

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Nexus at Palos		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review the facility failed to prevent resident to employee sexual abuse for one of one resident (R11) reviewed for abuse. This failure resulted in R11 not feeling safe. Findings include: On 2/24/2026 at 9:15am V20 (Family of R11) said that R11 was kissed on the cheek by V21 (Certified Nursing Assistant-CNA) and the facility make her feel like it was okay, and she felt unsafe after that. On 2/24/2026 at 10:45am V1 (Administrator) said that R11 complained of V21 walking up behind her and kissing her on the cheek. R11 wanted to call the police and we did. She made out a police report and it was unfounded. V21 denied it, he was sent home and later terminated. On 2/26/2026 at 2:45pm V13 (Assistant Director of Nursing-ADON) said that V19 informed her of what R11 said she then assessed R11, called the administrator who is the abuse coordinator, and she also wanted to call the police. On 2/26/2026 at 2:58pm V19 (Nurse) said that R11 complained of V21 walking up behind her kissing her on the cheek saying that was not the first time. V21 made this attempt before, and she feels uncomfortable. V19 said V19 called V13 (Assistant Director of Nursing-ADON) and informed V13 of what R11 said. On 2/26/2026 at 3:00pm V2 (Director of Nursing-DON) said, I was not in the facility at the time of the complaint. I expect all nursing staff to follow the abuse guidelines and that everyone has abuse training upon hiring. (V21) is no longer employed at the facility. An admission record indicates R11 has a cognitive communication deficit and depression. An abuse care plan, a progress notes dated with discharge, a witness statement on 1/2/2026, an incident report dated 1/2/2026. Facility Policy: 3/2022 Abuse Policy and Prevention Program 2022 Abuse Policy This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: Conducting pre-employment screening of employees and pre-admissions screening of residents: Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation and misappropriation of property. Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145650	Facility ID: 145650 If continuation sheet Page 1 of 5

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on interview, and record review the facility failed to provide a safe and orderly discharge for one of one resident (R9) reviewed for discharge. This failure resulted in R9 having to visit the local emergency room hospital for Dialysis treatment. Findings include:On 2/24/2026 at 10:40am V1 (Administrator) said R9 did not want to stay in the facility to ensure that a dialysis date and time was set up and confirmed R9 and family was aware that dialysis was not confirmed and proceeded to discharge home anyway. On 2/25/2026 at 2:28pm V10 (Director of Social Services) said he was made aware of this incident upon R9 transferring to the facility and that he immediately wrote a new discharge plan for the social workers to follow stating that if a resident does not want to stay for home supplies and confirmation of dialysis set up of date and time, then they would have to sign out AMA (against medical advice). On 2/24/2026 at 4:00pm, V22 (Family of R9) said on 11/23/2025, R9 was discharged home without a confirmed hemodialysis chair date or time. V22 said the social worker said they would call and inform them of the date and time as soon as possible and that all the paperwork was in. V22 said V22 never received a phone call. On 11/24/2025 the following morning R9 was taken to the local hospital emergency room to receive dialysis.On 2/26/2026 at 11:41am V2 (Director of Nursing-DON) said, I expect the social service staff to set up all home health care services including a confirmed dialysis date and time and if the resident insists on leaving, then they should notify the physician.An admission record indicated R9 has a diagnosis of end stage renal disease and dependence of renal dialysis. Records show an order summary report dated 2/24/2026 with a discharge home order on 11/21/2025; a care plan dated 11/11/2025 showing to assist with discharge planning and dialysis on Monday, Wednesday and Friday; and a progress note dated 11/23/2025 at 11:13 by social service stating dialysis time was pending and that the family chose to discharge home at 1pm stating they have a wheelchair available at home and that the assistant administrator and administrator had been notified.Facility Policy: 9/2025 DischargesGeneral: To establish a plan of how to discharge a resident from the facility to home, another facility, or the hospital. Responsible Party: RN, LPN and Social Services Discharge potential is assessed by the Social Services on admission.Social Services will meet with the resident/patient and/or family to set up outside services and equipment.15. The Social Service Department will enter a Discharge summary progress note into the patients EMR upon planned discharge from the facility.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review the facility failed to ensure that a safe discharge and transfer, was provided and the resident receive the correct medication for one of one resident (R9) reviewed for discharge. Findings include:On 2/24/2025 at 4:20pm V22 said the facility called her cell phone and ask them to bring the medications back to the facility. V22 said, It was not my family's. We returned the medication. It was not used. On 2/25/2026 at 2:57pm V18 (Licensed Practical Nurse-LPN) said that on 11/23/2025 she discharged and educated V22 (Family of R9) on medications and that they expressed understanding. The family was discharged home with the medications. Then about an hour later V18 said she noticed R9 medications and immediately called the family and asked them to return with the medications and pick up the correct medications. The family expressed understanding and returned the medications and retrieved the correct ones. On 2/26/2026 at 11:41am V2 (Director of Nursing-DON) said, I expect the nurses to discharge resident's using the two nurse system to verify the correct medication and dosage. When (V18) said she discharged (R9) with the wrong medications, the family was immediately called and ask to bring the medication back to the facility and pick up the correct medications. They did return them immediately and never used any of the medications. An admission record indicated R9 has a diagnosis of end stage renal disease and dependence of renal dialysis. Records show an order summary report dated 2/24/2026 with a discharge home order on 11/21/2025; an order summary with R9 medications; a care plan to administer medications as ordered; a discharge summary progress note dated 11/23/2025 of medication education and discharge teaching; and an incident report dated 11/23/2025 for discharge of wrong medications. Facility Policy: 1/2024 Resident Discharge-not to HospitalGeneral:To provide direction for residents discharge other than the hospitalProcedure:Complete Nursing section of Discharge instructions form in PCC (this form is opened by ss and completed nu nursing prior to discharge.)Once completed, instructions should be printed along with a medication list and reviewed with the resident /resident representative.All appropriate medications should be given to the resident at the time of discharge per physician orders.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician order for Bilevel Positive Airway Pressure (Bipap) machine usage affecting one (R2) of three residents reviewed for physician orders. Findings include: On 2/26/26 at 11:55AM, V7 (Licensed Practical Nurse Unit Manager), stated she confirmed physician order for R2 Bipap machine. V7 said V7 was unsure if R2 received it. On 2/26/26 at 12:15PM, V2 (Director of Nursing) stated R2 did have a physician order for Bipap to be used at night. V2 indicated that on Medication Administration Record a 9 recorded indicates not given/not administered. R2 is a [AGE] year-old admitted to the facility on [DATE] with the following diagnosis in part but not limited to: Displaced comminuted fracture of shaft of right tibia, chronic obstructive pulmonary disease with acute exacerbation, unspecified asthma, hyperlipidemia, essential hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, dependence on supplemental oxygen, syncope and collapse, prediabetes. Physician order dated 2/12/26 for Bipap: 20/7 with oxygen blend in 25-30% FiO2 to maintain pulse oximetry of 92-94%-full face mask. To be used every night. Staff to assist patient to put on at night. Progress note dated 2/12/26 - Nurse Practitioner note indicating R2 did not receive his Bipap machine. Medication Administration Record (MAR) dated 2/2026: order for Bipap: 20/7 with oxygen blend in 25-30% FiO2 to maintain pulse oximetry of 92-94%-full face mask. To be used every night. Staff to assist patient to put on at night. Indicates No administration/Not given from 2/12/26, 2/13/26, 2/14/26 and 2/15/26. Facility is unable to provide Policy on Following Physician orders. Facility Policy on Bilevel Positive Airway Pressure (Bipap) Purpose: Bi-Level Positive Airway Pressure (Bipap) provides non-invasive positive pressure at different levels during exhalation and may be appropriate for persons who require high pressure CPAP. Policy: Respiratory Therapy/ Nurses oversee the initiation and delivery of Bipap to residents who require Bipap. Procedure: Verify Physician order. 6. Document appropriately.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review the facility failed to ensure facility's daily nurse staffing information form posted at the front desk. This failure has the potential to affect 164 residents receiving care in the facility. Findings include: On 2/25/26 at 11:00AM, Observed that no daily staffing post is available or visible in the front desk. On 2/25/26 at 11:30AM, V1 (Administrator) said daily staff posting should be in the receptionist area, staffing coordinator does it. If daily staff posting not found at receptionist area, then it has not been posted. On 2/25/26 at 12:45PM, V2 (Director of Nursing) said daily staff posting should be posted at the receptionist desk at main lobby daily. On 2/25/26 at 1:04PM, V1 said there is no facility policy for daily staff posting, but it is a requirement to have it daily. Facility unable to provide policy.</p>		