

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Collinsville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a residents family of a fall in 1 of 4 residents (R8) reviewed for falls in the sample of 8. Findings Include: R8's Face Sheet, undated, documents R8 has the following diagnoses: Catatonic Schizophrenia, Anxiety Disorder, Repeated Falls, Hypertension, Major Depressive Disorder, and Type II Diabetes. R8's Minimum Data Set, dated [DATE], documents R8 has a BIMS (Brief Interview of Mental Status) score of 6, which indicates R8 has severe cognitive impairment. R8's Progress Notes document R8 had a fall on the following dates: 6/15/25; 7/4/25; 7/26/25; 7/27/25; 8/5/25; 8/7/25; 8/12/15; and two falls on 8/16/25. R8's progress notes fail to document that V18, R8's Family, was notified of these falls and any injuries sustained due to the fall. On 8/18/25 at 10:17 AM, V18, R8's Family, stated the facility used to notify him when R8 had fallen but they have not been doing that recently. V18 stated when he came in to see R8 the last time, R8 had a cut above his eye, and he asked the nurse what happened and that was how he found out R8 had fallen. V18 stated they haven't been notifying him of any changes with R8. On 10/18/25 at 10:35 AM, V3, Registered Nurse/Assistant Director of Nurses, stated they notify the family and physician when a resident falls. On 10/18/25 at 11:00 AM, V1, Administrator, stated they notify the physician family when a resident falls. The Fall Policy, undated, documents to complete the Accident/Incident report and notify the physician and responsible party.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the failed to provide enough CNAs (Certified Nursing Assistants) and Nurses when reviewed for staffing in the sample of 8. This failure has the potential to affect all 81 residents residing in the facility. Findings Include: On 8/15/25 at 8:50 AM, an initial tour of the facility was conducted with 2 CNAs and 2 Nurses working. On 8/15/25 at 10:00 AM, a follow up tour of the facility was conducted with 5 CNAs and 3 Nurses working. On 8/15/25 at 8:40 AM, R1 stated they don't have enough staff because they've had to use more agency staff the past two weeks so they must need more staff. On 8/15/25 at 8:40 AM, R3 stated he has fallen 3 times; he fell when he was getting up to go to the bathroom. R3 stated this last time, he slid off the bed and his a** hit the floor. R3 stated when he fell the first 2 times, staff helped him up right away, this last time, he couldn't reach his call light, so he crawled to the hallway, and there were crickets no one came, so he crawled back to his bed, reached for his cell phone and called 911. R3 stated he had to call 911 to get him off the floor, he didn't need to go to the hospital, he wasn't hurt. R3 stated the facility doesn't have enough of their own staff employed. On 8/18/25 at 8:20 AM, V14, Local Fireman, stated the department had received a call from a gentleman (R3) that had fallen and needed assistance. V14 stated upon their arrival, they searched for staff to find out what room R3 was in and what was going on. V14 stated they were unable to locate any staff in the building, eventually they found a nurse, unsure of name, outside smoking, that told them that she didn't tell anyone she was going out on break because she couldn't find anyone and that she was unaware of any resident calling 911 or being on the floor. V14 stated when they got to R3's room, he was located behind the door on the floor, with dried blood to his hands, face and head. V14 stated eventually they were able to locate a total of 4 employees including the nurse mentioned above. ON 8/18/25 at 8:24 M, V15, Local Police Department Officer/Supervisor, stated his officers were dispatched to the facility and upon arrival they were unable to locate staff and eventually a nurse, unsure of name, and another male staff member, unsure of name, were located outside smoking. V15 stated when they talked with the nurse, she couldn't give tell them where R3's room was. V15 stated the nurse told him R3 falls a lot and has a right to fall. V15 stated they began going down the hallway and heard R3 yelling. Upon entering R3's room, he was on the floor behind the door with dried blood on his hands and face. V15 stated R3 had a broken coat hanger next to him that he had been using to try and get staff's attention. V15 stated the nurse told them R3 was last checked on by her approximately 45 minutes before the first responders entered the building but she never opened the door. V15 stated this is not the first time they have been in the facility and couldn't locate staff. R3's Progress Note, dated 8/3/25 at 7:43 AM, documents the following: This nurse was notified by Officer that entered the facility that pt (patient) was on the floor in his room. Upon entering the pt room the pt had blood on both of his hands. This nurse then asked the pt what happened. Pt assessed by this nurse active ROM (Range of Motion) to all extremities, no head injuries, No bruises to back, arms, or legs. Pt has skin abrasion to right hand. Pt refused to go to the hospital and pt also refused to let this nurse dress the skin abrasion to his hand. Pt smells of liquor and pt has liquor in his silver bottle. The liquid appears to be mixed with (soda). The bottle smells like (alcohol). MD (Medical Doctor) aware. DON (Director of Nurses) aware. Family aware. The Daily Staffing Summary, dated 8/2/25, documents there were 2 nurses and 3 CNAs scheduled for night shift. The Daily Staffing Summary, dated 8/3/25, documents there were 3 nurses and 5 CNAs scheduled for day shift. The Timecard Reports, document there were 2 nurses and 4 CNAs working 8/3/25 the hours of 6:00 AM and 7:30AM. On 8/18/25 at 10:35 AM, V3, Registered Nurse/Assistant Director of Nurses, stated she was not here when R3 fell, she has heard different things but that is hearsay. V3 stated R3 is with it but he does have issues. V3 denied concerns with staffing and stated they run with a 6/3 ratio, 6 CNAs and 3 nurses. The Staffing policy, undated, documents it is the policy of the facility to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. The Resident Roster, dated 8/15/25, documents there are 81 residents residing in the facility.</p>		