| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145650 | A. Building<br>B. Wing | 05/01/2026 |

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

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their death of a resident policy by not having a registered nurse verify and timely pronounce the death for one resident. This affected one of one residents (R11) reviewed for death. This failure resulted in R11 being left on the ventilator and waiting almost two hours until police and emergencies services arrived to pronounce R11 death.Findings Include:R11 was admitted to the facility on [DATE] with a diagnosis of respiratory failure dependence on ventilator, tracheostomy status, seizures, and pneumonia.R11'a practitioner order for life sustaining treatment form (POLST) dated [DATE] documents: Do Not attempt Cardiopulmonary Resuscitation (CPR).R11's progress notes dated [DATE] at 10:25PM (22:25) documents: Upon making rounds around 1950, writer noticed resident unresponsive to name/touch, vital signs absent, no Vent alarms sounding. Resident was last seen alert to baseline by writer around 1745 when tube feeding was started post dialysis. Resident with DNR code status, Primary Physician notified. Emergency contact made aware. Police non-emergency called. Officer arrived with Emergency medical team (EMT). Resident pronounced 2137 by local hospital doctor.On [DATE] at 3:18PM, V42 (nurse, LPN) said she was the assigned nurse to R11 at time of death. V42 said she found R11 unresponsive during rounds around 7:50PM. V42 said she informed V47 (evening supervisor) about R1. V42 said she was not sure what to do because R11 was a DNR and not on hospice services. V42 said she confirmed R11's unresponsiveness with V47 (nurse Supervisor, LPN), V49 (RT) and V50 (RT). V42 said R11 eyes were closed and not responding. No vital signs were able to be obtained. V42 said she notified the doctor, family and non-emergency police about the death. V42 said she left a message with on-call doctor and was unable to recall if they called back. V42 said the police and emergency services arrived later and the hospital doctor pronounced the death.On [DATE] at 3:56P m, V47(nurse supervisor) said he was unable to recall if he was in the building at time of R11's death and did not participate in any care or assessment of R11 that he can recall.On [DATE] at 2:16PM, V49 (RT) said he does not recall R11's death or any care provided to R11 on [DATE].On [DATE] 3:47PM V50 (RT) said he was working the day R11 was found unresponsive. V50 said he was not assigned to R11 but recalled going to R11's room. Staff said he was a DNR and V50 returned to his rounds. V50 said he did not provide any care to R11.On [DATE] at 2:47PM, V2 (director of nursing, DON) said if a resident is found unresponsive and has a do not resuscitate order, two staff nurses which one has to be a registered nurse can pronounce the death and document the signs of death (mottling, absence of vital signs, loss of bowel and bladder) in the progress notes. V2 said staff V42 and V47 were educated on what to do for a resident's death after R11's death. V2 said staff do not need to call 911 to pronounce a death at the facility if the resident is a has do not resuscitate order.On [DATE] at 11:34AM, V3 (Assistant director of nursing, ADON) said staff are expected to call a registered nurse to pronounce a resident death that is a do not resuscitate (DNR). They should document time of death and notify family and physician. V3 said she received a call from V47 unsure what time about R11's death. V3 said while on the phone with V47 emergency services arrived at the facility. V3 said V47 was in-serviced on protocol for death after this incident for not following the policy. V3 said R11 should<br>(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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | not have been left on the ventilator after finding him unresponsive because it was dignity issue.R11's emergency services report dated [DATE] documents: Dispatched for dead on arrival with police. Crew found R11 in bed unresponsive and cold to touch. R11's nurse stated she noticed R11 absence of vital signs two hours prior to EMS arrival. The crew noted R11 was still attached to the ventilator and being provided ventilations. R11's respiratory therapist said that he did not want to disconnect R11 from the ventilator until the patient was pronounced dead. Crew called local hospital and MD confirmed death at 9:37 PM.R11's death certificate dated [DATE] documents time of death at 9:37 PMFacility death of a resident policy reviewed 12/25 documents: Appropriate documentation shall be made in the clinical record concerning death of a resident. A resident may be declared dead by a licensed physician or a registered nurse with physician accordance to state law. All information pertaining to a resident's death may be recorded in the nursing notes as applicable: pupils fixed and dilated, mottled discoloration of the body, absence of reflexes, loss of bowel and bladder, absence of vital signs, date and time. Document name and time of the person pronouncing the death. Attending MD will be notified. The attending physician must record cause of death in the medical record notes.V42 (nurse) nursing license documents licensed practical nurse.V47 (nurse) nursing license documents licensed practical nurse.Resident rights for people in long term care facilities undated documents: You have right to be treated with dignity and respect and must care for you in a manner that promotes your quality of life. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow its discharges policy and notify the family/emergency contact that R5 was being transferred to the hospital and the reason for the transfer. This affected one of three residents (R5) reviewed for notification of a change and Hospitalization.Findings include:On 4/22/26 at 3:10 PM, V2 DON (director of nursing) stated that upon transfer to the hospital staff should notify the resident's emergency contact or power of attorney. V2 stated a voicemail should be left asking the contact to return a call to the facility. V2 stated a follow-up call should occur within 15-20 minutes after the initial voicemail has been left. V2 stated the nurse should follow-up with the hospital for resident's diagnosis and/or if the resident was transferred/diverted to another hospital. R5's medical record, dated 12/7/25 at 8:36 PM, V5 (agency nurse) entered room and observed R5 shaking. V5 obtained vital signs blood pressure 159/132, pulse 86, temperature 100.6, respirations 20, and oxygen saturation level 97% on room air. V5 notified supervisor on duty of the change in condition. V5 contacted telehealth physician and was given order to send R5 out 911 for sepsis. V5 called family to notify them of transfer to hospital, no answer V5 left voice mail.There is no documentation in R5's medical record noting staff followed up with the hospital for admitting diagnosis or that R5 was transferred to another hospital. An attempt to contact V5 (agency nurse) was made on 4/21/2026 at 3:35 PM 4/24/2026 at 9:48 AM. V5 did not answer phone, and this surveyor was unable to leave a voicemail message.R5's hospital record, dated 12/8/25, notes R5 was transported from the facility to another hospital on [DATE]. R5 presented to the emergency room on 12/7 due to exhibiting shaking, fever and altered mental status. While there, R5 developed new onset atrial fibrillation with rapid ventricular response and was transferred to the second hospital on 12/8 at 1:43 AM.The facility's discharge guideline policy, reviewed 09/2025, notes in part to inform the resident/patient and the resident's/patient's responsible party of the transfer. Hospital transfers: document in the progress notes the condition of the resident/Patient, who was notified of transfer, where the resident/patient is going, mode of transportation, disposition of resident/patient belongings and medications, notification to all parties of the discharge. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Rapid Response Policy and hospital discharge orders for one resident (R13) who experienced seizure-like activity by failing to initiate a rapid response, obtain a blood glucose reading, remain with the resident until emergency medical services (EMS) arrived, and monitor blood glucose levels following a hypoglycemic event. These failures affected 1 of 3 residents reviewed for quality of care.Findings include:R13 was admitted to the facility on [DATE] with a diagnosis of hemiplegia, aphasia, anemia, end stage renal disease, and adult failure to thrive.R13's progress note dated 4/12/26 documents: Resident appears alert to name call and usually nonverbal due to history of stroke. Involuntary movement of eyes and seizure-like activity. No history of seizure with Involuntary movement. Spouse adamant about further evaluation to the nearest Emergency room. Weekend NP in during in-house rounds with a new order to send to emergency room via 911.R13's eInteract note dated 4/12/26 documents the following: At the time of evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: BP 168/85 - 4/12/2026 06:21 Position: Lying l/arm, Pulse: P 78 - 4/11/2026 20:55 Pulse Type: Regular, Respiratory Rate: R 18.0 - 4/11/2026 20:55, Temperature: T 98.0 - 4/11/2026 20:55 Route: Tympanic, Pulse Oximetry: O2 98.0 % - 4/11/2026 20:55 Method: Room Air and Blood Glucose: BS 119.0 - 3/8/2025 19:54.On 4/29/26 at 1:34 Pm, V15 (nurse) said she was assigned to R13 on day of hospital transfer. V15 said R13 was experiencing abnormal eye movements and family was present in the room. V15 said she called for the V60 (NP) who was in the building and assessed R13. V15 said she took R13 vital signs but not her blood sugar according to the documentation. V15 said R3's blood glucose was not checked because she was not a diabetic. V15 said she did not call a rapid response because there were two people in the room (V15 and V60), and they did not need assistance. V15 said she called 911 from her cellphone. V15 said she stayed with the resident until paramedics arrived. V15 said she only left the room to get the paperwork for the paramedics.R13's run report dated 4/12/26 documents; call received at 1:11PM, primary impression: Hypoglycemia. Under narrative: Crew dispatched for person having a seizure. Upon arrival crew found patient in bed with no staff on the scene in the room. Family on scene said R13 has not been acting normal. Blood glucose obtained reading 28.On 4/30/26 at 2:47PM, V2 (Director of nursing, DON) said if a resident was experiencing a change in condition or seizure like activity, she would expect staff to call a rapid response to have help to ensure an appropriate determination of the residents change in condition is made. During any change in condition, staff should check vital signs including blood sugar. One staff is expected to stay with the resident until emergency services arrive.On 4/29/26 at 11:34AM, V3 (Assistant director of nursing, ADON) said staff are expected to stay with the residents during a change in condition. V3 said staff would be expected to check the residents' blood sugar during a change in condition.On 4/30/26 at 2:06PM, V61 (MD) said during a change in condition he would expect staff to stay with the resident and check blood sugar with other vital signs.R13's hospital discharged paperwork dated 4/12/26 documents: Altered mental status with diagnosis of low blood sugar and chronic kidney disease. Under instructions: Continue monitoring her blood sugar.On 4/30/26 at 2:06PM, V61 (MD) said he was not aware of any orders to check R13's blood sugars and would expect staff to follow discharge recommendations.On 4/29/26 at 12:19PM, V12 (Nurse Practitioner, NP) said she did not review R13 readmission paperwork but would expect staff to have followed the discharge recommendations. V12 (NP) said she would expect glucagon and blood glucose checks to be ordered following an episode of hypoglycemia.R13's medical record did not document any blood sugar reading or orders after 3/8/25 in the medical record until new orders received on 4/30/26.R13's progress note dated 4/12/26 documents: Resident returned to the facility from (local) Hospital. No new orders. ED ordered blood sugars monitoring. Writer notified MD.Facility policy titled Rapid response dated 12/25 documents: to ensure early recognition and rapid clinical intervention for residents experiencing acute<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | changes in condition, preventing avoidable hospital transfers and improving resident outcomes. Triggers for rapid response documents altered mental status or somethings Is not right. Under procedure documents: obtain full vital signs, stay with the resident.Facility policy admission/readmission reviewed date 4/2025 documents: All medications should be reconciled with the resident/resident representative and verified with the primary physician or nurse practitioner; Physician order sheet should reflect any standing orders specific to the resident as well as medications and treatments that are ordered throughout the stay. All necessary admission information discussed above will be documented in the resident's clinical record. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on interviews and record reviews, the facility failed to follow its medication administration policy and check the administration record prior to administering a discontinued medication (Keppra - antiseizure medication) to one resident (R1) out of three reviewed for medication administration in a sample of 19.Findings include:On 4/22/26 at 11:00 AM, V12 NP (nurse practitioner) stated that V12 would expect the nurses to identify the resident with at least two resident identifiers prior to administering any medications. V12 stated that V12 would expect the nurse to call her or V19 (attending physician) immediately for any medication errors.On 4/22/26 at 3:10 PM, V2 DON (director of nursing) stated that on 4/1, R1's family expressed a medication concern that occurred prior to R1 leaving the facility for an outside physician appointment. V2 stated that V22 (nurse) administered a medication which had been discontinued. V2 stated that V2 went to R1's room immediately to assess R1. V2 stated that V22 administered Keppra 250mg (milligrams) to R1. V2 stated that V19 (attending physician) was notified, and V12 NP (nurse practitioner) assessed R1. V19 gave orders to monitor R1 and obtain a Keppra level. V2 stated that Keppra should have been removed from the medication cart as soon as it was discontinued. On 4/23/26 at 2:59 PM, V22 (nurse) stated that she does recall a medication error involving R1. V22 stated R1 was going out for an appointment and V22 was rushing to administer R1's medications before R1 left. V22 stated that because she was rushing and did not notice Keppra was not on R1's MAR (medication administration record). V22 stated she realized after R1 took the Keppra tablet that the Keppra had been discontinued. V22 stated that discontinued medications are not supposed to be kept in the medication cart. V22 stated that R1's Keppra medication had been discontinued and should have been removed by the nurse receiving the discontinuation order. V22 stated the nurse is supposed to do the five rights check to ensure right resident, right medication, right dose, right time, and right route. V22 stated she notified V2 DON and V19 (attending physician). V22 stated that most of the time she will let the resident know what medications resident is receiving prior to administering medications. V22 stated the physician instructed her to monitor R1 for any signs of drowsiness, disorientation, and lethargy. V22 stated V19 ordered for the outside laboratory service to obtain a Keppra level the following morning.On 4/24/26 at 9:58 AM, V19 (attending physician) stated he spoke with V22 (nurse) involved in administering the Keppra on 4/1 to R1. V19 stated he does not know reason V22 gave the Keppra because it had been discontinued. V19 stated R1 did not have any issues or side effects from receiving Keppra on 4/1.R1's POS (physician order sheet), dated 2/26/26, notes an order for levetiracetam (Keppra) 250mg by mouth every 12 hours for seizures. Keppra was discontinued on 3/12/26.R1's medical record, dated 4/1/26 at 9:30 AM, V22 noted administered medication pass at approximately 9:30 AM. R1 prepared for transportation to medical appointment. Post medication pass assessed R1 immediately. Notified physician and all other parties. R1 alert and oriented x 4, no signs of drowsiness, no acute distress, or signs/symptoms of seizures, weakness or any adverse reactions. R1's vital signs stable, blood pressure 120/89, temperature 97.8, heart rate 85, respirations 17, and oxygen saturation level 98% on room air. R1's family at bedside. V22 spoke with V19 prior to R1 leaving for appointment. V19 requested to draw laboratory testing and continue to monitor R1.R1's medical record, dated 4/1/26, V12 NP noted R1 seen due to nursing reports R1 was given Keppra today which is not currently ordered on profile. R1 is alert, reports no concerns or discomfort at this time. R1 is smiling and eating while in room. R1's family at bedside. V12 did spend significant time talking about current medications on profile, showed on computer current orders as they are written. Answered all questions regarding medications and management of care. R1's family is expressing ongoing concerns for prevention of any medication being given in future to R1. V12 did escalate to V2 DON and had discussion about medication safety with current nurse on duty. Laboratory testing has been ordered and is pending, continue to monitor for any adverse effect from Keppra. Please notify if any adverse effects occur.The facility's investigation of this medication error notes failure to verify active physician<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | orders in the eMAR (electronic medication administration record).The facility's medication administration policy, dated 04/2025, notes in part an order is required for administration of all medication. Check the medication administration record prior to administering medication for the right medication, dose, route, resident and time. |