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	05/26/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to document pressure ulcer treatments were administered per physician's orders twice a day and to reposition timely to promote healing of a pressure ulcer for 1 (R4) of 3 residents reviewed for pressure ulcers in the sample of 13. Findings include: R4's Undated Face Sheet, documents he was initially admitted to the facility on [DATE].R4's admission Minimum Data Set (MDS) dated [DATE] documents R4 was cognitively intact, three pressure ulcers.R4's Physician's Order Sheet (POS) dated 5/2026 cleanse sacrum wound with NS (normal saline), apply zinc barrier cream to periwound PRN (when needed), loosely pack wound bed with Dakin's moistened gauze and cover with dry clean dressing BID (two times a day) and PRN soiled every day and evening shift for wound healing. R4's Treatment Administration Record (TAR) dated 5/2026 no documentation sacrum pressure ulcer treatment was administered on evening shift on 5/2/2026, 5/17/2026 and on day shift on 5/3/2026, 5/15/2026 and 5/18/2026. R4's POS dated 5/2026 right heel cleanse wound with NS, apply Dakin's moistened gauze to wound bed and cover with ABD pad and gauze wrap BID every day and PRN every day and evening shift for wound healing. R4's TAR dated 5/2026 no documentation right heel pressure ulcer treatment was administered on evening shift on 5/17/2026 and day shift on 5/18/2026. On 5/21/2026 at 11:58 AM V11, Certified Nurse Assistant (CNA) and V12 CNA transferred R4 to his wheelchair using a Hoyer lift. On 5/21/2026 at 2:33 PM R4 was sitting up in his wheelchair in his room. R4 was alert and stated his pressure ulcer was hurting from sitting up but that staff told him he has to stay up in his wheelchair until at least 3:00 PM due to his family telling them he has to sit up that long. At that time R4 used his right arm to push against the right arm of his wheelchair and he attempted to reposition himself and he was grimacing at that time and said he was hurting badly. R4 pushed his call light and V13 CNA entered R4's room at 2:38 PM, promptly turned his call light off and asked him what he needs, R4 told V13 that he was hurting from sitting up since 12:00 PM and he wanted to lay down. V13 said OK and left R4's room. R4 sat up in his wheelchair and continued to attempt to reposition with facial grimacing and stated he feels like a kid because they make him stay up in his wheelchair which is demeaning to him. R4 stated he feels staff doesn't care that he is hurting and they won't assist him to bed until after 3:00 PM. On 5/21/2026 at 3:10 PM V14, CNA Supervisor and V13, CNA entered R4's room and transferred him to bed. V14 stated she was not aware that R4 wanted to lay down sooner than that and V13 stated she was told by staff that R4 has to stay up until 3:00 PM and so she didn't tell any staff that R4 wanted to lay down. On 5/26/10:20 AM V2, Director of Nurses (DON) stated R4 has chronic pressures on his sacrum and right heel, and he was admitted to the facility with them. V2 stated R4 recently had a family loss and his family wanted him to stay up 3-4 hours a day because he was getting depressed. When staff answer a resident's call light, she expects staff to respond to the resident's needs as soon as they enter the resident's room and definitely not enter the resident's room, turn the call light off and not assist the resident. V2 stated when R4 complained of buttocks/pressure ulcer is hurting due to the pressure from sitting up, she expected staff to immediately lay him down and even if his family wants him to stay up for 3 to 4 hours due to his depressed mood she expected staff to report R4 was complaining of increased pressure ulcer pain (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from sitting up and lay him down and she would let R4's family know why staff laid R4 down earlier than initially requested. R2 stated after nurses administer pressure ulcer treatments she expects the nurse to document the treatment was administered on resident's TAR and if staff don't document the treatment was administered then she can's say the treatment was administered she can't say staff are following physician's orders and she expects all staff to be following physician's orders and the facility's pressure ulcer policy as well. On 5/26/2026 at 11:45 AM V1, Administrator stated she is a nurse and stated if a resident has a pressure ulcer on their sacrum and the resident is left up for long periods of time the sacrum pressure ulcer could get worse due to the extended pressure from sitting up. The Facility's Wound Management Policy, reviewed 9/5/2025 documents per attending physician order, the nursing staff will initiate treatment and utilize intervention for pressure redistribution and wound management. A wound monitoring record will be completed for each wound.