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	06/21/2026

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 0550 Level of Harm - 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 treat residents with dignity and respect for 3 of 4 residents; (R6, R7 and R8); reviewed for Resident Rights in a sample of 14. This failure caused R6 to have feelings of being unworthy of care and shamed and feeling worse about herself. This failure caused R7 to feel worse about himself and like he is a bother to staff. This failure caused R8 to feel insignificant.Findings include:1.R6's Facesheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE] with diagnoses of, in part, rheumatoid arthritis, major depressive disorder, chronic pain and anxiety disorder.R6's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with chair to bed transfer.R6's Care Plan dated 12/16/24 documented she requires assistance with daily care needs.On 6/16/26 at 3:03 PM, V17 (CNA/Certified Nursing Assistant) stated to R6, you shouldn't be getting changed every day at shift change. V17 stated to R6, you can't be doing this all the time, this is ridiculous. V17 went with R6 into her room.On 6/17/26 at 8:53 AM, R6 was wheeling across the dining room crying. V11 asked R6 what was wrong. R6 stated to V11 she was told she was late and couldn't have breakfast. V11 stated to R6 No we will get you something, at least a bowl of cereal, they just need to clean a bowl for you. R6 went to a table and waited. At 8:57 AM, R6 was given a bowl of cereal.On 6/17/26 at 10:45 AM, R6 stated she feels like she is not getting the care she needs. R6 stated V6 (CNA) told her she wouldn't change her because she would need to wait until after lunch. R6 stated it makes her feel unworthy of care and shamed. R6 stated she wants to transfer to another facility where it might have nicer staff. R6 stated she feels like she can't ask for help, but she requires it because she needs a full body mechanical lift to be transferred right now. R6 stated earlier today staff were late getting me dressed and up out of bed for breakfast so by the time she got to the dining room breakfast was already done and that's not her fault. R6 stated a girl from the kitchen staff with red and black hair told her she couldn't eat breakfast because she was late. R6 stated she started crying after that because she was hungry and upset. R6 stated she's asked to get cleaned up multiple times which she can't control and has to urinate a lot because of the water pill she takes and some of the staff don't like she takes it. R6 stated they make her feel worse about herself.2.R7's Facesheet with a print date of 6/18/26 documented he was admitted to the facility on [DATE] with diagnosis of, in part, shortness of breath, localized edema, and pulmonary embolism without acute cor pulmonale.R7's MDS dated [DATE] documented he was cognitively intact and required partial/moderate assistance from staff for toileting hygiene and chair to bed or toilet transfers.R7's Care Plan dated 9/10/25 documented he requires assistance with daily care.On 6/17/26 at 12:44 PM, R7 stated he'll ask for help from the staff, and they will tell him to wait, that they are too busy at the time and will have to help him later. R7 stated the way the staff treat him makes him feel worse about himself and like he is a bother to them.3.R8's Facesheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE] with diagnoses of, in part, chronic obstructive pulmonary disease, type two diabetes mellitus, depression, and acquired absence of right leg below the knee.R8's MDS dated [DATE] (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

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	06/21/2026

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 0550 Level of Harm - Actual harm Residents Affected - Few	documented she was cognitively intact and required partial/moderate assistance from staff for toileting hygiene and chair to bed or toilet transfers.R8's Care Plan dated 10/23/24 documented she requires assistance with daily needs and for staff to assist with her activities of daily living.On 6/17/26 at 1:55 PM, R8 stated currently waiting to be cleaned up right now because she is soiled. R8 stated she told V10 (CNA) she was wet sometime around 1 o'clock today and his response to her was that she had to wait until he was done passing meal trays. R8 stated she is currently still sitting soaked, and it is very uncomfortable. R8 stated when she tells them they are being too rough (during care) they act like she is being a baby and tell her Oh, you're fine. R8 stated it makes her feel insignificant. R8 stated she's been told to help herself and wear pull ups instead of briefs to do things by herself, but she urinates too much for a pull up to hold. R8 pressed her call light at 1:57 PM, and at 2:01 PM, V14 responded and told her she would clean her up. At 2:04 PM, V14 (CNA) provided incontinent care for R8.On 6/18/2026 at 1:19 PM, R8 asked for assistance. V10 (CNA) stated that I'm busy passing trays. V10 did not provide R8 with any assistance.On 6/18/26 at 3:07 PM, V2 (Director of Nursing/DON) stated Some of these new people I wouldn't want taking care of me. I have high expectations. V2 stated if a resident is in need of assistance or requests help, staff should help them right away and not told to wait especially if not helping another resident at the time. V2 stated all residents should be treated with dignity and respect.On 6/18/26 at 3:30 PM, V29 (CNA) stated when a resident requests help or care, she would help them immediately or as soon as possible; all residents deserve to be treated with dignity and respect.On 6/20/26 at 12:44 PM, V26 (Medical Director) stated if a resident requests or needs assistance his expectation from staff is to respond and triage them appropriately. V26 stated it would be a case-by-case basis for what the staff response would cause a resident to feel. V26 stated all residents deserve to be treated with dignity and respect.The facility's Resident Rights policy last reviewed on 10/2025 documented the objective of the accommodation of the resident needs and preferences is to create an individualized, homelike environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preferences.

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	06/21/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain the environment in clean and good repair for 8 of 15 residents (R1, R3, R4, R5, R6, R9, R10, R14) rooms reviewed for environment in a sample of 15. Findings include:1 R5's Minimum Data Set (MDS), dated [DATE], documents that R5 is cognitively intact.On 6/15/2026 at approximately 2:15 PM R5 stated that his room is dirty, and housekeeping does not clean his room on a regular basis. R5 stated that there is stains on the floor that have been there for days. R5 stated that the shower room is unsafe and needs to be repaired. R5 stated that the drain is broken, and the door is broken.2. R3's MDS, dated [DATE], documents that R3 is cognitively intact.On 6/16/2026 at 9:13 AM R3 stated that sometimes they clean the room and sometimes they don't. R3 instructed to look under her bed they never clean there. R5 stated that she uses the 300/400 hall shower room. R4 stated that the baseboards were coming away from the wall and the toilet handle was broken.On 6/16/2026 at observed dried liquid under R3's bed and on floor between R3 and R4. Toilet handle was flipped backwards and unusable and the baseboard was peeling away from wall. 6/17/2026 at approximately 9:15 AM dried liquid remained or base board.3. R4's MDS, dated [DATE], documents that R4 is cognitively intact.On 6/15/2026 at 3:09 PM R4 stated that they clean the rooms with a broom but don't mop. R4 stated that the room has things that need to be fixed. R4 stated that she uses the 300 Hall shower room. 4. On 6/16/2026 at 12:30 Observed baseboards coming off walls in R1, R3, R4, R6 and R10s rooms. Observed The 300-hall shower room's door has multiple strips of wood like particles peeling away from and hanging off the door. With pieces of door hanging from door with sharp edges. On 3/15/2026 at 2:50 PM V5, Certified Nurse Assistant stated that R1, R3, R4, R5, R6, R9, R10, and R14 use the shower room. On 6/16/2026 at 1:38 PM V1, Administrator stated that there are rooms that require fixing and maintenance are working on it. V1 stated that she was not aware of the shower room door and would have it fixed. V1 stated that the facility is working to get it clean. V1 stated that there are 2 great housekeepers, and they are working to get and train more to the facility's standards.On 6/18/2026 at 3:07 PM V2, Director of Nursing, stated that there are areas in the building that require repairs. V2 stated that maintenance is aware and working on them. V2 stated that the facility is dirty with strong odors and that is a work in progress.On 6/16/2026 at 2:36 PM V4, Maintenance Director, stated that he was not aware of any repairs needed on the hall. V4 stated that they have a maintenance book. The staff are to document in the book repairs needed. V4 stated that also the staff utilize a text service for things that come up and he is able to address immediately. V4 stated that the book is looked at daily by himself and his staff.The facility's Quarterly Inspections, not dated, documents 6. All residents' rooms should be inspected for any repairs needed and proper operation of equipment.

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	06/21/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to provide timely incontinent care for 1 of 4 residents (R8); reviewed for incontinent care in a sample of 14.Findings include:R8's Facesheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE] with diagnoses of, in part, chronic obstructive pulmonary disease, type two diabetes mellitus, depression, and acquired absence of right leg below the knee.R8's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact and required partial/moderate assistance from staff for toileting hygiene and chair to bed or toilet transfers.R8's Care Plan dated 10/23/24 documented she requires assistance with daily needs and for staff to assist with her activities of daily living. R8's Care Plan dated 10/16/24 documented she is incontinent of bowel and bladder.On 6/17/26 at 1:55 PM, R8 stated currently waiting to be cleaned up right now because she is soiled. R8 stated she told V10 Certified Nursing Assistant (CNA) she was wet sometime around 1 o'clock today and his response to her was that she had to wait until he was done passing meal trays. R8 stated she is currently still sitting soaked, and it is very uncomfortable. R8 stated it makes her feel insignificant. R8 stated she's been told to help herself and wear pull ups instead of briefs to do things by herself, but she urinates too much for a pull up to hold. R8 pressed her call light at 1:57 PM, and at 2:01 PM, V14 responded and told her she would clean her up. At 2:04 PM, V14 (CNA) provided incontinent care for R8.On 6/18/2026 at 1:19 PM, R8 asked for assistance. V10 (CNA) stated that I'm busy passing trays. V10 did not provide R8 with any assistance.On 6/18/26 at 3:07 PM, V2 (Director of Nursing/DON) stated Some of these new people I wouldn't want taking care of me. I have high expectations. V2 stated if a resident is in need of assistance or requests help, staff should help them right away and not told to wait especially if not helping another resident at the time.On 6/18/26 at 3:30 PM, V29 (CNA) stated when a resident requests help or care, she would help them immediately or as soon as possible.On 6/20/26 at 12:44 PM, V26 (Medical Director) stated if a resident requests or needs assistance his expectation from staff is to respond and triage them appropriately.The facility's Incontinence Care policy last revised on 9/2025 documented all nursing staff are responsible for providing the care to keep residents as dry, comfortable and odor free as possible; also helping prevent skin breakdown.

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	06/21/2026

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 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 interview and record review the facility failed to provide pain management for 1 of 5 (R5) residents reviewed for medication administration in a sample of 15. This failure resulted in R5 experiencing excruciating and unbearable pain.Findings include:R5's Care Plan, dated 10/09/2023, documents PAIN: Resident has potential for an alteration in comfort r/t (related to) osteomyelitis and spina bifida.R5's, Minimum Data Set, dated [DATE], documents that R5 was cognitively intact and experiences pain almost daily. R5's Physician Order Sheet documents 4/8/2026 Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours for Pain. R5's Oxycodone HCl Oral Tablet 10 MG Medication Monitoring Control Record, dated 4/16/2026, documents last administered 5/1/2026 at 11AM. R5's Medication Monitoring Control Record, dated 4/29/2026, documents first dose administered 5/2/2026 at 6AM. R5's Medication Monitoring Control Record, dated 5/15/2026, documents no dose administered 5/18/26 at 12AM. Last dose administered 6/6/2026 at 12pm. R5's Medication Monitoring Control Record, dated 6/6/2026, documents first dose administered 6/7/2026 at 12 AM.On 6/15/2026 at approximately 2:15 PM R5 stated that there are times that the facility is late with his medication and sometimes it is not available at all. R5 stated that he has pain as high as 11 on pain scale 1-10. R5 stated that the pain is horrible, and it affects his day-to-day life. R5 stated that when he does not receive his pain medication his pain exceeds his normal level. R5 stated that it's unbearable.On 6/18/2026 at 3:07 PM V2, Director of Nurses, stated that pain is what the person says it is. If a resident says that they are experiencing pain, then they are. V2 stated that if the resident did not receive his pain medication timely or at all their pain would increase. V2 stated that R5 is alert and oriented and able to make own decisions. V2 stated that she has had some problems with the nursing staff administering the medication late and sometimes not at all. V2 stated that if the medications was not documented and a blank is in the MAR then the medication was not given. V2 stated that the facility has a locked pharmacy system. V2 stated that she has a lot of agency staff and they are not given a code for the system. V2 stated that this can delay medication administration and contribute to missed medication.On 6/20/26 at 12:44 PM, V26 (Medical Director) stated that if pain medication is not available and resident is in severe pain of 7 or higher, it would be a reasonable expectation their pain would increase.The facility's Medication Administration policy, dated 10/2025, documents that All medications are administered safely, and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 6. Check medication administration record prior to administering medication for right medication, dose, route, patient/resident, and time. 13. Verify that the medication is being administered at the proper time, in prescribed dose, and by correct route. 18. Document as each medication is prepared on the MAR. 26. If medication is ordered but not present, check to see if it was misplaced then call pharmacy to obtain the medication. If available obtain from contingency or convenience box.The Pain Management policy, dated 10/2025, documents that GENERAL: 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. GUIDELINE: 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

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	06/21/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, facility failed to ensure a nurse was appointed as charge nurse each shift and sufficient nursing staff to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being. This failure has the potential to affect all 82 residents in the facility. Findings include: The daily census provided on 6/15/2026 documents, dated 6/14/2026, documents 82 residents in the facility. The facility's Daily Staffing Sheet dated June 13, 2026, with a census of 77. It documents V15, Licensed Practical Nurse (LPN), V8, LPN, V22, LPN, and V9, Registered Nurse (RN), scheduled for 7:00 AM to 7:00 PM. V8 scheduled for 7:00 PM to 7:00 AM. The facility's Daily Staffing Sheet dated June 14, 2026, documents V8 scheduled for 7:00 AM to 7:00 PM. No other nurses scheduled for day shift. On 6/15/2026 at 2:15 PM R5 stated that last weekend there was no nurse. R5 stated that this happens a lot. R5 stated that he did not get his medication on time. R5 stated that he has to wait until a nurse comes in and sometimes its hours after the medication due. R5 stated that there was no nurse. No one.On 6/16/2026 at 4:28 PM R11 stated that this weekend there was no nurse for the hall.On 6/16/2026 at 9:13 AM R3, stated that there are no nurses. R3 stated that they don't show up and the others leave. R3 stated that this happens all the time. R3 stated that medication is not given on time or not at all.R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intactOn 6/17/2026 at 8:27 AM V18, CNA, stated that there were no nurses in the facility. V18 stated that shift change is at 7PM. V18 stated that the residents were asking for medication. V18 stated that sometimes the nurses are late. V18 stated that then around 9 PM there still wasn't a nurse. V18 stated that multiple attempts were made to contact management without success. V18 stated that finally around midnight a nurse showed up.On 6/17/2026 at 11:10 AM V8, LPN, stated that she was only scheduled for 6/13/2026 day shift and did not work in the evening. V8 stated that she is not sure why V8's name is on the evening because she did not work that shift and does not work evening shifts.On 6/17/2026 at approximately 1:13 PM V22, LPN, stated that not all scheduled nurses showed up for shift. On 6/17/2026 at 6:50 PM V9, RN, stated that they did have some problems with staffing over the weekend. V9 stated that calls were placed to management due to no relief. V9 stated that there was a nurse that came in and she was able to leave.On 6/17/2026 at 11:05 AM V2, Director of Nursing, stated that they are to run with 4 nurses. V2 stated that this past weekend there was an issue with staffing. V2 stated that with call offs and people not showing up for work there was only 2 nurses in the building. V2 stated that this is an ongoing problem due to agency not showing up and nurses leaving shift prior to relief. V2 stated that there was a delay in medication being administered due to no nurses being available. V2 stated that they have had some challenges with nurses in the facility. V2 stated that they use a program that manages the schedules and agency. V2 stated that the facility is actively hiring. V2 stated that she did have staff come in but was unsure of times but try to get those.As of 6/21/2026 at 2:00 PM the facility was unable to and did not provide additional nurse hours for 6/13/2026 and 6/14/2026.On 6/17/2026 at 10:48 AM V15, LPN, stated that she was scheduled for 6/13/2026 but called off and did not work the shift.On 6/18/2026 at 3:50 PM V1, Administrator, stated that they do not have a staffing policy and follow CMS guidelines.The daily census provided on 6/15/2026 documents, dated 6/14/2026, documents 82 residents in the facility.

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	06/21/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 82 residents who reside in the facility.Findings include:On 6/16/2026 May and June 2026 staffing schedules were reviewed. The facility did not have at least 8 consecutive hours of RN coverage a day for the following dates: 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/11, 5/13, 5/14, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/26, 5/29, 5/30, 5/31,6/1, 6/2, 6/3, 6/4, 6/6, 6/8, 6/9, 6/10, 6/11, 6/14, 6/15, 6/16, and 6/17.On 6/18/2026 at V2, Director of Nursing, stated that they have had some challenges with nurses in the facility. V2 stated that they use a program that manages the schedules. V2 stated that the facility is actively hiring.On 6/18/2026 at 3:50 PM V1, Administrator, stated they do not have a staffing policy and follow CMS guidelines.The daily census provided on 6/15/2026 documents, dated 6/14/2026, documents 82 residents in the facility.

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	06/21/2026

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 0755 Level of Harm - Minimal harm or potential for 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 interview and record review the facility failed to ensure medication was administered timely and as ordered for 4 of 4 (R1, R5, R6, R8) residents reviewed for medication administration in a sample of 14. Findings include: 1. R1's admission Record, dated 6/16/2026, documents that R1 admitted to the facility on [DATE] with the following diagnoses: Essential Hypertension, Dissection of Ascending Aorta, Gout, Syncope and Collapse, Acquired Absence of Right and Left Leg Below Knee. R1's Medication Administration Record (MAR), dated 4/126 to 4/30/26 documents that Carvedilol Oral Tablet 12.5 MG (milligram) (Carvedilol) Give 2 tablet by mouth two times a day for Elevated Blood Pressure scheduled 8PM blank on 4/28, 4/29, 4/30, and 5/15. R1's MAR, dated 5/1 to 5/31, documents that 5/15 morning dose of amlodipine Besylate Oral Tablet 5 MG, Aspirin 81 Oral Tablet Chewable 81 mg, Bisacodyl Rectal Suppository 10 MG, Apixaban Oral Tablet 2.5 MG (Apixaban) Give 2.5 mg, Gabapentin Oral Tablet 100 MG, Polyethylene Glycol 3350 Powder 17 gram, Protonix Tablet Delayed Release 40 MG, Sevelamer Carbonate Tablet 800 MG Give 2 tablet is blank. It also documents blanks for Acetaminophen Oral Tablet 500 MG 2 tablets 11AM and 3:00PM, Nystatin Mouth/Throat Suspension Give 5 ml (milliliter) 12PM and 5:00PM, Sevelamer Carbonate Tablet 800 MG Give 2 tablet 12PM and 5:00 PM. 5/18/2026 6AM Bisacodyl EC (enteric coated) 2 tablet by mouth one time a day 5/18 6AM dose blank. R1's MAR, dated June 1- June 30, documents that 6/8 6AM dose of Nystatin Mouth/Throat Suspension blank. 6/12 12PM Sevelamer Carbonate Tablet 800 MG, Acetaminophen Oral Tablet 500 MG, Nystatin Mouth/Throat Suspension R1's Medication Administration Audit Report, dated 6/18/2026 documents that R1's scheduled 9:00 AM medication was administered late. R1's Acetaminophen Oral Tablet 500 MG, Apixaban Oral Tablet 2.5 MG, Gabapentin Oral Tablet 100 MG, Protonix Tablet Delayed Release 40 MG, Aspirin 81 Oral Tablet Chewable, Polyethylene Glycol 3350 Powder, Sevelamer Carbonate Tablet 800 MG Give 2 tablet, Carvedilol Oral Tablet 12.5 MG, were administer on 6/7/2026 at 12:12 PM and on 6/7/2026 was administer at 2:14 PM. 2. R5's, MDS, dated [DATE], documents that R5 was cognitively intact and experience pain almost daily. R5's Physician Order Sheet documents 4/8/2026 Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours for Pain. R5's Oxycodone HCl Oral Tablet 10 MG Medication Monitoring Control Record, dated 4/16/2026, documents last administered 5/1/2026 at 11AM. R5's Medication Monitoring Control Record, dated 4/29/2026, documents first dose administered 5/2/2026 at 6AM. R5's Medication Monitoring Control Record, dated 5/15/2026, documents no dose administered 5/18/26 at 12AM. Last dose administered 6/6/2026 at 12pm. R5's Medication Monitoring Control Record, dated 6/6/2026, documents first dose administered 6/7/2026 at 12 AM. R5's Medication Administration Record, dated 6/1/2026 to 6/18/2026, documents that R5's 9:00 AM scheduled medication was administered outside of the administration window. R5's Fluticasone (continued on next page)

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	06/21/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Propionate Suspension 50 MCG (micrograms)/ACT, Potassium Chloride ER Oral Tablet Extended Release 20 MEQ, Metamucil Oral Powder 48.57, MiraLAX Oral Packet 17 GM, Buspirone HCl Oral Tablet 10 MG, rifaximin Oral Tablet 550 MG, Omeprazole 40 MG, Midodrine HCl Tablet 5 MG, Aldactone Oral Tablet 50 MG, Folic Acid Tablet 1 MG, Calcium Carbonate Oral Tablet 600 MG, Vitamin D Oral Tablet, Lasix Oral Tablet 20 MG, bupropion HCl ER (XL) Oral Tablet Extended Release 24 Hour (Bupropion HCl) Give 300 mg by mouth in the morning are scheduled for 9:00 AM. R5's 9:00 AM medications were administered 6/2/2026 at 3:26 PM, 6/6/2026 at 11:56 Am, 6/8/2026 from 12:12 PM to 12:31 PM, 6/11/2026 at 10:53 Am, 6/12/2026 at 12:21 PM and 6/17/2026 at 1:32 PM. On 6/15/2026 at approximately 2:15 PM R5 stated that there are times that the facility is late with his medication and sometimes it is not available at all. R5 stated that he has pain as high as 11 on pain scale 1-10. R5 stated that the pain is horrible, and it affects his day-to-day life. R5 stated that when he does not receive his pain medication his pain exceeds his normal level. R5 stated that it's unbearable. On 6/18/2026 at 3:07 PM V2, Director of Nurses, stated that pain is what the person says it is. If a resident says that they are experiencing pain, then they are. V2 stated that if the resident did not receive his pain medication timely or at all their pain would increase. V2 stated that R5 is alert and oriented and able to make own decisions. V2 stated that she has had some problems with the nursing staff administering the medication late and sometimes not at all. V2 stated that if the medications was not documented and a blank is in the MAR then the medication was not given. V2 stated that the facility has a locked pharmacy system. V2 stated that she has a lot of agency staff and they are not given a code for the system. V2 stated that this can delay medication administration and contribute to missed medication. 3. R6's Face Sheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE] with diagnosis of, in part, rheumatoid arthritis, major depressive disorder, chronic pain and anxiety disorder. R6's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact. On 6/17/26 at 10:45 AM, R6 stated she feels like she is not getting the care she needs. R6 stated they've missed medication administration for her on multiple days mostly for the day shift. R6 stated about three weeks ago on the weekend she remembers that happening. R6's May Medication Administration Record (MAR) documented on 5/16/26, she was not administered any of her 9:00 AM medications with a blank box. 4. R8's Face Sheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE] with diagnosis of, in part, chronic obstructive pulmonary disease, type two diabetes mellitus, depression, and acquired absence of right leg below the knee. R8's MDS dated [DATE] documents R8 is cognitively intact. R8's May 2026 Medication Administration Record (MAR) documented on 5/16/26, she was not administered any of her 9:00 AM medications with a blank box. R8's May 2026 MAR also documented that she did not receive any of her sliding scale insulin Lispro or blood glucose checks before meals 5/16/26 which were left blank. (continued on next page)

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	06/21/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Grievance Form dated 5/18/26 documented R8 made a grievance on medication administration for 5/16/26 and the grievance was confirmed; nurse was counseled. On 6/18/26 at 3:32 PM, V28 Licensed Practical Nurse (LPN) stated if the MAR has a blank box, it means it has not been administered. On 6/18/26 at 3:07 PM, V2 (DON/Director of Nursing) stated if medications are missing, she expects nurses to be getting on the phone with pharmacy and ordering them. V2 stated medications should be administered on time. V2 stated if the MAR has a blank box, that means it was not documented to be administered. The facility's Medication Administration policy, dated 10/2025, documents that All medications are administered safely, and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 6. Check medication administration record prior to administering medication for right medication, dose, route, patient/resident, and time. 13. Verify that the medication is being administered at the proper time, in prescribed dose, and by correct route. 18. Document as each medication is prepared on the MAR. 26. If medication is ordered but not present, check to see if it was misplaced then call pharmacy to obtain the medication. If available obtain from contingency or convenience box.

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	06/21/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to provide food at preferred temperature and palatable. This failure has the ability to affect all 82 residents in the facility. Findings include: On 6/16/2026 at 1:05 PM hall trays at top of hall sitting. At 1:15 PM trays delivered to 300 hall.On 6/16/2026 at 1:05 R9 her food was cold. R9 stated that this happens all the time. R9 stated that sometimes the cart sits in the dining room because there is no one to come and get it. Causing the food to sit, be late and cold. Sometimes don't get served until 1:30 pm.On 6/16/2026 at 1:16 PM R14 stated that her food is rarely hot. R14 stated that it's always late.On 6/17/2026 noon meal was observed. 12:00 PM dietary staff ready to serve with temperatures taken. At 12:04 PM, 12:06 PM, 12:10 PM and 12:13 PM V24 looked outdoor and stated that there were no nursing staff. At 12:14 PM V24 stated that there were nursing staff in dining room. First tray prepared and served 12:15 PM. Dining room completed at 12:44 PM. 12:45 PM 100/200 hall cart was prepared. 1:15PM 300/400 hall cart served. A test tray was requested to be sent from Dietary with the 300/400 cart. 127 PM last tray served, and test tray removed from the cart. At 1:29 PM temperatures on test tray were completed and noted as follows: potatoes temp 124.5F and chicken temp 127.2F. The food on the tray was luke warm to touch.On 6/18/2026 at approximately 10:15 AM V24, Dietary Manager, stated that the dietary staff only prepares the meals and the nursing staff delivers. V24 stated that dietary is not allowed to serve the food unless there is a CNA or Nurse in the dining room. V24 stated that this causes a delay with the kitchen. V24 stated that at 11:45 AM dietary gets the cards ready and 12:00 PM they are ready to serve. V24 stated that this is placed on hold until nursing staff is available. V24 stated that if they are late, it causes the food to be late. V24 stated that after the main dining room the hall trays are prepared. V24 stated that the carts are prepared and then given to the nursing. V24 stated that once out of the kitchen the nursing staff pass the trays. V24 stated that the food is sent out hot. Once it goes out of the kitchen its nursing.On 6/17/2026 at 3:10 PM V25, CNA, stated that the hall trays are brought to the hall by the nursing staff assigned to the dining room. V25 stated then its nursing responsibility to pass the trays. V25 stated that there have been times that the cart has sat for a while. V25 stated that sometimes they are in rooms helping residents and the cart comes out and there is no one to pass it. V25 stated that the residents do complain about the trays being late and not coming out on time.On 6/18/2026 at 3:07 PM V1, Director of Nursing, stated that once the trays have been made, they are brought to the hall and nursing are to serve the cart when it arrives to the floor. V1 stated that this has been an ongoing problem and residents and complaining of food being late and cold. The facility's Meal-Service- Palatability and Nutritive Value policy, dated 3/7/2025 documented that Policy: Food will be prepared, held, and served in a manner that maintains its nutritive value and palatability while ensuring food safety. Procedure: Serving Temperature; Hot foods will be served hot, and cold foods using thermal lids, heated or chilled plates, and thermal pellets as needed to enhance the dining experience.The daily census provided on 6/15/2026 documents, dated 6/14/2026, documents 82 residents in the facility.

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	06/21/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility failed to ensure the call light system was in place and working properly for 5 of 15 residents (R2, R3, R4, R6, R10) reviewed for call lights. Findings include: 1. R3's admission Record, dated June 16, 2026, documents that R3 was admitted [DATE] with the following diagnoses: Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Asthma, Obstructive Sleep Apnea, Epilepsy, Shortness of Breath, Type 2 Diabetes, Heart Failure, and Muscle Weakness. R3's Care Plan, dated 4/30/2026, documents that R3 has a self-care deficit in dressing and grooming r/t (related to) weakness. 1/27/2026 Resident is at high risk for falls r/t weakness. (R3) requires assistance with daily care needs r/t muscle weakness. R3's Minimum Data Set (MDS), dated [DATE], documents that R3 is cognitively intact and requires partial/moderate assistance with activities of daily living. R3's Call Light Ability Screen, dated 6/12/2026, documents that R3 can use a call light. On 6/15/2026 at 3:09 PM observed R3's room. No call light. No bell or horn observed in room. On 6/16/2026 at 9:13 AM observed no call light in room. Bell sitting on overbed table next to roommate's (R4's) bed. On 6/15/2026 at 3:05 PM bell rang. No response from staff. On 6/16/2026 at 9:13 AM R3 stated that she does not have a call light. R3 stated that they gave her a bell, but no one responds. R3 stated that she starts yelling and then after a while they come into the room. R3 stated that her roommate used to call for R13, but she has since moved. R3 stated that her roommates are good to her and help her but that's not their job. R3 stated that she can do some things for herself. But needs help with others. R3 stated that she is a brittle diabetic, and her blood sugar fluctuates. R3 stated that she gets weak and needs help. No one comes. No one cares. I need help sometimes. How am I supposed to get that. This thing (bell) is a joke. 2. R4's MDS, dated [DATE], documents that R4 is cognitively intact. On 6/15/2026 at 3:09 PM R4 stated that R3 does not have a call light. R4 stated that she guesses they share the one R4 has but R3 doesn't have a string. R4 stated that sometimes R4 has to call for R3 because R3 dings the bell and no one comes. 3. R2's Care Plan, dated 1/8/26, documents that ADL/Activities of Daily Living: Resident requires assist with daily care needs r/t weakness. Has a self-care deficit in dressing and grooming r/t weakness, and hepatic encephalopathy. Resident is at high risk for falls r/t weakness. R2's MDS, dated [DATE], documents that R2 requires substantial/max assistance with some ADLs and dependent on staff for transfers. R2's Call Light Ability Screen, dated 3/3/2026, documents that R2 can use a call light. (continued on next page)

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	06/21/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's Grievance, dated 4/10/2026, documents that Call light not working. Not lighting up outside room. On 6/16/2026 at approximately 10:30 AM observed R2 lying in bed. No call light in place. Observed metal plate on wall with metal button. No string attached. Button pushed. The light did not show outside R2'a door. On 6/16/2026 at approximately 10:30 AM R2 stated that he did have a problem with his call light. R2 stated that he did not have a way to call for help. R2 stated that they put a string on it and said it worked. R2 stated that if you look behind the dresser you will find the cord. R2 stated that it keeps coming apart. R2 stated that he needs help with getting up or even moving up in bed. R2 stated that if he is in pain or uncomfortable he is stuck. R2 stated that the string that was applied comes apart from the metal part of the call light and then he has no help, and it can take forever for them to come and check on him. 4. R6's Facesheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE]. R6's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact. On 6/17/26 at 10:45 AM, R6 stated her call light isn't working right now it's the string on the floor she has to pull. R6's call light was pushed down, and nothing was going off. R6's roommate's (R10) call light also did not work when pressed down. R6 stated she is scared of being in bed without any call light in the room working because she is not able to get up and sometimes the CNAs are nowhere to be found. 5. R10's Face Sheet with a print date of 6/18/26 documented she was admitted to the facility on [DATE]. On 6/17/26 at 10:45 AM, R10's call light did not work when pressed down. On 6/17/26 at 11:11 AM, V1 (Administrator) was notified of R6 and R10's call light not working. On 6/17/26 at 11:22 AM, V13 (Maintenance) stated the call lights for R6 and R10 are working now but V4 (Maintenance Manager) will be here soon to work on the other call lights not working still. On 6/15/2026 at approximately 2:50 PM V5, Certified Nurse Aide (CNA), stated that there are some residents that have bells. V5 stated that if you're in the hallway or near the resident's room when the bell rings you can hear it. V5 stated that if you are in a room and unless they are still ringing it when you come out you don't know anyone needs anything. On 6/16/2026 at 1:38 PM V1, Administrator, stated that there are rooms that don't have call lights and are broken. V1 stated that they are working on fixing them. V1 stated that call lights were ordered, and they were not compatible with the current system. V1 stated that she did give the resident without a call light a bell. V1 stated that she was not aware of the bells being a problem. On 6/16/2026 at approximately 2:55 PM V6, CNA, stated that R3 does not have a call light. V6 stated that R3's roommates calls for help for R3. V6 stated that the bells are low unless they bang on them and sometimes you can't hear them. (continued on next page)

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	06/21/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/2026 at 11:12 AM V1 stated that the facility does not have a call light policy for residents to have one. V1 stated that they do have a response policy. On 6/18/2026 at approximately 2:00 PM V1 stated that they received an estimate on 6/17/2026 to replace the call light system. V1 stated that they are now working on replacing the system. On 6/18/2026 at 3:07 PM V2, Director of Nursing, stated that there have been problems with the call light. V2 stated that the if more than 1 call light is going off at a time the systems will get overwhelmed and he call lights will stop working. V2 stated that maintenance has been working on it. V2 stated that there are areas in the building that require repairs. V2 stated that maintenance is aware and working on them. V2 stated that some residents have bells, but you can't hear them. On 6/18/2026 at 3:30 PM V30, CNA, stated that it is everyone's responsibility to answer the call lights. V30 stated that some residents have bells and if you are near them, you can hear the bell. V30 stated that if you are in a room and they ring the bell unless you heard it you would not know anyone needed anything. Resident Council Minutes, dated April 24/26 and May 2026, documents that Nursing Issues/Concerns Call lights are never being answered. The facility's Call light policy, dated 9/2025, documents that General: To provide the staff with guidance on responding to residents' request and needs. PROTOCOL: 3. Ensure call light is within resident's reach at all times. 4. When the patient or resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident. On 6/16/2026 at 2:36 PM V4, Maintenance Director, stated that the call light system is on the 300/400 hall is an old system. V4 stated that once the call lights are on for long periods of time it overheats the system and the call lights won't work. V4 stated that he communicates with the staff to make sure that they are not allowing the lights to stay on for long periods of time. V4 stated that on the call lights on 100/200 hall require a specific battery. V4 stated that he is waiting for them to come in. V4 stated that he was not aware of any repairs needed on the hall. V4 stated that they have a maintenance book. The staff are to document in the book repairs needed. V4 stated that also the staff utilize a text service for things that come up and he is able to address immediately. V4 stated that the book is looked at daily by himself and his staff. The facility's Quarterly Inspections, not dated, documents 6. All residents' rooms should be inspected for any repairs needed and proper operation of equipment.