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	06/02/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide medical records for 1 out of 1 residents (R3) reviewed for resident rights. Findings include: R3's face sheet documented she was admitted to the facility on [DATE] and discharged on 3/17/25 with diagnosis of, in part, metabolic encephalopathy, epilepsy, vascular dementia, and major depressive disorder. R3's MDS dated [DATE], documented she was moderately cognitively impaired. R3's State of Illinois: HIPAA (Health Insurance Portability and Accountability Act) Complaint Authorization for the Release of Patient Information Pursuant to 45 CFR (Code of Federal Regulations) 164.508 form documented V6 (R3's Daughter/Power of Attorney) completed it on 3/18/25. On page two of the State of Illinois: HIPAA Complaint Authorization for the Release of Patient Information Pursuant to 45 CFR 164.508 form, it documented the covered entity must act on a request for access no later than 30 days after receipt of the request and once processing is completed, records to be mailed. On 5/28/25 at 2:12 PM, V6 (R3's daughter) stated she requested medical records for R3 on 3/18/25 and still hasn't received them. V6 stated she handed the medical records request form to V7 (social services) and was told she would give it to the administrator since she was not at the facility at that time. On 5/29/25 at 12:35 PM, V7 (social services) stated V6 did sign paperwork when she came back for R3's belongings sometime in March. This surveyor showed the release of medical records form to V7, and she stated that was the form V6 handed to her. V7 stated the administrator was not in the building at that time, so she put it on V1's desk and notified her but didn't hear anything else about that afterwards. On 5/28/25 at 4:15 PM, V1 stated V6 never filled out a release of medical records form that she knows of and V5 (Vice President of Clinical Services) agreed. (continued on next page)

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
	145438	A. Building B. Wing	06/02/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 12:24 PM, V1 and V5 stated they had never seen the medical request form V6 filled out. V1 stated V7 never reported to her that V6 had turned in medical request forms.

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	06/02/2025

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 0689 Level of Harm - Minimal harm or potential for 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** Based on interviews, observations, and record reviews the facility failed to implement and/or revise an individualized plan of care following falls as well as complete a fall risk evaluation for 3 out of 5 residents, (R1, R2, R3); reviewed for accident hazards and supervision in a sample of 5. Findings include: 1.R1's face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, chronic obstructive pulmonary disease, anxiety disorder and chronic kidney disease. R1's Care Plan with an initiation date of 4/7/25, documented R1 had an actual fall with no injury; on 4/6/25 an unwitnessed fall, on 4/8/25 an unwitnessed fall with no injury; on 4/8/25 three unwitnessed falls with no injury, 4/10/25 unwitnessed fall with no injury, on 4/17/25 an unwitnessed fall with no injury, on 4/19/25 an unwitnessed fall with no injury, on 4/20/25 an unwitnessed fall, golf ball hematoma on head, and on 5/15/25 a fall with no injury. Intervention placed on 4/16/25 documented R1 is encouraged to wear non-skid socks and footwear. R1's Care Plan continued to document she was at risk for falls on 4/19/25. R1's Care Plan documented no new fall interventions in place were appropriate after falls on 4/8/25, 4/13/25, and on 4/26/25. R1's Minimum Data Set (MDS) dated [DATE], documented she was cognitively intact, has lower extremity impairment on both sides, uses a wheelchair, is dependent on the assistance of staff with toileting hygiene, and requires substantial/maximal assistance for getting from a sitting to a standing position, lying to sitting on side of bed, transferring from a chair to bed/bed to chair, toilet, and tub/shower transfers. The Facility Incident Report dated 2/28/25-5/28/25 documented R1 fell on 4/6/25, 4/8/25, 4/10/25, 4/12/25, 4/15/25, 4/17/25, 4/19/25, 4/20/25, 4/26/25, and 5/14/25. 2.R2's face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, chronic obstructive pulmonary disease, generalized anxiety disorder, and major depressive disorder. R2's MDS dated [DATE], documented she is cognitively intact and requires supervision or touching assistance with going from a sitting to standing position, and transferring from a chair to bed/bed to chair. R2's current Care Plan does not document R2 being at risk for falls. R2's Fall Risk Evaluations dated 3/16/25 and 4/6/25 documented she was at risk for falls. R2's Progress note dated 5/15/2025 at 7:50 PM, documented, Send to ER (emergency room) for evaluation and treatment due to fall, altered mental status, unsteady gait, and possible alcohol consumption which could cause a medication interaction. (continued on next page)

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	06/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Fall Investigation dated 5/15/25 at 7:51 PM, documented that R2 had a witnessed fall and noted R2 to have an unsteady gait. The investigation further documented, The provider and administrator were notified of fall. Neuro checks initiated. Will continue to monitor. R2's last Fall Risk Evaluation was dated 4/9/25. There were no Fall Risk Evaluations completed post fall on 5/15/25 for R2. On 5/29/25 at approximately 10:30 AM, R2 stated she likes to go outside on daily walks to keep her body up and moving. R2 stated on 5/15/25 she left the facility and tripped but didn't fall to the ground completely, she has a bad leg and stumbles a lot. R2 stated a lady saw her trip and was concerned and told me she couldn't drive me back but called to get someone to help. R2 stated she made it back to the facility safely. 3.R3's face sheet documented she was admitted to the facility on [DATE] and was discharged on 3/17/25 with diagnosis of, in part, metabolic encephalopathy, epilepsy, vascular dementia, and major depressive disorder. R3's Care Plan while at the facility, did not document her to be a high fall risk. R3's Fall Risk Evaluation dated 11/12/24, documented her to be a high fall risk. R3's MDS dated [DATE], documented she was moderately cognitively impaired, had inattention and disorganized thinking behavior present at fluctuating times, uses a walker, and required partial/moderate assistance to walk 10 feet and to go from a sitting to standing position. On 5/28/25 at 2:12 PM, V6 (R3's daughter) stated on 5/15/25, she was driving around 7:56 PM, and saw a lady crossing the intersection and fell, the lady stumbled a little bit and limped off towards the gas station. V6 stated she pulled over to ask if the lady was okay and she told her yes and that she was a resident at the facility. V6 stated she called 911 to check up on her and then the facility to let them know one of their residents fell and was out. V6 stated the police told her that the lady made it back to the facility safely. V6 stated she's very concerned the facility did not report the lady falling out in the intersection and wants to make sure the residents are safe. V6 stated she had seen R3 fall at the facility, but nothing was reported or done about them. On 6/2/25 at 2:10 PM, in a joint interview with V9, licensed practical nurse (LPN) and V10 (LPN), both stated that residents at risk for falls should have a fall risk care plan, a Fall Risk Evaluation is completed after a fall occurs, and new interventions are added to the care plan after a fall happens. V9 stated when R2 leaves the facility and comes back, she's not sure what she gets into, but she will be unbalanced and definitely a fall concern. V9 stated that R3 was a fall risk while at the facility and she made sure to implement precautions on her. On 6/2/25 at 2:58 PM, in a joint interview with V1, Administrator, and V5, [NAME] President of Clinical Services, stated R1 did not fall three times as it stated in her care plan on 4/8/25, she technically slid herself off her chair and was having behaviors. V5 stated she would not expect a fall risk care plan to be in place if a resident were considered to be a high fall risk, only if they have had falls prior. V5 stated it is in the fall policy that a fall risk assessment should be completed after a fall occurs. V5 stated she thinks the facility's care plans need work and plans to improve them. (continued on next page)

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	06/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Evaluation and Prevention Policy, undated, documented the policy will evaluate residents for their fall risk and develop interventions for prevention. Upon admission, the nursing/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid injury related to falls. The policy further documented the residents should be evaluated for their fall risk following a fall and if there was a loss of consciousness or the fall was unwitnessed, neuro signs should be initiated and checked for at least 72 hours. The policy also documented tat the analysis of falls included completing the Accident/Incident report and notify the physician and responsible party. Document the physician orders and/or response from the physician and responsible party. The IDT (interdisciplinary) team will review the plan of care and update the interventions as appropriate.