STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145438	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Collinsville	614 North Summit Collinsville, IL 62234

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44953 Based on interview, observation and record review the facility failed to ensure timely assesment for continuity of care for 1 of 3 residents (R1) reviewed for continuity of care in the sample of 3. This failure resulted in R1 with known epilepsy with seiziures, not receiving anti seizure medications for 4 days and being sent out for emergency treatment and had a seizure. Findings include: R1's Facesheet undated documents an admitted [DATE] and pertinent medical diagnoses of Epilepsy, unspecified., not intractable without status Epilepticus, Localization-related (Focal) (Partial) Symptomatic Epilepsy and Epileptic Syndromes with Complex Partial Seizures, Not Intractable Without Status Epilepticus, Major Depressive Disorder, Single Episode, Unspecified and Unspecified. Unspecified Atrial Fibrillation. R1's Physician Order Summary (POS) dated March 2025 documents R1's pertinent medications as Lacosamide 100 milligrams (mg) twice a day (Epilepsy), Fluoxetine 10 milligrams (mg) daily (Major Depressive Disorder), Metoprolol 1 tablet every 12 hours (Primary Hypertension) Amlodipine 10 milligrams (mg) (Unspecified Atrial Fibrillation), Levetiracetam 1000 milligrams (mg) twice a day all with a Start Date of 1/22/25 and Hold date from 3/14/25 to 3/17/25, Tradjenta 5 milligrams (mg) (Type 2 Diabetes Mellitus) 1 tablet daily Start Date of 2/5/25 and Hold date from 3/14/25 to 3/17/25. R1's Electronic Medication Administration Record (eMAR) dated March 2025 documents R1's 8:00 PM medications were held on 3/14/25, 3/15/25 and 3/16/25 for both 8:00 AM & 8:00 PM doses. The 8:00 AM dose on 3/17/25 was held. On 3/12/25 at 9:51 PM Nurse's Progress notes documents R1 was requesting her new pill. V17 Licensed Practical Nurse documents that R1 was overheard talking to her daughter (V5) about the new pill that she takes 3 times /day and then question as to if the daughter will bring it to her. V17 Licensed Practical Nurse documents that without an order for medication the medication could not be administered. (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/14/25 at 1:51 PM Nurse's Progress notes documents (V4) Social Service Director addressed the daughter in regards to her giving resident medication while she is on a Leave of Absence (LOA) with her. (V5) daughter was stated that she hasn't given resident any medications , but she did display a bottle of Antibiotics that was suppose to be given from a local pharmacy. The directions for administration were 1 tablet twice a day and there was a total of 10 pills given, but she (R1) only had 4 pills left. (V5) repeatedly stated that she had not given resident (R1) any medications. On 3/14/2025 an email from V7 Nurse Practitioner to V2, Diretor of Nursing, documented an order to hold the medication of R1 due to a report from facility nursing staff that it was a possibility that R1 was being double or tripled dose by V5, her daughter. On 3/20/25 at 9:37 AM V16 Licensed Practical Nurse (LPN) stated she was the one that was passing medications to R1 when she requested her new pill. As she (V16) was explaining to her that she did not have a new pill. R1 kept repeating that she had a new pill. R1 called her daughter (V5) and the conversation between the two of them was (R1) telling (V5) her daughter that she was not being given the new pill. (V5) R1's daughter came to the facility with a bottle of medicine and wanted it to be given to her mother. (V5) was advised that we could not give the medicine and we would need to obtain an order for the medication. On 3/20/25 at 11:31 AM V17 Nurse Practitioner stated she was on vacation for 2 weeks and V7 Psychiatric Nurse Practitioner (NP) was covering for her. V17 stated she was aware that (R1) was being followed by specialists but do not have any interactions with the specialists. V17 stated she was unaware of the labs ordered by the nephrologist. When she returned from vacation she did have an email from V7 advising that there was a possibility that R1 was receiving double dosages of a medicine thought to be an antibiotic. The move to hold the medication was based on not having any information as to why R1 was on any medication besides what was prescribed. V17 stated the expectation was for the specialist to contact us if they have any concerns. If she had any concerns she would contact them. On 3/20/25 at 11:43 AM V7 Psychiatric Nurse Practitioner stated she was not the regular provider for (R1). The nurse practitioner (V17) was on vacation and she (V7) was just covering for (V17). V7 stated she went with the information that was provided from the staff. The staff assumed (R1) was receiving double or triple doses of some type of medication. She (V7) did not know what the medication was and the staff did not specify the medication because they did not know. What was reported was (V5) the daughter was providing the medication to her mother (R1). On 3/20/25 at 12:25 V4 Social Service Director stated when (V5) daughter of R1 returned her mother (R1) to the facility she (V5) did not bring the medication or share that her mother was on a prescribed medication. We became aware of some medication only after the mother (R1) began asking about her new pill. On 3/20/25 at 4:20 PM V2 Director of Nursing stated we did what we were supposed to do. The staff continued to give prescribed medication until able to contact a provider. The order was via email dated 3/14/25 to Hold medications and to monitor (R1). Staff continued to monitor R1 until she was sent to the emergency room [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's medical records from a local hospital dated 3/17/25 documents residents seizure medications were stopped few days ago per the order of nursing home staff after they had negative interactions with (V5) patient's daughter . While in Triage patient had a tonic seizure lasting less than 1 minute. Patient was postictal and had a nasal trumpet inserted. On 3/21/25 at 10:26 AM V22 Medical Director stated the Nurse Practitioner's should be having contact with the specialist. On 3/21/25 at 2:30 PM V26 pharmacist stated the nurse practitioner dropped the ball, the nurse practitioner should have reviewed the medication before 3 days. It is definitely concerning because Lacosamide has a half-life of 13 hrs and Keppra has a half life of 6-8 hrs. Those meds are significant, while overdosing might be a concern, review of the medication and further assessment was warranted. Do not feel the facility was at fault, the problem lies with the nurse practitioner as a provider not reviewing or assessing the resident sooner. The facility did not have a policy on Continuity of Care.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52557 Based on interview and record review, the facility failed to ensure a resident with a diagnosis of epilepsy/seizures received their anti-convulsant medications as ordered by the physician for 1 of 3 (R14) residents reviewed for medications in the sample of 3. This failure resulted in R14 missing 10 doses of his anti-convulsant medication and requiring evaluation and treatment in the emergency room (ER) following seizure activity. Findings include: R14's facesheet dated 4/29/25 documents his diagnosis to include epilepsy, unspecified, intractable, without status epilepticus and localization-related (focal) (partial) symptomatic epilepsy, epileptic syndromes with complex partial seizures, intractable, without status epilepticus, and other seizures. R14's care plan dated 4/29/25 documents The resident has a seizure disorder. Interventions for this care plan include give seizure medications as ordered by doctor. Monitor/document side effects and effectiveness. R14's medication administration record (MAR) dated 3/1/25-3/31/25 documents R14 did not receive his oxcarbazepine (anti-seizure medication) oral tablet 600 mg (milligrams) two tablets at 6:00 PM on 3/29/25 and at 8:00 AM on 3/30/25. R14's progress note dated 3/29/25 at 5:05 PM documents: orders-administration note oxcarbazepine oral table 600 mg give 2 tablets by mouth two times a day for epilepsy-awaiting med. R14's progress note dated 3/30/25 at 8:47 AM documents his oxcarbazepine was not available and reorder awaiting pharmacy. R14's [DATE]/30/35 at 8:39 AM documents R14's lacosamide oral tablet (anti-seizure medication) 100 mg give one tablet by mouth two times a day for epilepsy was not available, reordered awaiting pharmacy. R14's MAR dated 4/1/25-4/30/25 documents he did not receive his lacosamide on 4/3/25 (PM dose) 4/6/25 (PM dose) 4/7/25 (PM dose) and 4/8/25 (AM and PM dose). R14's Controlled Drug Receipt/Record/Disposition Form dated 3/22/25 documents he ran out of his lacosamide 100 mg tablets on 4/5/25 after PM dose. R14's Drug Receipt/Record/Disposition Form dated 4/9/25 documents he did not receive his next dose of lacosamide until 4/9/25 at 8:30 AM. There is no documentation on these count sheets of R14 receiving AM doses of lacosamide on 4/6/25 or 4/7/25 AM doses. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R14's progress note date 4/1/25 at 4:45 PM documents Seizure activity noted in bed. Clonic episode lasting 2.5 minutes. Emesis noted. Resident placed in recovery position until seizure completion. EMS called. Post ictal phase noted with pupils dilated to 6. Walking around room without purpose and combative with staff. Unable to answer questions or respond appropriately. VS: 98.2, 88, 22, 131/74, and 95% on room air. No signs of pain or injury. Sent to (local hospital) for evaluation and treatment. On 4/29/25 at 12:50 PM V6 Nurse Practitioner stated she was first notified by staff to refill R14's lacosamide on 4/8/25. V6 stated she was reviewing R14's information from 4/6/25 and 4/7/25 and was not notified, but she would not know if staff reached out to another provider. V6 stated yes, it would be significant for R14 to receive anti-seizure medication since R14 has had seizures since the age of 9 and R14 is a difficult case and he needs to take his anti-seizure medications as ordered. On 4/29/25 at 1:50 PM V7 Pharmacy [NAME] Lead stated pharmacy was notified by fax on 4/8/25 at 7:21 PM requesting refill on R14's lacosamide. On 4/29/25 at 1:55 PM V8 Pharmacist stated lacosmide has a half-life of 13 hours, and R14 would have been sub therapeutic after 24-30 hours. V8 stated lacosamide was filled by pharmacy on 4/8/25 and started on 4/9/25. V8 stated R14 was sub therapeutic on 4/8/25 and 4/9/25 and was therapeutic by 4/10/25. V8 stated R14 was not therapeutic for 1 day and would not recommend doing this again. V8 stated R14 dodged a bullet that R14 did not have a seizure during that time. V8 stated he would consider this a significant medication error. V8 stated it is never recommended that a resident with a history of seizures misses any of their medication. On 4/29/25 at 1:22 PM V9 Registered Nurse (RN) stated she does not recall R14 ever being out of lacosamide, and if she pulled from pharmacies emergency stock of medication it would have been documented on a sheet. V9 stated she does not remember ever pulling a lacosamide for R14. V9 stated she is unsure of where she got R14's lacosamide doses on 4/625 and 4/27/25. On 4/29/25 at 2:20 PM V2 Director of Nursing (DON) stated as part of the plan of corrections she was auditing residents who took seizure medications. V2 stated if she saw a missed medication she would educate the nurse, and then should have documented everything in the resident's electronic medical record (EMR). V2 stated she went back and had to put late entries in some of the resident's progress notes related to missed medications. V2 acknowledged R14's controlled drug receipt/record/disposition form that stated R14 ran out of lacosamide after 4/5/25 PM and did not resume until 4/9/25 AM. V2 stated she has no idea how V9 RN would have gotten and documented lacosamide since the medication was not in the facility. V2 stated V11 Medical Doctor (MD) was called on 4/8/25 letting him know R14 needed a signed script for lacosamide. V2 unable to provide documentation of why R14's lacosamide was not refilled and available on 4/6/25. On 4/30/25 at 10:48 AM V2 stated lacosamide is not included in the emergency kit. The facilities policy revised 7/18/18 Emergency Pharmacy and Emergency Kits documents, Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved Emergency Medication kit/box or by special order from MAC Rx. MAC Rx supplies emergency medications including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities in compliance with applicable state and federal regulations to serve the immediate clinical needs of the resident. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The facilities policy undated policy Receiving Controlled Substances documents Procedures: H. Controlled substances are reordered when a four (4) day supply remains to allow for transmitted of the required written prescription to the pharmacist.