drills will be reviewed after the drill by the DON, ADON, and the Administrator.(This immediate action was initiated on [DATE], and will be completed 2x a week, including weekends, for 4 weeks and then weekly for 8 weeks.)The DON/Designee will conduct random staff interviews for at least five (5) employees to gauge knowledge for retention and determine if additional training is required. (This immediate action was initiated on [DATE] and will be done weekly for 8 weeks.)Any identified concern will be addressed immediately. An Ad-hoc QAPI meeting will be held weekly to review results of the audits and drills to determine if additional interventions are necessary to ensure compliance. (This immediate action was initiated on [DATE], then weekly for 8 weeks.) The Administrator, DON and Designee will monitor completion of this plan of removal.Date Facility Asserts Likelihood for Serious Harm No Longer Exists:Completion Date: [DATE]