STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus Pavilion at Belleville	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)
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 observation, interview, and record review, the facility failed to prevent abuse for 1 (R3) of 9 residents reviewed for abuse in the sample of 9.Findings include:R2's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnosis including aphagia (difficulty communicating verbally) bipolar, mood disorder, hemiplegia right side and anxiety.R2's admission Minimum Data Set (MDS) dated [DATE] documents he is cognitively intact and exhibited no behaviors. R3's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including bipolar and personal history of other mental and behavioral disorders.R3's Quarterly MDS, dated [DATE] documents he is cognitively intact and exhibited no behaviors. R7's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including depression, alcohol and cocaine abuse, high blood pressure and malignant neoplasm of bronchus and lung.R7's admission MDS, dated [DATE] documents R7 is cogitatively intact and exhibited no behaviors. R2's Draft Nurse's Note, dated 3/18/2026 at 5:46 PM V14, LPN (Licensed Practical Nurse) documents physical therapy notified nurse of resident getting into an altercation with another resident. Nurse evaluated resident. No injuries to resident. PT (patient) stated that resident struck roommate (R3) in face and left shoulder. Resident refused to get evaluated at hospital. Administrator, ADON (Assistant Director of Nurses) and NP (Nurse Practitioner) notified. R3's Draft Nurse's Note, dated 3/18/2026 at 5:37 PM V14, LPN documents physical therapy reported to nurse that resident got into altercation with roommate (R2.) Nurse evaluated resident. Redness to resident left side of face and upper left shoulder. Resident had a scrape across chest area. Resident stated, I want to go to the emergency room. EMT (Emergency Medical Technician) called. Resident transported to the emergency room. Administrator, ADON and NP notified. Resident moved to another room. R3's Nurse Practitioner Progress Note, dated 3/21/2026 documents chief complaint: physical altercation with injuries. On 3/18 physical therapy personnel reported that resident got into a physical altercation with roommate, on assessment redness noted to resident's left side of face and left shoulder, resident reported, my roommate attacked me. Resident noted to have a scratch measuring 4 inches in length to chest. Resident states, I want to go to the emergency room. On 3/31/2026 at 9:45 AM V13, Speech Therapist stated a few weeks ago (exact date unknown) R3 reported to her that his roommate, R2, punched him on the left side of his face and left shoulder. V13 stated she let R3's nurse know (name unknown), and she didn't report this to any other staff. V13 stated she didn't witness or observe R2 hit R3 but that R3 told her about it and R3 was very furious that R2 had hit him.On 3/27/2026 at 9:18 AM V14, LPN stated she worked day shift at the facility on 3/18/2026 from 7:00 AM to 7:00 PM and was assigned to R2 and R3. V14 stated around 5:30 PM R3 reported that his roommate, R2 hit him on the face and shoulder, and she assessed him immediately and R3 had reddened areas to his left face and left shoulder at that time. V14 stated she asked R2 if he hit R3 and R2 stated he didn't know anything. V14 stated she called V2, Director of Nurses (DON) and R3 was transferred to the emergency room shortly after that. V14 stated she didn't know why her nurse's note dated 3/18/2026 was documented as a draft and she most definitely wanted it to be a part of R2's and R3's medical records because it was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her nursing assessment of the residents after the allegation of abuse was made by V13.On 3/27/2026 at 8:40 AM R2 was interviewed by IDPH (Illinois Department of Public Health) surveyor and shook his head no when asked if he ever hit R3 and R2 also stated, no. R2 didn't answer any further questions that were asked. On 3/31/2026 at 11:25 AM R7 stated he was in his room a few weeks ago and recalled he witnessed R3 was self-propelling in his wheelchair by his room and R2 stood in front of R3 and hit him with his fist on the left side of R3's face. R7 stated he got up immediately and stood between R2 and R3 and told R2 he wasn't going to hit R3 again. R7 stated he watched R3 self-propel in his wheelchair down the hall and made sure R2 didn't follow him. R7 stated staff asked him what occurred a few days later and he told them what he saw between R2 and R3, but he has short term memory loss and couldn't recall the staff name he spoke to regarding the altercation.On 3/27/2026 at 10:15 AM V1, Administrator and V2, DON stated R3 is schizophrenic and bipolar. V1 and V2 stated R3 has been very manic and all over the facility the last few weeks. V2 stated her and V1 were at the facility on 3/18/2026 when R3 reported his roommate, R2 hit him on his left side of his face and left shoulder, and he was transferred to the ER (Emergency Room) per his request the same day. V1 stated R3 reported to her and V2 that R4, R7, V12 and V13 witnessed R2 hit him. V1 stated she interviewed staff and residents to see if they witnessed R2 hit R3, and they all said no.The Facility's Abuse Policy reviewed 9/2017 documents this facility is committed to protecting our residents from abuse and mistreatment by anyone including but not limited to other residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to investigate abuse for 1 (R3) of 9 residents investigated for abuse in the sample of 9.Findings include:R3's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including bipolar and personal history of other mental and behavioral disorders.R3's Quarterly Minimum Data Set (MDS), dated [DATE] documents he is cognitively intact and exhibited no behaviors.R3's Hospital Medical Record, dated 3/21/2026 documents an allegation of sexual abuse. R3's Hospital Medical Record, dated 3/23/2026 documents patient (R3) stated, He raped me [AGE] years old red hair and white.The Facility's Long-Term Care Facility Serious Incident Initial Report, dated 3/25/2026 documents administrator was notified of a sexual abuse allegation via hospital paperwork. Final report dated, 3/31/2026 documents (R3), a [AGE] year-old male, whose diagnosis includes bipolar disorder, pancytopenia, history of other mental disorders reported to hospital staff that he had been inappropriately touched. The final report had no documentation that the sexual abuse allegation of an [AGE] year-old male that had red hair and white raped R3 was investigated and 9 staff were documented as interviewed as part of the abuse investigation. Review of the staffing pattern dated 3/21/2026 night shift, none of the staff interviewed were working the night of the allegation of abuse, dated 3/21/2026. On 3/27/2026 at 9:10 AM V1, Administrator stated V1 stated she is the abuse coordinator at the facility, and she is responsible for ensuring abuse investigations are complete and thorough. V1 stated she was aware of the allegation of sexual abuse after she read through R3's hospital medical records. V1 stated no employees match the description of an [AGE] year-old with red hair and white that works at the facility so that allegation was unsubstantiated. V1 stated she also interviewed staff regarding the sexual abuse allegation, but she didn't know if the staff that were interviewed actually worked the night shift of 3/21/2026. The Facility's Abuse Policy reviewed 9/2017 documents this facility will implement systems to promptly and aggressively investigate all reports and allegations of abuse and mistreatment accurate and timely investigative reports.