STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the facility failed to prevent abuse for 6 of 7 residents (R10, R49, R50, R51, R62, R293) reviewed for abuse in the sample of 42. Findings include: 1.The Facility's Incident Initial Report, dated 1/6/24, documented, On 1/6/24 at 740p (7:40 PM) Nurse contacted Administrator and advised that the alleged victim was coming down C hall and tried getting around the alleged perpetrator and accidentally bumped into the victim. Nurse immediately separated the residents. Nurse assessed both residents in their rooms. No injuries noted. MD/POA (Medical Doctor/Power of Attorney) contacted. Police contacted. Investigation initiated. R62's Late Entry Progress Note, dated 1/7/24, by V16, Registered Nurse (RN), on 1/6/24 at 7:30 PM documented, Other res (resident) was attempting to propel self in Wc (wheelchair) by this res. This res began to call other res names and then started to slap other res left arm. Res immediately separated. Res denies pain. No inj (injuries) noted. On 1/24/24 at 5:47 PM, V16, Registered Nurse (RN), stated that she was at the nurse's station when she glanced down the hall and saw residents congregating. She continued to state that R10 had her arm reaching out toward R62 and heard loud voices but was unable to tell what was being said. V16 stated that she called out, Is that friendly? to which R50 said, No. V16 stated that she ran down the hall and saw R62 holding R10's arms and slapping R10's forearm. She stated that R62 was making physical contact with R10. She separated the residents and assessed them for injuries. She stated R62 tends to be quite cantankerous with staff, but she had never witnessed her in a physical altercation before. (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
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V31's (R294's Family's) Hand-Written Witness Statement, dated 1/6/24, documented, (R62) started shouting at (R3) get your fingers out of your mouth. Where's (Unknown Person), answer me, get your fingers out of your mouth. Stop chewing on your fingers and answer me. (R62) repeating this several times. Then (R50) tried to get more room in the hallway by asking (R62) if she would move out of way and move back into her room. (R62) shouted no at (R50), and called him fat and she wouldn't move. Then (R10) came out of her room and tried to get by. (R62) then started yelling, why are you so fat. Your the fatest (fattest) in this whole place. (R62) proceded (proceeded) to get her purse and hit (R10), (R10) put her hand up to defend herself when (R10) started yelling no (not) to hit her. It was (R62) that was doing the hitting. (R10) squeezed herself by (R62) and got her supplies from the cart. (R21) then got by (R62) also. (R62) repeatedly yelled you're a fat lady and the fatest (fattest) in this place. While this way (was) all going on (R21) came out into the hallway hearing (R62) shouting negative comments and try to calm (R62) down by shouting hey, hey. That's not right. Then nurse (V31) walked up trying to deescalate the whole situation. Note: When (R50) was trying and moved past (R62), (R62) yelled at (R50), aren't you going to thank me. (R50) then said no, aren't you going to apologize to me for calling me fat. On 1/24/24 at 4:15 PM, V31, stated she witnessed the altercation between R62, R50, and R10. She stated, (R62) was blocking the hall and kept calling (R50) extremely obese, fat, no good, verbally abusing him. (R50) said, Could you move back, please and (R62) said no. (R10) came out, (R62) reached out and whacked (R10) and grabbed her arm. (R62) hit (R10) with her purse a few times and again with her hand. (R62) moved back a little bit and then (R10) got through. Then (R62) was calling (R50) the fattest woman she has ever seen. And he is a man! (R62) has repeatedly gotten into fights with roommates. I think it is worse when the sun goes down. R10's Hand-Written Witness Statement, dated 1/6/24, documented, (R62) was in the hallway, I toad (told) to move back. She hit me. I held her arms so she couldn't hit. She called me big and fat. On 1/24/24 at 9:03 AM, R10 stated that the incident happened a while ago and cannot remember all the details, but R62 was hitting her, and she grabbed R62's arms to keep her from being hit again. R50's Hand-Written Witness Statement, not signed nor dated, documented, I was going back to the dining room and (R10) was in front of me and her and (R62) were arguing then (R62) started smacking. (R10) and (R10) grabbed her to get her to quit. On 1/24/24 at 4:08 PM, R50 stated, I came to get something from my room and (R62) was in the hallway in her wheelchair. She called me a fat*ss, saying I could not get through. I thought to myself I would wait until a nurse came to take care of it, but she ended up letting me through. I went in my room and when I came out (R10) was trying to get past (R62). (R62) was yelling at (R10) saying she was the fattest woman in the world. (R10) asked (R62) to let her through, then (R62) backed up a little bit, so (R10) rolled forward. (R62) then swung at (R10) and hit her arms four or five times until (R10) grabbed (R62)'s arms to block her from getting hit. By that time, the nurse came down and helped and took (R62) back to her room. On 1/23/24 at 11:15 AM, R62 stated, I've not had any problems with anybody. Yes, yes, I have. There is this one lady who always tries to sit in my chair in the dining room. She is just a pain in my butt. She drives me nuts. I don't have her name, but I can tell you who she is. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Incident Final Report, dated 1/6/24 documented, On 1/6/24 at 740p (7:40 PM) Nurse contacted (V1) and advised that the alleged victim was coming down C hall and tried getting around the alleged perpetrator and accidentally bumped into the alleged perpetrator's wheelchair. The alleged perpetrator got upset and made contact with the alleged victim. Nurse immediately separated the residents. Nurse assessed both residents in their rooms. No injuries noted. MD/POA contacted. Police contacted. During investigation, the alleged victim was trying to propel her wheelchair down the hall so that she could go to her room. As she went past alleged perpetrator the alleged perpetrator made contact with the alleged victim because the alleged perpetrator felt as if she was getting in her space. The alleged perpetrator make (made) contact with the alleged victim. The nurse immediately separated residents, did assessment on both residents with no concerns, police interviewed both residents with no concerns. SSD (Social Services Director) implemented 15 minute intervals to check in on residents, increased activities, SSD contacted (Counseling Company), and behavior tracking was done on both residents. R62's Face Sheet, undated, documented that R62 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, essential primary hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus with hyperglycemia, anxiety, encephalopathy, chronic kidney disease stage 3, and obesity. R62's Minimum Data Set (MDS), dated [DATE], documented that R62 was severely cognitively impaired and required substantial assistance rolling in bed and transferring. R62's Care Plan, dated 10/29/23, documented that the resident had episodes of verbal aggression toward staff and peers. R10's Face Sheet, undated, documented that she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, hypothyroidism, chronic pain, essential hypertension, osteoporosis, acute kidney failure, and body mass index 50.0-59.9. R10's MDS, dated [DATE], documented R10 was cognitively intact and ambulated via wheelchair. R10's Care Plan did not address risk for abuse. R10's Progress Note, dated 1/6/24 at 7:30 PM, V16, RN, documented, Res (resident) was attempting to propel self in Wc (wheelchair) by other res. Other res began to call this res names and then started to slap this res left arm. Res immediately separated. This res denies pain. No inj (injuries) noted. Head to toe assessment completed. MD police poa and admin notified. R50's Face Sheet, undated, documented, that R50 was admitted to the facility on [DATE] with diagnoses including cellulitis, chronic atrial fibrillation, major depressive disorder, chronic pain, essential primary hypertension, malignant neoplasm of endocrine pancreas, type 2 diabetes mellitus, and obesity. R50's MDS, dated [DATE], documented that R50 was cognitively intact and ambulated via wheelchair. R50's Care Plan, dated 3/1/23 did not address risk for abuse. R50's Progress Notes did not contain documentation regarding the 1/6/24 incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/26/24 at 8:17 AM, V1, Administrator, stated that she expects the staff to follow its abuse policy. 44953 2. The Facility's Incident Investigation, dated 1/5/24, documented, On 1/5/24, the alleged victim (R51) approached the nurse at Nursing station and advised that the alleged perpetrator (R293) made contact with him in his room. The alleged victim (R51) stated the alleged perpetrator (R293) had come out of the bathroom and tried to grab the alleged victims' belongings off of his bedside table. The alleged victim (R51) told the alleged perpetrator (R293) to not touch his things and the alleged perpetrator (R293) made contact with the alleged victim (R51). Nurses assessed both residents- no injuries noted to either party. There were no witnesses present during this incident. The alleged perpetrator (R293) was moved to a different room on a different hall. (Power of Attorney/Medical Director) and police were contacted. Investigation initiated. The Facility's Final Incident Investigation, dated 1/8/24, documented, SSD contacted (outside) counselling services for the alleged perpetrator, SSD also contacted psychiatrist to review the medications for the alleged perpetrator. Both parties are separated and are safe and away from one another. Quality team implemented 15-minute visuals on both parties and will continue to track both residents' behaviors. R51's Nurse Progress Notes, dated 1/5/24 at 1:00 PM, documented, (R51) came to the nursing station stating that his roommate hit him and was stealing stuff off of table. [NAME] did a head-to-toe assessment and no injury noted at this time (right) shoulder is not red or swollen. (Power of Attorney) was notified, (Medical Doctor) notified, and local police came to take a statement from both parties involved. Room changes were made to separate the two residents at this time. R293's Nurse Progress notes, dated 1/5/24 at 1:47 PM, documented, (R293) came to nursing station stating that roommate called him names and he wanted to be moved at this time. Roommate stated that resident was hitting him in the shoulder and stealing stuff off of his table. (Administrator) was contacted, (Power of Attorney) was contacted, (Medical Doctor) was notified, (Director of Nurses) is aware, and the local police came to take statements from both parties involved. Resident was moved to another room and is being placed on one-hour checks at this time. R293 Care Plan, dated 1/5/24, documented, Problem: Resident has physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, abusing others sexually). INTERVENTIONS: Resident will not harm others secondary to physically abusive behavior. Resident moved to another hall and room placed on every 1-hour check. Divert resident's behavior by Removing resident from area. Maintain a calm environment and approach to the resident. Assess whether the behavior endangers the resident and/or others. Intervene if necessary. On 1/21/24 at 10:00 AM, R51 stated that his roommate (R293) came out of the bathroom and tried to grab some cookies off his (R51) bedside table. He continued to state that when he resisted the roommate hit him in the face with his fist and that the staff moved him to another room. On 1/23/24 at 1:00 R293 stated that he did not hit R51 and continued to state R51 hit him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/25/24 V50, SSD, stated that R293 was a recent transfer in from a sister facility that abruptly closed down and that R293 had not presented any problems but was an identified offender. R51's Physician Order Summary, undated, documented that R51 was admitted to the facility 4/28/21 with medical diagnosis of Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant side, Generalized Anxiety Disorder, Cerebral Infarction due to Unspecified Occlusion or Stenosis of Left Vertebral Artery, Major Depressive Disorder, recurrent, unspecified, Sacroiliitis, not elsewhere classified, Spondylosis, unspecified and Presence of cardiac pacemaker. R51's MDS, dated [DATE], documented that his cognition was intact, with no behavioral symptoms exhibited. 42834 4. R49's Face sheet, undated, documented an admitted [DATE] and her diagnoses included Cerebral Infarction, Dysphasia, Hypertension, Type 2 Diabetes Mellitus. R49's MDS, dated [DATE], documented that her cognition was intact and uses a wheelchair for mobility and is dependent on staff for ambulation. R49's Care Plan, updated 8/10/2023, documented, I have a history of verbal altercations with (Specify: my peers, staff, etc.) Interventions include Provide me with a referral for psychiatric care as needed. Encourage my representative to provide input on interventions as indicated. Administer medication as ordered. The Facility's Incident Report, dated 12/28/2023, documented, Activity Director informed the Administrator that while the alleged victim was leaving the dining room that she accidentally bumped into the alleged perpetrator and the alleged perpetrator made contact with the alleged victim by grabbing her left arm. Nurse immediately separated Residents. Nurse assessed both Residents with no injuries noted, Nurse contacted POA/MD. Police notified, Investigation initiated. R49's Progress notes, dated 12/28/23, documented, This writer notified by DON that resident had been involved in a resident-to-resident altercation both verbal and physical. MD made aware. R49 denies any pain or discomfort. Skin assessment complete, no skin issues noted at this time. All parties notified. On 1/23/2024 at 1:25PM, V13, Activity Coordinator, stated, I reported the resident-to-resident altercation between (R49 and R62) to the Administrator, but I did not see anything. My assistant saw it and told me. That is when I reported it. On 1/23/2024 at 1:30PM V35, Activity Assistant, stated, At Bingo last month (R62) rolled up in her wheelchair to (R49). (R49) gently pushed (R62's) wheelchair out of the way and (R62) hit (R49) in the arm. I immediately separated them and told my supervisor. R49's Abuse log file contained an undated interview with R50, that documented, (R62) kept rolling and I told her to stop or (R62) would start running into us. Then (R62) kept rolling. (R62) was running into (R49)'S leg and that's when (R62) smacked the crap out of (R49) in the arm. This was all during bingo. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's abuse log file contained an undated interview with R49, that documented, On Tuesday December 28th around 10:40AM, I was playing bingo in the dining room when (R62) tried to squeeze her wheelchair between myself and (R50), it was bumping my bad leg, so I reached back and moved her chair off my leg and then (R62) slapped my left arm, then I pushed her back more. (R62) started crying. R49's abuse log file contained an undated interview with R62, that documented I (R62) was trying to play bingo and another resident (R49) slapped me on the arm so I (R62) slapped (R49) back and (R49) got mad at me. I started crying and left the dining room. Facility's abuse policy with a revision date of 7/2017, documented, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source, shall be promptly reported to local, state, and federal agencies (defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety 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** 44953 Based on interview and record review the facility failed to protect residents from employee misappropriation of resident funds and exploitation for one of 7 residents (R51) reviewed for misappropriation of resident property in the sample of 42. This failure resulted in an Immediate Jeopardy when V22, Certified Nursing Assistant, (CNA), began using R51's debit card without his permission on March 2, 2023, accruing more than $11,000.00 in charges. When R51 became aware, he was upset and worried about taking care of future expenses and needs. The Immediate Jeopardy began on 3/02/23, when V22 began using R51's debit card without R51's permission. On 1/26/24, at 4:00 PM, V1, Administrator, V3, Assistant Director of Nursing (ADON), and V47, Registered Nurse, RN, were notified of the Immediate Jeopardy. The surveyors confirmed by observation, interview and record review, the Immediate Jeopardy was removed on 1/29/24, but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Final Facility Reported Incident report, dated 6/26/23, documents On 6/23/23 at 3:00 pm, R51 and V32, R51's family friend, reported possible misappropriation of R51's funds. The Report documented R51 was unable to provide name, description or exact dates and times. R51 and V32 reported R51's checking account was missing $20, 000.00. The Report documented R51's bank was contacted, and bank statements were obtained, and R51's debit card cancelled. The Report documented upon review of the bank statements it was determined that several cash app accounts (financial services platform which allows individuals to quickly receive and send money to other people from their mobile devices) had been making charges using R51's debit card. The Report documented names that appeared on R51's bank statement for cash app were search identifying 3 staff members came up. The Report documented 2 staff members, 1 Certified Nursing Assistant (CNA) and 1 nurse were interviewed about the charge on R51's bank account and they produced proof of where a 3rd staff member had paid them for lunch they had ordered as a group on 2 separate occasions. The Report documented the third staff member was identified as V22, CNA. The Report documented V22 was immediately suspended pending investigation and resigned her position prior to completion of the investigation. The Report documented V22 denied in her written statement of taking any funds from any residents or using their debit cards. The Report documented the local police were called and report was filed with a report under case number (case # identified) by (V48) police officer and they began their investigation. The Report documented V32 friend of R51, took all of R51's credit cards home with him (V32). The Report documented upon interviewing R51 about the incident and if he had given permission to anyone to make these transactions. R51 stated that he only gives his card to the girls to get him a soda or snacks out of the vending machines and nothing else. The Report documented R51 had no knowledge of the funds missing from his account until 6/26/23 when V32 reported it to the Administrator. The Report documented R51 reported he (R51) has not had no other issues involving his bank accounts since being a resident of the facility. The Report documented even though V22 resigned her position with the facility, Administrator and HR Director did notify V22 of her terminated (sic) based on the 2 transactions that can be traced back to V22. The Report documented Police investigation remain on-going, and they will be working with the facility as they subpoenaed items from cash app to determine full extent of misappropriation and to proceed with criminal charges. The Report documented based on the investigation, the facility substantiated misappropriation of resident funds and the police investigation remain on-going. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Police Report dated 6/26/23 documents at approximately 3:57 PM V48, Police Officer was dispatched to nursing home in reference to a fraud report. The Police Report documented V48 met with R51 and V32 friend of R51 who helps manage R51's finances. The Police Report documented R51 and V32 friend of R51 reported they observed odd amounts of currency missing from R51's bank account. The Police Report documented R51 stated he has a debit card which he often handed to nursing staff to purchase snacks for R51 from a vending machine at the nursing home. The Police Report documents R51 reported that someone was using his debit card without permission. The Police Report documents R51 advised the debit card has been deactivated to prevent further fraudulent charges. The Police Report documents beginning on 3-2-23 charges on R51's account from cash app began to accumulate. The Police Report documents R51 provided bank statements from January 2023 to May 2023. The Police Report documents there were approximately 80 fraudulent charges on R51's through Cash App starting in March 2023 totaling at approximately $11,657. 36. The Police Report documents R51 stated there were numerous other fraudulent charges in June but the statements were not available yet. The Police Report documents R51 stated he did not give anyone permission to use his debit card other than to purchase him snacks from the vending machine. The Police Report displayed a list the Cash App username/[NAME] of all the recipients who received money from R51's account from March to May. The list consisted of twenty-seven (27) names. V48 Police Officer interviewed V3, Assistant Director of Nursing, ADON who was assisting R51 with his care. The Police Report documents V3 stated she suspected one of her co-workers V22 was the one who used R51's debit card. According to the Police Report, V48 conducted an open-source criminal history on V22 through the county courthouse and discovered V22 has an open case: Case number (case # included)-in an area Municipality: Charges-Aggravated ID Theft; Financial Exploitation of the Elderly (2 counts) [NAME] Trial set for 9-11-23. The Police report documented a search of area County Court documents a case number (case # included) set for trial 2/13/24 regarding V22 Misappropriation of R51's funds. R51's Bank Statements from March 2023 through June 2023 were reviewed. The Cash APP withdrawals began on 3/2/23. On 1/23/24 at 8:00 AM V1, Administrator stated she was unaware of any employees taking money or anything from residents. She stated she was not the administrator during that time and was unaware of the situation. V1 stated in-service training is on-going on all issues regarding resident care with an emphasis on abuse and prevention. V1 stated no resident has reported any theft to her. On 1/23/24 at 9:00 AM, V32, Friend of R51, stated he was reviewing R51's bank statement and discovered there were frequent cash app withdrawals on R51's statement. V32 stated when he questioned R51 about the cash app withdrawals, R51 denied making any withdrawals from his account. V32 stated R51 also denied giving anyone his debit cards. V32 stated the facility staff overheard the encounter between R51 and V32 and informed the Administrator. V32 stated 1 of the girls basically stole money from R51. V32 stated R51 gave her (V22) his debit card to get snacks out of the facility vending machines. V32 stated they contacted the bank and was informed that it was someone making withdrawals using a cash app. V32 stated the police are investigating, and the staff person is being charged. V32 stated The bank is refusing to refund R51's money because they said (R51) gave (V22) the debit card. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/23/23 at 10:00 AM V3, stated the staff always get together as a group and orders lunch. V3 stated one person will pick-up the food and each person will reimburse that person. V3 stated V22 reimbursed her with a cash app for the sum of $27.00. V3 stated V22 was assigned to R51 and was always in his room. V3 stated R51 trusted her because she always responded to his call light. V3 stated I was unaware that (V22) was using his debit card to purchase snacks or sodas from the vending machines until (V32) reported money missing from (R51's) account. When (V32) mentioned cash app I immediately thought of (V22). It was confirmed when I was questioned by the police. On 1/25/24 at 12:33 PM V48, Police Officer, stated he was called to the facility on [DATE] for a complaint of misappropriation of resident funds by a facility employee. V48 stated R51 and V32 reported that they noticed a lot of unusual transactions on R51's bank statements starting in March 2023. V48 stated R51 stated he had given his debit card to an employee to purchase snacks or sodas from the nursing home. V48 stated R51 did not give permission for his (R51) debit card for any other purchases and was unaware of its continued usage until 6/26/23. V48 stated V32 and the Administrator presented R51's bank statements to verify the unauthorized transactions. V48 stated both R51 and V32 were interviewed and did not appear to be falsifying statements. V48 stated he interviewed V3 and V27, CNA, who gave statements implicating V22. V48 stated V22 had left the premises and was unavailable for interview, but the facility had obtained a written statement from V22, denying the allegations. V48 stated the case was turned over to a detective, V49 for further investigation. On 1/25/24 at 2:30 PM, V32 stated the bank statements were provided to the prior facility Administrator and thought they could be made available. V32 stated initially R51 was upset and worried about the money stolen from him. R51 was worried about not being able to take care of his future needs. On 1/26/24 at 8:00 AM V49, Detective, stated the investigation of the case is on-going. V49 stated V22 was arrested and released pending trial. V49 stated the investigation regarding the misappropriation of funds from R51 and others are on-going. V49 stated at this point because of the on-going investigation, they are unable to prove or disprove if other residents were victimized by V22. V49 stated the police investigation is also including 3 other nursing homes where V22 was employed and has alleged misappropriated resident funds. On 1/26/24 at 8:45 AM R51 stated he had not talked about the money stolen from his account because he tries not to think about it. R51 stated he did give V22 his debit card one or two times to purchase snacks or sodas out of the vending machines. R51 denies giving V22 his debit card for further purchases. On 1/26/24 at 11:00 AM V19, CNA Coordinator, stated, I was unaware of the problem until I was interviewed by the police. They told me that my name was on (R51's) bank statement as receiving a cash app payment of $20.00. I explained that was because a coworker, (V22), reimbursed me for buying her lunch. I had no idea (V22) had set up a cash app using (R51's) bank account. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/29/24 at 2:00 PM V53, former facility Administrator, stated when he became aware of the concern expressed by R51 and V32, the bank was contacted with R51's and V32's permission and the bank statements were obtained. V53 stated copies of the bank statements documenting that $20,000.00 was missing from R51's account was included with the investigation. V53 stated R51 was using a flip phone and has no knowledge of how to set up or use a Cash APP. V53 stated the police were called, and they began their investigation. V53 stated he did maintain contact with the police department and the prosecuting attorney for updates on the case until he longer was employed at that facility. V53 stated V22 was not at work that day and was contacted at home that she was being suspended pending the outcome of the investigation. V53 stated V22 denied stealing money from R51 and then resigned from this employment. R51's Face Sheet undated documents diagnosis of Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease affecting non-dominant side, Generalized Anxiety Disorder and Major Depression Disorder. R51's Minimum Data Set (MDS) dated [DATE] documents R51 is cognitively intact and does not exhibit disorganized thinking. The facility Policy and procedures Investigating Incidents of Theft and/or Misappropriation of Resident Property revised April 2017 documents residents have the right to be free from theft and/or misappropriation of personal property. The Policy documents Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The Immediate Jeopardy that began on 3/02/23 was removed on 1/29/24, when the facility took the following actions: 1. Identification for Residents Affected or Likely to be Affected: -The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. Completion date: January 29th, 2024. -All staff were in-serviced by V1, Administrator, and V50, Social Services Director. The in-service included that staff will not take money from a resident for any reason, including taking money from the resident to obtain snacks from the vending machine, reporting any suspicion of a fell ow employee accepting money or gifts from a resident. Completed 1/29/24. -All staff were given a competency evaluation concerning the in-service material. The evaluation was conducted by V50. Completed 1/29/24. -The facility has appointed a selected group of employees permitted to assist residents with vending machine snacks or drinks, or any other necessary needs of the resident concerning exchange of money between an employee and resident. All residents and employees were informed. V13, Activity Director, V68, Accounts Receivable, V5, Dietary Manager, and V50, SSD. Completion 1/29/24 -The in-service was completed by V1 and V50. Completed on 1/29/24. -All residents are considered at risk for misappropriation of funds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. Completion date 1/29/24. -A QAPI team reviewed the policies regarding misappropriation of funds. -All staff have been in serviced regarding misappropriation of funds. See above. -A competency evaluation was given to each staff member regarding misappropriation of funds. See above. A Resident Council Meeting was called to notify residents of the procedures set forth including the appropriate staff members permitted exchange money with residents. -Residents who did not attend Resident Council were educated on changes on 1/29/24 by V13. -A log has been created that requires V50, V68, V5 and V13 to record any exchange of money between themselves and the residents. -A QAPI has been written addressing each issue listed above. -A Performance Improvement Tool has been created on 1/29/24 that reviews staff knowledge of the above-mentioned policies. -The Administrator will identify concerns during daily meetings. Any concerns identified will be addressed immediately. -The performance improvement (QAPI) monitoring and auditing procedures were initiated, and all findings will be presented at the monthly QAPI meeting. -Monitoring/auditing and reporting will continue for a minimum of four (4) weeks. A weekly ad-Hoc QAPI meeting will be held to discuss results of the monitoring/auditing to determine if addition interventions are necessary to ensure residents safety and compliance. -QAPI team consist of V1, V2, Director of Nursing, V3, Assistant Director of Nursing, V5, V68, V13, V22, Certified Nursing Assistant, V58, Restorative Aide, V18, Registered Nurse/Wounds, V28, Infection Control, V25, Maintenance Supervisor, V50, V20, Human Resource Director, and V69, Marketing Coordinator. The team completed the following from 1/26 through1/31/24 to validate the facility's abatement plan: V2, V3, V36, V57, V58, V64, V65, V66, V67 were interviewed about the in-services they received related to abuse and the Misappropriation of residents' property and that only certain designated management personnel will be allowed to obtain items for residents from vending machines. Among residents R23, R45, R8's, R71, and R54's were interviewed and were aware of the change in obtaining items from the vending machines if they are unable to on their own. The facilities in-services and policies were reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on observation, interview, and record review, the facility failed to ensure safe beverage serving temperatures to prevent thermal burns and adequate supervision to prevent falls for 3 of 9 residents (R60, R62, and R68) reviewed for accidents/hazards in the sample of 42. These failures resulted in R62 and R68 sustaining second degree abdominal burns and R60 falling and sustaining nasal fracture. Findings include: 1.R62's Face Sheet documents R62 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, essential primary hypertension, chronic obstructive pulmonary disease, type 2 diabetes mellitus with hyperglycemia, anxiety, encephalopathy, stage 3 chronic kidney disease, and obesity. R62's Minimum Data Set (MDS) dated [DATE] documented R62 was severely cognitively impaired and required substantial assistance rolling in bed and transferring. R62's 11/2/23 Care Plan documents R62 obtained a burn to her abdomen after spilling hot tea on her abdomen. The Facility's Incident Initial Report sent to IDPH (Illinois Department of Public Health) on 11/2/23 documents, On 11/2/2023 at 9a (9:00 AM) it was reported to (V1, Administrator) from Nurse that (V19, Certified Nurse's Aide/CNA/ Coordinator) went to give (R62) hot tea in the dining room. (R62) asked (V19) for a hug, as (V19) went to hug (R62) she accidentally tapped cup with her elbow as she was hugging resident which made the cup of hot tea spill on the resident's abdomen. Nurse immediately took (R62) to her room and assessed (R62) and noted a blister on (R62)'s abdomen. (R62) was not upset and told (V19) she knew it was an accident and was okay. Nurse contacted MD/POA (Medical Doctor/Power of Attorney). Investigation initiated. R62's Progress Note by V17, Registered Nurse (RN), on 11/2/23 at 9:22 AM documents, resident was sitting in dinning [sic] room when staff member and resident hugged knocking over hot tea onto resident abd (abdomen) and staff arm. Resident taken to room assessed and given first aide to abd are [sic]. skin noted to be red with slight blistering. md (Medical Doctor) and poa (Power of Attorney) notified. n.o. (New Order) for ssd (Silver Sulfadiazine) cream and to keep area covered. On 1/23/24 at 1:00 PM, V17, Registered Nurse/RN, stated she did not witness R62's accident in the dining room. She stated, I guess (R62) had a Styrofoam cup of hot tea, and she went to hug (V19), and their hands kind of got tangled up, and it ended up getting spilled on her. (V19) came and got me. It was red. It was a decent sized area to the lower abdomen. It hurt her. The tea was steaming out of the cup. I very rarely work on that hall, but I notified the daughter and the doctor. V17 stated It got pretty nasty after the first few days and (R62) was seen by (Wound Consultant Company) for quite a while. I can't say if the coffee was always that hot. The Facility had gone back and forth over the coffee; it was too hot for a while, then it was too cold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	V19, Certified Nursing Assistant (CNA)'s Hand-Written Statement dated 11/2/23 documents, At breakfast (R62) ask me to get her some hot tea. I went to get (R62) some hot tea took it back to her and sat it in front of her and she reach out to give me a hug forgetting the hot tea for her, and I went to hug he (her) back and my right arm hit the cup of hot tea and it spilled on my arm and also (R62) stomach and I reported to the nurse. On 1/23/24 at 11:12 AM, V19 stated, (R62) asked for a cup of hot tea, so I went and got it for her and set it down on the table. She reached her arms out to hug me and it got her stomach and my right elbow. I got (V17) and we pulled (R62) out (of the dining room) to the shower room. Her stomach was red but didn't blister. I think (V17) got Silvadene for her stomach and also for my arm. I felt so bad, I cried. On 1/23/24 at 11:15 AM, R62 stated, It was an accident. One of the girls dumped hot tea on me and it was steaming hot. It was nasty for a while. It is all healed up now. She felt terrible, she did not mean to do it. The Facility's Incident Final Report submitted to IDPH on 11/2/23 documents, On 11/1/2023 at 9a (9:00 AM) it was reported to (V1) from (V17) that (V19) went to give (R62) hot tea in the dining room. (R62) asked (V19) for a hug, as (V19) went to hug (R62) she accidentally tapped cup with her elbow as she was hugging (R62) which made the cup of hot tea spill on (R62)'s abdomen. (V17) immediately took (R62) to her room and assessed (R62) with interventions in place. (R62) remains at baseline. (V17) contacted MD/POA. Upon investigation, (V17) had applied silver sulfadiazine cream to (R62)'s abdomen. In conclusion, the quality assurance team met, new interventions were discussed: silver sulfadiazine to be applied 2x day to abdomen covered with dry dressing. Kitchen informed to offer lids for hot drinks. R62's Physician Order Report documents 11/3/23 order, Cleanse burn to abdomen with NS (Normal Saline) or wound cleanser, apply SSD (Silver Sulfadiazine) cream and calcium alginate, cover with silicone bordered foam dressing. Change twice daily and PRN (as needed) if soiled. R62's (Wound Consultation Company) documentation dated 11/8/23 documents, Nursing requests that I examine her abdomen, which was noted on 11/2 to have a burn on her abdomen from a spill of hot tea, currently treating with silvadene. The burn to R62's abdomen measured 14 cm (centimeters) x 17cm x 0.3cm and required mechanical debridement. On 1/23/24 at 8:40 AM, V7, Dietary Aide, stated they were previously writing down the temperatures of hot beverages, but she was off work for a couple days and they might have stopped. She stated, It's supposed to be no more than 140 Fahrenheit (F). I didn't calculate it today. On 1/23/24 at 8:43 AM, V5, Dietary Manager, stated, I thought it was supposed to be 145-150 F. V5 stated You want it a little hotter going in to the hall trays, because if you put them on at 140-145 F here (the cart) it'll be down to 120 F when it gets to them, and they are going to complain that it's too cold. 145 F is the goal. On 1/23/24 at 9:52 AM, V7, Dietary Aide, said the department stopped tracking temperatures almost two months ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/24 at 9:56 AM, V1, Administrator, stated the Facility added hot beverage temperatures to QAPI (Quality Assurance Performance Improvement). On 1/23/24 at 10:02 AM, V5, Dietary Manager, provided QAPI notes from 11/8/23 and stated, Apparently they were only supposed to take the temperatures for four weeks. She was unsure if there is a policy on hot beverage temperatures but will check on it. On 1/23/24 at 1:43 PM, V2, Director of Nursing (DON), stated, (R62) had a decent size wound and was treated by (Wound Consultant Company). She was on prophylactic antibiotics. When it first happened, it was not open and had just started to blister at the time. I didn't realize it would be hot enough to cause burns like that. It should be under 140 F. I was not told dietary was no longer checking the temperatures. I thought that was a process they put in place here. On 1/25/24 at 2:39 PM, V1, Administrator, stated she was unaware that staff was no longer taking hot beverage temperatures and would expect staff to be aware of safe serving temperatures and provide beverages to residents at safe temperatures. She stated, The Facility Policy for serving temperatures states staff will follow the guidelines, so I provided the list of our guidelines. For hot beverages, they have to temp at 140 F or below. The Facility's undated Serving Temperatures for Hot and Cold Foods documents, Staff will follow the guidelines below when serving hot and cold beverages and food. It documents hot beverage temperatures are per Facility Guidelines. The Hand-Written document signed by V1, Administrator, on 1/25/24 documents, For hot beverages, they have to temp at 140 F or below. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities documents a water temperature 155 F can cause a third-degree burn in one second. It documents burns can occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure. 34964 2. R68's Event Report dated 11/7/23 at 8:15 PM documents, Resident states that hot tea was spilled on her abdomen at breakfast. States it may have happened a day or so ago. She states she can't remember how it got spilled. States she might have bumped her cup. Burn is on right mid quadrant of abdomen, approximately 1.5-inch x (by) 1 inch with popped blister mid region. The Event documents, Partial thickness burn (Second Degree) extend through the epidermis and into the dermis. These burns are typically very painful, red, blistered, moist, soft and blanch when touched. Examples include burns from hot surfaces, hot liquids or flame. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/24 at 9:33 AM R68 stated the burn on her abdomen is healed now. She stated it happened when the CNA was putting her tray down on the table at breakfast. She stated she could not remember if the CNA had handed her the cup of tea or if it was on the table, but it spilled on her. R68 stated the tea was very hot but it didn't hurt too bad and V15, CNA told her to have the nurse look at it. R68 stated after breakfast she went to the nurse's station and showed the burn to V17, Registered Nurse (RN) who was her nurse that day. R68 stated V17 told her, Yeah, that's a burn but didn't do anything at that time. R68 stated nobody did anything about her burn until V16, RN, came to work that night and looked at it and put a dressing on it and then the wound nurse started seeing her. R68 stated the wound nurse told her she had a third degree burn on her abdomen. R68 stated it seems like the tea is always too hot and she has to wait for it to cool down before she can drink it. She stated she doesn't want to act like she knows more than she does, but she has worked as a dietary aide in the past and she knows they have to check the temperatures of the food and drinks. R68 stated after she was burned the staff did start taking temperatures of the drinks for a while, but she doesn't know if they still do them. She stated the temperatures were cooler for a while, but they are hotter again lately. R68 stated when the incident happened, V15 asked her right away if she was alright, but it didn't hurt too bad, so she kept her same shirt on. R68 stated V17 was standing right there and didn't do anything. R68 stated V17 didn't look at it until she wheeled herself to the nurse's station after she was done with breakfast. On 1/25/24 at 9:00 AM R68 was lying in bed and pulled her blanket back and lifted her shirt to show writer a light pink quarter-sized faint scar that she stated was from her burn that happened when the hot tea spilled on her. R68's MDS dated [DATE] documents she is alert and oriented. R68's Physician Order dated 11/8/23 documents she may be seen by the specialized wound consultant. R68's Wound Consultant progress note dated 11/8/23 documents this was the initial consult for R68 who suffered a burn of her abdomen on 11/5/23. The note documented wound consultant ordered a treatment of: cleanse with normal saline or wound cleanser, apply Santyl and calcium alginate and cover with dry dressing; change daily and as needed. R68's Care Plan dated 11/5/23 documents, I obtained a burn to my abdomen related to spilled hot tea. Interventions for this care plan document, Assess my burn and document weekly on my condition including the size, color, drainage, odor until healed; Avoid giving me warm liquids in cups without a lid. Cool my liquids before providing them to me. May substitute chocolate milk for hot chocolate; Observe my burn for signs and symptoms (s/s) of healing or lack of healing and send report to providers COC (change of condition) if observed; Observed for s/s of pain related to my wound and treat my pain as indicated; Wound nurse to monitor, consult with NP, MD, and hospice (R68 not on hospice). Treat as ordered until healed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/24 at 10:00 AM V15, CNA stated on the day R68 was burned with hot tea she was giving R68 her breakfast tray in the dining room. V15 stated she had set the cup of hot tea down on the table and the nurse, V17, spoke to her and she turned around to face the nurse, and when she turned back around, she thinks she may have bumped the table, or R68 bumped the table and the hot tea spilled onto R68's abdomen and thigh. V15 stated she grabbed the bib off the table and blotted the hot tea off R68's shirt and pants right away. She stated the hot tea was in a coffee cup. V15 stated the nurse was standing right there and said she would look at R68's skin after she was finished with breakfast. V15 stated she looked at R68's skin when it happened and her abdomen was very red where the hot tea had spilled on her, and her thigh was red, but not as bad. V15 stated she did not know if the nurse looked at it or not and she (V15) looked at it again before the end of her shift and it was still very red, but she was not sure if there was a blister or not on the area. V15 stated after the incident they (facility) had a meeting about it, and they started checking the temperatures of the hot drinks before they put them out for the CNAs to use. V15 stated they started using different containers to pour from but then residents were complaining the coffee and tea was not hot enough. She stated the kitchen checks the temperatures before they put the water for tea and the coffee out, but she has not seen them actually do it, but the dietary aides had told her they have to check the temperatures now before they put them out. V15 stated she has not known any other residents who have been burned by hot liquids, more often they complain the coffee and tea is not hot enough. On 1/23/24 at 1:03 PM V17, RN stated she was told about R68's burn on a day she was not working. V17 stated she did not know about R68's burn and was not told about it when it happened. V17 stated she wrote a statement that she was not aware of R68's burn and turned it into the Director of Nursing. V17 stated it was a few days later that she heard about the burn on a chat group that was between the nurses, including the DON and Assistant Director of Nursing (ADON). She stated she had never seen R68's burn, but then stated she may have done the treatment a couple of times. She stated the last time she saw it, there was no longer a treatment in place. On 1/23/24 at 1:40 PM V2, Director of Nursing (DON), stated she does not know exactly when R68's burn occurred but she thinks it happened on 11/5/23 but nothing was reported to her until 11/7/23 when the night shift nurse called her. V2 stated the Medical Doctor (MD) was also notified of R68's burn at that time. V2 stated R68's burn was small on her abdomen. She stated she was not even aware that the temperatures of the tea were hot enough to cause that type of burn. On 1/23/24 at 1:50 PM during phone interview, V16, RN stated she works night shift and documented finding R68's burn on 11/7/23. V16 stated she was giving R68 her nighttime insulin and when she pulled her shirt up to give her the injection, she saw the burn on R68's right abdomen. V16 stated R68's answers were vague and iffy about when it occurred. V16 stated she notified the physician of the burn right away but was not sure if he gave her the order that night or the next day for the treatment. V16 stated the burn was open and scabbed over. She stated it was just a little smaller than a half dollar. V16 stated the wound did not look infected but looked like a blister that had popped and was drying up. V16 stated besides the MD, she also reported the burn to the DON and ADON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	01/24/24 10:50 AM V24, Wound Nurse Practitioner returned call and stated she had assessed and treated both R68's and R62's burns and would have considered them both to be second degree burns because they were both blistered and then opened. She stated they both healed without problem. V24 stated she does not know off the top of her head what temperature of hot liquid would cause these second-degree burns, but she knows the facility reconciled the problem with the hot water temperatures because she was concerned other residents could be hurt. V24 stated she discussed concerns with V2, DON and V3, ADON while they were making rounds. On 1/25/24 at 9:06 AM V41, Medical Doctor stated he is familiar with R68 and remembers when she had the burn from the hot tea. He stated sometimes when a person has a burn, they don't have pain right away, but he would expect to be notified right away of the incident. V41 stated the area should be assessed to monitor for changes in the burn. 42834 3. R60's Face Sheet, undated, documented R60 was admitted on [DATE] with diagnosis of Congestive Heart Failure, Type 2 Diabetes Mellitus, Idiopathic Progressive Neuropathy, Chronic Kidney Disease, Malignant of Prostrate. R60's MDS, dated [DATE] documents R60 uses manual wheelchair. R60's MDS documents R60 requires substantial/maximum assist with toilet transfers and partial/moderate assist with toilet hygiene. R60's Care Plan with problem start date of 11/12/23, documents R60 is at risk for falls due to diagnosis of idiopathic progressive neuropathy. The Care Plan Interventions include provide individualized toileting interventions based on needs/patterns, order comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase the fall risk, implement exercise program that targets strength, gait, and balance. All Intervention start dates are 11/12/23. R60's Care Plan updated 12/15/2023 documents I have experienced an actual fall on 2/21/2022, 6/26/23, 12/13/23. The Care Plan Interventions include provide me with follow up care as indicated related to my injury until healed, nonskid socks applied to feet, complete post fall assessments and monitoring per facility protocol, notify my provider if any change in condition is observed, Dycem applied to wheelchair, physical/Occupational therapy referral, interdisciplinary team to review fall and provide interventions. R60's Fall Risk assessment dated [DATE] documents R60 has visual impairment, has balance and gait problem while walking, has impaired mobility, and is at risk for falls. The facility's incident report form dated 12/13/2023 at 12:30PM, Nurse advised Administrator that resident was found to be on floor in resident bathroom face first. Nurse immediately assessed Resident. Resident was noted with laceration to nose. Resident stated he was trying to move up on toilet and lost his balance. Nurse immediately called 911 and sent to (local hospital ER) for evaluation. MD (medical doctor)/POA (Power of Attorney notified). Investigation initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0689 Level of Harm - Actual harm Residents Affected - Few	R60's Progress Note, dated 12/13/2023 at 12:46PM documents Writer heard crash in resident's bathroom. Resident noted to be on floor, face first. Resident able to answer questions and respond appropriately. Laceration noted to nose. Blood coming from nose. Bump noted to forehead. Numerous skin tears noted to BUE (bilateral upper extremities). Resident laying on left arm. Pain noted to left arm. 911 called. R60 transported to (local hospital) ER (emergency room). R60's Progress Note, dated 12/13/2023 at 6:30PM documents R60 returned at this time from local hospital. The Note documented R60 returned via ambulance stretcher with x2 emergency medical technicians, EMTs, present. The Note documented R60 had a hematoma noted to forehead, lacerations noted to bridge of nose, and left arm. The Note documented Computerized Tomography (CT) scans note frontal scalp hematoma, fractures to nasal bones, nasal septum, and frontal and ethmoid sinuses. Resident was started on amoxicillin-potclavulanate 875-125mg Q (every) 12 hours for 10 days. Discharge report from hospital ER nurse states resident does have sutures to nasal lacerations which will need to be removed in 7-10 days. R60's CT scan report dated 12/13/2023 at 2:11PM documents Findings: Maxillofacial CT: There is a frontal scalp hematoma. There is a laceration of the nose. There are fractures of the nasal bones, nasal septum, and frontal and ethmoid sinuses including the medial walls of the orbits and the anteroinferior aspect of anterior cranial fossa. There is a small focus of pneumocephalus There is mucosal thickening in the paranasal sinuses. The mastoid air cells are normal. There is extensive dental disease. On 1/24/2024 at 10:45AM V29, Certified Nursing Assistant, CNA, stated I put (R60) on the toilet. I did leave the bathroom. He was able to adjust himself and had the call light. I heard the nurse yell and (R60) was on the floor. He had landed on his face and there was a lot of blood. I'm not sure what he was trying to do. On 1/24/2024 at 11:20AM V30, Licensed Practical Nurse, LPN, stated The day (R60) fell I was out passing meds in the hallway, and I heard him yell out. He was left in the bathroom by himself and fell face first into the sink. (R60) was known to readjust himself when sitting. We called 911 and he went to the hospital. On 1/24/2024 at 3:10PM V3, Assistant Director of Nursing, ADON, stated I would expect a resident with a history of falls to be supervised while in bathroom and not left unattended. On 1/25/2024 at 9:09AM V41, Medical Director, stated If (R60) has history of falls and is at risk for falls I would expect (R60) to need supervision. Fall policy with a revision date of 2018 states University Care Center will provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs. All resident falls that occur within the facility will be tracked, analyzed, and trended. This information will be used to assist facility management and direct care staff in maintaining a safe environment. It is the responsibility of the facility to assure that all residents are assessed to determine fall risk and history or falls. Individualized preventative approaches should be provided to assist with fall prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on interview and record review, the facility failed to adequately assess and ensure a resident receiving continuous Gastrostomy tube (G-tube) feeding did not experience significant weight loss for 1 of 2 residents (R13) reviewed for nutrition in the sample of 42. This failure resulted in R13 having an insidious significant weight loss of 12 pounds in three months while receiving nutrition via G-tube. Findings include: R13's Face Sheet, undated, lists her diagnoses to include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Aphasia following unspecified cerebrovascular disease, Dysphasia following cerebral infarction, and Gastrostomy status. R13's Minimum Data Set (MDS) dated [DATE] documents her weight as 198 even though her weight documented under vital signs in her electronic medical record (EMR) documents her weight as 189# on 11/4/23, which was the last weight documented before the MDS was done. According to the MDS, R13 has a feeding tube, and incorrectly documents R13 had no significant weight loss/ gain. R13's Care Plan documents the problem dated 10/12/20: I am at risk for alteration in nutrition r/t (related to) other specified nutritional deficiencies, specified depressive episodes, pure hypercholesterolemia, gastrostomy status, unspecified dementia without behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting left, dysphagia following cerebral infarction, Type 2 diabetes mellitus with hyperglycemia, NPO (Nothing by mouth) status. The goal for this care plan with target date of 4/25/24 documents, I will maintain my weight +/- 5 pounds (lbs) through next review date. The interventions for this care plan include the following: Administer medications as ordered; allow me time to perform task of eating a meal-assist as needed, (R13 is unable to eat anything by mouth); Gastrointestinal tube feeding (Glucerna 1.2 80 ml/hr (milliliters per hour); R13's Physician Order dated 1/4/24 documents, Diet: NPO Glucerna 1.2 65 ml/hr continuous 22 hrs (hours) *hold 2 hrs per day*. Flush with 300 ml H2O every 4 hours. Special instructions: 50 ml before and after each medication administration; Observe and report to MD (medical doctor) s/s (signs and symptoms) of malnutrition: emaciation, muscle wasting, significant weight loss which is 3 pounds in a week, over 5% in one month, over 10% in 3 months, over 10% in 6 months; Observe/document/report to MD (Medical Doctor) if I have signs of dysphagia: (i.e. (for example): pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appearing concerned. (R13 is NPO); RD (registered dietician) to evaluate and make diet change recommendations prn. Weight to be completed monthly and prn. R13's Physician Order dated 1/4/24 document: Diet: NPO Glucerna 1.2 65 ml/hr continuous 22 hrs (hours) *hold 2 hrs. per day*. Flush with 300 ml H2O every 4 hours. Special instructions: 50 ml before and after each medication administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0692 Level of Harm - Actual harm Residents Affected - Few	R13's Registered Dietician (RD) progress note dated 10/31/2023 at 9:11 AM documents Readmit/TF status. readmitted to facility 10/27 from hospital dx (diagnoses) COVID/UTI (Urinary Tract Infection). Weight (10/12)-189 lbs, BMI-30.5. Noted weight has had trend down -2 lbs x 1 month, -4 lbs x 3 months, -7 lbs x 6 months. NPO with Glucerna 1.2 55 ml/hr continuous with 300 ml water flush Q4 and 50 ml flush before/after meds. Provides: 1518 kcals, 76 g pro, and 1018 ml fluid (2818 ml total with flushes). Prostat 30 ml daily ordered. No skin concerns noted at this time. [NAME] meds: mvi (multivitamin), levemir, levetiracetam, reglan, senna, folic acid. Weekly weights in place to monitor nutritional status closely. Current tube feeding fluids/water flushes exceeding estimated fluid needs. RECOMMEND: 1. d/c (discontinue) prostat 30 ml daily as no skin concerns at this time 2. Suggest increase tube feeding to Glucerna 1.2 65 ml/hr continuous (hold 2 hours/day for ADLs) to better meet estimated energy needs. Monitor weights, tube feeding tolerance, and labs as available. R13's last Registered Dietician (RD) progress note was dated 11/16/23 at 3:07 PM and documented: RD consulted due to weight loss. Current weight 182# (pounds), showing trend down. NPO with Glucerna 1.2 55 ml/hr continuous with 300 ml water flush every 4 hours and 50 ml flush before/after meds. Provides: 1518 kcals, 76 g (grams) protein, and 1018 ml fluid (2818 ml total with flushes). Prostat 30 ml daily ordered. No skin concerns noted at this time. Weekly weights in place to monitor nutritional status closely. Recommend: 1. Suggest increase tube feeding to Glucerna 1.2 65 ml/hr continuous (hold 2 hours/day for ADLs (Activities of Daily Living) to better meet estimated energy needs. Monitor weights, tube feeding tolerance, and labs as available. RD to follow up as needed. There were no further RD progress notes documented in R13's EMR after 11/16/23 as of 1/23/24. On 1/25/24 at 10:45 AM V2, Director of Nursing (DON) provided an email document dated 1/2/24 that documents she notified the facility's RD that R13 receives tube feedings for nutrition, her weight was 183# and now it's 177#, and that weight was verified with a re-weight. In the document V2 asks the RD, Is this an intentional decrease in her weight? and requested the RD review and advise with any recommendations she has. On 1/25/24 at 10:45 AM V2 provided a document titled, Weight dated 1/4/24 from the facility's RD that documented, I had noticed that her (R13's) weight was trending down. I also noticed that her TF (tube feeding) was decreased. Here are my recommendations to prevent further weight loss: Increase tube feeding to Glucerna 1.2 65 ml/hr continuous (hold 2 hours/day for ADLs) to better meet estimated energy needs. Monitor weights, tube feeding tolerance, and labs as available. The RD recommendations dated 10/31/23 and 11/16/23 to increase R13's tube feeding to 65 ml/hr was not followed until after another RD recommendation was received on 1/4/24 to increase the tube feedings to 65 ml/hr after R13's Medical Doctor V41 was notified of R13's continued weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0692 Level of Harm - Actual harm Residents Affected - Few	On 1/25/24 at 10:45 AM V2 provided a copy of a photocopied text message to V41, Medical Doctor (MD) dated 1/2/24 that documented, (R13) receives tube feeding for nutrition. Was 183 now 177, verified with second. Another message at 1:30 PM documented, The dietician to review. She shouldn't have weight loss with tube feeding. V2 stated this was V41's response to her notification of R13's weight loss and she notified the RD of the need to review R13 for weight loss. V2 stated she could not find any other notifications that V41 had been notified of R13's weight loss prior to this date. R13's Electronic Medical Record was reviewed for weights. R13's weights were documented as: 7/23 (195#); 8/8/23 (192#); 9/12/23 (191#); 10/3/23 (197#); 11/4/23 (189#), 12/23/23 (183#), and 1/4/23 (177#). These weights represent R13 having a 4% weight loss in one month, and 10% weight loss (significant) at both 3 and 6 months. On 1/23/24 at 4:10 PM V3, Assistant Director of Nursing (ADON) provided R13's reweight taken just now as 176.4#. On 1/24/24 at 9:00 AM V2 stated they just got a new dietician, so she does not know if she is aware of R13's additional weight loss. V2 stated she does not know why R13 was not weighed in December as she is just learning the electronic system. V2 stated when tube feeding is running using a generic bag for the formula, the bag should be labeled with the date and time it was hung and the name of the formula should be included since there is no label on a bottle with this information. On 1/25/24 at 9:06 AM V41, MD, stated he was looking back in his notes/emails from the facility and does not see where the facility notified him that R13 continued to lose weight. V41 stated he would expect the facility to notify him of changes and recommendations from the Registered Dietician and would not expect a resident who is consistently receiving tube feeding to have significant weight loss. On 1/25/24 at 11:10 AM V2 stated she does have documentation of some of R13's weekly weights and provided paperwork. She also provided a copy of emails to V41 dated 1/2/24 when facility reported R13's weight loss to him. V2 also provided documentation of assessment by RD dated 1/4/24 that recommends increasing tube feeding to Glucerna 1.2 to 65 ml/hr continuous (hold 2 hours/day for ADLs) to better meet estimated energy needs. Monitor weights, tube feeding tolerance, and labs as available. Writer asked V2 if she was aware that the dietician had recommended these changes on 10/31/23 and again on 11/16/23 and it was not done. V2 stated she was not aware of those recommendations. The facility's policy, Weight Assessment and Intervention, revised September 2008, documents, The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 5. The Dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100]: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0692 Level of Harm - Actual harm Residents Affected - Few	a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. 2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: f. Increased need for calories and/or protein; h. Fluid and nutrient loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on observation, interview and record review, the facility failed to follow their policy and the resident's care plan to ensure proper placement of gastrostomy tubes (g-tubes) and ensure the correct enteral formula is provided for residents with g-tubes for 1 of 2 residents (R13) reviewed for g-tubes in the sample of 42. Findings include: On 1/21/24 at 12:21 PM R13 was lying in her bed with her tube feeding infusing at 65 ml/hr (milliliter per hour) per her g-tube. There was no label documenting what formula is being given per g-tube or when current formula was initially started for R13's tube feeding that was infusing per g-tube. The bag containing the tube feeding formula was a generic bag that formula was added to, not a labeled formula container. There was no documentation on the bag with time or date the tube feeding formula was hung, name of resident, or what formula was contained in the bag. On 1/23/24 at 3:55 PM a bag of tube feeding formula was infusing per R13's g-tube with the date and time of 1/23/24 at 4:00 AM written on bag, but it did not have resident's name or what formula was contained in the bag. The tube feeding was infusing at 65 ml (milliliter) / hour via R13's g- tube. On 1/24/24 at 8:05 AM R13's bag of tube feeding formula was infusing per her g-tube and had the date/time of 1/24/24 at 3:00 AM written on the bag but no other information was documented on the bag regarding what the formula is infusing per the g-tube or the resident's name. On 1/24/24 at 3:10 PM V26, Licensed Practical Nurse (LPN) was observed administering R13's afternoon medication via her g-tube. V26 set up each of the following medications in separate medication cups: Keppra 5 mls/500 mg (milligram), Reglan 10 mg tablet, Atorvastatin 80 mg, Folic Acid 1 mg tablet, and Senna Plus 8. 6/50 mg tablet. V26 crushed each of the tablets separately and maintained them in separate medication cups. She then took all medication cups into R13's room and placed them on the bedside table and poured 15 ml of water into 5 separate medication cups. She then placed R13's tube feeding pump on hold and removed the tube feeding tubing from R13's g-tube. V26 pulled up approximately 25 ml of water into syringe, placed her stethoscope on R13's abdomen and pushed the H2O through R13's g-tube while listening. V26 stated, I hear gurgling, so the g-tube is in the right place. V26 then removed the syringe without pulling back on the plunger to check for residual as ordered. V26 then placed syringe without the plunger into R13's g-tube and poured one of the medication cups containing 15 mls of H2O into the tube, followed by R13's crushed Keppra that was still dry. V26 had to add extra water to get the dry medication to flush through the tube. After that initial medication, V26 added water to each of the medications to dissolve the medication so it would flush easier. V26 flushed the g-tube with 15 mls of water after each medication, except R13's Atorvastatin which required extra water to flush it through the tube due to size of the pill. After administering all medications, V26 restarted R13's tube feeding via her g-tube. When asked why she did not check the residual, V26 stated she was not sure if there was an order for that in R13's orders or if it was part of the facility's protocol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Face Sheet, undated, lists her diagnoses to include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Aphasia following unspecified cerebrovascular disease, Dysphagia following cerebral infarction, and Gastrostomy status. R13's Minimum Data Set (MDS) dated [DATE] documents her weight as 198 even though her weight documented under vital signs in her electronic medical record (EMR) documents her weight as 189# on 11/4/23, which was the last weight documented before the MDS was done. According to the MDS, R13 has a feeding tube, and had no significant weight loss/ gain. R13's Care Plan dated 10/9/20 documents I require a tube feeding related to dysphagia following cerebral infarction, nutritional deficiencies. The goal for this care plan, with a target date of 4/25/24 documents, I will maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and symptoms of malnutrition or dehydration through review date. The interventions for this care plan include: Check for tube placement and gastric contents/residual every shift; hold feeding if residual is 200 milliliters or greater per facility protocol and record. Discuss with the family/caregivers/myself any concerns about tube feeding, advantages, disadvantages, potential complications. Elevate head of bed (HOB) with tube feedings as per facility policy-specify. I am able to manage the following with tube feeding and water flushes: 60 mph (milliliters per hour) tube feeding with 150 every 4 hours water (H2O) flush. I am dependent with tube feeding and water flushes. See Medical Doctor (MD) orders for current feeding orders. Listen to lung sounds every shift. Notify MD for signs of fluid overload. Observe, document, report to MD prn (as needed): Aspiration-fever, SOB (shortness of breath), tube dislodged, infection of tube site, self-extubation, tube dysfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, or dehydration. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide local care to g-tube site as ordered and observe for s/s of infection. Quarterly and prn dehydration assessments. RD (Registered Dietician) to evaluate quarterly and prn. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. Record I&O (Intake and Output) as per facility policy. ST (speech therapy) evaluation and treatment. R13's Physician Orders dated 5/8/23 document: Enteral Feeding: Check tube placement by aspirating stomach contents twice a day and check tube placement prior to use by auscultation and aspiration; monitor residual. Flush with 50 ml of water before and after each med pass. The facility's policy, Enteral Feedings-Safety Precautions, revised November 2018 documents, 1. All personnel responsible for preparing, storing, and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. Preventing errors in administration: 2. On the formula label document initials, date, and time the formula was hung, and initial that the label was checked against the order. Preventing aspiration: 1. Check enteral tube placement every 4 hours and prior to feeding or administration of medication. 2. Check gastric residual volume as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45947 Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, and distributed in a manner that prevents potential foodborne illness. This has the potential to affect all 89 residents living in the Facility. Findings include: On 1/21/24 at 8:05 AM in the dry storage room there was a stack of boxes stored directly on the floor, including two boxes of potato chips with a box of saltine crackers on top. There was a box of Styrofoam cups, and a box of food storage covers on the highest shelves that came within 12 inches of the ceiling. The three-door freezer had a cardboard box of frozen uncooked beef that had been placed directly on top of a cardboard box of broccoli florets. The box of beef had a label stating, Uncooked - Must Be Cooked to 160 F (Fahrenheit). On 1/21/24 at 8:12 AM the walk-in refrigerator contained four plastic containers labeled jello that were dated 1/10 with a use by date of 1/17. There was a plastic bag with an item that resembled raw bacon with no label or date. On 1/21/24 at 8:14 AM on top of the microwave there was a one-quart storage tub containing a white powdery substance that was not labeled or dated. On 1/21/24 at 8:17 AM the beverage refrigerator next to the steam table contained an opened 46-ounce carton of mildly thick water and an opened 46-ounce jug of honey thick water that were not dated upon opening. On 1/19/24 at 8:20 AM, V7, Dietary Aide, was rinsing off dishes and stated she would be running the dishwasher soon. Regarding testing of the dishwasher temperatures and sanitizing solution, she pointed at V6 and stated, She could tell you better than me. V6, Cook, stated the dishwashers V8 and V9 are responsible for testing the dish machine. V8, Dietary Aide, stated, I don't know, I just started. On 1/21/24 at 8:54 AM, V7, Dietary Aide, stated the plastic bag in the refrigerator was bacon, and the white powder on the microwave was thickener. V6, Cook, stated, We will get rid of the (gelatin). V5, Dietary Manager, stated, I just started last week, but I'm going to get it organized. On 1/21/24 at 9:24 AM, food temperatures were obtained from the steam table using a metal calibrated thermometer after the last resident tray was served. The oatmeal measured 135 Fahrenheit (F), the pureed eggs measured 91 F, the pureed sausage measured 82 F, the gravy measured 87 F, and the mechanically ground sausage measured 81 F. V6, Cook, stated the steam table may not be working. On 1/23/24 at 4:00 PM, V25, Maintenance, stated the steam table is functioning properly, but V6 did not have it turned on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/23/24 at 11:56 AM, V1, Administrator, stated she expects dietary staff to follow food service policies for storage and serving temperatures. The Facility's Food Preparation and Service Policy revised 4/2019 documents, Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Appropriate measures are used to prevent cross contamination. These include: Storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigerator. The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. Mechanically altered hot foods prepared for a modified consistency diet remain above 135 F during preparation or they are reheated to 165 F for at least 15 seconds. The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff. The Facility's Food Receiving and Storage Policy revised 7/2014 documents, Foods shall be received and stored in a manner that complies with safe food handling practices. Foods in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). All foods stored in the refrigerator will be covered, labeled, and dated (use by date). Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods. Beverages must be dated when opened and discarded after twenty-four (24) hours. Other opened containers must be dated and sealed or covered during storage. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 1/21/24 documents there are 89 residents living in the Facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42834 Based on observation, interview and record review the facility failed to ensure an Infection Preventionist has the professional training and qualifications to perform in this role. This has the potential to affect all 89 residents living in the Facility. Findings include: On 1/21/2024 at 9:15AM V1, Administrator, stated V28, Certified Nursing Assistant, CNA, is the Infection Control Preventionist. On 1/30/2024 at 9:45AM V28 stated I really don't remember the training. If I have questions, I go to V18, Registered Nurse, and (V56, Regional Nurse). I do not have an associate degree. I am a Certified Nursing Assistant. I do handwashing and peri care training. I do not do infection control. (V3, Assistant Director of Nursing, ADON), does training on infection control. On 1/30/2024 at 10:25AM V18, Registered Nurse, stated I did the Infection Control training years ago. I have retired since then. I know I do not have a certificate. If (V28) is not here, infection control would refer to me. I usually work three days per week. On 1/30/2024 at 9:45AM V28 provided a certificate dated 3/2/2023 stating Nursing Home Preventionist Training Course. On 1/30/2024 at 10:30AM V3, Assistant Director of Nursing, ADON, stated she has not completed Infection Control Training. On 1/30/2024 at 11:00AM V56, Regional Nurse, stated I am here 3-4 days a week. I review tracking and trending, surveillance, and Antibiotic Stewardship. If I am not here V18 steps in. On 1/30/2024 at 11:00AM V56, provided a training certificate dated 3/2/2023. On 1/21/2024, 1/23/2024, 1/24/2024, 1/25/2024, 1/26/2024, V56 was not observed in the facility. Facility in services dated 3/7/2023 documents V28 conducted in services on Cross Contamination, and Personal Protective Equipment. Facility Infection Surveillance Policy, with a revision date of 2018 states The infection preventionist will be a licensed nurse delegated by the Director of Nursing Services and approved through the facility administrator. The Policy documents The infection preventionist will conduct ongoing surveillance for infections that have substantial impact on potential resident outcomes. Surveillance will include information on the need for transmission-based precautions, ordered treatments, preventative measures in place and newly ordered. Distinction will be made between acquired and admitted with infections as well as regarding of the infection is determined as an actual infection based on guidelines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Long-Term Care Facility Application for Medicare and Medicaid, CMS 671, dated 1/21/24 documents there are 89 residents living in the Facility.