

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: 145290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
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)		
F 0600 Level of Harm - 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 interview, observation, and record review, the facility failed to provide a safe resident environment and protect residents from abuse for 1 of 10 residents (R2) reviewed for resident abuse in the sample of 10. The findings include: R2's admission Record, dated 6/2/26, documents R2 was originally admitted to the facility on [DATE] with diagnosis of Schizophrenia, Major depressive disorder, Anxiety disorder, Wernicke's Encephalopathy, Cocaine abuse, Hypertension (HTN), Hyperlipidemia, Falls, Anemia, and Sleep disorder. R2's Care Plan, dated 8/16/19, documents R2 has a diagnosis (DX): Schizophrenia. She is at risk for impaired social interaction, disturbed sensory perception, defensive coping and disturbed thought processes. Interventions: 1:1's with resident as needed and as resident requests, assist resident to an area that is calm, quiet and free of stimuli as much as possible if resident allows, resident is on enhanced supervision. R2's Care Plan, dated 9/1/19, documents R2 is at risk for abuse and/or neglect related to DX: Schizophrenia, Major Depression, and Cognitive impairment, psychotropic medication use, poor judgement skills. Interventions: 9/1/19: If resident becomes difficult during care, make sure resident is safe and walk away, allow resident time to calm down, then reapproach, keep resident safe from harm at all times, report any suspected abuse and/or neglect immediately to Administrator. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a severe cognitive impairment and is dependent on staff for activities of daily living (ADLs), and supervision/touching assistance for transfers. R2's Nurses Note, dated 5/30/26 at 8:45 AM, documents Staff and resident approached this nurse and expressed that she was scratched across the face by peer. Residents separated immediately after incident occurred by staff. Resident was assessed 3 scratches notes with minor bleeding. Resident was escorted to room and face was cleaned. NP (Nurse Practitioner) and Abuse coordinator name aware of situation. Plan of care to continue. R1's admission Record, dated 6/2/26, documents R1 was admitted to the facility on [DATE] with diagnosis of Schizophrenia, Dementia, Asthma, Heart Disease, HTN, and Hyperlipidemia. R1's Care Plan, dated 1/30/26, documents R1 is at risk for abuse and neglect related currently in long term care facility and having schizophrenia, dementia, mood disturbance and anxiety. Interventions: Assess resident for abuse and neglect upon admission and quarterly, Assure resident that he/she is in a safe and secure environment with caring professionals. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (i.e., social worker, nurse, CNA (certified nursing assistant), peer) and by verbalizing thoughts, needs and feelings, Assure the resident that staff members are available to help and department heads maintain an open door policy, Continue to in-service the staff about abuse and neglect, Continue to monitor medication, ADLs, status and behaviors. It continues R1 requires assist with daily care needs r/t (related to) decreased cognition, dementia and the absence of her right leg. Interventions: Assist resident with ADLs. It continues R1 is a smoker. She is at risk for smoking related injuries. She is supervised while smoking. Interventions: Educate resident on facility smoking policy and smoking safety practices, Staff will assess the resident's ability to smoke safely, Staff will supervise resident during all scheduled smoking times to ensure safe handling of cigarettes, lighters, and other smoking materials. R1's Care (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 0600 Level of Harm - Actual harm Residents Affected - Few	Plan, dated 4/29/26, documents R1 has diagnosis of Schizophrenia and may display symptoms that include but not limited to: being out of touch with reality (delusional or hallucinations), may have disorganized speech or erratic behavior, decrease in activities. Diagnosis of mental illness. Resident will stay in her room with her door closed and when staff goes in there, she will cuss you out. Interventions: Administer medications as prescribed the physician, Encourage participation in activities, Encourage participation in facility events and groups, Encourage the use of support system, Notify psychiatrist of any change in behavior. It continues R1 presents with moderate to extreme anxiety related to her mental diagnosis. Interventions: Encourage the resident to express feelings during supportive group and/or one-to one programs, Evaluate the potential factors contributing to feelings of anxiety. Work with the resident to use coping skills to eliminate anxiety, Teach the resident anxiety/stress management skills. It continues R1 presents with signs and symptoms of persistent anger towards self and others related to psych diagnosis. The resident will not let you in her room she will yell and cuss you out. Interventions: Encourage resident to utilize coping skills techniques, Encourage the resident to express feelings during supportive group and/or one to one programs, Encourage the resident to utilize anger management techniques and to seek out a staff member when anger persists. R1's MDS, dated [DATE], documents R1 has a severe cognitive impairment and requires supervision/touching assistance for most ADLs. R1's Nurses Note, dated 5/30/26 at 7:54 AM, documents Staff notified this nurse that resident was allegedly involved in an incident that occurred at the end of the 400 while waiting to smoke. Resident noted to be verbally aggressive upon arrival. Residents already separated at this time. De-escalation attempted with resident with no success. Abuse coordinator made aware, NP called and gave the order to send resident to (local hospital). Staff stayed with resident to monitor until transfer completed. (Local EMS) and (Local Police Department) arrived to transport resident. Resident left facility headed to (local hospital) at approx. (approximately) 8:30. R1's Nurses Note, dated 6/1/26 at 10:16 AM, documents Resident admitted to (local hospital) with diagnosis Schizophrenia. On 6/2/26 at 10:40 AM, R2 was seen in a tall back wheelchair with small scratches under her left eye and left chin. When asked what happened, R2 stated she had her back turned and was attacked from behind. R2 stated the resident hit her several times in the face and head and hurt her. When asked what she was doing, R2 stated she was just sitting there waiting to go smoke. When asked what happened after the incident, R2 stated the staff took her to her room and the nurse checked her out. On 6/2/26 at 12:00 PM, V1, Administrator, stated what she heard was that R1 and R2 were heading out to smoke and for some reason, R1 reached out and scratched R2 below her left eye. V1 stated R1 was sent to the hospital for her behaviors. V1 stated V11, Certified Nursing Assistant (CNA), witnessed the event and notified V5, MDS Nurse, who looked on the camera to see what happened, then he notified her. On 6/2/26 at 12:30 PM, V5, MDS Nurse, stated that V11, CNA, was with R1 and stated that R1 hit R2. V5 stated he reviewed the camera and R2 was by the vending machine and had her back to R1, they were yelling at each other, then R1 hit R2 across the face. V5 stated it really wasn't witnessed because R2 was off the camera, but you could see R1 charging towards R2, then R2 went up the hall yelling for a CNA to help her. V5 stated he questioned R1, and she denied hitting or even touching R2. V5 stated he called the NP and V1 to advise them what happened and the NP told them to send R1 to the hospital for her behaviors. On 6/2/26 at 12:45 PM, V2, Director of Nursing (DON) showed the video recording of the event that occurred on 5/30/26. This video showed R1 sitting in her wheelchair by the door that leads out to the smoking deck. R1 appears to be flailing her arms while yelling. Other residents began going down the hall to line up to smoke, along with multiple staff members, who eventually redirected the residents to head to the front door to smoke outside because they didn't have the door key to let them out. The video showed all residents and staff leaving that area except for R1 who remained sitting at the end of the hall. The video then showed R1 rolling herself across the hall and toward where R2 was sitting, then rolled herself back to her position at the end of the hall. The video then showed R2 rolling down the hall toward the nurse's desk and was met half way by V11. There (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	were no staff seen at the end of the hall at the time when (R1) rolled herself to where (R2) was located, then rolled herself back to her original space. On 6/2/26 at 1:15 PM, V11 stated I was the only one working the hall and thought I would help everyone get outside to smoke. (R1) was already sitting at the end of the hall yelling and cursing at everyone and at no one. I didn't see (R2) get down the hall, but she usually sits around the vending machine and waits to smoke. I did hear (R1) and (R2) yelling and cursing at each other at the end of the hall, but I thought they had stopped. All the residents who came down the hall had to go back to the front to go out and smoke, but we couldn't get (R1) to go with us. (R1), (R2), and another resident (R6), were the only ones left down there. R6 always sits on the sofa by the vending machine and probably saw the whole thing. Since I was the only one on that hall, I left the area and was walking back down the hall towards the nurses desk, when I heard (R2) yelling and turned around to see (R2) coming at me and was bleeding on her face. There were no staff left at the end of the hall and if I could rethink it, I would have stayed with them. On 6/4/26 at 9:45 AM, V5 stated When that incident occurred at the end of the hall, (R1) was acting her normal expressive self by yelling out and flailing her arms around. (R1) was elevated in a loud almost different language while talking to herself. I talked to her and asked her to calm down and when I walked away from the end of the hall, I felt that (R1) was calmed down. (R2) was sitting in her wheelchair at the vending machine and I don't recall her yelling or talking because she is also loud and I would definitely know if she was. I was the one who told the staff to take all the residents to the front to smoke because of the incident, that is why they all went out front. I am not aware of (R1) and (R2) having issues with each other. I called EMS (emergency medical services) after talking with the NP (Nurse Practitioner) and they in turn called the police to respond as well. They both showed up and took (R1) to the hospital. On 6/4/26 at 9:53 AM, V13, Police Sergeant, stated I responded with another officer to the facility for a call for an aggressive resident. We always respond with the EMS for their safety. I was only told that the lady (R1) was waiting to smoke, got agitated and aggressive and needed to go to the hospital. She even got agitated with us and was pulling away from the officer almost like she was wanting to fight us. The staff didn't tell me anything about an assault, but they may have said something to the other officer (V14). Typically, the resident is usually very aggressive or physical with someone when they call us for assistance. There was no report done for the incident since it was an EMS assist. On 6/4/26 at V14, Police Officer, stated We got a call to assist EMS at the facility for an agitated female. The facility makes medical decisions for that person, and they needed her to go to the hospital. The staff told me that she was waiting to go smoke, but it was taking too long, and she didn't want to wait, so she got impatient and irritated and became aggressive. They said she was being aggressive with others, but I was not told she assaulted anyone. I was told she scratched someone but thought it was a staff member. We have been there before for aggressive residents, and we respond to keep EMS safe. There was no report made for this incident. On 6/4/26 at 11:15 AM, V1 provided her final report for the incident, dated 6/4/26, documents Administrator was notified of resident-to-resident altercation. Residents were immediately separated and 1:1 support was provided to both residents. Nursing assessment was completed on both residents. NP & responsible parties were notified of the incident. Investigation started and final report to follow. (R1), [AGE] year-old female, who has resided in the facility since 1/13/26. PMH (past medical history) Schizophrenia, hypertension, and hyperlipidemia. Unable to determine the BIMS (basic interview for mental status) score. (R1), [AGE] year-old female, who has resided in the facility since 7/31/19. PMH Major depression, HTN, and anxiety disorder. Unable to determine the BIMS score. On 5/30/26 at approximately 7:11 AM, (R1) and (R2) were at the end of the hall. (R1) was being her baseline, verbal and animated and (R2) was wheeling up and down the hall waiting for the smoke break. (V11, CNA) heard loud noises and went to inspect. Immediately separated and wheeled (R2) to (V5). (V5) directed staff to go sit with (R1) and he wheeled (R2) to her room. Performed a skin assessment. (R1) was sent to the hospital for evaluation. After review of statements and interviews, abuse cannot be substantiated. Care plans and medical record were reviewed and updated. Police did come on site, (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	report #2026032470. On 6/4/26 at 11:50 AM, V15, Registered Nurse (RN), stated (R1) gets aggravated easily. I have seen her slap the EMS guys when they come to pick her up. She usually just wheels herself around the halls talking or yelling to herself. I have not seen her attack anyone other than the EMS guys. She does not like to be talked to. On 6/4/26 at 12:00 PM, V16, CNA, stated I see (R1) agitated a lot. She is usually talking to herself and waving her arms around. I have seen her swing at the EMS guys when they show up for her. She has been agitated for the last couple of weeks because they moved her room and she doesn't like it. On 6/4/26 at 12:05 PM, R1 returned from the hospital and was seen rolling herself up and down the halls. When attempting to ask R1 questions, she got irritated and stated, Leave me alone and don't talk to me. then wheeled herself down the hall talking to herself. The facility's Abuse Prevention Policy, dated 9/2017, documents in part This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.		