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	12/04/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure a resident was free from neglect when they failed to monitor, assess, and put forth interventions for resident safety with a disregard for resident care, comfort or safety for 1 of 6 residents (R2) reviewed for Resident Neglect in the sample of 9. This failure resulted in physical harm of R2, being sent to the emergency room multiple times for his injuries from falls, and R2 being left saturated in urine and feces with no staff checking on him. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 4/8/25 when the facility failed to put fall interventions in place after R2 experienced a fall. R2 also experienced falls on 4/8/25, 4/11/25, 4/19/25, 4/23/25, 5/9/25, 5/26/25, 8/26/25, 9/11/25, 9/19/25x2, 9/21/25x2, and 9/22/25 with no new fall interventions entered, and with R2 observed to be left soiled in his room with the door closed for five hours with no staff checking or cleaning him. V21, Regional Director of Operations, V2, Director of Nursing (DON), and V3, (Assistant Director of Nursing (ADON), were notified of the Immediate Jeopardy on 12/2/25 at 3:18 PM. The surveyor confirmed by observations, interview, and record review, the Immediate Jeopardy was removed on 12/4/25, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training.The findings include: 1. R2's admission Record, dated 11/18/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 1/28/25, documents R2 is at Risk for Falls. Interventions: If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol.R2's Care Plan, dated 11/10/25, documents R2 has had an actual fall:4/8/25 witnessed fall with no injury - Intervention: No new interventions.4/11/25 witnessed fall with small re-open area to left chin and lump on back of head - no new interventions.4/19/25 unwitnessed fall with no injury - Staff educated to place roommate wheelchair on the outside of room when not in use.4/23/2025 unwitnessed fall - Educated staff to walk to and from meals.5/9/25 unwitnessed fall with no injury - Staff to assist 1:1 during residents increased agitation episodes/periods.5/26/25 unwitnessed fall with no injury - Staff to ensure resident has on non-skid socks. 5/29/2025 unwitnessed fall with hematoma - Intervention: Sent to ER (emergency room) for eval.5/31/2025 unwitnessed fall with no injury - Intervention: Educate staff to be within arm's reach of resident during 1:1. 6/10/25 fall with no injury - Intervention: Resident made 1:1 for remainder of shift.6/11/25 witnessed fall w/ no injury - Intervention: Pharmacy contacted for medication review. 6/15/2025 unwitnessed fall w/no injury - Intervention: Keep in visual when out of bed. 6/15/2025 unwitnessed fall with L (left) hematoma to elbow - Intervention: Reeducate staff on 1:1. 6/17/25 witnessed fall no injury - Intervention: Staff to assist with seating to a chair with arms. 6/21/25 witnessed fall - Intervention: Staff to ensure that entryways are clear of clutter/residents. 6/23/25 witnessed fall no injury - Intervention: Staff to ensure chair is up against wall before resident sits down. 6/23/25 witnessed, skin tear to left knee - Intervention: Staff to increase toileting rounding with resident. 7/4/25 unwitnessed, with minor injury - Intervention: Staff to remove nightstand from room. 7/14/25 witnessed fall, no injury - Intervention: Staff educated not to put their hands on his back.7/26/25 witnessed fall - Intervention: Staff to assist resident to bed after evening snack.7/27/25 unwitnessed fall, no injury - Intervention: Staff to ensure that resident remote is kept within reach.8/5/25 witnessed fall, no injury - Intervention: Staff will keep pitchers of liquid out of reach. 8/7/25 witnessed fall - Intervention: Sent to hospital for eval/treatment.8/12/25 unwitnessed fall no injury - Intervention: Resident is to be placed in bed at lowest position.8/13/25 unwitnessed fall with injury - Intervention: Encourage resident to utilize wheelchair for mobility.8/16/25 unwitnessed fall, no injury - Intervention: Staff reeducated to frequently toilet resident. 8/18/25 witnessed fall - Intervention: Staff to add (non-slip pad) to wheelchair.8/26/25 witnessed fall - Intervention: No new interventions.9/2/25 unwitnessed fall with no injury - Intervention: Staff to keep door to room open for frequent visual checks.9/4/25 unwitnessed fall with no injury - Intervention: Overnight staff to assist resident to chair in Tv room for AM activities.9/7/25 witnessed fall - Intervention: Staff reeducated not to place hands on resident back.9/11/25 witnessed fall - Intervention: No new interventions.9/13/25 unwitnessed fall - Intervention: Scheduled Care Plan meeting with (Local Hospice) to discuss frequent falls. 9/13/25 unwitnessed fall - Intervention: Reeducate overnight staff to assist resident to chair in TV room for AM activities.9/13/25 unwitnessed fall - Intervention: Provide an early morning snack.9/15/25 unwitnessed fall - Intervention: Contacted (Local Hospice) to get prn medications scheduled 9/19/25 witnessed fall -

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide effective fall prevention and supervision for 1 of 3 residents (R2) reviewed for falls in the sample of 9. R2 is documented as experiencing 50 falls in the facility from 4/8/25 through 12/1/25. This failure resulted in R2 experiencing an injury on 4/11/25, 5/29/25, 6/15/25, 6/23/25, 7/4/25, 8/7/25, 8/13/25, 9/13/25, 10/14/25, 10/29/25, 11/7/25, 11/13/25, and 12/1/25 with R2 being sent to the emergency room on 8/7/25 with fall/contusion, 8/13/25 with fall/head injury with laceration, 10/14/25 with questionable fall/laceration of finger, 10/29/25 with fall/abrasion to face, and 11/7/25 with fall/closed head injury.This failure resulted in an Immediate Jeopardy, which was identified to have begun on 4/8/25 when the facility failed to put fall interventions in place after R2 experience a fall. R2 also experienced falls on 4/8/25, 4/11/25, 4/19/25, 4/23/25, 5/9/25, 5/26/25, 8/26/25, 9/11/25, 9/19/25x2, 9/21/25x2, and 9/22/25 with no new fall interventions entered.V4, Regional Nurse Consultant, was notified of the Immediate Jeopardy on 12/2/25 at 12:18 PM. The surveyor confirmed by observations, interview, and record review, the Immediate Jeopardy was removed on 12/4/25, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training.The Findings Include:1. R2's admission Record, dated 11/18/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 1/28/25, documents R2 is at Risk for Falls. Interventions: If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol.R2's Care Plan, dated 11/10/25, documents R2 has had an actual fall:4/8/25 witnessed fall with no injury - Intervention: No new interventions.4/11/25 witnessed fall with small re-open area to left chin and lump on back of head - no new interventions.4/19/25 unwitnessed fall with no injury - Staff educated to place roommate wheelchair on the outside of room when not in use.4/23/2025 unwitnessed fall - Educated staff to walk to and from meals.5/9/25 unwitnessed fall with no injury - Staff to assist 1:1 during residents increased agitation episodes/periods.5/26/25 unwitnessed fall with no injury - Staff to ensure resident has on non-skid socks.5/29/2025 unwitnessed fall with hematoma - Intervention: Sent to ER (emergency room) for eval.5/31/2025 unwitnessed fall with no injury - Intervention: Educate staff to be within arm's reach of resident during 1:1.6/10/25 fall with no injury - Intervention: Resident made 1:1 for remainder of shift.6/11/25 witnessed fall w/ no injury - Intervention: Pharmacy contacted for medication review. 6/15/2025 unwitnessed fall w/no injury - Intervention: Keep in visual when out of bed. 6/15/2025 unwitnessed fall w L hematoma to elbow - Intervention: Reeducate staff on 1:1. 6/17/25 witnessed fall no injury - Intervention: Staff to assist with seating to a chair with arms. 6/21/25 witnessed fall - Intervention: Staff to ensure that entryways are clear of clutter/residents. 6/23/25 witnessed fall no injury - Intervention: Staff to ensure chair is up against wall before resident sits down. 6/23/25 witnessed, skin tear to left knee - Intervention: Staff to increase toileting rounding with resident. 7/4/25 unwitnessed, with minor injury - Intervention: Staff to remove nightstand from room. 7/14/25 witnessed fall, no injury - Intervention: Staff educated not to put their hands on his back.7/26/25 witnessed fall - Intervention: Staff to assist resident to bed after evening snack.7/27/25 unwitnessed fall, no injury - Intervention: Staff to ensure that resident remote is kept within reach.8/5/25 witnessed fall, no injury - Intervention: Staff will keep pitchers of liquid out of reach. 8/7/25 witnessed fall - Intervention: Sent to hospital for eval/treatment.8/12/25 unwitnessed fall no injury - Intervention: Resident is to be placed in bed at lowest position.8/13/25 unwitnessed fall with injury - Intervention: Encourage resident to utilize wheelchair for mobility.8/16/25 unwitnessed fall, no injury - Intervention: Staff reeducated to frequently toilet resident.8/18/25 witnessed fall - Intervention: Staff to add (non-slip pad) to wheelchair.8/26/25 witnessed fall - Intervention: No new interventions.9/2/25 unwitnessed fall with no injury - Intervention: Staff to keep door to room open for frequent visual checks.9/4/25 unwitnessed fall with no injury - Intervention: Overnight staff to assist resident to chair in Tv room for AM activities.9/7/25 witnessed fall - Intervention: Staff reeducated not to place hands on resident back.9/11/25 witnessed fall - Intervention: No new interventions.9/13/25 unwitnessed fall - Intervention: Scheduled Care Plan meeting with (Local Hospice) to discuss frequent falls.9/13/25 unwitnessed fall - Intervention: Reeducate overnight staff to assist resident to chair in TV room for AM activities.9/13/25 unwitnessed fall - Intervention: Provide an early morning snack.9/15/25 unwitnessed fall - Intervention: Contacted (Local Hospice) to get prn medications scheduled 9/19/25 witnessed fall - Intervention: No new intervention9/19/25

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	12/04/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care for 2 of 3 residents (R2, R3) reviewed for incontinent care in the sample of 9. This failure resulted in R2 lying in urine and feces for hours and any reasonable person would not like to sit in their urine or feces with staff not checking on them or cleaning them up timely. The findings include: 1. R2's admission Record, dated 11/18/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 3/3/25, documents R2 has FUNCTIONAL bladder incontinence r/t catatonic schizophrenia. Interventions: Clean peri-area with each incontinence episode, ensure the resident has unobstructed path to the bathroom, limit fluids 2-3 hours prior to bedtime, monitor and document intake and output as per facility policy, monitor/document for signs/symptoms UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R2 is always incontinent of both bowel and bladder.On 11/17/25 at 8:25 AM, R2 was seen lying in bed, awake, with blanket off him and to the side of the bed. There is a noticeable wet spot on R2's sheet underneath his buttocks. The door to the room is closed.On 11/17/25 at 10:25 AM, R2 still seen lying in bed in the same position, unchanged from earlier, still has visible wet spot on his sheet, and the door to room remains closed. On 11/17/25 at 12:10 PM, R2 was seen lying in bed, appears to be same as earlier. When asked if he has gotten up today R2 nodded his head no. When asked if he has been cleaned up yet, R2 nodded his head no. The sheets under R2 appeared to be even more saturated in urine with a brownish stain around the wet area with a foul odor. R2's door remains closed.On 11/17/25 at 12:24 PM, V12, Certified Nursing Assistant (CNA), and V14, Licensed Practical Nurse (LPN), both walked to R2's door, opened it and looked inside, then closed the door and walked on down the hall without checking on R2.On 11/17/25 at 12:43 PM, V14, LPN, took a lunch tray into R2's room to assist in feeding him.On 11/17/25 at 12:50 PM, V14 walked out of R2's room with R2's lunch tray and placed it in cart in the hall.On 11/17/25 at 1:00 PM, R2 was still lying in bed now with his blanket pulled up and over him. When asked if he was cleaned up yet, R2 nodded no, when asked if he was still wet, R2 nodded yes. R2 pulled back his blanket showing that his sheet was still saturated with the brownish stain, his clothes were also saturated, and still with a foul odor. On 11/17/25 at 1:05 PM, V14 returned and was sitting at R2's bedside assisting R2 with his drinks. On 11/17/25 at 1:15 PM, V14 left after assisting R2 to eat and drink while R2 was saturated with urine/feces in bed. V14 failed to clean him or have CNAs clean him and instead covered R2 up with his blanket and left the room while closing the door behind him.On 11/17/25 at 1:35 PM, V16 stated (R2) was up when I came on this morning and I helped to put him in his bed after breakfast, maybe around 9:00 AM. The other CNA on this hall left and I was the only one. I have been everywhere, and I did open (R2's) door earlier to see if he was still breathing, but I didn't have the time to check for incontinence.On 11/17/25 at 1:40 PM, V15 stated I hate to see him like this. It's too bad that I didn't know he was sitting like this earlier.On 11/17/25 at 1:42 PM, V15 and V16 entered to provide incontinent care on R2, both donned gloves with no hand hygiene seen done. Both CNAs pulled R2's shirt off, which was also saturated in urine. Both assisted R2 to stand by the side of his bed with each CNA holding onto R2's arm and no gait belt used. R2's pants were dropped to the floor and his saturated incontinence brief removed with both urine and feces inside. V16 held onto R2 while he stood by side of his bed during peri-care with R2's pants remaining wet and around his ankles. V15 had same soiled gloves on and reached in to get a wet washcloth, from a few washcloths inside a plastic measuring container with water, grabbed a washcloth, then put it back in the water, changed her gloves, then got a wet cloth again, sprayed peri-cleaner on the cloth, and began wiping R2's buttocks, and anal area. V15 changed gloves with no hand hygiene done, then repeated wiping R2 with wet cloths including down his legs, groins, and peri-area. There was no wiping or cleaning of R2's penis or testicles. V15 put a clean incontinence brief between R2's legs and fastened it, walked to his recliner and pushed the recliner over to R2 and while still unlocked, had R2 pivot and sit into the recliner. V16 then removed R2's wet pants and socks, then using same gloves, searched for pants in R2's closet. On 11/19/25 at 10:25 AM

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	12/04/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide hand hygiene while performing resident care for 3 of 4 residents (R2, R3, R8) reviewed for infection control in the sample of 9.The findings include:1. R2's admission Record, dated 11/18/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 3/3/25, documents R2 has functional bladder incontinence related to catatonic schizophrenia. Interventions: Clean peri-area with each incontinence episode, ensure the resident has unobstructed path to the bathroom, limit fluids 2-3 hours prior to bedtime, monitor and document intake and output as per facility policy, monitor/document for signs/symptoms UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R2 is always incontinent of both bowel and bladder. On 11/17/25 at 1:42 PM, V15, Certified Nursing Assistant (CNA), and V16, CNA, entered to provide incontinent care on R2. Both donned gloves with no hand hygiene seen done prior to. Both CNAs pulled R2's shirt off, which was also saturated in urine. Both assisted R2 to stand by the side of his bed with each CNA holding onto R2's arm and no gait belt used. R2's pants were dropped to the floor and his saturated incontinence brief removed with both urine and feces inside. V15 used her soiled gloves and reached in to get a wet washcloth, from a few washcloths inside a plastic measuring container with water, grabbed a washcloth with her soiled glove, then put it back in the water, changed her gloves with no hang hygiene done between glove change, then got a wet cloth again, sprayed peri-cleaner on the cloth, and began wiping R2's buttocks, and anal area. V15 changed gloves again with no hand hygiene done, then repeated wiping R2 with wet cloths including down his legs, groins, and peri-area. V16 then removed R2's wet pants and socks, then using same gloves, searched for pants in R2's closet before doffing her gloves. Both CNAs left the room with no hand hygiene seen done.2. R3's admission Record, dated 11/18/25, documents R3 was originally admitted to the facility on [DATE] with diagnosis of Type 2 DM, Anemia, Atherosclerotic Heart Disease (ASHD), Bipolar disorder, Left below knee amputation (BKA), Morbid obesity, Hernia, Peripheral Vascular Disease (PVD), Major depressive disorder, Anxiety disorder, Falls, HTN, Myalgia of muscles, non-pressure chronic ulcer of skin, Chronic Obstructive Pulmonary Disease (COPD), and Schizophrenia.R3's Care Plan, dated 6/24/25, documents R3 has functional bladder incontinence related to physical limitations, poor toileting habits. Interventions: Clean peri-area with each incontinence episode, encourage fluids during the day to promote prompted voiding responses, monitor and document intake and output as per facility policy, monitor/document for signs/symptoms UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. It continues R3 has bowel incontinence related to immobility, poor diet. Interventions: Check resident every two hours and assist with toileting as needed, provide bedpan/bedside commode, provide loose fitting, easy to remove clothing, provide peri-care after each incontinent episode.R3's MDS, dated [DATE], documents R3 is cognitively intact and is dependent on staff for ADLs, including toileting. R3 is always incontinent of both bowel and bladder.On 11/17/25 at 11:20 AM, V11, CNA, and V12, CNA, entered to do incontinent care on R3. Supplies were already on a bedside table with both CNAs already having gloves on. R3's incontinence brief unfastened and open, V12 sprayed R3's peri-area with peri-care, obtained a wet washcloth and wiped the top of R3's peri-area, wiped down each groin, then testicles while folding washcloth between areas. Using the same gloves, V12 then wiped the tip of R3's penis but failed to pull back the foreskin to wash his entire penis, then changed gloves with no hand hygiene seen done. There was no hand hygiene seen done between glove changes and before leaving the room.3. R8's admission Record, dated 11/18/25, documents R8 was originally admitted to the facility on [DATE] with diagnosis of Malnutrition, Pneumonia, Chronic Kidney Disease, Major depressive disorder, Congestive Heart Failure, Anemia, generalized anxiety disorder, Major depressive disorder, Respiratory failure, Atrial-Fibrillation, Cystitis, Glaucoma, Drug induced subacute dyskinesia, Benign prostatic hyperplasia (BPH), HTN, Arthritis, and Schizophrenia.R8's Care Plan, dated

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	145438	A. Building B. Wing	12/04/2025

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F 0915 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident room has a window to the outside that meets requirements (continued on next page)

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	145438	A. Building B. Wing	12/04/2025

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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 0915 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain a homelike environment for 1 of 4 residents (R4) reviewed for home like environment in the sample of 9.The findings include: R4's admission Record, dated 11/18/25, documents R4 was admitted to the facility on [DATE] and was discharged on 10/30/25R4's Minimum Data Set (MDS), dated [DATE], documents R4 was cognitively intact.On 11/13/25 at 1:24 PM, V5, R4's Daughter/Power of Attorney (POA), stated (R4's) room window had a hole in it and flies were getting in. I went to the store and bought some tape to cover the hole and a fly swatter to kill the flies. On 11/13/25 at 3:00 PM, V7, Maintenance Director, stated he is not aware of any windows that may have a hole in them. V7 stated the staff will put a work order on his door and he addresses them that same day. V7 stated if there was a window with a hole in it, he would have to ask his Regional Manager for approval to have a new glass cut for that window, in the meantime, he has sheets of plexiglass that he can cover that area with. V7 stated the only window related work order he has had lately was in therapy a window came off track. On 11/17/25 at 8:15 AM, R4's previous room, now has R7 in the room. Upon examination of window, there is a piece of plexiglass with one screw into the left side with the top and right-side having duct tape, which is not sticking anymore, and the plexiglass is pulled away from the actual window and not secured to the frame. There are visible openings to the outside on the bottom of the plexiglass (top of air conditioner/AC unit), the entire right side and the top of the plexiglass due to it being loose and not secured to the frame. The outside wind was seen blowing the plexiglass inward. There were no flies seen in R7's room.On 11/17/25 at 8:40 AM, V7 walked into the room to observe the status of the window in that room. V7 stated I have only been here a year and when a window AC unit gets put in, I put a piece of plexiglass above the AC unit to cover the opening because the slide window has to come out. I know when it is my job because I secure it with four screws and then I duct tape the edges, and this one only has one screw holding it in place, so I did not do this. When shown the open gaps with wind blowing the plexiglass, V7 acknowledged the openings and stated I was not aware of it, and no one has submitted a work order. I will have it fixed immediately.On 11/17/25 at 8:45 AM, R7 stated he was not aware of any hole in his window, and he has not seen any flies in his room.On 11/17/25 at 8:56 AM, V7 stated he called his Regional Manager, and they approved for it to be replaced, and he called the glass company, and they will be cutting a piece of plexiglass to fit that area. V7 stated he will replace the plexiglass today.On 11/18/25 at 2:30 PM, R7's window has been temporarily fixed by V7. There is another piece of plexiglass that appears to fit that area better and is secured with two screws on each side along with tape closing any gaps around the window.On 11/19/25 at 11:45 AM, V7, Maintenance Director, stated I was able to order a new plexiglass that will fit exactly the space above the AC unit. That way any room that still has their AC, I will replace it with a piece of plexiglass that will fit that area exactly and will secure it with four screws and ensure that there are no openings.On 11/19/25 at 11:10 AM, V21, Regional Director of Operations, stated I would expect any staff member who notices a crack or hole in a window to put in a work order and notify maintenance to get it fixed. In the meantime, and if needed, I would possibly move the resident out of that room until it gets fixed.On 11/19/25 at 12:30 PM, V18, CNA, stated If I find anything that needs fixed, I will let a manager know and put in a work order.On 11/19/25 at 12:35 PM, V2, Director of Nursing (DON), stated I would expect staff to fill out a work order and give to maintenance so he can fix it. There are forms outside his door for staff to use. If it was a danger to the resident, we would try to move that resident to a different room. Most residents would refuse to move because that is their home.On 11/19/25 at 1:45 PM, V12, CNA, stated If we find anything that is broke or needs repaired, I will let maintenance know and fill out a work order that are outside his door.The facility's Physical Plant & Environmental Policy & Guidelines, undated, documents in part it is of the utmost importance to provide a safe, hospitable, clean and organized facility and grounds to ensure an environment that is conducive to providing the best care, comfort and home-like surroundings for residents. The building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping, and ensuring compliance with current federal, state, local, and NFPA (National Fire Protection Association) codes. Policy Implementation: Ensure maintenance work orders are completed in a timely manner and ensure items necessary for repairs are ordered to complete repairs.