

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Breese		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 North First Street Breese, IL 62230	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the privacy policy for 1 (R5) of 3 residents reviewed for privacy in the sample of 3. Findings include: R5's Undated Face Sheet documents he was initially admitted to the facility on [DATE]. R5's Quarterly Minimum Data Set (MDS) dated [DATE] documents he is alert. On 9-17-2025 10:35 AM V10, Former LPN stated she received a text message on her personal cell phone on 9/6/2025 which included V1 Administrator, V3 ADON and V24 RNC and it had R5's first and last name and documented detailed health information regarding R5 which she felt was not appropriate to communicate via cell phone text message because it is not secure or encrypted and it's a HIPAA/privacy violation. V10 stated the text message was initiated by V3. V10 stated she responded to the text message immediately, Please delete my name and do not message me again. Probably shouldn't put HIPAA information with an employee you banned from your facility. An undated text message sent at 12:21 PM documents V3, ADON initiated the text message which included V1, V3, V10 and V24. The text message read resident name (R5) he pulled his midline out this morning. He did this twice with PICC when we tried to treat previously. A urine was collected because he was increasingly confused and urine was very mucousy and odorous. He has a midline that we were treating him for EBSL in his urine but pulled it out this morning. He has about 10 more doses to go before completion of therapy. We have tried wrapping it in coban and putting long sleeves on him but he is confused and doesn't remember one day from the next. I know we ow have to get approval for reinsertion. I feel like if we don't treat him then he is going to go septic and end up in the hospital or worse. What do you suggest? Thank you. Three undated screenshots of the text messages were submitted and reviewed for evidence which showed the above information. R5's Nursing Notes dated September 2025, no documentation of staff sending a text message with his medical information in it. On 9/12/2025 at 10:15 AM V1, Administrator stated they don't text message resident names or medical information because that would be a privacy/HIPPA issue. On 9/17/2025 at 10:50 AM V24, Regional Nurse Consultant stated she received a text message recently (date unknown) that had a resident's first and last name and medical information in it. V24 stated the text message was from V3, ADON and she knew immediately it was an issue because text messages are not secure for resident medical information, and it was a HIPAA/privacy issue. On 9/17/2025 at 11:00 AM V1, Administrator stated V3 the ADON sent her a text message on her cell on 9/6/2025, the text message included a resident's first and last name and detailed medical information. V1 stated she inserviced all staff, including V3 regarding not text messaging resident's names or medical information because text messages or not encrypted or secure and it is a HIPAA/privacy issue. V1 stated she expected all staff to follow the facility policies and procedures, including the facility's privacy policy. On 9/17/2025 at 11:05 AM V3, ADON confirmed the phone number was hers that initiated the text message and stated she recalled the resident's name was R5 and she meant to text message the R5's name and medical information to V1, and V25, [NAME] President of Operations and V24, RNC but she accidentally put the wrong person in the group which included V10, Former LPN, after V10 replied with no to message her anymore she realized she text messaged the wrong person and stopped any further text messages regarding R5 and his medical care. V3 stated sending the text message to V10 was an accident and she knew better than to text message a resident's name and medical information but it was a weekend and she needed guidance on how to proceed with caring for R5. V3 stated V1 inserviced her on 9/8/2025 regarding not text messaging resident's names and medical information because it's not secure or encrypted and stated she won't text message resident information again. The Facility's HIPPA Policy and Procedure, dated 6/1/2025, documents this policy applies to all employees with access to personal health information (PHI.) This includes all administrative, clinical and support staff. Definition: PHI: any information recorded in any form, that relates to health, provision of health care that can be linked to an individual. Staff members will receive training on HIPAA policies and procedures, with additional training provided as rules and regulations evolve. This training includes but is not limited to privacy practices, security measures and breach notification procedures. Violations of this policy may result in disciplinary action.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prescribe physician ordered medications upon admission for 2 (R1 and R3) of 3 residents reviewed for pharmacy services in a sample of 3. Findings include: 1. R1's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnosis including anxiety disorder, major depressive disorder, bipolar disorder and panic disorder. R1 was covered by Med A benefits. R1's Hospital Discharge Paperwork, dated 8/7/2025, documents continue these medications which included Austedo XR 24 milligrams (mg) take 48 mg by mouth daily for treatment of depression and Vraylar 3 mg 1 capsule by mouth daily for treatment of depression. R1's Physician's Summary Report, dated 8/7/2025 documented do not send on Austedo XR 24 milligrams (mg) 2 tablets by mouth a day for treatment of depression and Vraylar 3 mg give 1 capsule by mouth once a day for treatment of depression. R1's Medication Administration Record (MAR), dated 8/2025, documents no Austedo 48 mg daily for treatment of depression or Vraylar 3 mg daily for treatment of depression was documented administered. 2. R3's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] and diagnosis including diabetes mellitus due to underlying condition with diabetic polyneuropathy. R1 was covered by Med A benefits. R3's Hospital After Visit Summary, dated 7/18/2025 documents Ozempic 1 mg into the skin once a week for treatment of diabetes was marked out and a handwritten note documented, Not while at facility. R3's MAR dated 8/2025, no documentation staff administered the physician prescribed medication Ozempic 1 mg into the skin once a week for treatment of diabetes. On 9/12/2025 at 2:00 PM V9, Pharmacist stated he receives resident's medication list upon admission to the facility, and he fills the prescriptions he can. When a medication is over the facility \$200 threshold per medication he completes a high cost form which shows the current medication and the cost of it and then he documents an alternative lower cost medication and the cost of it then he emails the form to administration at the facility and they forward it to the resident's provider to see what they want to do which is either order the high price medication or chose to prescribe the low cost medication. When he receives a resident's medication list and staff document do not send or not while at facility he doesn't fill or send those medications and doesn't complete a high cost form because staff are communicating not to send the medication and if in the future the facility requests those medications marked that and if they are high cost medications, he would then send the facility the high cost form with an alternative low cost so the resident's provider can approve either medication. V9 stated R3's hospital discharge medication list dated 8/17/2025 was sent to him to fill the medications and the medication Ozempic 1 mg to treat diabetes was documented not while at facility. V9 stated R3 was prescribed no other medication to treat diabetes while she resided at the facility. V9 stated R1's POS dated 8/7/2025 was sent to the pharmacy with handwritten documentation do not send on the medications Austdro 24 mg take 48 mg by mouth daily for depression and Vraylar 3 mg by mouth daily for depression. V9 stated he didn't know what staff documented not to send the medications, but he didn't question it. On 9/12/2025 at 2:25 PM V11, Pharmacy [NAME] Director stated the facility has a \$200 threshold for each medication the facility fills, if the medications cost more than that threshold the pharmacy staff are instructed to complete a high cost medication form and documents a lower cost alternative medication on the form and email it to the facility then the provider decides what medication they want to prescribe and the facility sends it back to the pharmacy and the medication is filled. V11 stated R3's Ozempic 1 mg medication to treat diabetes was an injectable and they are always expensive, V11 stated Ozempic is a high-cost medication and cost around \$1500.00 a month. V11 stated R1's medication Austrdro 48 mg daily for depression is very expensive and costs \$6,000.00 for a 14-day supply and Vraylar 3 mg for depression is also expensive as it cost \$700.00 for a 14-day supply. V11 stated these medications for R1 and R3 were not filled from the pharmacy because staff handwrote a note on the medication list that stated, do not send or not while at facility. V11 stated she was the billing director, and she didn't know who documented not to send the medication on the resident's medication lists that were sent to the pharmacy. On 9/16/2025 at 10:00 AM V23, Nurse Practitioner stated she wasn't aware the facility wrote on R1's and R3's admission medication list that was sent to pharmacy with a handwritten note not to fill medications. V23 stated the facility staff don't have the authority to not fill physician prescribed medications and it most definitely should not be occurring. V23 stated R1 has multiple mental health diagnoses including major depressive disorder and abruptly stopping any of those medications including Austedo and Vraylar to treat her major depressive disorder could cause her to downward spiral into</p>		