

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Nexus at Alton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Actual harm Residents Affected - Few	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 interview and record review the facility failed to initiate the process to timely obtain prescription medication for 2 of 6 residents (R1, R3) reviewed for medications in the sample of 10. This failure resulted in R1 experiencing unnecessary severe pain and suffering. Findings Include:1.R1's admission Record, print date of 11/17/25, documented R1 has diagnoses including acquired absence of right leg above the knee, peripheral vascular disease, cellulitis of left lower limb, type 2 diabetes mellitus, COPD (chronic obstructive pulmonary disease), hereditary and idiopathic neuropathy, hyperlipidemia, anxiety disorder, depression, heart failure, and hypertension. R1's MDS (Minimum Data Set), dated 8/21/25, documented R1 is cognitively intact, and requires partial/moderate assistance with transfers. R1's progress note, dated 11/10/25 and authored by V11 Nurse Practitioner, documented R1 was hospitalized from [DATE] - 11/10/25 for acute worsening of chronic left lower extremity venous ulcers with cellulitis and MRSA (methicillin resistant staphylococcus aureus) history; she received IV antibiotics and wound care. On return, she reports mild baseline leg pain (2/10). It continues, Past Surgical History: Right above-knee amputation (AKA) for compartment syndrome and foot infection (recent) - surgical wound debridement (left foot, recent). R1's Lyrica medication order, print date of 11/18/25, documented R1's Lyrica order was initiated on 1/21/25. This order documented Lyrica capsule 75 MG (Pregabalin) *controlled drug*, give 1 capsule by mouth three times a day for nerve pain. On 11/17/25 at 10:15 AM R1 stated the facility has been out of her Lyrica for 5 days. R1 stated when she asks the nurses about it, they just reply it has been ordered. On 11/17/25 at 10:53 AM V5 RN (Registered Nurse) stated (R1) is out of her Lyrica. V5 stated she is not sure how long she has been out. Surveyor asked V5 if the issue is with R1's physician not being notified in time to re-new her Lyrica prescription and V5 replied I think so because most of the agency nurses don't go through the cart to see what needs re-ordered. V5 then stated she went through the med cart this am and made a list of re-fills that are coming due for the nurse practitioner to send in. Surveyor asked V5 if R1's Lyrica will be delivered this evening and V5 replied it might come in this evening. On 11/17/25 at 2:13 PM V5 RN stated R1 is still out of her Lyrica and didn't receive her noon dose. Surveyor asked what the #9 on R1's MAR indicates for R1's Lyrica that was supposed to be administered today at noon and V5 replied 9 means it's on order from the pharmacy. R1's November 2025 MAR (Medication Administration Record) documented a #9 rather than a check mark for R1's Lyrica capsule 75 MG on the following dates and times R1 was supposed to receive her scheduled Lyrica: 11/15/25 at 6 AM, 11/15/25 at 9 PM, 11/16/25 on all 3 scheduled doses at 6 AM, 12 PM, and 9 PM, on 11/17/25 on all 3 scheduled doses at 6 AM, 12 PM, and 9 PM, and on 11/18/25 at 6 AM. This MAR documented chart codes #9 = other/see nurse notes. R1's progress note, dated 11/15/25 at 6:16 AM, documented e-MAR administration notes, Lyrica capsule 75 MG, give 1 capsule by mouth three times a day for nerve pain, med not available, reorder sent to pharmacy. R1's progress note, dated 11/15/25 at 9:43 PM, documented Lyrica capsule 75 MG, give 1 capsule by mouth three times a day for nerve pain, med not available, reorder sent to pharmacy. R1's progress note, dated 11/16/25 at 5:21 AM, documented Lyrica capsule 75 MG, give 1 capsule by mouth three times a day for nerve pain, (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 0755 Level of Harm - Actual harm Residents Affected - Few	med not available, reorder sent to pharmacy. R1's progress note, dated 11/16/25 at 5:24 PM, documented Lyrica capsule 75 MG, unavailable, reordered, awaiting new. R1's progress note, dated 11/16/25 at 10:16 PM, documented Lyrica capsule 75 MG, med not available. R1's progress note, dated 11/17/25 at 5:45 AM, documented Lyrica capsule 75 MG, med not available. R1's progress note, dated 11/17/25 at 12:45 PM, documented Lyrica capsule 75 MG, on order. On 11/18/25 at 8:00 AM V5 RN stated R1's Lyrica did not come in last night. Surveyor asked V5 if she knows the reason the Lyrica did not come in and V5 replied the Nurse Practitioner doesn't have a NPI (National Provider Identifier) number yet. On 11/18/25 at 8:05 AM R1 stated her Lyrica manages her nerve pain especially the phantom pain she experiences due to her leg amputation. R1 stated today is day 6 without the medication and her phantom pain rating has been between a 7 and 10 on a scale of 0 to 10. R1 stated when she receives her Lyrica as ordered her phantom pain averages a 3 on the pain scale. On 11/18/25 at 9:18 AM Surveyor asked V2 DON (Director of Nursing) if she knows why R1 has not been receiving her Lyrica medication. V2 stated no and she would find out what is going on with the medication because every Wednesday she goes to all the nurses and asks them what residents need narcotic drug refills from the Physician. Surveyor asked V2 if she feels it is acceptable for R1 not to receive her Lyrica as ordered for the last 4 days and V2 replied no. Surveyor then asked V2 if she can find out why R1's Lyrica order has not been refilled and if it is because the Nurse Practitioner does not have a NPI number yet. V2 stated she would check into it. On 11/18/25 at 9:42 AM V11 APRN (Advanced Practice Registered Nurse) stated she does have a NPI number, or she couldn't practice at the facility. V11 stated she just received her DEA (Drug Enforcement Administration) number this week and the nurse must be referring to that although the Physicians have been signing off on the controlled drug orders. Surveyor asked V11 if it is acceptable for R1 to go without her Lyrica for over 4 days and V11 replied it is never okay for a patient to go without their scheduled medication. On 11/18/25 at 10:32 AM Surveyor asked V2 DON and V5 RN if R1's Medication Monitoring/Control Record documented R1's last Lyrica was administered at 9 PM on 11/14/25 if that means that is the last time R1 received her scheduled Lyrica. V2 replied not necessarily because the nurses should get one from the E-kit. Surveyor asked V5 in the presence of V2 if she pulled a Lyrica from the E-Kit on 11/17/25 for R1 and V5 replied no. V5 then confirmed again to Surveyor that she did not administer R1's Lyrica as scheduled on 11/17/25. On 11/18/25 at 3:20 PM surveyor asked R1 if her pain has been at a zero since she has not been receiving her scheduled Lyrica and R1 replied my pain is never a zero and you are the only nurse who has asked me about my pain in the last 3 days. R1 stated her phantom pain was between a 7 - 10 this am and since the facility got her Lyrica back in stock and she received her noon dose today her pain is back down to a 3. On 11/18/25 at 3:32 PM surveyor asked V2 DON if R1's most recent count sheet documenting R1's last dose of Lyrica was administered on 11/14/25 at 9 PM is the last time R1 received her Lyrica until today at noon. V2 stated as far as she knows it was because pharmacy has not sent any documentation showing it was administered from the E-kit and that V13 ADON stated they couldn't have got any Lyrica for R1 out of the E-kit without a new order because the E-kit does not have R1's required dosage. On 11/19/25 at 9:33 AM V13 ADON (Assistant Director of Nursing) presented an incident report to surveyor for R1 not receiving her Lyrica as ordered. V13 stated the incident says the Lyrica was to be on hold until it came in stock. Surveyor asked why the order was never placed on hold and V13 stated when he was called on 11/14/25 about R1 being out of her Lyrica he told the nurse to call the doctor and put the order on hold, but the nurse must not have followed through on that. R1's incident report, dated 11/15/25 at 6:15 AM and authored by V13, documented this writer was notified by the floor nurse that resident's Lyrica is out of stock. Resident assessed for pain. No c/o pain or discomfort voiced. Physician notified. New order obtained to place the medication on hold until the medication becomes available from the pharmacy. R1's progress notes do not document anything regarding this incident report. On 11/19/25 at 10:16 AM V11 Nurse Practitioner stated she checked the physician notification records for R1 and there is nothing documented regarding R1's physician and/or clinician who was on (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	call being notified of R1 being out of Lyrica nor was an order implemented to hold R1's Lyrica until it was delivered to the facility.2.) R3's admission Record, print date of 11/17/25, documented R3 has diagnoses including cerebral infarction, type 2 diabetes mellitus, COPD, hypokalemia, anemia, coagulation defect, hypothyroidism, hyperlipidemia, anxiety disorder, obstructive sleep apnea, hypertension, nonrheumatic mitral valve insufficiency, generalized osteoarthritis, and depression. R3's MDS, dated [DATE], documented R3 is cognitively intact and is dependent on staff and a mechanical lift for transfers to and from her wheelchair. R3's care plan, undated, documented R3 is diabetic, resident is at risk for hypo/hyperglycemia related to diagnosis of diabetes mellitus with interventions including administer medication as ordered. On 11/17/25 at 11:35 AM R3 stated she has not been receiving her Ozempic injection every week as ordered, and the nurses tell her they can't find it when she asks them about it. R3's physician order, print date of 11/19/25 and order date of 10/16/25, for Ozempic documented order summary: Ozempic (2 MG/dose) subcutaneous solution pen-injector 8 MG/3ML (semaglutide), inject 2 mg subcutaneously one time a day every Thursday for diabetes give 2 mg dose, pen should last 28 days - 4 doses. R3's MAR, dated 11/2025, documented Ozempic (2 MG/dose) subcutaneous solution pen-injector 8 MG/3ML (semaglutide). Inject 2 mg subcutaneously one time a day every Thursday for diabetes, give 2 mg dose, pen should last 28 days, 4 doses. Administration date of 11/6/25 at 6 PM documented #9 (other/see nurse's note).R3's progress note, dated 11/6/25 at 5:35 PM documented Ozempic (2 MG/dose), inject 2 mg subcutaneously every Thursday for diabetes give 2 mg dose pen should last 28 days, 4 doses, medication not in. On 11/19/25 at 11:06 AM V1 Administrator stated she expects residents to receive their medications as ordered.The facility's Pharmacy Services policy, dated 9/2017, documented pharmacy services are provided by a licensed pharmacy. The role of the pharmacy, as well as pharmacy policies are outlined in the pharmacy policy manual. Responsible Party: DON, Administrator. Guideline: 1. Pharmaceutical services are available to ensure that resident's medications and biologicals are provided as ordered. 2. The facility does not accept money, goods, or services free or below cost from any pharmacy. 3. Pharmaceutical services provide appropriate methods and procedures for the procurement, dispensing and administration of drugs and biologicals per the individual pharmacy policy. 4. Pharmacy services are monitored to assure that the drug distribution system, to include the ordering, labeling and administering of drugs and biologicals, is in compliance with established policies and procedures. 5. Pharmacy services are provided on a 24-hour basis.		