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	05/29/2026

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 0580 Level of Harm - Actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy regarding notification of changes in resident condition by failing to notify the physician and/or nurse practitioner of a resident's new complaint of pain and inability to bear weight on the right lower extremity. This affected one of three residents reviewed for change in condition notification. The failure resulted in a delay in assessment and treatment of an undiagnosed right hip fracture. This failure affected one (R3) of three residents reviewed for notification.Findings include:R3 was admitted to the facility on [DATE] with diagnoses of history of malignant neoplasm of breast, weakness, mixed hyperlipidemia, unspecified fall, hypotension, anxiety disorder, insomnia, unspecified severe protein calorie malnutrition, major depressive disorder, constipation, alcohol abuse, gastroesophageal reflux disease, cognitive communication deficit, metabolic encephalopathy, difficulty walking. R3's Brief Interview for Mental Status (BIMS) assessment revealed a score of four/ fifteen on her Minimum Data Set (MDS) dated indicating severe impairment.R3's incident report dated 11/26/2025 documents: resident was observed to be lying on the floor on her right side next to her bed, following a loud noise noted from her room. The resident denied hitting her head. Lacerations and redness noted on right and left knee. Laceration noted on right ankle. Redness noted on the right hip. Resident reports no pain.R3's physical therapy (PT) notes dated 11/26/2025 documents: intermittent pain level of 3 out of 10 at rest to right hip and 8 out of 10. What relieves pain are prescribed medications and remaining still. What exacerbates pain is sitting and bending. On 11/28/2025, PT (physical therapy) notes document an intermittent pain level of 4 out of 10 at rest to right hip and a constant pain level of 8 out of 10 with movement to right thigh verbalized by R3. It documents that R3 performed sit to stand 3 times with walker support and took 2-3 small steps max assist secondary to pain on the right lower extremity.On 11/29/2025, PT (physical therapy) notes document an intermittent pain level of 3 out of 10 to right hip and thigh verbalized by R3. On 12/3/2025, PT notes document an intermittent pain level of 4/10 at rest to right hip and an intermittent pain level of 8/10 with movement to right thigh and hip. Patient unable to ambulate at this time secondary to severe pain on the right lower extremity. On 12/5/2025, PT (physical therapy) notes document an intermittent pain level of 4 out of 10 to the right hip at rest and a pain level of 8/10 with movement to right hip and thigh verbalized by R3. Patient presents with severe pain to the right lower extremity and unable to put weight on that leg and has difficulty standing.On 12/7/2025, PT notes document that right lower extremity range of motion is decreased due to contracture. On 12/8/2025, PT notes document an intermittent pain level of 7/10 at rest to right hip and an intermittent pain level of 7/10 with movement to right thigh and hip. On 12/12/2025, PT notes document an intermittent pain level of 3/10 at rest to right hip and an intermittent pain level of 8/10 with movement to right thigh and hip. Patients present with right lower extremity severe pain on the anterior thigh area and tightness on the right knee flexion tightness.R3's Occupational therapy (OT) notes dated 12/1/2025 documents: R3 verbalized a pain level of 5 out of 10 to RLE (right lower extremity) described as aching, limiting lower body ADL's (activities of daily living) and functional mobility tasks. What relieves pain are prescribed medications and remaining still. What exacerbates (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
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F 0580 Level of Harm - Actual harm Residents Affected - Few	pain is sitting, standing, and bending. On 12/8/2025, OT (Occupational therapy) R3 verbalized a pain level of 5 out of 10 to RLE (right lower extremity) described as aching, limiting lower body ADL's (activities of daily living) and functional mobility tasks. What relieves pain are prescribed medications and remaining still. What exacerbates pain is sitting, standing, and bending.R3's progress noted dated 12/22/2025 at 2:00 PM (14:00) documents: received resident in bed no signs or symptoms of distress noted. Family to see resident with concerns and requesting resident to be sent to hospital. Nurse practitioner and Assistant Director of Nursing made aware. Progress note dated 12/22/2025 at 2:55 PM (14:55) shows local ambulance arrived at 2:40pm . All necessary documents are given in hand. Resident left the facility via stretcher, stable with no signs and symptoms of apparent distress. dressed appropriately for the weather. accompanied by two men crew. escorted to local hospital.R3's progress notes do not document any notification to the doctor or nurse practitioner about pain or changes to right lower extremity.R3's hospital record dated 12/22/26 documents: R3 coming to the hospital for confusion and generalized weakness. R3 complaining of right hip pain. Under musculoskeletal it documents there is tenderness to palpation of the right hip and tenderness with any range of motion of the right hip. Right hip x-ray dated 12/22/25 documents: superolateral displaced right femoral neck fracture. Under HPI: R3 states she may have fallen two weeks ago, Daughter was called who states the last time she saw R3 walking was four weeks ago. Right femoral neck fracture may have been due to a fall 2 weeks prior to presentation and was contributed to by osteoporosis.On 5/27/26 at 1:06PM, V11 (APRN) said he saw R3 during her stay at the facility. V11 said staff will usually verbally report to him any changes to the residents. V11 said he does not recall ever being notified of any pain in R3's right leg or inability to ambulate. V11 said if he was notified of the pain or changes to her leg, he would have done a thorough assessment of R3's leg and probably would have ordered an x-ray.On 5/27/26 at 3:09PM, V16 (NP) said she was not notified of R3 having any pain or inability to bear weight on right leg. V16 said if she was notified, they would have ordered an x-ray.On 5/27/26 at 10:45AM, V2 (Director of nursing, DON) said if a resident has complaints of pain the doctor or nurse practitioner should be notified of the pain. If resident experiences pain during therapy, its expected the therapist should notify the nurse. Nurses should then report to the doctor and document any interventions provided. V2 does not recall any concerns related to R3 pain or changes in condition.Facility policy change in resident condition review 9/2025 documents it is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. Nursing will notify the resident's physician or nurse practitioner when there is a significant change in the resident's physical, mental, or emotional status. Communication with the resident and their responsible party as well as the physician will be documented in the resident's medical record or other appropriate documents.Facility policy pain management review date 10/2025 documents: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. Licensed nursing may notify the health care provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on the individual's pain factors.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate nursing care and follow physician recommendations by failing to obtain a right hip x-ray after a Resident experienced a fall and subsequently exhibited redness to the right hip. This deficient practice affected one of three residents reviewed for improper nursing care. This failure resulted in a delay in diagnostic evaluation, assessment and treatment of a injury. Following a change in condition, R3 was transferred to the hospital, where diagnostic imaging revealed a right hip fracture.Findings include:Based on interview and record review, the facility failed to provide appropriate nursing care and follow physician recommendations by failing to obtain a right hip x-ray after a resident experienced a fall and subsequently exhibited redness to the right hip. This deficient practice affected one of three residents reviewed for improper nursing care. This failure resulted in a delay in diagnostic evaluation, assessment and treatment of an injury. Following a change in condition, R3 was transferred to the hospital, where diagnostic imaging revealed a right hip fracture.Findings include:R3 was admitted to the facility on [DATE] with diagnoses of history of malignant neoplasm of breast, weakness, mixed hyperlipidemia, unspecified fall, hypotension, anxiety disorder, insomnia, unspecified severe protein calorie malnutrition, major depressive disorder, constipation, alcohol abuse, gastroesophageal reflux disease, cognitive communication deficit, metabolic encephalopathy, difficulty walking. R3's Brief Interview for Mental Status (BIMS) assessment revealed a score of four/ fifteen on her Minimum Data Set (MDS) dated indicating severe impairment.R3's incident report dated 11/26/2025 documents: Resident was observed to be lying on the floor on her right side next to her bed, following a loud noise noted from her room. The resident denied hitting her head. Lacerations and redness noted on right and left knee. Laceration noted on right ankle. Redness noted on the right hip. Resident reports no pain.R3's physician progress note dated on 11/26/2025 at 01:38 AM documents under subjective: [AGE] year-old female with multiple falls, here for rehabilitation, unfortunately fell again, this time with laceration to right knee and a small bump to her right hip, with no lack of mobility or reported pain by the patient. She clearly has no other complaints however she is somewhat of a poor historian. Under assessment/plan documents: fall, initial encounter, setting of multiple falls, now with small lacerations to right knee, but no lack of mobility to be concerned with fracture. Patient also with injury to right hip, mobile. Agree with need for imaging of the same, however as no immobility can tolerate non STAT imaging #Debility, setting of multiple falls, will need ongoing therapy as tolerated, or evaluation of the same. Under plan/ treatment notes will you have to sign verbal orders entered by the nurse? Yes, orders were given to be cosigned in EMR. Orders given / Nursing instructions right hip radiograph. The following statements are true I reviewed prior external documentation. I obtained history from an independent historian. I reviewed prior test/lab or other results. I ordered new test/labs and/or imaging. I advised tele presenter to request another telehealth visit for any acute changes in clinical condition or questions. Patient should be seen by primary team within 1-2 days (or as soon as possible based on primary team schedule). Was the patient sent to the ED? Patient not sent out. Did you place call to ED for initial handoff? Patient not sent out. Provider: [V17(MD)].R3's medical record and physician orders did not document an Xray to right hipR3's progress noted dated 12/22/2025 at 2:00 PM (14:00) documents: Received resident in bed no signs or symptoms of distress noted. family to see resident with concerns and requesting resident to be sent to hospital. Nurse practitioner and Assistant Director of Nursing made aware. Progress note dated 12/22/2025 at 2:55 PM (14:55) shows local ambulance arrived at 2:40pm . All necessary documents are given in hand. Resident left the facility via stretcher, stable with no signs and symptoms of apparent distress. dressed appropriately for the weather. accompanied by two men crew. escorted to local hospital.R3's hospital record dated 12/22/26 documents: R3 coming to the hospital for confusion and generalized weakness. R3 complaining of right hip pain. Under musculoskeletal it documents there is tenderness (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to palpation of the right hip and tenderness with any range of motion of the right hip. Right hip x-ray dated 12/22/25 documents: superolateral displaced right femoral neck fracture. Under HPI: R3 states she may have fallen two weeks ago, Daughter was called who states the last time she saw R3 walking was four weeks ago. Right femoral neck fracture may have been due to a fall 2 weeks prior to presentation and was contributed to by osteoporosis.On 5/27/26 at 10:45AM, V2 (Director of nursing, DON) said she expects all staff to follow physician orders. V2 said all staff are responsible for reviewing progress notes and orders. V2 said the team will review the resident's record following a fall as part of the fall review. V2 said when R3 returned from the hospital she reviewed the chart and saw the progress note on 11/26/25 with hip XRAY order. V2 said she did speak to V3 (nurse), and the nurse was terminated due to the not ordering the x-ray.On 5/27/26 at 3:09PM, V16(NP) said she expects staff nurses to follow any physician recommendations for their residents if they are not available and report to them the following day any changes or orders received by on call physician or tele health.Employee report dated 12/30/25 showed that V3 failed to carry out provider order given on 11/26/2025 approximately 1:38 AM via tele health visit. R3 had fallen. V3 was given orders to obtain X-ray to right hip. V3 did not order nor obtain x-ray for R3. V3 also charted no new orders given.Facility policy Physician orders reviewed 9/2024 documents: Physician orders may be written by the provider or received by telephone by a licensed nurse or other licensed or registered health care specialist who are legally authorized to do so. Verbal orders are those given to the nurse by the physician in person or by telephone, however, they are not written by the physician in the medical record. Policy Explanation and Compliance Guidelines: Physician orders are followed as written; if there is a question about the order, contact the physician for clarification. For verbal orders, repeat any prescribed orders back to the physician or health care provider. Use clarification questions to avoid misunderstandings. Enter the order into the medical record manually or electronically; complete the order and indicate the name of the physician or health care provider giving the order. The nurse transcribes the order. The physician should sign the order on his/her next visit to the facility or within the time frame required by the facility. Follow through with orders by making appropriate contact or notification (e.g., lab or pharmacy).

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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 follow its pain management policy by failing to adequately assess, monitor, and manage pain for one of three (R3) reviewed for pain management. This failure resulted in R3 following a fall, experiencing ongoing right lower extremity pain that was not comprehensively evaluated or effectively managed. This resulted in R3 experiencing unmanaged pain, an inability to fully participate in therapy services.Findings include:R3 was admitted to the facility on [DATE] with diagnoses of history of malignant neoplasm of breast, weakness, mixed hyperlipidemia, unspecified fall, hypotension, anxiety disorder, insomnia, unspecified severe protein calorie malnutrition, major depressive disorder, constipation, alcohol abuse, gastroesophageal reflux disease, cognitive communication deficit, metabolic encephalopathy, difficulty walking. R3's Brief Interview for Mental Status (BIMS) assessment revealed a score of four/ fifteen on her Minimum Data Set (MDS) dated indicating severe impairment.R3's incident report dated 11/26/2025 documents: resident was observed to be lying on the floor on her right side next to her bed, following a loud noise noted from her room. The resident denied hitting her head. Lacerations and redness noted on right and left knee. Laceration noted on right ankle. Redness noted on the right hip. Resident reports no pain. R3's Occupational therapy (OT) notes dated 12/1/2025 documents: R3 verbalized a pain level of 5 out of 10 to RLE (right lower extremity) described as aching, limiting lower body ADL's (activities of daily living) and functional mobility tasks. It also documents what relieves pain are prescribed medications and remaining still. What exacerbates pain is sitting, standing, and bending. On 12/8/2025, OT (Occupational therapy) R3 verbalized a pain level of 5 out of 10 to RLE (right lower extremity) described as aching, limiting lower body ADL's (activities of daily living) and functional mobility tasks. It also documents what relieves pain are prescribed medications and remaining still. What exacerbates pain is sitting, standing, and bending. R3's physical therapy (PT) notes dated 11/26/2025 documents: intermittent pain level of 3 out of 10 at rest to right hip and 8 out of 10. What relieves pain are prescribed medications and remaining still. What exacerbates pain is sitting and bending. On 11/28/2025, PT (physical therapy) notes document an intermittent pain level of 4 out of 10 at rest to right hip and a constant pain level of 8 out of 10 with movement to right thigh verbalized by R3. It also documents that R3 performed sit to stand 3 times with walker support and took 2-3 small steps max assist secondary to pain on the right lower extremity.On 11/29/2025, PT (physical therapy) notes document an intermittent pain level of 3 out of 10 to right hip and thigh verbalized by R3. On 12/3/2025, PT notes document an intermittent pain level of 4/10 at rest to right hip and an intermittent pain level of 8/10 with movement to right thigh and hip. Patient unable to ambulate at this time secondary to severe pain on the right lower extremity.On 12/5/2025, PT (physical therapy) notes document an intermittent pain level of 4 out of 10 to the right hip at rest and a pain level of 8/10 with movement to right hip and thigh verbalized by R3. Patient presents with severe pain to the right lower extremity and unable to put weight on that leg and has difficulty standing.On 12/7/2025, PT notes document that right lower extremity range of motion is decreased due to contracture. On 12/8/2025, PT notes document an intermittent pain level of 7/10 at rest to right hip and an intermittent pain level of 7/10 with movement to right thigh and hip. On 12/12/2025, PT notes document an intermittent pain level of 3/10 at rest to right hip and an intermittent pain level of 8/10 with movement to right thigh and hip. Patients present with right lower extremity severe pain on the anterior thigh area and tightness on the right knee flexion tightness. R3's progress noted dated 12/22/2025 at 2:00 PM (14:00) documents: Received resident in bed no signs or symptoms of distress noted. family to see resident with concerns and requesting resident to be sent to hospital. Nurse practitioner and Assistant Director of Nursing made aware. Progress note dated 12/22/2025 at 2:55 PM (14:55) shows local ambulance arrived at 2:40pm . All necessary documents are given in hand. Resident left the facility via stretcher, stable with no signs and symptoms of apparent distress. dressed appropriately (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	for the weather. accompanied by two men crew. escorted to local hospital.R3's hospital record dated 12/22/26 documents: R3 coming to the hospital for confusion and generalized weakness. R3 complaining of right hip pain. Under musculoskeletal it documents there is tenderness to palpation of the right hip and tenderness with any range of motion of the right hip. Right hip x-ray dated 12/22/25 documents: superolateral displaced right femoral neck fracture. Under HPI: R3 states she may have fallen two weeks ago, Daughter was called who states the last time she saw R3 walking was four weeks ago. Right femoral neck fracture may have been due to a fall 2 weeks prior to presentation and was contributed to by osteoporosis.On 5/27/26 at 11:53Am, V8 (physical therapist assistant, PTA) said if a resident complains of pain during therapy, they will report it to the nurse and document it in their therapy note. Depending on the patient or pain they may try to do other exercises, may hold off on therapy or try medication for pain. V8 said he worked with R3 and recalled R3 complaining of pain to her right leg and would not walk or put weight on her right leg. V8 said he reported the pain to the nurses but was unable to recall which nurses.On 5/27/26 at 1:06PM, V11 (APRN) said he saw R3 during her stay at the facility. V11 said staff will usually verbally report to him any changes to the residents. V11 said he does not recall ever being notified of any pain in R3's right leg or inability to ambulate. V11 said if he was notified of the pain or changes to her leg, he would have done a thorough assessment of R3's leg and probably would have ordered an x-ray. V11 said R3 did not have complaints of constant pain at time of his visits. He recalls R3 having intermittent pain but never appeared to have any signs of a fracture. V11 said most people, even if confused, who have sustained a fracture would be showing some signs of pain. V11 recalls during his visit on 12/12/26 family was present, and he ordered Tylenol scheduled due to concerns of the R3 being restless not for pain. V11 was asked if restlessness could be a sign of pain and he said R3 did not show any concern related to a fracture. V11 said R3 history of drinking and encephalopathy may have contributed to her not experiencing pain or showing signs of pain as would be expected with a fracture.On 5/27/26 at 10:45AM, V2 (Director of nursing, DON) said if a resident has complaints of pain the doctor or nurse practitioner should be notified of the pain. Staff should offer pain medication if available. If pain medication is given staff are expected to follow up to see if pain improved. If pain did not improve or medication was not effective, they would inform the doctor. Pain can be documented in progress notes or a pain assessment. Pain is monitored every shift and documented on medication administration record. If resident experiences pain during therapy, its expected the therapist should notify the nurse. Nurses should then report to the doctor and document any interventions provided. V2 does not recall any concerns related to R3 pain or changes in condition. V2 did not present any pain assessments or investigation of R3's complaints of pain during the survey.R3's medication administration record for November and December do not document any pain medication given to R3 from 11/24/25-12/12/25.R3's medical record did not document any assessments of pain after documentation of pain in therapy notes.Facility policy pain management review date 10/2025 documents 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. 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. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following observing for the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the residents pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions; and modifying approaches as necessary. It is (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	important to recognize cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain. For example, some cultures value stoicism and a high threshold for pain which may influence a resident's willingness to report pain or accept pain-relieving interventions. It also documents that pain is assessed using the comprehensive pain assessment form with significant change, following a fall, when new pain is identified. Licensed nursing may notify the health care provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on the individual's pain factors.