STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145650	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus at Palos	10426 South Roberts Palos Hills, IL 60465

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement respiratory care interventions including ensuring the application of hand mitten restraint as ordered, and to maintain patency of trach tubes due to resident history of chronic pulling of tracheostomy tube according to the plan of care for 1 of 3 (R4) residents reviewed for tracheostomy care. As a result of the facility's noncompliance with mittens not being applied and monitored by staff, R4 was able to reach her tracheostomy tubing and self-decannulated which led to her expiring. Findings Include:Based on interview and record review, the facility failed to implement respiratory care interventions including ensuring the application of hand mitten restraint as ordered, and to maintain patency of trach tubes due to resident history of chronic pulling of tracheostomy tube according to the plan of care for 1 of 3 (R4) residents reviewed for tracheostomy care. As a result of the facility's noncompliance with mittens not being applied and monitored by staff, R4 was able to reach her tracheostomy tubing and self-decannulated which led to her expiring.The Immediate Jeopardy began on [DATE]. V1 (Administrator) was notified on [DATE] at 2:31 PM of the Immediate Jeopardy. The facility presented an initial removal plan of [DATE]. The plan was accepted, and on [DATE] the surveyor conducted an onsite record reviews and interviews to confirm the removal plan was implemented. V1 was informed the Immediate Jeopardy was removed on [DATE].Although the immediacy was removed, the facility remains out of compliance at severity level II until the facility can evaluate the effectiveness of the removal plan and maintain substantial compliance with this regulation.R4 is a [AGE] year-old with the following diagnosis: aphasia following cerebral infarction, acute respiratory failure with hypercapnia, tracheostomy status, dependence on supplemental oxygen. R4 admitted on [DATE] and expired in the facility on [DATE].On [DATE], R4 was found unresponsive with the tracheostomy pulled out and later pronounced expired in facility by paramedics. On [DATE] at 9:44 AM, V1 (Administrator) and V2 (Assistant Director of Nursing) informed surveyor that their electronic medical records (EMR) were down from [DATE] until the morning of [DATE]. All clinical documents were produced manually during this time. However, a completed progress note was not provided because it was not done as confirmed by V2. There was also no documented incident report of [DATE] provided to the surveyor.A police report from [NAME] Hills Police Department was obtained pertaining to the death incident of R4 on [DATE]. Report indicate V17 (Agency Nurse) informed V3 ([NAME] Hills Police) that she was the nurse for R4. According to report on [DATE], between the times of 5:55AM and 6:05AM, V17 was in the room assisting another resident when V17 observed R4's trach tube not in place and R4 was unresponsive. Police interview of V11 (Respiratory Therapist/RT) indicated that he was the respiratory therapist of R4 and approximately at 4:45 AM of [DATE], V11 was in the room of R4 assisting with trach care. V11 stated R4 is supposed to wear glove restraints (identified as mittens) to prevent her from removing her trach tube as she has history of removing her trach tube. Report indicated that V11 stated he did not observe R4 wearing glove restraints while in the room. Report indicated an interview with V16 (Nursing Supervisor) was also completed. V16 stated R4 was supposed to always wear the glove restraints according care plan. V17 stated that it was her first time working with R4 and was unaware that glove restraints were to be in place. Additionally, V17 reported that the facility online medical records database of R4 for physician orders and plan of care were inaccessible and V17 was not provided with updates, information or paperwork pertaining to R4 by the prior shift nurse. V16 informed V3 that there should be a binder at nurse station with R4's plan of care information. Report indicated V3 checked the binder and did not appear to be properly filled out.On [DATE] at 10:25AM, V3 ([NAME] Hills Police Department) stated he arrived at facility with R4 unresponsive and 911 paramedics working on her. Staff were interviewed and nurse on duty/ Agency nurse told V3 at approximately 5:55A - 6:05A R4 was observed with trach not in place (pulled out). V3 said while in the facility he did not observe R4's mittens in placed. V3 said employee informed him that electronic access to chart was down from a week to a week and half. V17 stated she did not get report from outgoing nurse regarding R4's mitten needs to be in placed at all times and V17 has no knowledge of facility restraint policy. V3 stated he believed there was neglect on facility as staff do not know their restraint policy and there was no hand off report from nurse to nurse according to his interview with agency nurse who was on duty.On [DATE] at 11AM, in separate interviews, V2 and V4 (Restorative Nurse) both stated R4 should have mittens on at all times to maintain trach patency because R4 has a history of pulling on trach tubes.On [DATE] at 10:28AM, V7 (Attending Physician/AP), stated he is the AP in facility only and not R4's community doctor. V7 said the