

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Nexus Pavilion at Belleville		STREET ADDRESS, CITY, STATE, ZIP CODE 727 North 17th Street Belleville, IL 62226	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate nursing staff to provide nursing and related services to meet the residents' needs safely and to administer their medications for 4 out of 4 residents (R4, R5, R6, R7) reviewed for medications in the sample of 7.</p> <p>Findings include:</p> <p>1. R4's undated face sheet documented R4 has diagnoses including spina bifida with hydrocephalus, moderate malnutrition, cognitive communication deficit, epilepsy, neurogenic bowel. Paraplegia and neuromuscular dysfunction of the bladder.</p> <p>R4's minimum data set (MDS) dated [DATE] documented R4 is cognitively intact and requires a wheelchair for mobility.</p> <p>R4's Care plan dated 4/11/2025 documented assistance needed with all activities of daily living (ADL's), fall risk, seizure disorder, skin issue risk, range of motion functional limitation, self-care deficit related to bed mobility, self-straight cath related to neurogenic bladder, urostomy care.</p> <p>R4's May 2025 medication administration record (MAR) reviewed for 5/18/2025 8:00 am and 12:00 pm medications left blank for administration entry areas. This consisted of eleven medications not being given. This included lactobacillus 1 capsule twice daily (BID), Vitamin D 1 tablet daily, Eliquis 2.5 milligrams (mg) BID, folic acid 1000 micrograms (mcg) daily, gabapentin 400 mg three times per day (TID), multivitamin with minerals 1 tablet daily, MiraLAX 17 grams daily, Senna S 8.6-50 mg BID, Vitamin C 500 mg daily and Zyrtec 10 mg daily.</p> <p>R4's Physician order set (POS) dated 6/2/2025 confirmed these medication orders lactobacillus 1 capsule BID, Vitamin D 1 tablet daily, Eliquis 2.5 mg BID, folic acid 1000 mcg daily, gabapentin 400 mg TID, multivitamin with minerals 1 tablet daily, MiraLAX 17 grams daily, Senna S 8.6-50 mg BID, Vitamin C 500 mg daily and Zyrtec 10 mg daily.</p> <p>On 5/22/2025 at 12:35 pm, R4 stated that for 5/18/2025 she did not receive any medications until 6:30 pm and did not receive any of her morning medications. R4 stated she did not see a nurse all day long except for the one that came from one of the other floors to assist her with personal care. She did not remember who that nurse was. R4 stated that she did not have any effects from not receiving her medications. R4 stated that she told V16, RN, who came on at 6:30 pm that she had not received any day medications. R4 stated that V16 only gave her scheduled evening medications.</p> <p>(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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 5/22/2025 at 12:40 pm, R5 stated that on last Sunday, May 18th, she did not receive any of her day medications due to a call-in and no nurse assigned to the 200-hall. These medications included Invega 12 mg daily, lamotrigine 100 mg daily, olanzapine 10 mg daily, omeprazole 20 mg daily, sertraline 50 mg daily, and tolterodine 4 mg daily. R5 stated she didn't feel any ill effects from not having received her medications. R5 is unaware of other times when there has not been a nurse on the hall.</p> <p>3. On 5/22/2025 at 12:50 pm, R6 stated that she did not receive her morning medications on 5/18/2025 including amlodipine 10 mg daily, Ativan 0.5 mg TID, divalproex 500 mg BID, famotidine 20 mg BID, Haldol 20 mg BID, Ingrezza 40 mg daily, lidocaine patch daily, magnesium 400 mg daily, metoprolol 50 mg BID, olanzapine 30 mg daily, protonix 40 mg daily, sertraline 250 mg daily, and tramadol 50 mg four times per day (QID). R6 stated that V13, CNA, had told her there was not a nurse on the hall that day. R6 stated she didn't tell anyone about the missed medications because she forgot. R6 stated that by not receiving her morning medications she was very moody and tearful. R6 added that she needs her medications. R6 stated she told V16 that she hadn't received any of her medications all day. R6 stated that V16 told her she was aware of this.</p> <p>4. R7's undated face sheet documented she has diagnoses of paranoid schizophrenia, hallucinations, and disorder of plasma-protein metabolism.</p> <p>R7's MDS dated [DATE] documented that she is cognitively intact. She requires no adaptive equipment for mobility and requires supervision for all activities of daily living (ADL's).</p> <p>R7's care plan dated 4/26/2025 documented she is at risk for developing an impairment in functional joint mobility, complications with communications, and schizophrenia.</p> <p>R7's POS dated 6/2/2025 documented orders for scheduled medications including benztropine 1 mg BID, risperidone 4 mg BID and hydroxyzine 50 mg TID.</p> <p>R7's May MAR documented that she did not receive her morning or afternoon medications on May 18, 2025, as the place for administration time documentation was left blank.</p> <p>On 5/23/2025 at 3:35 pm V16 stated that she did work 5/18/25 evening shift on the 200-hall and remembered that there had not been a nurse on the 200-hall during the day shift on 5/18/2025.</p> <p>On 5/23/2025 at 8:15 am, V8, regional nurse consultant stated that an incident report will be filed on the missed medications on 5/18/2025 for the residents on the 200-hall. V8 stated she had first learned of the missed medications on the 200-hall in the Monday morning meeting on 5/19/2025 and had instructed staff to notify the physician and file an incident report. V8 was unaware this had not been completed and now told V2, Director of Nurses (DON) to complete this. V8 stated that residents not receiving their scheduled medications is a medication error. V8 stated that the nurse on the 100-hall should have passed medications on the 200-hall on 5/18/2025.</p> <p>On 5/23/25 at 8:30 am, V6, CNA, stated she worked on the 100-hall on 5/18/2025 and that there was no nurse during the day shift for the 200-hall</p> <p>On 5/23/2025 at 3:35 pm V16 stated that she did work 5/18/25 evening shift on the 200-hall and remembered that there had not been a nurse on the 200-hall during day shift</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/2/25 at 2:00 pm, V6 stated that on 5/18/2025, if one of the residents on the 200-hall needed something a nurse from the 100-hall or 400-hall could cover. V6 did not hear any complaints from any of the residents on the 200-hall that day.</p> <p>On 6/2/25 at 1:40 pm, V24, LPN, stated that she was unit manager on 5/18/2025 and about 9:00 am she sent a text to V2 to inform her they were short a nurse on the 200-hall. V2 returned text to V24 around 11:00 am and told her to split the halls so that the 100-hall nurse would also take the 200-hall; the 300-hall nurse already had the 400-hall and the 500-nurse remained downstairs. V24 stated that she wasn't aware these instructions weren't followed until she came upstairs at the end of her shift around 2:30 pm and a few of the residents told her they had not received their medications on that day. V24 notified V2 who told her she would make some calls to staff to see if someone could come in.</p> <p>On 5/22/2025 at 1:55 pm, V9, Nursing Supervisor, stated that she received a call from V2 around 5:00 pm asking her to come in and work that evening that there had not been a day nurse on the 200-hall that day. V9 was listed on the staffing sheet for 5/18/2025 as working on the 200-hall. However, V9 stated that she worked on the 300-hall when she arrived about 7:30 pm because there was already someone working on the 200-hall.</p> <p>On 5/23/2025 at 3:00 pm, V21, Nurse Practitioner, reviewed medications missed by R4, R5, and R6 and stated that it was not detrimental for R4 and R5. V21 stated it was also not detrimental for R6 after reviewing her vital signs for the day. V21 stated that R6 had been on her medications since 12/2024 and would see a tolerance built up in her body.</p> <p>On 6/2/25 at 11:40 am, V21 explained further that R6 had been on her scheduled medications for over six months and since she had been taking them for some time. The fact that she missed a dose of her scheduled medications does not put her at a great risk of any adverse reactions.</p> <p>On 6/2/25 at 12:05 pm, V21 stated that R7 missing her morning medications on 5/18/2025 caused no detrimental effects for her either.</p> <p>Staffing Policy with a review date of 9/2023 documented that staffing is based on the Illinois Department of Public Health (IDPH) formula for determining number and levels of staff. Staffing is then increased based on the needs of the resident population. Staffing is supplemented as needed by outside agencies. It is the staff members' responsibility to be at work when they are scheduled.</p> <p>Medication administration policy reviewed on 4/2024 documented that all medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. If medication is not given as ordered document the reason on the MAR and notify the health care Provider if required. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner and a note should reflect the situation in the resident's medical record.</p> <p>Facility assessment tool updated or assessment date of 3/5/2025 and reviewed with quality assessment (QA) on 1/16/2025 documented under staffing plan that 5.8 average nurses are needed per day who provide direct care with 30.8 nursing personnel with administrative duties. This number was brought to V1's attention who revised it to list 6 nursing personnel with administrative duties per day.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the administration of scheduled morning and afternoon medications for 4 out of 4 residents (R4, R5, R6 and R7) reviewed for medication administration in the sample of 7.</p> <p>Findings include:</p> <p>1. R4's undated face sheet documented R4 has diagnoses including spina bifida with hydrocephalus, moderate malnutrition, cognitive communication deficit, epilepsy, neurogenic bowel. Paraplegia and neuromuscular dysfunction of the bladder.</p> <p>R4's minimum data set (MDS) dated [DATE] documented R4 is cognitively intact and requires a wheelchair for mobility.</p> <p>R4's Care plan dated 4/11/2025 documented assistance needed with all activities of daily living (ADL's), fall risk, seizure disorder, skin issue risk, range of motion functional limitation, self-care deficit related to bed mobility, self-straight catheterization related to neurogenic bladder, and urostomy care.</p> <p>R4's May 2025 medicine administration record (MAR) for 5/18/2025 8:00 am and 12:00 pm medications, the place for administration entry areas was left blank. This consisted of eleven medications not being given. These included gabapentin, vitamin D, folic acid, multivitamin, MiraLAX, Vitamin C, Zyrtec, lactobacillus, Eliquis and senna. R4's physician order sheet (POS) dated 6/2/2025 documented the following morning scheduled medications ordered lactobacillus 1 capsule twice daily (BID), Vitamin D 1 tablet daily, Eliquis 2.5 milligrams mg BID, folic acid 1000 micrograms (mcg) daily, gabapentin 400 mg three times per day (TID), multivitamin with minerals 1 tablet daily, MiraLAX 17 grams daily, Senna S 8.6-50 mg BID, Vitamin C 500 mg daily and Zyrtec 10 mg daily.</p> <p>On 5/22/2025 at 12:35 pm, R4 stated that on 5/18/2025 she did not receive any medications until 6:30 pm. She did not receive any of her morning medications. R4 stated she did not see a nurse all day long except for the one that came from one of the other floors to assist her with personal care. R4 stated that she did not have any effects from not receiving her medications. R4 stated that she told the nurse that came on at 6:30 pm that she had not received any day medications. R4 stated she normally receives 8:00 am medications and 11:00 am medications, but due to not having a nurse on that hall she didn't. R4 stated that the V16, RN, only gave her scheduled evening medications.</p> <p>2. On 5/22/2025 at 12:40 pm, R5 stated that on last Sunday, May 18th, she did not receive any of her day medications. R5 was noted to be cognitively intact during this interview. R5's POS dated 6/2/25 documented scheduled morning medication orders including Invega 12 mg daily, lamotrigine 100 mg daily, olanzapine 10 mg daily, omeprazole 20 mg daily, sertraline 50 mg daily, and tolterodine 4 mg daily. R5 stated she didn't feel any ill effects from not having received her medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 5/22/2025 at 12:50 pm, R6 stated that she did not receive her morning medications on May 18, 2025. R6 was noted to be cognitively intact during this interview. R6's POS dated 6/2/2025 documented ordered scheduled morning medications including amlodipine 10 mg daily, Ativan 0.5 mg TID, divalproex 500 mg BID, famotidine 20 mg BID, Haldol 20 mg BID, Ingrezza 40 mg daily, lidocaine patch daily, magnesium 400 mg daily, metoprolol 50 mg BID, olanzapine 30 mg daily, protonix 40 mg daily, sertraline 250 mg daily, tramadol 50 mg four times per day (QID). R6 stated that V13, CNA, had told her there was not a nurse on the hall that day. R6 stated she didn't tell anyone about the missed medications because she forgot. R6 stated that by not receiving her morning medications she was very moody and tearful. R6 added that she needs her medications. R6 stated she told V16 that she hadn't received any of her medications all day and V16 told her that she knew this.</p> <p>4. R7's undated face sheet documented she has diagnoses of paranoid schizophrenia, hallucinations, and disorder of plasma-protein metabolism.</p> <p>R7's MDS dated [DATE] documented that she is cognitively intact. She requires no adaptive equipment for mobility and requires supervision for all ADL's.</p> <p>R7's care plan dated 4/26/2025 documented she is at risk for developing an impairment in functional joint mobility, complications with communications, and schizophrenia.</p> <p>R7's POS dated 6/2/2025 documented orders for scheduled medications including benztropine 1 mg BID, risperidone 4 mg BID and hydroxyzine 50 mg TID.</p> <p>R7's May MAR documented that she did not receive her morning or afternoon medications on May 18, 2025.</p> <p>On 5/23/2025 at 3:35 pm V16 stated that she did work 5/18/25 evening shift on the 200-hall and remembered that there had not been a nurse on the 200-hall during the day shift on 5/18/2025.</p> <p>On 5/23/25 at 9:25 am, medications had been completed on the 100, 200, 400 and 500-halls V5, registered nurse (RN), did not complete morning medication pass on the 300-hall until 11:30 am on that day.</p> <p>On 6/2/25 at 10:15 am, V8 stated that V5 giving morning medications at 11:30 am, is only acceptable of the medications had administration times of 10:30 am or 12:30 am, not if they were 9:00 am morning medications that V5 was passing. She added that an incident report will be filed, and the physician will be notified. She would have expected morning medications to be completed by 10:00 am.</p> <p>On 5/23/2025 at 8:15 am, V8, Regional Nurse Consultant stated that an incident report will be filed on the missed medications on 5/18/2025 for the residents on the 200-hall. V8 stated she had first learned of the missed medications on the 200-hall on the Monday morning meeting on 5/19/2025 and had instructed staff to notify the physician and file an incident report. V8 was unaware this had not been completed and now told V2, Director of Nurses (DON) to complete this. V8 stated that residents not receiving their scheduled medications is a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/23/25 at 3:00 pm, V21, Nurse Practitioner reviewed medications missed by R4 and R5 on 5/18/2025 and stated that it was not detrimental for these residents to have missed their medications for that date. V21 stated there was no detrimental effects for R6 after reviewing her vital signs for the day that she missed medications. V21 stated that R6 had been on her medications since 12/2024 and will have a tolerance built up in her body.</p> <p>On 6/2/25 at 11:40 am, V21 explained further that R6 had been on her scheduled medications for over six months and since she had been taking them for some time, the fact that she missed a dose does not put her at a great risk of any adverse reactions.</p> <p>On 6/2/25 at 12:05 pm, V21 stated that R7 missing her morning medications on 5/18/2025 caused no detrimental effects for her.</p> <p>On 6/2/25 at 11:00 am V8 provided a list of 16 residents on the 200-hall who did not receive their medications on 5/18/2025 and stated that incident reports were written for these residents.</p> <p>Policy titled 'Medication Pass Times' dated 6/2015 with a review date of 9/2024 documented medications are administered according to a standard schedule, resident needs, and physician orders. Medication can be administered an hour before and an hour after the scheduled dose time.</p> <p>Policy titled 'Medication Error' dated 6/2015 and revised in 5/2017 with a review date in 9/2022 documented an incident report is completed immediately after an error is discovered to ensure proper resident follow-up. It documented that an incident report is completed for all medications errors, all medication errors are reported to the health care provider and to the resident. The DON reviews medication errors and reports them as appropriate. Upon discovering the error, a resident observation is completed by the nurse. Documentation of the resident observation is placed in the progress notes.</p>		