STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145785	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus at Mascoutah	901 North Tenth Street Mascoutah, IL 62258

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent misappropriation of resident medications in 2 of 7 residents (R1, R2) reviewed for abuse in the sample of 7. This past non-compliance occurred on 6/2/26 with a correction date of 6/2/26. Findings Include:1) R1's Face Sheet, undated, documents R1, in part, has the following diagnosis: Osteomyelitis, Malignant Neoplasm of the Endometrium, Pain in Bilateral Feet, Neuropathy, and OA (Osteoarthritis). R1's MDS (Minimum Data Set), dated 5/27/26, documents R1 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R1 is cognitively intact. R1's Care Plan, dated 5/4/23, documents R1 is at risk for abuse. R1's Progress Note, dated 6/2/26 9:00 PM, documents the following: Resident notified by administrator (she is her own responsible party) of an ongoing investigation regarding a potential medication diversion incident involving facility staff. Resident was informed that a review of medication administration records is being conducted to determine whether any residents may have been affected. Resident was advised that the investigation remains ongoing and that appropriate regulatory agencies and authorities have been notified as required. At the time of notification, no adverse effects related to medication administration were identified. Resident was reassured that measures have been implemented to ensure continued medication, safety and quality of care. Resident was provided the opportunity to ask questions and verbalized understanding of the information provided. R1's Progress Note, dated 6/3/26 at 1:52 PM, documents the following: Family member notified on 6/3/26 of an ongoing investigation regarding a potential medication diversion incident involving facility staff. Family informed that resident may have been affected and that the facility is reviewing medication administration records and investigating the matter. Family advised that no adverse effects have been identified at this time and that appropriate corrective actions and notifications are being made. Family verbalized understanding and was given the opportunity to ask questions. On 7/2/26 at 10:00 AM, R1 was interviewed and was unable to recall any details of the misappropriation of medication. 2) R2's Face Sheet, undated, documents, in part, the following diagnosis: OA, Gout, Chondromalacia of the Right Knee, Patellar Tendinitis of the Left Knee, and Myalgia. R2's MDS, dated [DATE], documents R2 has a BIMS score of 12 indicating R2 has moderate cognitive impairment. R2's Care Plan, dated 3/11/26, documents R2 is at risk for abuse. R2's Progress Note, dated 6/2/2026 9:05 PM Resident notified by administrator (he is his own responsible party) of an ongoing investigation regarding a potential medication diversion incident involving facility staff. Resident was informed that a review of medication administration records is being conducted to determine whether any residents may have been affected. Resident was advised that the investigation remains ongoing and that appropriate regulatory agencies and authorities have been notified as required. At the time of notification, no adverse effects related to medication administration were identified. Resident was reassured that measures have been implemented to ensure continued medication, safety and quality of care. Resident was provided the opportunity to ask questions and verbalized the understanding of the information provided. R2's Progress Note, dated 6/3/26 at 1:54 PM, documents the following: Family member notified on 6/3/26 of an ongoing investigation regarding a potential medication diversion incident involving facility staff. Family informed that resident may have been affected and that the (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility is reviewing medication administration records and investigating the matter. Family advised that no adverse effects have been identified at this time and that appropriate corrective actions and notifications are being made. Family verbalized understanding and was given the opportunity to ask questions. On 7/2/26 at 8:20 AM, R2 was interviewed and was unable to recall any details of the misappropriation of medications. The facility Abuse Investigation Final Report on R1 and R2, dated 6/8/26, documents, in part, on 6/2/26 an allegation of abuse and diversion of medications was reported. The summary documents the following: During routine medication review, staff identified evidence that narcotic medication cards had been tampered with. Further examination revealed that narcotic tablets had been removed from the blister pack and replaced with other non-prescribed pills. Upon identification of the concern, the facility immediately secured the affected medications, notified appropriate parties, and initiated a comprehensive investigation. The investigation confirmed that narcotic medication cards belonging to two residents had been tampered with and that the prescribed controlled substances had been removed and replaced with other pills. As a result, the facility substantiated that drug diversion had occurred. Despite extensive interviews and record review, the facility was unable to identify the individual responsible for the diversion. All nurses with access to the medication cart were interviewed. No admissions were obtained, no witnesses observed the diversion, and the investigation did not reveal sufficient evidence to determine which staff member removed the medications. On 7/2/26 at 8:30 AM, V1, Administrator, stated R1 and R2's medication cards, unable to recall the medications, looked like the medication was popped out of the card, a different medication was placed in the card, and tape was placed over the back to seal the medication in. V1 stated they did a thorough investigation and was unable to identify who did it. V1 and V3, ADON (Assistant Director of Nurses), stated neither resident was administered the medication that was tampered with. V3 stated she has been doing the audits and has not had any concerns and there have been no further problems. On 7/2/26 at 10:50 AM, V8, LPN (Licensed Practical Nurse), stated she was doing the narcotic count with V9, LPN, when she noticed that the back of the medication cards belonging to R1 and R2, had been cut open, the 3-4 pills that had been inserted were not the same medications, verified by the number printed on the actual pills, that were supposed to be in there and then the covering had been pushed back over the medications. R8 was unable to recall which medications they were but she believed it was oxycodone on both R1 and R2. V8 stated she spoke with V9 who normally only works the 200-hall, and she was not the nurse that did the narcotic count with the prior shift, so this was the first time she had seen those medications. V8 stated she immediately took the cards of medication, secured them and then reported it to V2, DON (Director of Nurses) On 7/2/26 at 1:15 PM, V2, DON, stated that she had been notified about the discrepancy in the medications with R1 and R2. V2 stated she completed a full narcotic count on all controlled substances. V2 stated both R1 and R2's oxycodone medication cards had some random punch marks where the oxycodone had been removed and another medication, later verified as trazadone was replaced where the oxycodone had been and then the covering had been placed back over where those medications had been located. V2 stated the residents had not been given any of the trazadone that she was aware of. V2 stated she interviewed all of the nursing staff including V10, Agency, LPN, who was the nurse that had worked the 100-hall and had access to the medication cart prior to V8, LPN. V2 stated V10 told her that she had not noticed any of the medications appearing to be opened. The Abuse Prevention Program Facilities Procedures, undated, documents the following, in part, the facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and secure environment. Prior to the survey date, the Facility took the following actions to correct the noncompliance on 6/2/26. Immediate Actions: On 6/2/26, the facility immediately removed all medications identified in the discrepancy from service. The Medical Director and Responsible Parties of both residents were notified. Residents were assessed for any adverse effects with appropriate medical follow up provided. An immediate 100% audit of all narcotic cards were completed by V2 and V3 on 6/2/26. On 6/2/26, the medication carts, medication rooms, and (continued on next page)

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