STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000813	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus at Alton	**3523 WICKENHAUSER , ALTON, Illinois, 62002**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2548805/2617036 2548751/2615717 2548723/2614551	S0000		10/01/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		10/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to provide Physician prescribed medication for 2 of 7 (R2, R9) reviewed for medications in the sample of 20. This failure resulted in R9 missing 6 doses of pain medication leaving her in pain. Findings include: 1. On 9/17/25 at 10:00 AM, R9 stated I ran out of my pain medication oxy (oxycodone). I went for 3 days without pain medication. I wanted to cut my leg off it hurt so bad. I take it for my phantom pain in my right leg and the wound infection in my left leg. I don't know why I ran out either they didn't reorder it, or pharmacy didn't deliver it. R9's Minimum Data Set, dated 8/21/25, documents R9 is cognitively intact. On 9/25/25 at 1:47 PM, V4 LPN, stated R9 did run out of her oxycodone. Her prescription had run out, and I think she was changing providers or something. R9's Physician Order, dated 9/13/25, documents, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth every 4 hours for Pain. R9's September 2025 Medication Administration Record documents R9 did not receive her prescribed 5 mg of Oxycodone on 9/15/25 the 9 AM dose, 1 PM dose, 5 PM dose, 9 PM dose, 9/16/25 1 AM dose, and the 5 AM dose. 2. R2's Physician Order, documents, "oxyCODONE HCl Oral Tablet 15 MG (Oxycodone HCl) (Oxycodone HCl) Give 7.5 mg (milligrams) by mouth six times a day for pain start date of 5/8/25. R2's Nurses Note, dated 8/29/2025 06:32, documents, "Call out to (pharmacy) to obtain the status of order for pain medication. Per pharmacy a quantity of 4 was ordered and 2 sent. Remaining 2 will be sent this morning. New order from MD (Medical Doctor) will be needed."	S9999		

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S9999	Continued from page 2 R2's Medication Administration Record (MAR), dated August 2025, documents R2 did not receive the prescribed oxycodone 7.5 mg on 8/28/25 10 PM dose, 8/29/25 2 AM dose, and 6 AM dose. R2's Minimum Data Set, dated 6/18/25, documents R2 is cognitively intact. On 9/16/25 at 11:27 AM, R2 stated about a month or so ago I ran out of my pain medication, but it is better now. On 9/25/25 at 1:16 PM, V2, Director of Nurses stated that R2 missed 3 doses of oxycodone. On 9/24/25 at 10:02 AM, V4, Licensed Practical Nurse, stated, sometimes we do run out of pain medication for the residents. I will call the doctor and get them to send over a prescription to the pharmacy if a new prescription needed to be written. If their order needs to be rewritten, you can't get the medication from the (emergency medicine dispensing machine). On 9/24/25 at 9:01 AM, V2, Director of Nurses, stated, we are in the middle of changing pharmacies. The nurses should be calling pharmacy when the resident is down to a weeks' worth of pills. If the resident needs a new prescription, the pharmacy will call the doctor, and the doctor will send a prescription. If the resident does run out of medication, we have the (emergency medicine dispensing machine) which the staff can pull medications from. Most narcotics are in there. The policy medication Administration, dated 4/25, documents, "26. If medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain from the contingency or convenience box. 27. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner, and a note should reflect the situation in the resident's medical record." (B)	S9999		