

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 06/11/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to maintain resident dignity while eating in the dining room for 3 of 25 residents (R12, R77, R126) reviewed for resident dignity in the sample of 42. The findings include: 1. R77's admission Record, dated 6/10/26, documents R77 was originally admitted to the facility on [DATE] with medical diagnosis of Traumatic Brain Injury (TBI). R77's Care Plan, dated 11/29/22, documents R77 has potential for weight fluctuation related to good intake of meals, and he receives a snack at HS (hours sleep) daily, but he has diagnosis of Type 2 diabetes mellitus (DM), psychosis, cocaine abuse and unspecified focal TBI which may affect his intakes and/or weight. Interventions: Provide diet as ordered, he does use weighted utensils, staff assist with meal set up and feeding as needed, monitor and encourage diet compliance as needed. It continues 3/6/24: R77 at nutritional risk as disease progresses: type 2 DM and Hypertension (HTN). 11/16/25: Has had weight loss over last 3 months. 2/15/26: Has had weight loss x last 6 months, stable x 1 month. 4/12/26: Weight stable. Interventions: Provide diet as ordered, weighted utensils to be used with all meals. R77's weights have been stable each month for the past three months. R77's Minimum Data Set (MDS), dated [DATE], documents R77 has a severe cognitive impairment and requires setup/clean-up assistance for eating. R77's Physician Order, dated 1/20/26, documents Regular diet, Mechanical/Soft texture, Thin Liquids consistency. Weighted utensils for diet. R77's Physician Order, dated 10/7/24, documents Adaptive Equipment: Weight Utensils. On 6/8/26 at 12:05 PM, During the lunch observation, R77 was sitting at the dining room table in a dining room chair that was about 2-3 feet away from the table. R77's plate of food was on the table along with regular utensils with R77 unable to reach his food, and his left hand was contracted. V11, Licensed Practical Nurse (LPN), checked R77's blood sugar, pushed him close to the table, then got R77's fork and mixed all his food up together on the plate and while standing, began feeding R77. After V11 walked away, R77 was observed having difficulty using a normal utensil to pick up the food and feed himself. On 6/11/26 at 1:15 PM, V1, Administrator, stated I would expect all staff to sit while assisting residents with feeding and to provide the necessary utensils to the residents. 2. R12's Face Sheet, admission date of 03/26/26, documents R12 has diagnoses of but not limited to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia, severe, with mood disturbance, disorientation, and Alzheimer's disease. R12's Minimum Data Set (MDS), dated [DATE], documents R12 is severely cognitively impaired, and she requires partial/moderate assistance with eating. R12's Care Plan, admission date of 03/26/26, documents Resident requires one assist with daily care related to recent falls. Resident has had a significant change in health, is unable to eat regular diet consistency, resident requires max assist with Activities of Daily Living (ADLs) and needs help eating and requires help and cuing from staff. On 06/08/2026 at 12:00 PM, V6, Restorative Aide was seen standing up and assisting R12 with her noon meal. She was seen wiping R12's face with the clothing protector. On 06/10/2026 at 12:08 PM, V29, CNA is currently standing while she is assisting R12 with her noon meal. 3. R126's Face sheet, admission date of 07/04/24, documents she has diagnoses of but not limited to need for assistance with personal care and chronic obstructive pulmonary disease (COPD). R126's MDS, dated [DATE] documents she is cognitively intact, and she requires supervision or touching assistance with eating. R126's Care Plan, admission date of 07/04/24, documents R126 has the potential for weight fluctuation related to (r/t) varied intake of meals and declining offers of alternatives offered and she has diagnoses of psychosis, bipolar disorder, schizophrenia, COPD, and emphysema which may affect her intakes and/or weight. Interventions include but are not limited to encourage intakes as needed. On 06/08/2026 at 12:08 PM, R126 was seen trying to eat her hamburger and having trouble eating it with no teeth. V12, Certified Nursing Assistant (CNA) was standing up and assisting her with her meal. On 06/11/2026 at 10:35 AM, V1, Administrator said when it comes to the staff assisting the residents with their meal, she would expect them to be sitting down when assisting them with their meal. The Illinois Long-Term Care Ombudsman Program Residents Rights, not dated, documents Your rights to dignity and respect. It also documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer pain medications for 3 of 4 residents (R5, R84 and R101) reviewed for pain in the sample of 42. This failure resulted in R5 experiencing phantom pain, R84 experiencing excruciating pain in wrist and back, and R101's pain being elevated to a level 8 on a scale of 1-10 for 2 days. Findings include: 1 On 6/8/2026 at 10:27AM R101's wife stated her husband has not had his pain medication for 2 days and he needs it. R101 agreed he had not had his pain medication and needed it. R101's current face sheet documents a diagnosis in part of acute hematogenous osteomyelitis left ankle and foot, cellulitis of left lower limb, personal history of other malignant neoplasm of bronchus and lung. R101's medication administration record (MAR) dated June 2026 documents Hydrocodone-Acetaminophen oral tab 10-325mg (milligram); give one tablet every 6 hours as needed for pain with start date 6/4/2026. R101's MAR documents R101 did not receive Pain medication from 6/4/2026- 6/9/2026 at 9:30AM. R101's Minimum Data Set (MDS) dated [DATE] documents R101 cognitively intact with a Brief Interview of Mental Status (BIMS) of 15. R101's care plan dated 3/14/2026 documents pain, R101 has an alteration in comfort. R101's care plan documents intervention; administer pain meds and treatments as order, assess effectiveness of pain medication. On 6/8/2026 at 10:31AM V7 Licensed Practical Nurse (LPN) stated they are out of medications over here. V7 stated I don't understand it. On 6/10/2026 at 1:55PM R101 stated the days his pain medication was not available he was in pain in his back and would rated the pain level on a scale of 1-10 at a level 8. R101 stated the pain medication controls his pain. On 06/10/2026 at 1:03 PM V28, psychiatric nurse practitioner stated sometimes residents have reported to her their medications are not available. V28 stated she would expect medications to be administered as ordered. 2. R84's Care Plan, dated 7/29/2025, documents that PAIN: Resident has an alteration in comfort Advanced Disease process, Chronic physical. It also documents 7/29/2025 Administer pain meds and treatments as ordered. R84's Minimum Data Set, dated [DATE], documents that R84 is cognitively intact. R84's Physician Order, dated 7/25/2026, documents Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 6 hours related to Unspecified Fracture of unspecified wrist and hand. R84's Medication Monitoring/Control Record, dated from 4/17/2026 to 5/30/2026 documents (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Tramadol not administered on 4/17 at 6p, 4/27 at 12AM, 5/12 at 6p, 5/20 to 5/26, 5/27 12AM, 6AM, and 12PM, 5/28, 5/29 12AM and 6AM, 5/30 12AM and 6AM On 6/9/2026 at 3:30 PM R84 stated that he has a lot of pain. R84 stated that he took Vicodin in the past and that helped his pain. R84 stated that he now takes Tramadol and that takes the edge off but doesn't take the pain away. R84 stated that when he doesn't get it his pain is excruciating. R84 stated that he was out of the Tramadol recently for about a week. R84 stated that they gave him a pill here and there, but his pain level was so high it didn't really touch it. R84 stated that the last pill was given on a Tuesday and his medication didn't come in until Sunday. R84 stated that he was raised to be a man and not complain about pain. R84 stated that it doesn't change the fact that he was in excruciating pain. R84 stated that it was hard to get out of bed. On 6/10/2026 at 9:40 AM V22, Licensed Practical Nurse, stated that R84's medication had run out. V22 stated that it's an insurance issue. V22 stated that R84 takes the tramadol 4 times a day. V22 stated that when the medication is sent it is sent in 30 cards which run out within days of receipt, and the process must start all over which causes delays. V22 stated that R84 was originally admitted to a different hall and came with a brace to his wrist. V22 stated that R84 was on Norco but because of R84's cirrhosis of the liver the medication had to be discontinued. V22 stated that R84 is challenging to read. V22 stated that with psych patients the missing of 2 doses of medication can cause a problem. 3. R5's Physician Order sheet documents Cyclobenzaprine HCl Oral Tablet 5 MG (Cyclobenzaprine HCl) Give 5 mg by mouth every 8 hours as needed for muscle relaxer related to COMPLETE TRAUMATIC AMPUTATION AT KNEE LEVEL, LEFT LOWER LEG, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 25 mg by mouth one time a day for Elevated Blood Pressure-Not given. Levothyroxine Sodium Oral Tablet 88 MCG (Levothyroxine Sodium) Give 88 mcg by mouth in the morning related to HYPOTHYROIDISM On 6/9/2026 at 8:47 AM observed R5's medication pass. R5's Levothyroxine Sodium Oral Tablet 88 MCG and Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG scheduled for 8AM was unavailable and not given. R5 requested Cyclobenzaprine HCl Oral Tablet 5 MG. The medication was not administered. When asked why R5's did not receive her medication V17, LPN, stated that she did not administer the medication. The medicine was not in the medication cart and needed to be reordered. On 6/10/2026 at 2:44 PM when asked if R5's medication came in V17 stated that if the Cyclobenzaprine HCl Oral Tablet 5 MG was in the cart she did not see it to administer it. On 6/11/2026 at 10:32 AM R5 stated that she has been doing good with her behaviors and anxiety. R5 stated that when she doesn't get her medication as ordered she starts to have increased anxiety and starts having behaviors that are hard to control. R5 stated that any medication that missing causes her anxiety to go crazy. R5 stated that they run out of her medication routinely or tell her it's not available. R5 stated that she is a bilateral amputee of her left leg. R5 stated that she has severe phantom pain. R5 stated that she requests her muscle relaxer twice a day because she has excruciating cramps in her left leg and toes. R5 stated that the pain can be unbearable. R5 stated that yesterday she had phantom cramps and spasms in her legs and toes. On 06/10/2026 at 3:10PM V1 Administrator stated the pharmacy that provides services usually has a 24 hour turn around or they can do an emergency run. V1 stated the nursing staff can also utilize the (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	emergency medication dispenser at the facility. V1 stated would expect residents to have medications as ordered. The facility policy pain management policy dated, reviewed 10/2025 document the purpose is to facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our resident's the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. The policy documents The pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: Observing for the potential for pain Effectively recognizing the presence of pain Identifying the characteristics of pain Addressing the underlying causes of the resident's pain Developing and implementing approaches to pain management Identifying and using specific strategies for different levels and sources of pain Monitoring for the effectiveness of interventions; and modifying approaches as necessary.		

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that medication was ordered and available in a timely manner for 6 of 6 (R5, R58, R84, R77, R101, R113), residents in a sample of 42. This failure resulted in R84 not receiving his pain medication and experiencing increased and excruciating pain, R5 not receiving a muscle relaxer and experiencing phantom cramps and pain in left lower extremity amputation. It also resulted in R58 not receiving is clonazepam and experiencing increased anxiety and chest pain resulting in transportation to hospital. Findings include:1 .R84's Care Plan, dated 7/29/2025, documents that PAIN: Resident has an alteration in comfort Advanced Disease process, Chronic physical. It also documents 7/29/2025 Administer pain meds and treatments as ordered. R84's Minimum Data Set, dated [DATE], documents that R84 is cognitively intact. R84's Physician Order, dated 7/25/2026, documents Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 6 hours related to Unspecified Fracture of unspecified wrist and hand. R84's Medication Monitoring/Control Record, dated from 4/17/2026 to 5/30/2026 documents Tramadol not administered on 4/17 at 6p, 4/27 at 12AM, 5/12 at 6p, 5/20 to 5/26, 5/27 12AM, 6AM, and 12PM, 5/28, 5/29 12AM and 6AM, 5/30 12AM and 6AM On 6/9/2026 at 3:30 PM R84 stated that he has a lot of pain. R84 stated that he took Vicodin in the past and that helped his pain. R84 stated that he now takes Tramadol and that takes the edge off but doesn't take the pain away. R84 stated that when he doesn't get the pain medicine his pain is excruciating. R84 stated that he was out of the Tramadol recently for about a week. R84 stated that they gave him a pill here and there, but his pain level was so high it didn't really touch it. R84 stated that the last pill was given on a Tuesday and his medication didn't come in until Sunday. R84 stated that he was raised to be a man and not complain about pain. R84 stated that it doesn't change the fact that he was in excruciating pain. R84 stated that it was hard to get out of bed. On 6/10/2026 at 9:40 AM V22, Licensed Practical Nurse, stated that R84's medication had run out. V22 stated that it's an insurance issue. V22 stated that R84 takes the tramadol 4 times a day. V22 stated that when the medication is sent it is sent in 30 cards which run out within days of receipt, and the process must start all over which causes delays. V22 stated that R84 was originally admitted to a different hall and came with a brace to his wrist. V22 stated that R84 was on Norco but because of R84's cirrhosis of the liver the medication had to be discontinued. V22 stated that R84 is challenging to read. V22 stated that with psych patients the missing of 2 doses of medication can cause a problem. 2. R5's Physician Order sheet documents Cyclobenzaprine HCl Oral Tablet 5 MG (Cyclobenzaprine HCl) Give 5 mg by mouth every 8 hours as needed for muscle relaxer related to COMPLETE TRAUMATIC AMPUTATION AT KNEE LEVEL, LEFT LOWER LEG, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 25 mg by mouth one time a day for Elevated Blood Pressure-Not given. Levothyroxine Sodium Oral Tablet 88 MCG (Levothyroxine Sodium) Give 88 mcg by mouth in the morning related to HYPOTHYROIDISM On 6/9/2026 at 8:47 AM observed R5's medication pass. R5's Levothyroxine Sodium Oral Tablet 88 (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Some	MCG and Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG scheduled for 8AM was unavailable and not given. R5 requested Cyclobenzaprine HCl Oral Tablet 5 MG. The medication was not administered. When asked why R5's did not receive her medication V17, LPN, stated that she did not administer the medication. The medicine was not in the medication cart and needed to be reordered. On 6/10/2026 at 2:44 PM When asked if R5's medication came in V17 stated that if the Cyclobenzaprine HCl Oral Tablet 5 MG was in the cart she did not see it to administer it. On 6/11/2026 at 10:32 AM R5 stated that she has been doing good with her behaviors and anxiety. R5 stated that when she doesn't get her medication as ordered she starts to have increased anxiety and starts having behaviors that are hard to control. R5 stated that any medication that missing causes her anxiety to go crazy. R5 stated that they run out of her medication routinely or tell her it's not available. R5 stated that she is a bilateral amputee of her left leg. R5 stated that she has severe phantom pain. R5 stated that she requests her muscle relaxer twice a day because she has excruciating cramps in her left leg and toes. R5 stated that the pain can be unbearable. R5 stated that yesterday she had phantom cramps and spasms in her legs and toes. 3. R101's Care Plan, dated 3/4/2026, documents that Infection: Resident has active infection, osteomyelitis. It also documents Administer medications as ordered. R101's Progress Note- Follow Up note, dated 5/13/2026, documents [AGE] year-old male with PMHx of diabetes, plantar surface ulcerations, non-small cell lung cancer. Presents with 1 week of worsening redness and pain on the dorsal aspect of the left foot. Treated for a wound with infection on the ball of the left foot about 1 month ago. Diagnosed with acute hematogenous osteomyelitis (left ankle/foot) and cellulitis (left lower limb). No fever or chills reported. Physical exam: Erythema on dorsal left foot, callus/lesion on ball of left foot, no edema in lower extremities Assessment/Plan:M86.072 - ACUTE HEMATOGENOUS OSTEOMYELITIS, LEFT ANKLE AND FOOTMRI on 03/03/2026 showed a soft tissue wound extending to the joint space with increased marrow signal in the first metatarsal, sesamoids, and great toe phalanges, flexor hallucis tenosynovitis, and joint effusion with synovitis, suspicious for acute infection. X-ray on 03/02/2026 revealed osteolysis of the left great toe sesamoid, suggestive of bone involvement. CRP was elevated at 27.4 mg/L and ESR at 31 mm/hr on 03/02/2026, indicating ongoing inflammation. CBC on 04/30/2026 showed mild anemia (Hgb 9.8 g/dL) and albumin was low at 3.1 g/dL. Blood cultures drawn on 03/02/2026 showed no growth. Erythema on dorsal left foot and callus/lesion on ball of left foot, no edema in lower extremities observed on 05/06/2026. Wound care personnel reported wound to left foot increasing in diameter compared to measurements on admission. IV Cefepime dose and IV Daptomycin dose started on 05/10/2026 and 05/11/2026, respectively. R101's Physician Order Sheet documents 5/10/2026 Cefepime HCl Solution 2 GM/100ML Use 2 gram intravenously every 8 hours for Foot Infection for 5 Weeks. 5/10/2026 Daptomycin Intravenous Solution Reconstituted (Daptomycin) Use 540 mg intravenously one time a day for Foot infection for 5 Weeks Give 540mg. (8mg/kg) weight is 148. R101's Medication Administration Record (MAR) documents 5/10/2026 Cefepime HCl Solution 2 GM/100ML Use 2 gram intravenously every 8 hours for Foot Infection for 5 Weeks. Scheduled for 6AM, 2PM, 10PM. The MAR documents blanks for 6AM on 5/11, 5/12, 5/14, 5/16, 5/18, 5/20, 5/21, 5/22, 5/23, 5/25, 5/29, 5/30. It documents for 2PM- 5/13, 5/15, 5/16, 5/19, 5/26, 5/27. It documents for 10 PM 5/10, 5/11, 5/13, 5/15, 5/16, 5/17, 5/19, 5/20, 5/21, 5/24, 5/28 and 5/29. (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Some	R101's Medication Administration Record documents 5/10/2026 Daptomycin Intravenous Solution Reconstituted (Daptomycin) Use 540 mg intravenously one time a day for Foot infection for 5 Weeks Give 540mg. (8mg/kg) weight is 148. Scheduled for 8:00 AM documents blank 5/13, 5/15, 5/16, 5/19, and 5/27. On 6/11/2026 at 11:27AM R101 stated that he does not receive his IVs as ordered. R101 stated that sometimes he gets them and sometimes he doesn't. R101 stated that his infection is in his bone and if he doesn't receive his treatment the infection will not go away. R101 stated that it scares him because they are supposed to make sure he gets it. R101 stated that he goes out on leave, but he can wait if they are going to do his IVs. R101 stated that the infection can kill him and cause him to lose more of his foot. R101 stated that this is what was explained to him at the hospital when his toe was amputated. On 6/11/2026 at 12:05 PM V4, Infection Preventionist, stated that she is over the antibiotic program. V4 stated that R101 is receiving 2 antibiotic therapy related to infection in wound. V4 stated that R101 is supposed to receive the medication as prescribed. V4 stated that she has become aware of the blanks in R101's MAR. V4 stated that the blanks indicate that the medication was not administered. V4 stated that the LPN's are assigned to the hall but the RN is responsible for the IV infusion. V4 stated that she is not sure if the medication was administered and not signed off or if it wasn't given. V4 stated that she can't verify if the medication was given. On 6/11/2026 at 12:12 PM V1, Administrator, stated that she was not aware of R101 not receiving his medication except when R101 came to V1 and told V1 that he had not received his IV medication. V1 stated that at that time she questioned her Director of Nursing. V1 stated that if the RN gave the medication, it would be signed off. On 6/11/2026 at 12:13 PM V3, Regional Nurse Consultant, stated that what should have happened is the medication was missed the physician should have been notified and new order received. V3 stated that if the RN administered the medication, it would be signed off. The facility's PHYSICIAN IV ORDERS Policy, dated May 2022, documents that the purpose of this policy is to provide guidelines for IV medication orders to be consistent with principles of safe and effective order writing so that all prescribed medications are administered safely and accurately. 4. R58's admission Record, not dated, documents that R58 was admitted to facility on 3/25/2026 with a diagnosis of Anxiety. R58's Care Plan does not address R58's anxiety. It does document 4/13/2026 R58 demonstrate a significant mood distress/ depression related to a diagnosis of depression. R58's Minimum data Set (MDS) dated [DATE] documents R58 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 15. R58's POS documents 5/29/2026 clonazepam Oral Tablet 0.5 MG (Clonazepam) *Controlled Drug* Give 0.5 mg by mouth every 12 hours as needed for anxiety for 14 Days. R58's Psychiatric Note, dated 6/4/2026 at 3:25 PM documents follow up for depression and anxiety. R58's note documents Clonazepam 0.5mg tab every 12 hours as need for 14 days. (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Some	R58's Nurses Notes, dated 6/6/2026 at 11:51 AM, documents that Note Text: Resident requests Clonazepam for increased anxiety. Resident has order for 0.5mg q 12 hours but medication has not been delivered from pharmacy. Call placed to pharmacy and informed pharmacy is awaiting a new Rx (prescription) from the MD (doctor). Call placed to Provider on call and detailed message left. Resident given support and is stable at this time. Resting in bed with call light in reach. R58's Nurses Notes, dated 6/6/2026 at 6:00 PM, documents that Note Text: Resident called 911 and requested EMS (emergency medical service) transfer him to ER (emergency room) for evaluation of chest pain. EMS to facility and informed this nurse that resident called with request for transfer to ER. Bedside assessment performed with EMS, Vital signs stable 98.9 - 81 - 20 -143/76 - 100% room air. Resident reports chest pain, mid chest, feels like a rock is sitting on my chest. Call placed to Provider on call and detailed message left. R58's Medication Monitoring/Control Record, received date 5/8/2026, documents last dose administered 6/3/2026 at 10:42 PM. R58's Medication Monitoring/Control Record, received date 6/9/2026, documents first dose administered 6/9/2026. R58's after visit summary dated 6/8/2026 documents reason for visit: chest pain and abdominal pain. R58's after visit summary documents diagnosis; Benzodiazepine withdrawal, hypokalemia, chest wall pain. The after-visit summary documents pick up these mediations at Walgreens; Clonazepam On 06/08/2026 at 10:40AM R58 stated he is supposed to get clonazepam as needed every 12 hours for anxiety. R58 stated has not had any medication available since last Thursday. R58 stated he went out to the emergency room (ER) over weekend. R58 stated he was given medication and IV fluids for dehydration. R58 stated he has taken the medication for 20 years and he needs the medication. R58 stated the ER physician had called in a script to Walgreens and as of today still does not have the medication. R58 stated I am doing horrible. On 6/8/2026 at 10:31AM V7 Licensed Practical Nurse (LPN) stated they are out of medications over here. This is an MI facility, and the residents don't have their medications. V7, LPN stated R58 does not have any clonazepam. On 06/10/2026 at 1:03 PM V28, psychiatric nurse practitioner stated she was not aware that R58's clonazepam was not available. V28 stated R58 could experience withdrawals from not having the medication. V28 stated not having medication available could increase R58's anxiety. R58 stated sometimes residents have reported to her their medications are not available. V28 stated she would expect medications to be administered as ordered. 06/10/2026 at 3:10PM V1 administrator stated she was aware that R58 did not have his medication. V1 stated the script was sent to pharmacy. V1 stated the pharmacy that provides services usually has a 24 hour turn around or they can do an emergency run. V1 stated the nursing staff can also utilize the emergency medication dispenser at the facility. V1 stated would expect residents to have medications as ordered. The facility's SPECIFIC MEDICATION ADMINISTRATION PROCEDURES 11B15: INFUSION THERAPY MEDICATION ADMINISTRATION: MEDICATIONS ADDED TO INFUSION PREPARATIONS BY THE NURSE IN THE FACILITY. Purpose To provide for the safe, accurate, and effective administration of (continued on next page)		

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 06/11/2026
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.			
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F 0755 Level of Harm - Actual harm Residents Affected - Some	parenteral medications directly into the vascular system. Procedures: A. Obtain infusion therapy medication. E. Complete Infusion Therapy Solution/Additive label and place on IV bag or bottle. 5. On 6/9/26 at 9:25 AM, V11, LPN, was observed passing medications to R77. V11 opened the Vitamin D3 bottle, got a capsule out and put it on top of the dirty cart, then used her bare hands to pick it up and put it into the medicine cup. V11 then put the medicine cup on top of another cup of meds inside the top drawer of the medication cart, both seen unlabeled with no resident name. V11 left to get something to mix the medications in, came back and opened the drawer and picked up one of the medicine cups and crushed the pills, then mixed them with yogurt. V11 stated they are out of apple sauce and pudding, so she has to use yogurt to mix the medications in. V11 then administered R77's medications to him. On 6/11/26 at 1:15 PM, V1, Administrator, stated I would expect the nurses to maintain infection control and safe administration of medication practices while administering medications to residents. The facility's Oral Medication Administration Policy, dated 5/2022, documents in part Perform hand hygiene when beginning a med pass, or when contact with resident is expected or has occurred. For solid medications: I) Pour or push the correct number of tablets or capsules into the souffle or plastic cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. 6.R113's Facesheet with a print date of /10/26, documented he was admitted to the facility on [DATE] with diagnosis of, in part, anxiety disorders and major depressive disorder. R113's MDS dated [DATE] documented he was cognitively intact. R113's Psychiatry/Med-Management Follow Up Evaluation Note dated 5/26/26 at 8:58 PM documented, . R113 reports passive suicidal ideation for three months. R113 denies plan or intent for suicide. R113 has safety planning and will tell staff if his symptoms worsen. R113 does not attend group activities. R113 states he prefers to be alone. R113 reports constant worrying. Will increase sertraline to 200mg (milligrams) daily and monitor symptoms . R113's MAR (medication administration record) for May 2026 documented he was administered 150 mg of sertraline on 5/26/26 through 5/31/26. R113's MAR for June 2026 documented he was administered 150 mg of sertraline 6/1/26 through 6/10/26. R113's Summary Report documented on 3/12/26 an order to start Sertraline HCl (hydrochloride) oral tablet 50 mg give 3 tablets by mouth one time a day related to other specified anxiety disorders. On 6/8/26 at 10:11 AM, R113 stated he is supposed to get 150 mg of Zoloft (sertraline) in three 50 mg tablets, but a lot of the agency nurses will come in and not realize this then give him just one tablet so he's only getting 50 mg then. R113 stated he sometimes doesn't get it at all and the next day he starts to feel more depressed and anxious. R113 stated Zoloft helps with his suicidal thoughts also but currently doesn't have any. R113 stated he sometimes will get negative thoughts also. On 6/10/26 at 8:31 AM, R113 stated they were supposed to increase his Zoloft and haven't done that (continued on next page)		

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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.			
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F 0755 Level of Harm - Actual harm Residents Affected - Some	yet and doesn't know why. R113 stated his depression, anxiety and passive suicidal ideations have not improved if anything they have remained the same. R113 stated if someone were to ask him if he cared that he would die the next day he would respond saying he couldn't care either way. R113 stated he's had those thoughts for 20 years now. R113 stated he feels like he has fallen through the cracks here and they've overlooked him because he is more independent but wishes he wouldn't have to be so on top of everything for them to make sure he is getting the care he needs. On 6/10/26 at 12:57 PM, V28 (Psych Nurse Practitioner/NP) stated she wanted to increase R113's Zoloft to 200 mg after seeing him on 5/26/26 with a goal to decrease or improve his symptoms of anxiety, depression, and passive suicidal thoughts. V28 stated she was not aware R113 had not had his increased dose of Zoloft yet. V28 stated she expects orders to be followed as recommended by her. V28 stated it is a concern he did not get his increased dose, and he risked staying at his baseline symptoms with no improvement. On 6/10/26 at 1:14 PM, V1 (administrator) and V3 (regional nurse consultant) both stated they expect orders to be followed as written for medications. The facility's Oral Medication Administration Record, revised on 2018, documented the procedure involved reviewing and confirming medication orders for each individual resident on the Medication Administration Record prior to administering medication to each resident.		