STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus at Alton	3523 Wickenhauser Alton, IL 62002

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to follow its Fall Prevention and Management policy and complete a root cause analysis after each fall, failed to implement interventions after each fall, and failed to implement fall interventions according to resident care plans for 3 of 4 residents (R2, R3, R6) reviewed for falls in the sample of 15. Findings Include: 1. R2's medical diagnosis form, print date of 5/21/25, documented R2 has diagnoses including aphasia following cerebral infarction, apraxia, cerebrovascular disease, hemiplegia, type 2 diabetes mellitus, depression, anxiety, hypertension, heart disease, contractures of lower extremities, and dementia. R2's MDS (Minimum Data Set), dated 2/24/25, documented R2 is severely cognitively impaired and dependent on staff for all ADLS (Activities of Daily Living). R2's fall risk evaluation, dated 2/18/25, documented R2 is at high risk for falls. R2's care plan, undated, documented R2 is at high risk for falls related to poor communication/comprehension, gait/balance problems, incontinence secondary to CVA (cerebrovascular accident). R2's care plan does not document R2's fall on 5/17/25 nor any new fall prevention interventions to reduce R2's fall risk. R2's fall report, dated 5/17/25 at 10 AM, documented this RN (Registered Nurse) was preparing medications at the med cart for another client at the end of 300 hall. This RN observed from the end of the hall R2 lying on the floor in the hallway in front of her wheelchair. RN questioned CNA (Certified Nurse Assistant) on hall if she saw resident fall. CNA denied witnessing fall. Both CNA and this RN had observed resident in wheelchair in hallway moments ago and several times throughout the morning. RN questioned multiple staff about incident due to this RN and CNA assigned to the floor are new staff and unfamiliar with resident's norms. All staff deny witnessing the fall and confirm this is unusual for R2. Immediate Action Taken: This RN and nurse from 400 hall assessed R2 for injuries and obtained vital signs, called 911. This form does not document a root cause analysis of this fall nor any interventions to reduce the risk of R2 sustaining further falls. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's EMR (electronic medical record) does not document this fall in R2's progress notes, does not document that R2 went to a local emergency room for treatment after the fall, nor is there any post fall monitoring of R2 documented after she fell on 5/17/25. R2's local Emergency Department reports, dated 5/17/25, documented reason for visit was a fall, R2 is a [AGE] year-old female with a history of apraxia and aphasia presenting to the ED (Emergency Department) via EMS (emergency medical services) for an unwitnessed fall. Patient was found on the floor next to her wheelchair. It continues, no definite injury noted at the time. CT (computed tomography) without obvious intracranial acute finding. Patient can be discharged to follow up with primary physician. On 5/21/25 at 2:17 PM V2, DON (Director of Nursing) stated R2 did recently have a fall from her wheelchair, was sent to the ER but they did not find any injuries, and that the paramedics told the facility nurses that R2 needs to be tied down in her chair. Surveyor asked V2 if she expects the nurses to document falls and follow up monitoring on residents who fall and V2 replied normally the nurses are supposed to document falls, complete a fall report in risk management, monitor the resident for 3 days after the fall, assess pain, and complete post fall evaluations. V2 stated she does not know why this was not done for R2's fall. On 5/29/25 at 2:43 PM, V1 Administrator and V2 DON stated R2's intervention is on her care plan. Surveyor pulled care plan history, and it documented R2's fall intervention was added to her care plan on 5/23/25 after surveyor entered on the complaint on 5/21/25. V2 confirmed the intervention was added on 5/23/25. 2. R6's face sheet, print date of 5/27/25, documented R6 has diagnoses including dysphagia following cerebral infarction, chronic obstructive pulmonary disease, unsteadiness on feet, schizoaffective disorder, depression, anxiety disorder, peripheral vascular disease, osteoarthritis, and repeated falls. R6's MDS, dated [DATE], documented R6 is moderately cognitively impaired and requires partial to moderate assistance and a wheelchair with transfers and mobility. R6's Fall Risk Evaluation form, dated 4/14/25, documented R6 is high risk for falls. R6's care plan, undated, documented resident is at high risk for falls related to cognition, CVA (cerebrovascular accident), and frequent falls prior to admission to facility. She is non complaint with her transfer status and continues to transfer self. R6 slid out of her wheelchair on 2/19. R6 fell out of bed on 3/4. 5/23 (non-skid) tape applied to resident's wheelchair to prevent further falls due to sliding out of wheelchair. 3/25 trying to transfer into her chair when the chair moved. 4/14 fall. 4/26 fall. This care plan documented interventions including on 3/25 new wheelchair was given to resident for transfer, on 4/14/25 side rails applied to bed, and on 7/25/24 floor mats while in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's incident report, dated 3/26/25, documented CNA alerted that resident was on the floor, this nurse goes to access resident, resident sitting on her bottom in front of the bed. Resident stated that she did not hit her head, resident c/o (complained of) right leg pain when asked how she fell resident stated she was trying to transfer into her chair when the chair moved. This nurse educated resident on using call light and asking for help, this nurse gave resident PRN (as needed) pain med for pain. This nurse and CNA transferred resident into the chair. Resident description: resident stated she was trying to transfer into her chair when the chair moved. This form documents additional areas to be completed including predisposing environmental factors, predisposing physiological factors, predisposing situation factors, and predisposing situation factors and all are blank. This form does not document a root cause analysis of the fall was completed, nor a new fall intervention was implemented. R6's incident report, dated 4/14/25, documented this nurse was notified that resident was on floor next to bed. Witnessed by staff, resident rolled out of the bed trying to sit up to get out of bed. No injuries noted, no complaints of pain or discomfort. Resident stated that she rolled out of the bed when trying to get up. The remainder of this form is blank including mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors, nor is there a root cause analysis documented. This incident report does not document a new intervention was implemented to reduce R6's risk of experiencing further falls. R6's care plan, undated, documented side rails were added to R6's bed on 4/14/25. R6's incident report, dated 4/18/25, documented resident was in room yelling for help. When this writer entered room resident was lying on the floor on back near bed. Resident attempted to self-transfer. Noted resident's call light was within reach, but resident did not utilize call light for assistance. Resident was wearing grip socks at time of fall. Resident stated, I hit my head, my head and right leg hurt. Resident sent to ER d/t (due to) hitting head, and c/o pain in right leg and head. This incident report does not document a root cause analysis of the fall nor that a new intervention was implemented to reduce R6's risk of experiencing further falls. R6's care plan was not updated with a new fall prevention intervention following this fall she sustained on 4/18/25. R6's progress note, dated 4/19/25 at 2:55 AM, documented resident returned from hospital via ambulance. No noted injuries seen at this time. On 5/27/25 at 10:30 AM R6 was observed sleeping on her bed. R6's bed did not have side rails attached to either side of the bed, there was no mat on the floor next to the bed, and no non-skid mat on R6's wheelchair that was sitting next to her bed. On 5/27/25 at 2:48 PM V2 DON stated the root cause analysis of each fall, and the new fall prevention intervention should be documented on the incident report and added to the care plan. 3. R3's medical diagnosis form, print date of 5/21/25, documented R3 has diagnoses including vascular dementia with mood disturbance, cerebral infarction, aphasia, hemiplegia, schizoaffective disorder, hypertension, depression, hyperlipidemia, and mood disorder. R3's MDS, dated [DATE], documented R3 is severely cognitively impaired and dependent of staff for all ADLS (activities of daily living). R3's fall risk evaluation, dated 4/25/25, documented R3 is high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan, undated, documented R3 is at high risk for falls, R3 experienced 2 falls on 4/25/25, and an intervention of activities will offer diversion activities. R3's incident report, dated 3/27/25 at 8:30 AM, documented called to the front door by staff who stated that resident barreled through the front door. When staff tried to pull him back in, he slid out of his w/c (wheelchair) landing on his buttock in the entry way. When asked if he was hurt, he shook his head no. Residents speech is altered and difficult to understand, he wouldn't talk to staff. Resident assessed and assisted to his w/c (wheelchair) with 2, he tried to put himself on the ground again while pulling back into the facility. This incident report does not document a root cause analysis of this fall nor an intervention to reduce the risk of R3 experiencing additional falls. R3's care plan does not document an intervention was added after this fall. R3's incident report, dated 4/25/25 at 5:30 PM, documented I saw resident going through the front doors as I was coming out of the kitchen, I went to the front door to stop him. I tried to push him back in and he planted his feet and grabbed the door to keep me from bringing him back inside. 2 CNAs came to the front to try and encourage him to return back in the door and he kept planting his feet and grabbing at things to avoid returning back inside. The 2 CNAs then pick up the w/c and resident put himself on the floor, refusing to cooperate with staff, they did a 2-man lift returning resident to his w/c, when attempting to bring him back and away from the door, he put himself in the floor a 2nd time. Resident unable to communicate and be understood. This incident report does not document a root cause analysis nor an intervention to reduce R3's risk of further falls. R3's incident report, dated 4/25/25 at 5:45 PM, documented Nursing Description: again, upon trying to return resident to his room he refused and for the 2nd time he put himself on the floor again. Resident Description: Again, resident is difficult to understand. Resident was 2 man lifted into his w/c and remains at the front door. This report does not document a root cause analysis of this fall nor a fall intervention to decrease R3's risk of experiencing more falls. R3's activity attendance records, dated 4/30/25 - 5/28/25, documented R3 only attended 1 activity between these dates. On 5/29/25 at 8:52 AM V15, Activity Director, stated R3 does not come to activities, she does not know what fall interventions R3 has in place, and no one has informed her of R3's fall interventions. On 5/29/25 at 10:57 AM V15 Activity Director stated R3 has not had an activity assessment completed since he was admitted to the facility. V15 stated it should have been completed on admission and quarterly. On 5/29/25 at 2:32 PM V1, Administrator, stated the nurses or DON are supposed to complete a root cause analysis after each fall, a new intervention is supposed to be care plan and implemented after each fall, and fall interventions should be in place according to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Prevention and Management policy, dated 5/2015, documented General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Responsible Party: RN, LPN (Licensed Practical Nurse), DON. Guidelines; Upon admission: 1. A fall risk evaluation will be completed on admission, readmission, and quarterly significant change and after each fall. 2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP (Individual Service Plan) with interventions implemented to minimize fall risk. Facility Guideline following a fall incident: 1. Evaluate the resident for any injury and notify the physician and emergency contact. 2. Complete a fall incident report in the (EMR) risk management portal. 3. A fall risk evaluation is completed by the nurse. A score of 10 or greater indicated the resident is at high risk for falls. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. 5. Complete the follow-up monitoring form every shift for 72 hours.