

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001069		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
NAME OF PROVIDER OR SUPPLIER Nexus at Berwyn				STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE , BERWYN, Illinois, 60402			
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S0000	Initial Comments Complaint Investigations: 2692477/2789388 2692476/2789377 2692508/2791629	S0000				03/14/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1035a) 300.1210b) 300.1210d)3) 300.3240a) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and	S9999				03/14/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations are not met as evidenced by: Based on observations, interviews, and record review, the facility failed to initiate and continue cardiopulmonary resuscitation (CPR) for one resident (R1) who required resuscitative care until Emergency Medical Services (EMS) assumed resuscitative efforts. This failure has the potential to affect 106 residents that are identified as full code. Findings include: Per the facility's video tapes on 2/24/26: At 6:58 AM, V4 CNA (certified nurse aide) was seen entering one south nursing unit, walking directly to R1's room, open the door then immediately shut the door, and exit nursing unit. At 7:17:27 AM, V7 CNA (certified nurse aide) was observed opening R1's door, entering room, then exiting room to get V3 LPN (licensed practical nurse). At 7:17: 53 AM, V3 and V7 look in R1's room. V3 was observed walking away from R1's room while V7 enters R1's room. At 7:18:32 AM, V7 exits R1's room and exits nursing unit.	S9999				03/14/2026	

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S9999	Continued from page 2 At 7:20:06 AM, V6 CNA was observed entering R1's room. At 7:20:20 AM, V5 LPN was observed standing in R1's doorway looking into R1's room and then returning to nurses' station. At 7:20:34 AM, V6 CNA was observed exiting R1's room and calling for help. At 7:21:08 AM, V3 LPN was observed walking down hallway towards R1's room. V3 enters R1's room briefly then exits room. V8 RN enters R1's room briefly then exits the room and nursing unit. At 7:21:59 AM, V5 LPN was observed walking the emergency cart to R1's room and then walking to the nurses' station. There is no backboard observed on the emergency cart. At 7:23:04 AM, V8 RN (registered nurse) was observed entering R1's room. At 7:23:35 AM, V3 LPN was observed removing towels from linen room across from R1's room and handing to V8 who was standing in R1's doorway. At 7:25:20 AM, V3 was observed entering R1's room. At 7:25:34 AM, V11 CNA was observed bringing several clear large plastic bags to R1's room. At 7:25:44 AM, V3 was observed exiting R1's room with a large clear plastic bag with soiled linens. V3 exited nursing unit to dispose of bag. 7:27:15 AM, staff exit R1's room. V3 LPN returns and stands by R1's doorway. 7:29:05 AM, EMS crew arrive on unit. Between 7:21:59 until EMS crew arrived at R1's room at 7:29:14 AM, staff did not obtain a backboard. The manual resuscitation bag, oxygen tank, and the automated external defibrillator (AED) remained on the emergency cart. The facility's code blue documentation sheet (attached to crash cart) for 2/24/26 requested from V1 and V2. This sheet was not provided for review during this survey. On 2/28/26 at 3:00 PM, V4 CNA (certified nurse aide) stated that she worked 2/24/26 day shift. V4	S9999				03/14/2026	

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S9999	Continued from page 3 stated that while she was rounding on the residents on the one north nursing unit, she heard a code blue announced overhead. V4 stated that she ran to the one south nursing unit. V4 stated that she was instructed to call EMS 911. V4 stated that she called 911 and waited in the main lobby for the ambulance crew to arrive. V4 stated that she did not return to the one south nursing unit to assist with CPR (cardiopulmonary resuscitation) efforts for R1. Per the facility's video surveillance tapes, V4 was seen entering one south nursing unit at 6:58 AM and walking directly to R1's room, open the door then immediately shut the door, and exit nursing unit. At 7:22:49 AM, V4 was observed returning to one south nursing unit with a large clear plastic bag and enter R1's room. At 7:23:26 V4 exits R1's room briefly then re-enters room. At 7:26:30 V4 was observed throwing soiled towels/linens into the large plastic bag then proceed to the nurses' station. On 2/28/26 at 3:15 PM, V5 LPN (licensed practical nurse) stated that on 2/24/26 she worked the day shift. V5 stated that as she was coming on shift, she heard a code blue called. V5 stated that she performed chest compressions. V5 stated that she switched off with V3 LPN. V5 denied observing any bowel movement on or around R1's bed. Per the facility's video surveillance tapes, at 7:20 AM, V5 was observed entering the one south nursing unit and walking directly to R1's room, opens door, looks in and then closes door. At 7:21 AM, V5 exits nursing unit. At 7:21:59 AM, V5 walks to R1's room with the emergency cart, places it next to room and walks away. V5 does not return to R1's room until 7:28:43 AM. V5 exits R1's room at 7:29:00 AM. On 2/28/26 at 2:35 PM, this surveyor attempted to interview V6 CNA, day shift CNA on 2/24/26, but was unsuccessful. V6's phone disconnected. This surveyor reviewed V6's employee file for additional phone number(s). There was one other phone number listed in V6's file from 2023. This surveyor was unsuccessful, no longer phone number for V6. On 2/28/26 at 3:10 PM, this surveyor attempted to interview V7 CNA, day shift CNA on 2/24/26, but was unsuccessful. V7 did not return my call. On 3/13/26 at 11:25 AM, V7 was interviewed. V7 stated that V7 was informed by the CNA on the previous shift that R1 was not changed during the night. V7 stated that when she went to R1's room at 7:17 AM, she observed R1's brief off and feces and urine in R1's bed.			S9999			03/14/2026

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S9999	Continued from page 4 On 3/3/26 at 5:30 AM, V3 LPN stated that he saw R3 in R1's room. V3 stated that he was giving R1 and R3 private time and did not want to interrupt. V3 stated that at 6:30 AM, R3 was still in R1's bed. V3 stated that at 6:55 AM R3 exited R1's room. V3 stated that at 7:10 AM he went into R1's room, R1 was unresponsive. V3 stated that he called a code blue, initiated CPR, and called EMS 911 from the nurses' station phone. V3 stated that he is not sure who was performing chest compressions, he never went back into R1's room. V3 stated that he did not go into R1's room until the paramedics arrived. V3 stated that the crash cart was in R1's room, the manual resuscitation bag was in room, not sure if it was used. V3 stated that after he called 911, he printed R1's face sheet and e-interact form for the paramedics. V3 stated that the morning shift nurses responded to the code blue, does not know the names of staff. V3 is unable to state with certainty that chest compressions and rescue breathing were done since he did not go back into room. On 3/5/26 at 7:46 AM, V3 LPN stated that he was instructed to lie regarding this event involving R1. V3 would not state who informed him to lie. When questioned what the truth is, V3 stated that he wants to get his story straight before speaking any further to this surveyor. On 3/5/26 at 12:45 PM, V3 LPN stated that he went to R1's room at 6:30 AM and instructed R3 to leave R1's room. V3 stated that at 7:00 AM he saw R1 sleeping. V3 stated that at 7:15 AM, R1 was found unresponsive. V3 stated that there was dirty linen in R1's room. V3 stated that he was running around trying to figure out what to do. When questioned about chest compressions during a code blue, V3 responded you are not supposed to stop chest compressions before EMS crew takes over the care of the resident. V3 stated that there was feces on R1's bed and the floor and R1 was wet due to incontinence. V3 stated that towels were placed on the floor so staff would not step in the feces. V3 acknowledged cleaning the resident and/or floor does not take precedence over performing CPR. On 3/6/26 at 10:33 AM, V8 RN (registered nurse) stated that she worked on the one north nursing unit on 2/24/26. V8 stated that when she arrived to work she went to the one north nursing unit to prep the medication cart and receive report from V3 LPN (night shift nurse). V8 stated that she heard staff calling V3 by name and then call a code blue. V8 stated that she ran to R1's room and found R1 unresponsive. V8 stated that the crash cart was			S9999			03/14/2026

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S9999	Continued from page 5 brought to R1's room and CPR was initiated. V8 stated that she and another staff were performing CPR, she asked to switch, and left R1's room. V8 stated that she returned to R1's room and continued to perform CPR. V8 stated that she left R1's room because no staff were on the one north nursing unit. V8 stated that she does not know which other staff were present during CPR or performing CPR. V8 stated that she passed the EMS crew in the main lobby as they were entering facility. Per the facility's video surveillance tapes, V8 was observed at 7:21:31 AM entering R1's room; exiting room at 7:21:34 AM, and exiting the nursing unit at 7:21:45 AM. At 7:23:26 AM, V8 was observed standing in the doorway for R1's room. V8 is handed a stack of towels from V3 LPN and re-enters R1's room at 7:23:43 AM. At 7:25:24 AM, V8 exits R1's room. At 7:26:52, V8 obtains a large clear plastic bag and more towels. At 7:27:12 AM, V8 was observed standing in R1's doorway speaking with V3, briefly re-enters R1's room, and exits room at 7:27:50 AM and walks to nurses' station before exiting unit. On 3/2/26 at 12:52 PM, V9 (EMS paramedic) stated that when the crew arrived at R1's bedside, there was no medical equipment (backboard, manual resuscitation bag, oxygen tank) in room and V3 was the only person in R1 and R2's room and he was speaking with R2. V9 stated that the crew immediately placed backboard under R1 and placed manual resuscitation bag over R1's mouth and nose, CPR was initiated. V9 stated that a mechanical chest compression system was applied to R1 and R1 was placed on stretcher and transported to ambulance then hospital. V9 stated that CPR continued in ambulance and in hospital. V9 stated that there was no return of spontaneous circulation for R1. V9 stated that R1's jaw and right arm showed signs of rigor mortis (stiffening of the muscles) and right arm was cold to touch. V9 stated that R1's torso felt warm to touch so CPR was initiated. The EMS report, dated 2/24/26, notes dispatch was notified at 7:22:47 AM for a resident with breathing problems. The EMS crew arrived at facility at 7:27:31 AM; at R1's bedside at 7:28:26 AM. The EMS crew left the scene at 7:38 AM. The summary notes crew members were dispatched to the facility for a female resident not breathing. Upon arrival, crew was approached by nursing staff that informed crew that R1 was not breathing and informed crew they were performing CPR prior to EMS arrival. Staff also informed crew of finding R1 in the morning			S9999			03/14/2026

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S9999	Continued from page 6 "like that". Crew noted no CPR in progress upon arrival to R1. Crew noted R1 laying supine in bed, pulseless, apneic and unresponsive. R1 was alert and oriented x 0/4 with a glasgow coma scale of 3 out of 15. Crew began manually performing compressions. Crew placed the cardiac monitor defibrillation pads on R1. Crew analyzed rhythm and noted asystole (no ventricular contraction) on the monitor. Crew started to assist R1 with manual ventilations via manual resuscitation bag at 15 liters/minute of oxygen. Crew transferred R1 from R1's bed to the stretcher. While R1 was placed on the stretcher, crew placed the mechanical chest compression system on R1 and resumed CPR. Crew secured the patient's arms to the mechanical chest compression system and secured device to R1. Nursing staff gave all patient information to crew member. While moving R1 t to the ambulance, crew had mechanical compressions and ventilations continuing. Once in the ambulance, crew placed a device to maintain R1's airway and continued ventilation. Crew secured airway device and confirmed airway device was appropriately inserted. Crew established an IO (interosseous) catheter in R1's left humeral head with no complications. Crew administered the first round of Epinephrine 1:10 via IO. Crew then paused CPR for a rhythm and pulse check. Crew noted no pulse and R1 to remain in asystole. Crew resumed CPR and ventilations. Crew then secured R1 onto the stretcher and transported R1 to the closest hospital. En route, the hospital was contacted via telemetry and crew alerted the hospital of a cardiac arrest. R1 was transferred to a bed in the emergency department, and a handoff report was given to the primary Physician and primary nurse. R1's hospital record, dated 2/24/26, notes R1 presented to the emergency room at 7:41 AM, CPR in progress. Asystole noted entire time. Per EMS, R1 was found down at facility, unknown down time. R1 exhibiting rigidity of the right upper extremity and jaw on intubation attempt. R1 warm to touch. Pupils fixed and dilated. En route an airway device was inserted. In the emergency department, CPR continued. R1 was unresponsive, skin was cool and dry, pupils fixed and dilated. A rapid sequence endotracheal intubation was performed. R1 went through three rounds of epinephrine in the emergency room, five rounds total during her resuscitation. R1 remained asystole on the monitor on all pulse checks. On final pulse check, bedside echocardiogram performed which showed cardiac standstill. Time of death called at 7:56 AM. American Heart Association 2025 guidelines for adult CPR notes early high-quality CPR and prompt			S9999			03/14/2026

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S9999	Continued from page 7 defibrillation are the most important interventions associated with improved outcomes in adult cardiac arrest. For adult cardiac arrest, rescuers should perform chest compressions with the patient on a firm surface. Start CPR until advanced care arrives. The adult BLS (basic life support) algorithm notes start with compressions, check for visible object in mouth before giving breaths, start CPR, begin bag-mask ventilation with oxygen. High-Quality CPR notes push hard (at least 2 inches [5 cm]), push fast (100-120/min) and allow complete chest recoil, minimize interruptions in compressions, avoid excessive ventilation, change compressor every 2 minutes, if no advanced airway, 30:2 compression-ventilation ratio. (A)		S9999			03/14/2026	