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	05/29/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly notify 4 (R5, R7, R12, and R14) of 6 residents prior to a room change reviewed for notification of room changes in a sample of 15.Findings Include:1.) R5's Undated Face Sheet documents R5 was originally admitted to the facility on [DATE] with diagnoses of Rheumatoid Arthritis of Left Hip, Post-Traumatic Stress Disorder, Unsteadiness on Feet, and Need for Assistance with Personal Care.R5's Minimum Data Set (MDS) dated [DATE] documents R5 is cognitively intact.On 5/26/26 at 8:46 AM R5 stated she is currently in room [ROOM NUMBER]xx. R5 stated she was not informed of her room change prior to moving, and the facility did not inform her family.R5's Census List documents on 12/27/25 R5 resided in room [ROOM NUMBER]xx-B and on 1/15/26 a room change was completed and R5 moved to room [ROOM NUMBER]xx-B.2.) R7's Undated Face Sheet documents R7 was admitted to the facility on [DATE] with medical diagnoses of Type 2 Diabetes Mellitus, Hypertension, Chronic Kidney Disease, and Muscle Weakness.R7's MDS dated [DATE] documents R7 is cognitively intact.On 5/27/26 at 1:10 PM R7 observed in room [ROOM NUMBER]xx. R7 stated she was not notified by the facility before her room was changed.R7's Census List documents on 1/21/26 R7 resided in room [ROOM NUMBER]xx-A and on 2/1/26 a Liability change was made and R7 was moved to room [ROOM NUMBER]xx-A. R7's Census List documents on 3/9/26 R7's room was changed to 4xx-B and on 4/1/26 R7's room was changed to 3xx-A.3.) R12's Undated Face Sheet documents R12 was admitted to the facility on [DATE] with medical diagnoses of Pulmonary Embolism without Acute Cor Pulmonale, Prediabetes, and Personal History of Other Venous Thrombosis and Embolism.R12's MDS dated [DATE] documents R12 is cognitively intact.On 5/27/26 at 8:48 AM, R12 observed in room [ROOM NUMBER]. R12 stated he was not notified prior to his room move.R12's Census List documents on 2/1/26 R12 resided in room [ROOM NUMBER]xx-B, had a room change on 3/25/26 to room [ROOM NUMBER]-B, had a room change on 4/20/26 to room [ROOM NUMBER]xx-A, and had another room change on 5/17/26 to room [ROOM NUMBER]xx-C.4.) R14's Undated Face Sheet documents R14 was originally admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Abnormalities of Gait and Mobility, Muscle Weakness, Hypertension, End Stage Renal Disease, and Chronic Diastolic Congestive Heart Failure.R14's MDS dated [DATE] documents R14 is moderately cognitively impaired.On 5/27/26 at 2:50 PM R14 observed in room [ROOM NUMBER]xx. R14 stated he was not informed that his room would be changing by the facility and when he went to his room his belongings were gone, and he was told his room had been moved.R14's Census List documents on 4/1/26 R5 resided in room [ROOM NUMBER]xx-A and on 4/10/26 R14 had a room change to 4xx-C.R14's Grievance Form dated 3/10/26 documents Description: Resident was not notified about moving to a different room. Resident was not present during moving of personal items. Resident would like to return to previous room. Steps of Investigation: Administer talked with (R14), explained room move was necessary related to insurance and him being in correct bed to bill correctly. Explained going forward he would be notified prior to moving his belongings.On 5/28/26 at 8:40 AM, V1, Administrator, stated they were not doing the room (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	move notifications properly and she has educated the staff. V1 stated R14 was out of the facility and staff moved his belongings to a different room and did not notify him. V1 stated R14 was upset and filed a grievance.The Facility's Room Change/Transfer within Facility Policy Dated 12/2017 documents When a resident is being moved to a new room at the request of the facility, the residents, family or resident representative shall receive an explanation in writing of why the move is required. The resident will be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. Resident will be notified by a staff representative of room transfer request including reasons for the transfer, and will notify the resident regarding the proposed location of the new room and the potential new roommate(s).

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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. Based on interview and record review, the facility failed to provide wound care services as ordered by the Physician for 1 of 7 residents (R3) reviewed for Abuse and Neglect, in the sample of 15. This failure resulted in R3 being hospitalized for wound infections. Findings Include:R3's Face Sheet, undated, documents R3 has the following diagnoses, in part: Need for Assistance with Personal Care, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Hypertension (HTN), ESRD (End Stage Renal Disease), Muscle Wasting/Atrophy, and Anemia. R3's MDS (Minimum Data Set), dated 4/6/26, documents R3 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R3 is cognitively intact. R3 requires substantial/maximal assist with toileting is always incontinent of urine, frequently incontinent of bowel, has two-foot ulcers, a diabetic foot ulcer, and a wound infection. R3's Pressure Ulcer Risk Assessment, dated 12/31/25, documents R3 is at risk for pressure ulcer development.R3's POS (Physician Order Sheet) documents the following: 5/26/26 Bactrim DS Tablet 800-160 MG (Milligrams) Give 1 tablet by mouth every 12 hours for Wound Infection for 7 Days. R3's POS documents the following treatment/wound care orders: 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to the left calcaneus (heel bone), apply kerlix as directed one time a day. 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to right calcaneus, apply kerlix as directed one time a day. 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to right plantar (sole/bottom) foot apply kerlix s directed one time a day. 4/13/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to the right medial foot, and apply kerlix as directed. 3/31/26 Povidone-Iodine External Solution 7.5 % (Povidone-Iodine) Apply to right foot topically one time a day for right foot. R3's Treatment Administration Record (TAR), dated 5/2026, fails to document that the above wound care orders were completed as ordered on 5/8/26; 5/10/26; 5/15/26; 5/16/26; 5/17/26; 5/21/26; and 5/24/26. R3's Progress Notes were reviewed with no documentation that R3's treatments were completed on the above dates.R3's Hospital History & Physical, dated 5/26/26, documents the following: (R3) with ESRD, on daily dialysis, CHF, COPD (Chronic Obstructive Pulmonary Disease), DM, (Diabetes Mellitus), Depression, HTN, prior history of heart attack, status post stenting, on 2 liters of oxygen, chronic wound status, post removal of hardware with application of integra bilayer to the right foot. R3 is here because of worsening wound infection. Patient currently stays at (Long Term Care Facility) and goes to the wound care clinic once a week. Patient says that the nursing home ought to have been changing wound dressings daily but says that wasn't done. Patient says she would feel pain more on her right ankle, radiating to the upper part of her legs. She has been feeling nauseated for several days. Endorses chills but says she can't tell if she had a fever. Assessment and Plan: Wound infection, PAD (Peripheral Artery Disease), history of MRSA (Methicillin Resistant Staph Aureus), stage 3 pressure injury to the sacral region, and ulcers of both feet with necrosis of muscle. Multiple wounds in both feet with significant purulent drainage and evidence of necrosis. On 5/28/26 at 9:37 AM, V22, Wound Care Provider, stated she saw R3 at the wound clinic on 5/26/26, R3's right foot wound had purulent drainage, she was worried that R3 had osteomyelitis, so she sent R3 to the emergency room. V22 stated R3 was admitted to the hospital with osteomyelitis of the right foot and the hospital physician is saying that R3 might need an amputation, but there haven't been any final decisions made as of yet. V22 stated she had concerns that the facility was not completing the dressing changes as ordered to R3's foot so she attempted to contact nursing management at the facility multiple times, but no one would call her back. V22 stated when she saw R3 last week, R3 had maceration to her buttocks, when she saw her on 5/26/26, she had full skin breakdown on her buttocks, and she doesn't think the facility was turning and positioning R2 leading to the further breakdown. V22 stated when she gives orders, she expects the facility to follow them. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/28/26 at 1:06 PM, V3, DON (Director of Nurses), stated the treatments should be completed as ordered and would be documented on the TAR or in the progress notes.The Abuse Prevention Program, dated 2/7/17, documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their Abuse Prevention Policy by not reporting an injury of unknown origin for 1 (R2) of 7 residents, reviewed for abuse, neglect, and injuries of unknown origin in the sample of 15.Findings Include:R2's Undated Face Sheet documents R2 was admitted to the facility on [DATE] with medical diagnoses of Aphasia, Hemiplegia, Weakness, Abnormal Posture, Contracture of the Right and Left Knee, Contracture of the Right and Left Ankle, and Dementia.R2's Care Plan Date Initiated 11/19/13 documents R2 has a communication problem related to Cerebrovascular Accident (CVA). [NAME] is nonverbal and only able to make unintelligible sounds and is unable to communicate effectively with verbal and non-verbal gestures.R2's Care Plan Date Initiated 3/2/17 documents R2 is considered at risk for abuse/neglect due to mood cognition, weakness, behavioral/physical deficits.R2's Minimum Data Set (MDS) dated [DATE] documents R2 is rarely/never understood, has a memory problem, has an upper and lower extremity impairment on both sides, uses a wheelchair, needs supervision or touching assistance with eating, is dependent on staff for toileting hygiene, showering/bathing, personal hygiene, rolling left and right, lying to sitting on side of bed, chair/bed to chair transfers, and is always incontinent of bladder and bowel.R2's Nurses Notes dated 5/13/26 at 10:09 AM documents This nurse was called into the resident's room at 6am and informed that the resident had an area on her chest and wanted to know if I was aware. When the nurse entered the resident's room and accessed the area this nurse noted a large raised, firm, warm to touch, dried popped blistered area that extends from right arm pit, and severely painful area to right upper chest and shoulder. Nurse checked progress notes, and nothing had been documented and there was not risk management completed. So, the nurse called (V1) Administration and notified her of the findings. This nurse informed (V1) that a staff Certified Nursing Assistant (CNA) said that the areas were noticed by a night nurse on Sunday night. Head to toe assessment completed and the following was also noted bruising and swelling on the chest area, bruising on the right side, scattered bruises, scabs, and discoloration on bilateral lower extremities (BLE). The right elbow is very swollen and painful. Buttocks skin is intact. Pedal, brachial, and radial pulses noted to be weak on the right side. The administrator informed the nurse that a police officer would be coming to the facility to see the resident. Female Officer came 0745 and evaluated the resident and took pictures of some of her areas. Officer asked when this first notice and nurse informed her that CNA said that Sunday night nurse was aware and had taken pictures and notified the other nurse that night.R2's Hospital Records dated 5/13/26 documents Chief Complaint: patient presents with bruising. History of Present Illness (HPI): Per staff member, bruising reportedly noted Sunday and Monday to patient's chest and right shoulder, with no documentation of any injuries. She is unable to provide any history about what happened due to be nonverbal. Exam concern described for significant bruising and swelling of the right chest wall, right axilla, and right upper arm, with an associated scrape in the armpit/axilla.The Facility's Initial Report dated 5/13/26 documents Staff reported to administrator while performing care noticed a dark discoloration under right armpit. Medical Director (MD) notified, and order received to send to emergency room (ER) for evaluation. Investigation initiated. Final report to follow.R2's Local Police Department Incident Report Dated 5/13/26 documents On 05/13/26 at approximately 0728 hours, I was dispatched to (Nursing Facility), in regards to (R2) having a large amount of bruising and unknown injuries. I arrived on scene and contacted Nurse (V26), (V26) advised she was working nights last night when she was advised of an issue with (R2). (V26) advised she did an assessment on (R2) after being told about some bruising on (R2's) right side. (V26) advised she reviewed (R2's) paperwork and was unable to locate any previous documentation of this injury, but was advised the night nurse on Sunday, 05/10/26, verbally stated she noticed bruising. During (V26's) assessment, she observed yellow discoloration on (R2's) right arm, both breasts, and the right side under (R2's) arm. (V26) advised she observed what appeared to (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be a large, red and purple blister near (R2's) right armpit, and purple bruising down her side and underneath her right breast. (V26) advised the right side of (R2's) body near her injuries was cold to the touch and the skin was tight. (V26) advised she noticed (R2's) right leg was cold to the touch compared to the left, and all of the pulses on her right side were much weaker than the left. (V26) advised during her assessment, although (R2) is nonverbal, she noticed (R2) to be in excruciating pain when touching the right side of her body and the right extremities.On 5/27/26 at 11:10 AM V26, Registered Nurse (RN), stated she was asked by a CNA if she was aware of R2's shoulder and chest area being swollen. V26 stated she did not see anything noted in R2's report sheets or nurses notes. V26 stated when she assessed R2, she noticed a large, raised area under R2's breast and bruising with discoloration to R2's arm and under arm, V26 stated she does not remember what side of R2's body this was on. V26 stated she was not informed of any bruising of discoloration when she received report on R2. V26 stated she called V1, Administrator, regarding the bruising and V1 stated she was not aware. V26 stated V1 informed V26 to start an investigation and interview staff. V26 stated the local police department was notified and R2 was sent to the local hospital for evaluation.On 5/28/26 at 12:18 PM V30, RN, stated she noticed some bruising on the night of 5/10/26 when she worked with R2. V30 stated she observed bruising under R2's right arm by R2's breast, to the top and middle of R2's right breast that extended to R2's left breast. V30 stated the worst bruise was on R2's right side and it extended to R2's bend of her arm. V30 stated the bruises were green and yellow in color, in different stages of healing, and looked as though they had been there awhile. V30 stated she is not sure if she documented the bruising and if she did not, she meant to. V30 stated she did not report the bruising to V1, Administrator, because she assumed another staff member already did.On 5/28/26 at 2:03 PM V24, CNA, stated she was not working on R2's hall on the night of 5/10/26, but remembers V30 coming to the nurse's station showing pictures of bruises on R2. V24 stated V30 asked if any staff knew of the bruises on R2 and no staff members were aware. V24 stated she asked V30 what the next step was regarding the bruises and V30 mentioned contacting V1. V24 stated she knows staff is supposed to report any bruising or injuries to V1 immediately, but she was not going to tell V30 what to do, since V30 is the nurse and was in charge. V24 stated V30 did not report the bruises to V1 that night.On 5/28/26 at 4:00 PM V1 stated allegations of abuse, neglect, or injuries of unknown origin, are to be reported to her immediately.On 5/29/26 at 9:16 AM V1, Administrator, stated she was first notified of the bruising to R2 on 5/13/26. V1 stated she expects her staff to follow the facility policy on reporting any allegation of abuse, neglect, or injury of unknown origin. V1 stated she was not aware of any staff member noticing the bruising on R2 on 5/10/26, and if she was notified then, she would have reported it right away.The Facility's Abuse Prevention Program Date Reviewed 9/2017 documents Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Internal Reporting Requirement and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations, or other abnormalities of unknown source the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin immediately to Administration for 1 (R2) of 7 residents reviewed for abuse in a sample of 15.Findings Include:R2's Undated Face Sheet documents R2 was admitted to the facility on [DATE] and has a medical diagnosis of Aphasia, Hemiplegia, Weakness, Abnormal Posture, Contracture of the Right and Left Knee, Contracture of the Right and Left Ankle, and Dementia.R2's Care Plan Date Initiated 11/19/13 documents R2 has a communication problem related to Cerebrovascular Accident (CVA). [NAME] is nonverbal and only able to make unintelligible sounds and is unable to communicate effectively with verbal and non-verbal gestures.R2's Care Plan Date Initiated 3/2/17 documents R2 is considered at risk for abuse/neglect due to, mood cognition, weakness, behavioral/physical deficits.R2's Minimum Data Set (MDS) dated [DATE] documents R2 is rarely/never understood, has a memory problem, has an upper and lower extremity impairment on both sides, uses a wheelchair, needs supervision or touching assistance with eating, is dependent on staff for toileting hygiene, showering/bathing, personal hygiene, rolling left and right, lying to sitting on side of bed, chair/bed to chair transfers, and is always incontinent of bladder and bowel.R2's Nurses Notes dated 5/13/26 at 10:09 AM documents This nurse was called into the residents room at 6am and informed that the resident had an area on her chest and wanted to know if I was aware. When the nurse entered the residents room and accessed the area this nurse noted a large raised, firm, warm to touch, dried popped blistered area that extends from right arm pit, and severely painful area to right upper chest and shoulder. Nurse checked progress notes and nothing had been documented and there was not risk management completed. So, the nurse called (V1) Administration and notified her of the findings. This nurse informed (V1) that a staff Certified Nursing Assistant (CNA) said that the areas were noticed by a night nurse on Sunday night. Head to toe assessment completed and the following was also noted bruising and swelling on the chest area, bruising on the right side, scattered bruises, scabs, and discoloration on bilateral lower extremities (BLE). The right elbow is very swollen and painful. Buttocks skin is intact. Pedal, brachial, and radial pulses noted to be weak on the right side. The administrator informed the nurse that a police officer would be coming to the facility to see the resident. Female Officer came 0745 and evaluated the resident and took pictures of some of her areas. Officer asked when this first notice and nurse informed her that CNA said that Sunday night nurse was aware and had taken pictures and notified the other nurse that night.R2's Hospital Records dated 5/13/26 documents Chief Complaint: patient presents with bruising. History of Present Illness (HPI): Per staff member, bruising reportedly noted Sunday and Monday to patient's chest and right shoulder, with no documentation of any injuries. She is unable to provide any history about what happened due to be nonverbal. Exam concern described for significant bruising and swelling of the right chest wall, right axilla, and right upper arm, with an associated scrape in the armpit/axilla.The Facility's Initial Report dated 5/13/26 documents Staff reported to administrator while performing care noticed a dark discoloration under right armpit. Medical Director (MD) notified and order received to send to emergency room (ER) for evaluation. Investigation initiated. Final report to follow.R2's Local Police Department Incident Report Dated 5/13/26 documents On 05/13/26 at approximately 0728 hours, I was dispatched to (Nursing Facility), in regards to (R2) having a large amount of bruising and unknown injuries. I arrived on scene and contacted Nurse (V26), (V26) advised she was working nights last night when she was advised of an issue with (R2). (V26) advised she did an assessment on (R2) after being told about some bruising on (R2's) right side. (V26) advised she reviewed (R2's) paperwork and was unable to locate any previous documentation of this injury, but was advised the night nurse on Sunday, 05/10/26, verbally stated she noticed bruising. During (V26's) assessment, she observed yellow discoloration on (R2's) right arm, both breasts, and the right side under (R2's) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arm. (V26) advised she observed what appeared to be a large, red and purple blister near (R2's) right armpit, and purple bruising down her side and underneath her right breast. (V26) advised the right side of (R2's) body near her injuries was cold to the touch and the skin was tight. (V26) advised she noticed (R2's) right leg was cold to the touch compared to the left, and all of the pulses on her right side were much weaker than the left. (V26) advised during her assessment, although (R2) is nonverbal, she noticed (R2) to be in excruciating pain when touching the right side of her body and the right extremities.On 5/27/26 at 11:10 AM V26, Registered Nurse (RN), stated she was asked by a CNA if she was aware of R2's shoulder and chest area being swollen. V26 stated she did not see anything noted in R2's report sheets or nurses notes. V26 stated when she assessed R2, she noticed a large, raised area under R2's breast and bruising with discoloration to R2's arm and under arm, V26 stated she does not remember what side of R2's body this was on. V26 stated she was not informed of any bruising of discoloration when she received report on R2. V26 stated she called V1, Administrator, regarding the bruising and V1 stated she was not aware. V26 stated V1 informed V26 to start an investigation and interview staff. V26 stated the local police department was notified and R2 was sent to the local hospital for evaluation.On 5/28/26 at 12:18 PM V30, RN, stated she noticed some bruising on the night of 5/10/26 when she worked with R2. V30 stated she observed bruising under R2's right arm by R2's breast, to the top and middle of R2's right breast that extended to R2's left breast. V30 stated the worst bruise was on R2's right side and it extended to R2's bend of her arm. V30 stated the bruises were green and yellow in color, in different stages of healing, and looked as though they had been there awhile. V30 stated she is not sure if she documented the bruising and if she did not, she meant to. V30 stated she did not report the bruising to V1, Administrator, because she assumed another staff member already did.On 5/28/26 at 2:03 PM V24, CNA, stated she was not working on R2's hall on the night of 5/10/26, but remembers V30 coming to the nurse's station showing pictures of bruises on R2. V24 stated V30 asked if any staff knew of the bruises on R2 and no staff members were aware. V24 stated she asked V30 what the next step was regarding the bruises and V30 mentioned contacting V1. V24 stated she knows staff is supposed to report any bruising or injuries to V1 immediately, but she was not going to tell V30 what to do, since V30 is the nurse and was in charge. V24 stated V30 did not report the bruises to V1 that night.On 5/28/26 at 4:00 PM V1 stated allegations of abuse, neglect, or injuries of unknown origin, are to be reported to her immediately.On 5/29/26 at 9:16 AM V1, Administrator, stated she was first notified of the bruising to R2 on 5/13/26. V1 stated she was not aware of any staff member noticing the bruising on R2 on 5/10/26, and if she was notified then, she would have reported it right away.The Facility's Abuse Prevention Program Date Reviewed 9/2017 documents Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Internal Reporting Requirement and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations, or other abnormalities of unknown source the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain.

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	145427	A. Building B. Wing	05/29/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide showers to 4 of 6 residents (R2, R5, R7, R15) reviewed for Activities of Daily Living (ADL) care in a sample of 15.Findings Include:Findings Include:1.) R2's Undated Face Sheet documents R2 was admitted to the facility on [DATE] and has medical diagnoses of Aphasia, Hemiplegia, Weakness, Abnormal Posture, Contracture of the Right and Left Knee, Contracture of the Right and Left Ankle, and Dementia.R2's Minimum Data Set (MDS) dated [DATE] documents R2 is rarely/never understood, has a memory problem, has an upper and lower extremity impairment on both sides, uses a wheelchair, needs supervision or touching assistance with eating, is dependent on staff for toileting hygiene, showering/bathing, personal hygiene, rolling left and right, lying to sitting on side of bed, chair/bed to chair transfers, and is always incontinent of bladder and bowel.R2's Care Plan Date Initiated 11/19/23 documents R2 has Activities of Daily Living (ADL) Self Care Performance Deficit related to Cerebrovascular Accident (CVA).R2's Shower Sheets document R2 last received a shower on 4/16/26.On 5/26/28 at 9:00 AM R2 observed in bed wearing a hospital gown, R2's hair appears matted and greasy.On 5/27/28 at 12:28 PM R2's hair appeared unkept, matted, and greasy.2.) R5's Undated Face Sheet documents R5 was originally admitted to the facility on [DATE] with medical diagnoss of Rheumatoid Arthritis of Left Hip, Post-Traumatic Stress Disorder, Unsteadiness on Feet, and Need for Assistance with Personal Care.R5's MDS dated [DATE] documents R5 is cognitively intact, has a lower extremity impairment of both sides, uses a wheelchair, needs substantial/maximal assistance with toileting hygiene, showering/bathing, need partial/moderate assistance with sitting to standing and chair/bed to chair transfers, is frequently incontinent of bladder, and occasionally incontinent of bowel.R5's Care Plan Date Initiated 12/16/24 documents ADL: R5 requires assist with daily care needs related to need for assistance with ADLs.R5's Physician Order dated 6/13/25 at 11:40 PM documents patient requesting assistance with daily showers in the morning for showering and hygiene- requesting morning time showers, assist with showering.On 5/26/26 at 8:46 AM R5 stated she received a shower about two weeks ago and has not been offered or received a shower since.R5's Shower Sheets document R5 last received a shower on 5/15/26.3.) R7's Undated Face Sheet documents R7 was admitted to the facility on [DATE] with medical diagnoses of Type 2 Diabetes Mellitus, Hypertension, Chronic Kidney Disease, and Muscle Weakness.R7's MDS dated [DATE] documents R7 is cognitively intact, needs partial/moderate assistance with toileting hygiene, showering/bathing, needs supervision or touching assistance with chair/bed to chair transfers, and is occasionally incontinent of bladder.R7's Care Plan Date Initiated 1/27/26 documents ADL: R7 requires assist with daily care needs related to muscle weakness.On 5/26/26 at 9:21 AM R7 stated she has been in the facility since January and has only received 1 shower. R7 stated she is not offered a shower or bed bath weekly.R5's Shower Sheets document R5 last received a shower on 3/26/26.4.) R15's Undated Face Sheet documents R15 was admitted to the facility on [DATE] with medical diagnosis of Cerebral Infarction, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Unsteadiness on Feet, Weakness, and Hypertension.R15's MDS dated [DATE] documents R15 is cognitively intact, uses a wheelchair, needs supervision or touching assistance with toileting hygiene, showering/bathing, chair/bed to chair transfers.R15's Care Plan Date Initiated 11/29/25 documents ADL: R15 requires assist with daily care needs related to use of wheelchair and broken right clavicle.On 5/27/26 at 10:27 AM R15 stated very seldom does she receive a shower and is unsure when the last time she received one. R15 stated she filed a grievance regarding showers, and nothing has changed.R15's Shower Sheets documents R15 last received a shower on 5/13/26.The Facility's Grievance Form dated 3/2/26 documents Description: (R15) states that when she gets her showers, which is rare, that the staff will let her into the shower room and leave her unattended. (R15) states that she is unable to wash herself properly and that the staff does not help her. Steps of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Investigation: Spoke with resident shower days is Wednesday and Saturdays. Need assistance would like to have showers everyday and need standby assistance, to wash back and dry back. Summary/Findings: showers not given.R15's Grievance Form dated 3/16/26 documents Description: would like to shower daily prior to bedtime with staff standby assistance. Summary/Findings: Resident only had one shower last week.The Facility's Grievance Form dated 1/21/26 documents Resident reported not getting shower twice a week or weekly at times.The Facility's Grievance Form dated 5/4/26 documents Issue with getting showers.On 5/28/26 at 1:06 PM V3, Director of Nursing, stated the shower sheets she has provided are the only shower sheets and documentation she has that showers were given and done.On 5/28/26 at 4:00 PM V1, Administrator, stated showers are to be given at least weekly, they try to give them twice weekly, it depends on the resident's preference, some request it more often.The Facility's Activities of Daily Living Dependent Residents Policy Date Revised 1/2023 documents Purpose: to ensure that dependent residents in the facility receive regular, safe, and respectful bathing assistance as part of their Activities of Daily Living (ADLs), in alignment with their care plan, preferences, and clinical needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete pressure ulcer care and monitoring in 2 of 7 residents (R3, R4) reviewed for the Treatment/Services to Prevent/Heal pressure ulcers, in the sample of 15. This failure resulted in R3 being admitted to the hospital with wound infections. Findings Include:1) R3's Face Sheet, undated, documents R3 has the following diagnoses, in part: Need for Assistance with Personal Care, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Hypertension (HTN), ESRD (End Stage Renal Disease), Muscle Wasting/Atrophy, and Anemia. R3's MDS (Minimum Data Set), dated 4/6/26, documents R3 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R3 is cognitively intact. R3 requires substantial/maximal assist with toileting is always incontinent of urine, frequently incontinent of bowel, has two foot ulcers, a diabetic foot ulcer, and a wound infection. R3's Pressure Ulcer Risk Assessment, dated 12/31/25, documents R3 is at risk for pressure ulcer development.R3's POS (Physician Order Sheet) documents the following: 5/26/26 Bactrim DS Tablet 800-160 MG (Milligrams) Give 1 tablet by mouth every 12 hours for Wound Infection for 7 Days. R3's POS documents the following treatment/wound care orders: 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to the left calcaneus (heel bone), apply kerlix as directed one time a day. 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to right calcaneus, apply kerlix as directed one time a day. 4/14/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to right plantar (sole/bottom) foot apply kerlix s directed one time a day. 4/13/26 Clean wound with wound cleanser, moisten gauze and pack into wound, then apply gauze over wound to the right medial foot, and apply kerlix as directed. 3/31/26 Povidone-Iodine External Solution 7.5 % (Povidone-Iodine) Apply to right foot topically one time a day for right foot. R3's Treatment Administration Record (TAR), dated 5/2026, fails to document that the above wound care orders were completed as ordered on 5/8/26; 5/10/26; 5/15/26; 5/16/26; 5/17/26; 5/21/26; and 5/24/26. R3's Progress Notes were reviewed with no documentation that R3's treatments were completed on the above dates.R3's Hospital History & Physical, dated 5/26/26, documents the following: (R3) with ESRD, on daily dialysis, CHF, COPD (Chronic Obstructive Pulmonary Disease), DM, (Diabetes Mellitus), Depression, HTN, prior history of heart attack, status post stenting, on 2 liters of oxygen, chronic wound status, post removal of hardware with application of integra bilayer to the right foot. R3 is here because of worsening wound infection. Patient currently stays at (Long Term Care Facility) and goes to the wound care clinic once a week. Patient says that the nursing home ought to have been changing wound dressings daily but says that wasn't done. Patient says she would feel pain more on her right ankle, radiating to the upper part of her legs. She has been feeling nauseated for several days. Endorses chills but says she can't tell if she had a fever. Assessment and Plan: Wound infection, PAD (Peripheral Artery Disease), history of MRSA (Methicillin Resistant Staph Aureus), stage 3 pressure injury to the sacral region, and ulcers of both feet with necrosis of muscle. Multiple wounds in both feet with significant purulent drainage and evidence of necrosis. On 5/28/26 at 9:37 AM, V22, Wound Care Provider, stated she saw R3 at the wound clinic on 5/26/26, R3's right foot wound had purulent drainage, she was worried that R3 had osteomyelitis, so she sent R3 to the emergency room. V22 stated R3 was admitted to the hospital with osteomyelitis of the right foot and the hospital physician is saying that R3 might need an amputation, but there haven't been any final decisions made as of yet. V22 stated she had concerns that the facility was not completing the dressing changes as ordered to R3's foot so she attempted to contact nursing management at the facility multiple times, but no one would call her back. V22 stated when she saw R3 last week, R3 had maceration to her buttocks, when she saw her on 5/26/26, she had full skin breakdown on her buttocks, and she doesn't think the facility was turning and positioning R2 leading to the further breakdown. V22 stated when she gives orders, she expects the facility to follow them. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2) R4's Face Sheet, undated, documents R4 has the following diagnoses, in part: Type 2 DM, Stage 4 CKD, Anemia, and HTN.R4's MDS, dated [DATE], documents R4 has a BIMS score of 15. R4's Care Plan, dated 2/9/26, documents R4 is at risk for skin complications.R4's POS documents the following orders: 1/27/26 Cleanse wound with wound cleaner, pat dry. Apply Medi honey to sacrum area with bordered gauze one time a day for wound care. 1/27/26 Cleanse wound with wound cleaner, pat dry. Apply Medi honey to right heel and with bordered gauze one time a day.R4's Nursing admission Observation, dated 12/31/25, has no documentation that R4's skin was assessed.R4's Nursing admission Assessment, dated 2/19/26, documents R4 has skin conditions that require monitoring/treatment, however there were no measurements, locations, or description documented.R4's Skin Assessment, dated 2/19/26, documents there were no new findings. There wasn't any documentation of the current areas.There wasn't any documentation in R4's records that the facility had documented measurements or a description of the wounds from 1/15/26 through her discharge to the hospital on 2/25/26.On 5/28/26 at 1:06 PM, V3, DON (Director of Nurses), stated the treatments should be completed as ordered and would be documented on the TAR or in the progress notes.The Skin Management: Pressure Injury, Lower Extremity Ulcer Evaluation, and Documentation, policy, dated 6/2015, documents, in part, pressure injuries will be evaluated, a picture taken and the following areas documented weekly: location, stage, size, depth, presence and location of undermining/tunneling/sinus tract, exudate, pain, wound bed, and wound edges. Wounds will be measured on a weekly basis. If a wound shows no signs of healing after three weeks, a reevaluation of the wound will be done. Reevaluation of the treatment plan including determining whether to continue or modify the current treatment interventions.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, the facility failed to supply a mechanism to alert staff that assistance is needed while residents are in their room, including a call light for 2 (R7, R12) of 6 residents in a sample of 15.Findings Include:1.) R7's Undated Face Sheet documents R7 was admitted to the facility on [DATE] with medical diagnoses of Type 2 Diabetes Mellitus, Hypertension, Chronic Kidney Disease, and Muscle Weakness.R7's Minimum Date Set (MDS) dated [DATE] documents R7 is cognitively intact, needs partial/moderate assistance with toileting hygiene, showering/bathing, needs supervision or touching assistance with chair/bed to chair transfers, and is occasionally incontinent of bladder.R7's Care Plan Date Initiated 1/27/26 documents Activities of Daily Living (ADL): R7 requires assist with daily care needs related to muscle weakness.On 5/26/26 at 9:21 AM R7 stated she does not have a call light in her room. R7 denied having a bell or device to use to let staff know she needs assistance. R7 stated if she needs to get staff's attention, she will yell for the staff and hope they hear her and come help.On 5/26/26 at 9:21 AM no call light was observed for R7 to use.On 5/26/26 at 3:22 PM no bell observed on R7's table or in R7's room for R7 to use.2.) R12's Undated Face Sheet documents R12 was admitted to the facility on [DATE] with medical diagnoses of Pulmonary Embolism without Acute Cor Pulmonale, Prediabetes, and Personal History of Other Venous Thrombosis and Embolism.R12's MDS dated [DATE] documents R12 is cognitively intact, uses a wheelchair, needs partial/moderate assistance with toileting hygiene, showering/bathing, sitting to standing, chair/bed to chair transfers, and is always continent of bladder and bowel.R12's Care Plan Date Initiated 9/10/25 documents ADL: R12 requires assist with daily care needs related to weakness after recent hospitalization.On 5/27/26 at 8:48 AM R12 stated he doesn't have access to his call light or a bell and doesn't know what to do if he needs help since he doesn't have access to that.On 5/26/26 at 10:05 AM V1, Administrator, stated she ordered a 3rd call light for the rooms with 3 residents, and the call lights should be in today. V1 stated she did purchase a bell for the residents to use while they wait for the call lights to come in.The Facility's Call Light Response Policy Date Revised 9/2025 documents Ensure call light is within resident's reach at all times.