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	12/23/2025

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 - 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 interview and record review the facility failed to ensure R8's batteries in alarm working, as identified as an intervention for falls for R8, for 1 of 5 residents (R8) reviewed for accidents in the sample of 67. This failure resulted in R8 falling and fracturing humerus. Prior to the survey date of 12/15/2025, the facility had taken the following action to correct the noncompliance:1 On December 2, 2025, the facility [NAME] President of Clinical Services reviewed the Fall evaluation and Prevention policy.2. On December 2, 2025, the Regional Nurse Consultant in-serviced the Facility Administrator, DON, ADON, MDS Coordinator were in-serviced on Fall Prevention Policy.3. On December 2, 2025, the Administrator/DON/ Designee Initiated In-service with front-line staff on Fall Prevention Policy and where to verify Care Plan Interventions. In-servicing ongoing. 4. On December 3, 2025, the DON/ADON/ CNA staffing coordinator initiated In-serviced Nursing staff on how to find care plan/fall interventions in EHR. Staff will not work next shift until Fall Prevention In-service is completed. In-servicing on going.5. On December 2, 2025, the RNC/RDO completed an initial audit of all falls from 4/8/25 to present to ensure current interventions are initiated and effective. Care plans will reflect interventions that are effective and/or within the last 90 days. Audits are ongoing.6. On December 2, 2025, the RNC/RDO/DON/ADON completed an initial audit of fall risk assessments to ensure that appropriate prevention interventions are in place & care plans are reflecting those interventions. Audits are ongoing.7. On December 2, 2025, the RDO implemented quality assurance tool. An audit will be completed 5x/week x 4 weeks during clinical meeting to ensure that any fall, has a root cause analysis, progressive intervention, and care plan is updated by the DON/ADON and on-going audit.8. On December 2, 2025, the Interdisciplinary Team initiated a root cause analysis for Fall Prevention and interventions being placed on care plan and physically in place will be reviewed weekly during Facility Risk Meeting x 4 weeks.Findings include:1. The facility long-term care facility serious injury incident and communicable disease report dated 7/9/2025 at 10:05AM documents nurse observed resident sitting on buttocks in front to the bathroom floor door with her walker flipped over in front of her. Report documents resident was assessed and complained of pain to her right arm, in house x-ray was obtained per dr order x-ray results on 7/9/2025 revealed acute humeral fracture documents investigation initiated per protocol, follow up will be sent. The facility long term care facility serious injury incident and communicable disease report dated 7/11/2025 documents Nurse Practitioner gave order to send resident to the emergency room for further evaluation. During emergency room evaluation R8 was diagnosed with Urinary Tract Infection (UTI) and Bradycardia. The report documents resident was interviewed prior to leaving for the ER. she stated she was on her way to the bathroom, could not recall why she was on the floor. The report documents in conclusion the Quality Assurance (QA) committee met and determined that the fall and fracture was a result of her R8's altered mental status. Intervention when R8 returned was to include educating her to ask for assistance to and from the bathroom and resuming Occupational Therapy (OT) and Physical Therapy (PT) for strengthening and safety awareness. R8's x-ray of Right humerus 2 plus views dated 7/8/2025 at 16:00pm documents acute humeral fracture. R8's facility unwitnessed fall report dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/8/2025 at 10:05 documents nurse observed resident sitting on buttocks in front of the bathroom door with walker in front of her tipped over, resident is alert and orientated, resident has hematoma to right wrist, resident bed alarm was plugged up but not sounding appropriately. nurse assessed resident with ROM to right arm and resident wasn't able to do ROM to R arm. Resident was assisted from floor to bed with a mechanical lift with assist of two. Report documents R8 stated that she was going to the bathroom, came out of bathroom and loss balance and stated that her arm was twisted and behind her. Report documents hematoma to back of Right hand. Report documents mental status oriented to person, place and time. The report documents predisposing environmental factor; fall alarm. The fall report documents predisposing physiological factor as gait imbalance. The report documents no statements found. R8's progress notes dated 7/9/2025 at 11:33AM documents incident note. Interdisciplinary Team (IDT) met to review resident's unwitnessed fall. Care plan reviewed and updated. Resident is at risk for fall related to uses a walker, weakness, paranoid schizophrenia, diabetes, depression, cardiac arrythmia, bipolar disorder, cardiac medications, antihypertensives, and psychotropic medication use. Current fall interventions include staff assisted resident in organizing her room and ensured the floor was free from clutter, informed to utilize call light for assistance for help for both her and roommate, removed ill-fitting shoes and replaced with non-slip socks, and resident to sit in shower chair for every shower. root cause for fall, alarm was not sounding. Intervention: staff to ensure that fall alarm has working batteries. R8's hospital H and P documents R8 was admitted to the hospital on [DATE] with bradycardia, right humeral fracture with non-op management, pain control and to continue immobilizer.R8's Minimum Data Set (MDS) dated [DATE] documents R8 is cognitively intact with a BIMS of 15. R8's MDS documents R8 requires partial to moderate assistance for personal hygiene, lower body dressing and sit to standing. On12/18/2025 at 1:24PM V19 Certified Nursing Assistant (CNA)stated she is not aware of any interventions in place for falls for R8.On 12/18/2025 at 2:31PM V2, Director of Nursing (DON) stated fall interventions should be in place for residents. V2 stated if a resident has an alarm in place staff should check to make sure batteries are working.On 12/19/2025 per telephone interview at 12:12PM V32, physician stated R8's fall resulting in a fractured humerus could have been prevented if R8's alarm had been sounding. V32 stated staff need to check batteries to ensure they are working. The facility Fall evaluation and prevention policy dated, reviewed 6/1/25 documents the purpose is to ensure the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The policy documents the goal is to prevent falls if possible and avoid any injury related to falls. The policy will evaluate residents for their fall risk and develop interventions for prevention. The policy documents the goal is to prevent fall if possible and avoid injury related to falls. The policy documents risk factor associated with aa fall are intrinsic risk factors for falls include changes that are part of normal aging as well as certain acute or chronic conditions and medications. The following are examples of common intrinsic risk factors: gait and balance disorders, confusion, incontinence, Parkinson's disease, vision and hearing impairments, depression, seizure disorder, previous falls, certain medication classes such as: antipsychotics, sedatives and hypnotic, tricyclic antidepressants. The policy document the Interdisciplinary team (IDT) will review the plan of care and update the interventions as appropriate. The policy documents education of staff related to fall prevention documents providing a safe environment for residents, cause and risk factor for falls as well as the interventions to manage risk, safe transferring techniques, use of assistive devices, exercise programs to improve balance, gait and strength.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pain medication according to physician's order and effectively treat pain for 1 of 4 residents reviewed for pain management is a sample of 67. This failure resulted in R2 experiencing days of increase excruciating pain and feeling like no one cares.Findings include:1 R2's Electronic Health Record, not dated, documents admission date of 3/24/2025 and lists the following diagnosis: Peripheral Vascular Disease, Occlusion and Stenosis of bilateral Carotid arteries, Anxiety, Polyneuropathy, Dorsalgia, Weakness, Disease of the Spinal Cord, Chronic Pain, Spinal Stenosis, Cervical region, and Spondylolysis Lumbar Region.R2's Care Plan, dated 9/23/2025, documents that R1 has Acute Pain / Chronic Pain. It also documents interventions: Apply hot or cold packs for comfort. Determine Resident's satisfactory pain level. Establish a pain management treatment plan. Evaluate for non-verbal indicators of pain. Evaluate pain. Monitor for factors / activities that precipitate or aggravate pain. Utilize adaptive equipment as needed.R2's Minimum Data Set, dated [DATE], documents that R2 is cognitively intact. It also documents that R2 frequently experiences pain, and the pain interferes with day-to-day activities.R2's Administration Note, dated 11/27/2025 at 7:21 PM, documents that Orders-Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain oos (Out of stock).R2's Administration Note, dated 11/28/2025 at 8:33 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain Medication unavailable.R2's Administration Note, dated 11/28/2025 at 11:30 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain Medication unavailable.R2's Health Status Note, dated 12/11/2025 at 1:55 PM, documents that Note Text: V32, Physician, in for rounds this day. rec'd order to increase his Norco from 5 mg to 7.5 mg. sent order to pharmacy for fill, requested pharmacy to send proper script to md office for fill out. will have previous order continue until new script is filled and delivered.R2's Administration Note, dated 12/13/2025 at 12:15 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain drug unavailable, MD notified of new script needed pharm aware.R2's Administration Note, dated 12/13/2025 8:18 PM Orders - Administration Note, Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain This medication is unavailable at this time. Medication requires a new Rx per pharmacy. This nurse called on call provider and left a voice message informing the MD that medication requires a new Rx. Pending a reply.R2's Administration Note, dated 12/13/2025 8:24 PM, documents that Orders - Note Text: Tizanidine HCl Oral Tablet 2 MG Give 1 tablet by mouth in the evening for Pain Medication is currently unavailable at this time. Medication is not present in Pyxis to administer. Medication is on order at this time Pending delivery from pharmacy.R2's Administration Note, dated 12/14/2025 02:10 AM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain Still waiting for response in regards to pharmacy receiving new script for new dosage.R2's Administration Note, dated 12/14/2025 11:41 Orders - Administration Note, Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain drug unavailable, talk to pharmacist states some will be delivered tonight.On 12/16/25 at 8:21 AM, V15, LPN, was observed giving R2 his morning medications when R2 told V15 that they changed his pain medication and now he seems to be in pain again. V15 stated she was off for five days and when she looked in R2's orders, she stated Yes, they did reduce his pain medicine. Why would they do that when he is still in pain. I will have to call and check on that.On 12/16/2025 at 11:20 AM R2 stated that he has severe pain. R2 stated that when he receives his pain medication the pain is manageable. R2 stated that the pain never goes away. R2 stated that they have been running out of his medication. R2 stated that (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	just last week he had to sit in pain for days because they didn't have his medication. R2 stated that the pain is unbearable. R2 stated that he has migraines that feel like someone is tearing open his skull from the inside. R2 stated that the amount of pressure is unbearable. R2 stated that he injured his back years ago and the pain is overwhelming. R2 stated that when he is in that much pain he doesn't want to be bothered, easily irritated, and agitated with everyone even the people he likes. R2 stated that once the medication comes in it takes a long time to get the pain under control. R2 stated that he received an increase in his pain medication last week and have not received it yet. How am I supposed to live in that much pain. R2 stated that he has not had or been offered any ice packs. R2 stated that the nurses don't even ask him if he is in any pain. They don't ask. They don't care.On 12/22/2025 at 12:39 PM When asked why R2 hadn't received his Norco 7.5mg pain medication as prescribed on 12/11/2025. V2, Director of Nursing, stated that R2's Norco 7.5mg tablet was not available and R2 hadn't received his Norco 7.5mg because the pharmacy hadn't received a script. V2 then verified that R2 had not received his medication as prescribed. When asked why R2 had not received his Norco 5mg as prescribed on 11/27/2025, 11/28/2025, 11/29/2025, 12/13/2025 and 12/14/2025 V2 stated that there is no excuse for that because the nurses have access to the medication in the Nexus medication machine that's located in the medication room. V2 stated that the Norco is available in the medication machine. V2 stated that when a new or reorder for a narcotic is given the pharmacy is notified and a script is sent. V2 stated that the nurse is to follow up and verify the script was received by the pharmacy and the medication is then sent out. If the medication is not delivered the nurse is to follow up with the pharmacy. V2 stated that this process takes 24 to 48 hours. V2 stated that if a resident missed his dose of pain medication he would be in pain.On 12/23/2025 at 8:48 AM V33, Pharmacist stated that they received an order for R2's Norco 7.5mg. V33 stated that they had not received a script for this medication and was unable to send this medication out. V33 stated that they have requested the script from the provider by fax, phone and email without success. V33 stated that they have also contacted the facility and sent appropriate forms in attempt to get script. V33 stated that at this time R2's Norco has not been filled. V33 stated that they did receive a refill request on 12/14/2025 for Norco 5mg and due to having a script this medication was sent out. V33 stated from 12/11/2025 to 12/14/2025 the nexus system had not been accessed for R2. V33 stated that because of the class of medication the medication requires a code that is given by the pharmacy. The facility's Pain Management policy, dated 6/1/25, documents that Purpose: To ensure accurate assessment and management of the resident's pain. Policy Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Procedure: II. Pain Management: A. The Licensed Nurse will administer pain medication as ordered, and document medication administered on the Medication Administration Record (MAR).

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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** Based on interview, observation, and record review, the facility failed to administer medications according to the professional standards, including having a Licensed Nurse administer the medications, and ensuring the residents are taking their medications, for 2 of 4 residents (R2, R6) reviewed for medication errors in the sample of 67.The findings include: 1. R6's admission Record, dated 12/17/25, documents R6 was originally admitted to the facility on [DATE] with diagnosis of Malnutrition, Catatonic Schizophrenia, Anxiety Disorder, Hypertension (HTN), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), Major Depressive Disorder, and Pneumonitis.R6's Care Plan, dated 3/3/25, documents R6 has Impaired Coping, has a Self-Care Deficit, Risk for Decreased Cardiac Output, Risk for Impaired Communication, Decreased Cardiac Output, Arrhythmia, Hypertension, Disturbed Sensory Perception: Audible/Visual, Malnutrition. It continues 12/1/25: R6 has a behavior problem related to catatonic schizophrenia, anxiety and depression. examples walking fast for hours without sitting down, attempts at grabbing items not belonging to him and walking up onto others quickly. Interventions: Administer medications as ordered. R6 has Diabetes Mellitus. R6 is on anticoagulant therapy related to atrial fibrillation. Interventions: Administer Anticoagulant medications as ordered by physician. R6 is on diuretic therapy. Interventions: Administer Diuretic medications as ordered by physician. R6 is on pain medication therapy. Interventions: Administer Analgesic medications as ordered by physician. R6 uses antidepressant medication related to Depression Diagnosis. Intervention: Administer Antidepressant medications as ordered by physician. R6 uses anti-anxiety medications. Intervention: Administer Anti-Anxiety medications as ordered by physician. R6 uses psychotropic medications. Intervention: Administer Psychotropic medications as ordered by physician. R6 has fluctuations in mood related to Catatonic Schizophrenia. Interventions: Administer medications as ordered.R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs).R6's Physician Order (PO), dated 12/16/25, documents May crush medication.R6's PO, dated 11/10/25, documents Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (milligram) Give 2 capsule by mouth one time a day for Anticonvulsants.R6's PO, dated 10/1/25, documents Austedo Oral Tablet (Deutetrabenazine) Give 6 MG by mouth every 12 hours for Psychosis.R6's PO, dated 9/30/25, documents Haloperidol Tab 5 MG Give 1 tablet by mouth two times a day for Schizophrenia.R6's PO, dated 2/10/25, documents Carvedilol Oral Tablet 3.125 MG Give 1 tablet by mouth two times a day for HTN Take with meals.R6's PO, dated 8/29/25, documents Furosemide Oral Tablet 20 MG Give 1 tablet by mouth two times a day for diuretic.R6's PO, dated 4/17/25, documents Hyoscyamine Sulfate Oral Tablet Disintegrating 0.125 MG Give 1 tablet by mouth every 4 hours as needed for secretions.R6's PO, dated 3/18/25, documents Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth four times a day.On 12/16/25 at 8:00 AM, V15, Licensed Practical Nurse (LPN), was observed administering medications to R6. V15 obtained all R6's medications from the medication cart. V15 crushed up all medications except for the Depakote capsules which were opened and put in with all the other crushed meds. V15 mixed the crushed medications with a spoonful of oatmeal. After mixing the medications in the oatmeal, V15 put the spoonful of oatmeal mixed with medications in the bowl of oatmeal and delivered it to R6's room where V16, Certified Nursing Assistant (CNA) was sitting assisting R6 with breakfast. V15 placed the bowl of oatmeal with the spoon of medications onto R6's breakfast tray and left the room. V16 attempted multiple times to feed R6 his oatmeal, not knowing that there were medications in the bowl, and each time R6 refused to eat the oatmeal. On 12/16/25 at 8:50 AM, V16, CNA, stated (R6) did not eat any of his oatmeal this morning. Someone came in and took his breakfast tray out of the room. R6 did not get any of his morning medications.R6's Incident Note, dated 12/16/25 at 9:21 AM, and documented on 12/17/25 at 8:22 AM by V2, Director of Nursing (DON), documents During medication administration it was identified that prescribed oral medications were crushed and mixed into oatmeal (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	for consumption. Resident did not consume the medication mixed with the food as resident refused breakfast this AM. Nurse Practitioner (NP), DON notified, left message for Power of Attorney (POA) to notify. No return call back will continue to attempt.R6's Health Status Note, dated 12/16/25 at 1:44 PM, documents Resident continues on hospice services with care focused on comfort and safety. Resident remains on 1:1 supervision with 15-minute safety checks in place. During this shift, resident was noted to exhibit wandering behaviors, requiring continued close monitoring. Resident refused breakfast despite staff encouragement, verbally stating no. Later in the shift, resident accepted and consumed pudding cups and consumed approximately 50% of lunch. At the time of this note, resident is sitting in the small dining/TV room with staff in close proximity. No acute distress noted.On 12/17/25 at 8:45 AM, R6 seen in bed with V16, CNA, at bedside. R6 appears clean and dry and without odors. When asked if she ever gives a resident their medications, V16 stated No, I'm not licensed to give medications to a resident and would not do so. On 12/16/25 at 2:25 PM, V4, Assistant Director of Nursing (ADON), was advised of R6 not receiving his morning medications from V15, LPN. V4 stated Well, that would contribute to some of his behaviors lately.On 12/16/25 at 3:40 PM, V28, Nurse Practitioner (NP), stated I was not aware of (R6) not getting any of his medications today, only that he was having behaviors this morning and that was probably because he didn't sleep last night. I did stop (R6's) Eliquis, but I did not stop his Plavix or Aspirin. The Depakote DR Sprinkles I believe is approved to sprinkle over food and such, so it is ok for them to open the capsules. I'm not sure what to say about the CNA, but I would not expect the CNA to be given him his medications. (R6) has all his medications ordered and he should be getting them as ordered. If (R6) has missed multiple doses, that could contribute to behaviors.2. R2's admission Record, dated 12/17/25, documents R2 was admitted on [DATE] with diagnosis of Peripheral Vascular Disease (PVD), Stenosis of carotid arteries, HTN, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Polyneuropathy, Dorsalgia, Disease of spinal cord, Alcohol abuse, Depression, Generalized Anxiety Disorder, Major Depressive Disorder, Spondylolysis, and Spinal stenosis.R2's Care Plan, dated 9/23/25, documents R2 is at risk for Harm: Self Directed or Other-Directed, 11/13/25: R2 is/has potential to be verbally aggressive, 9/12/25: R2 has a behavior problem, resident has been verbally aggressive, Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness.R2's MDS, dated [DATE], documents R2 is cognitively intact and requires supervision/touching assistance for ADLs and transfers.R2's PO, dated 3/24/25, documents Calcium Carbonate Oral Tablet Chewable, Give 2 tablet by mouth in the morning.On 12/16/25 at 8:21 AM, V15, LPN, gave R24 his medications in one medicine cup with his Calcium Carbonate tablets in another cup. V15 left the Calcium Carbonate sitting on his bedside table and stated, He will take that when he wants to. and left the room.On 12/23/25 at 8:20 AM, V23, LPN, stated When passing meds, I make sure the resident takes them before I leave the room and would never leave them for a CNA to give them to the resident.On 12/23/25 at 8:25 AM, V17, LPN, stated I stand by the resident to make sure they take the medication and don't choke on them. I would not leave them with a CNA for them to give to the resident.On 12/23/25 at 8:35 AM, V15, LPN, stated I always watch the resident take their meds and would never leave the meds with a CNA for them to give to the resident.On 12/23/25 at 9:20 AM, V2, Director of Nursing (DON), stated I would expect the nurses to stand by the resident and ensure the resident takes all their medications. They should never leave the medications with a CNA or at the resident's bedside.The Facility's Medication Administration Policy, dated 6/1/25, documents in part Medications will be administered by a Licensed Nurse per the order of Attending Physician or licensed independent practitioner or as consistent with state law. III. Medications must be given to the resident by the Licensed Nurse to prepare the medication, to as consistent with state law. V. Medications may be administered one hour before or after the scheduled medication administration time. VIII. Medications will not be left at bedside. IX. If the attending physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order. Procedure: VIII. Compare the licensed practitioner's prescription/order with MAR (Medication Administration Record) (first check). XV. Administer the (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	medication to the resident. XVI. The licensed nurse will remain with the resident until the medicine is actually swallowed.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to have the State Inspection report readily available for residents to read without asking. This had the potential to affect the 78 residents who resided in the facility.Finding includes:On 12/17/2025 at 1:30 PM a resident council meeting occurred. During the meeting R66, R57, R12, and R15 stated that they did not know where the inspection book was located or that they could look at it. When informed that the survey book is in the front lobby, R66, R57, R12, and R15 stated that they can't go to the lobby without permission.On 12/17/2025 at 1:40 PM R66 stated that the staff do not let you go to the lobby. R66 stated that the staff must put the code in. R66 stated that if you go through it and the alarm goes off, they chase you down like a criminal.R66's Fall Risk Evaluation, dated 12/2/2025, documents that R66 is alert and oriented x3.On 12/17/2025 at 1:41 PM R57 stated that the staff do not allow them in the lobby unless they are leaving the facility. R57 stated that if anything is in the lobby they wouldn't know about it and would not have access to it. R57 stated that there is an alarm on the door.R57's Minimum Data Set (MDS), dated [DATE], documents that R57 is cognitively intact.On 12/16/2025 at 2:03 PM V16, CNA, stated that residents do not go out in the lobby without staff. V16 stated that the staff must let them out to the lobby. On 12/17/2025 at 1:43 PM R12 stated that he does not know where the inspection book is and doesn't know how to find it. R12 stated that they guard the lobby with their life.R12's MDS, dated [DATE], documents that R12 is cognitively intact.On 12/17/2025 at 1:45 PM R15 stated that she is the president of resident council. R15 stated that they don't have access to the lobby without staff permission and help due to the door alarm.On 12/17/2025 at 11:27 AM V1, Administrator, stated that the facility does not have a policy for the survey book. V1 stated that they follow the Guidelines.The facility's Resident Rights policy, dated 6/1/25, documents that the resident has the right to Examine survey results.The Department of Health and Human Services Centers for Medicare and Medicaid Services Long-Term Facility Application for Medicare and Medicaid Form, dated 12/15/2025, documents 78 residents residing in the facility.

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	12/23/2025

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, observation, and record review, the facility failed to staff a Registered Nurse (RN) for eight hours per day, seven days a week for October, November, and December of 2025. This failure has the potential to affect all 78 residents residing in the facility.The findings include:On 12/15/25 at 8:30 AM, upon entering the facility and each day of the survey, there were three Licensed Practical Nurse (LPNs) working and no RNs.On 12/22/25 at 9:13 AM, V4, Assistant Director of Nursing (ADON), stated No, we don't have any RNs on our schedule, and I am an LPN. When asked about the one RN listed on the December schedule, V4 stated I don't even know who that is. On 12/22/25 at 9:15 AM, When asked about no RNs working in the facility, V1, Regional Administrator/Director of Operations, stated I believe that is correct, there are no RNs working here.On 12/22/255 at 9:17 AM, V2, Director of Nursing (DON), stated We don't have any RNs on our schedule except for one PRN (as needed) Nurse, and she hasn't worked in a while. I did hire one, but she has not started yet.A review of the nurse schedule for the past three months, documents in October 2025, there were two RNs on the schedule with a total of three days worked. The November nurse schedule documents no RNs on the schedule the entire month. The December nurse schedule, documents one RN on the schedule and she has not worked any shifts.On 12/22/25, V1 stated This is the only policy we have on staffing. We do not have one that covers RN's or the daily posting of staff. The Facility's Staffing Policy, undated, documents It is the policy of (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. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health. The division of nursing needs by shift will be calculated based on the resident census and needs. Licensed nurses are required to be licensed by the State in which they are practicing. Copies of current licenses shall be displayed in the facility. Nurse aids are required to be certified by the State in which the facility is located in compliance with Federal and State regulations. In addition, employees providing hands on care to residents shall agree to a criminal records search to demonstrate he/she has no convictions of abuse, neglect, or misappropriation of resident property according to State regulations. No person may provide direct resident care without certification and records check. RNs are required to be licensed by the State in which they are practicing. Copies of current licenses shall be displayed in the facility.The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 12/15/25, documents 78 residents reside in the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on interview, observation, and record review, the facility failed to post the nurse staffing data daily at the beginning of each shift. This failure has the potential to affect all 78 residents residing in the facility.The findings include:On 12/15/25 at 8:30 AM, upon entering the facility and each day of the survey, there was no posting of the facility staffing found anywhere in the facility.On 12/22/25 at 9:15 AM, When asked about posting of staffing daily, V1, Regional Administrator/Director of Operations, stated They have not been doing that here.On 12/22/255 at 9:17 AM, When asked about posting of staffing for public to see, V2, Director of Nursing (DON), stated We haven't been doing that.On 12/22/25, V1 stated This is the only policy we have on staffing. We do not have one that covers RN's or the daily posting of staff. The Facility's Staffing Policy, undated, documents It is the policy of (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. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health. The division of nursing needs by shift will be calculated based on the resident census and needs. Licensed nurses are required to be licensed by the State in which they are practicing. Copies of current licenses shall be displayed in the facility. Nurse aids are required to be certified by the State in which the facility is located in compliance with Federal and State regulations. In addition, employees providing hands on care to residents shall agree to a criminal records search to demonstrate he/she has no convictions of abuse, neglect, or misappropriation of resident property according to State regulations. No person may provide direct resident care without certification and records check. RNs are required to be licensed by the State in which they are practicing. Copies of current licenses shall be displayed in the facility. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 12/15/25, documents 78 residents reside in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store, label, and discard expired medication. This has the potential to affect all 78 residents residing in the facility.Findings include:On 12/16/2025 at 8:12 AM the 200 Hall Medication room was inspected. In the refrigerator located in the medication room contained: 1. 1 clear plastic with R41's Bisacodyl 10mg suppository with expiration date 7/31/2025. The clear bag contained 20 suppositories. 2. 1 open and partially used multidose vial of Tuberculin. No open date. The Tuberculin box documents house stock. The Tuberculin (Aplisol) Purified Protein Derivative (Mantoux) Tubersol package insert, dated April 2016, documents A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. On 12/16/2025 at 8:19 AM V14, Licensed Practical Nurse (LPN), verified that R41's suppositories were expired and should have been removed from use, destroyed, and reordered. V14 stated that R41 does have a current order for the bisacodyl 10mg. V14 stated that the tuberculin multidose vial was open and in use. V14 stated that the multidose vial should have an open date on the box or the vial. V14 stated that this is done at the time that the vial is accessed for the first time. V14 stated that Tuberculin has a shorter expiration and use by date once open. V14 stated that placing the open date on the vial or box is how they make sure the medication is not used passed the use by or new expiration date. V14 verified that there was not an open date, or any date written on the box or vial. On 12/16/2025 at 9:00 AM the 100/300 Hall Medication Room was inspected. The refrigerator located inside the medication room contained: 3. Bisacodyl 10mg suppositories. 6 Bisacodyl 10mg suppositories with expiration date 7/2023 and 10 Bisacodyl 10mg suppositories with expiration date 8/2024. 4. Acetaminophen 650 mg suppositories. 4 Acetaminophen 650 mg suppositories with expiration date 7/2024, 11 Acetaminophen 650 mg suppositories with expiration date 9/2025, and 3 Acetaminophen 650 mg suppositories with expiration date 8/2025. 5. 1 open and partially used multidose vial of Tuberculin. No open date. On 12/16/2025 9:07 AM V17, Licensed Practical Nurse (LPN), stated that the Bisacodyl suppositories and the Tuberculin are stock medications. V17 stated that these medications are for stock medications and are used for every resident as long as they have an order. 6. R85's package of 8 Acetaminophen 650 mg suppositories with discard date 10/18/2025, and expiration date November 2025 on label. R85's EHR documents that R85 was discharged from the facility on 3/26/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On 12/16/25 at 8:28 AM, V15, LPN, prepared to administer Lispro Insulin 2units to R55. V15 drew up the Insulin in a syringe and set it on the cart. When asked about the date of 10/2/25 that was written on the box of Insulin, V15 stated that is when it was opened. V15 then checked the actual label, and the insulin was dispensed to the facility on [DATE] and V15 then stated, I don't know why anyone would write that date on there because it was before we even got it. When asked how long the Insulin was good for once opened, V15 stated It's good for 30-days. I guess I should throw this one away. V15 threw that bottle of Insulin and the syringe out and obtained a new bottle from the med room. If not questioned, V15 was prepared to administer the expired Insulin to R55. On 12/23/25 at 8:20 AM, V23, LPN, stated If I find any medications that are expired, I will remove it from the cart and obtain a new bottle and would not give the expired med to the resident. On 12/23/25 at 8:25 AM, V17, LPN, stated If I find an expired medication, I will dispose of the med and get another one and would not give it to the resident. On 12/23/25 at 8:35 AM, V15, LPN, stated Anytime I find expired medications, I dispose of it and will get another bottle. I check the resident cards weekly for anything expired and the Director of Nursing (DON) and Assistant Director of Nursing (ADON) checks the carts for expired bottles. On 12/23/25 at 9:20 AM, V2, DON, stated I would expect staff to properly dispose of contaminated linen and not throw them on the floor. Me and the ADON do check the med carts monthly and if a nurse finds something expired, they should bring it to us, and we will dispose of it and make sure they have a replacement. The Facility's Medication Storage policy, dated 8/1/25, documents that Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles. Guidelines: 4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. 5.Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 15. Facility should ensure that medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed or returned to the provider. 16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law. 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to properly store, label and date opened food. This failure has the potential to affect all 78 residents at the facility.Findings include:On 12/15/2025 at 8:50AM during the initial tour of the kitchen; dry storage room floor has case of [NAME] choice diced pears in box on the floor. The walk-in refrigerator inside door on the shelf on right has opened carton of traditional scrambled egg mix. There is no date on the carton identifying when the scrambled egg mix was opened. On another shelf 2 separate clear containers with green lids contained noodle in broth. The 2 containers were not labeled or dated, a metal container with metal lid contained cooked cereal, no label or date on container, metal container of sliced tomatoes covered with clear wrap, unlabeled, and not dated, metal container of sliced onions covered with clear wrap unlabeled and undated, opened bottle of thick and easy thickened orange juice with half of orange juice out of container is not dated. In the walk-in freezer Box with plastic bag of mixed vegetables on shelf in freezer, plastic bag open .box labeled white fully cooked diced chicken 3/8 inch has plastic bag containing chicken has been opened, not sealed or dated. The Central Management Services (CMS) 671 Long Term Care Facility Application for Medicare and Medicaid dated 12/15/2025 documents a census of 78. On 12/17/2025 at 11:15AM V9 dietary manager stated all opened food in the freezer and refrigerator should be labeled and food should not be stored on the floor. The facility policy Storing, food storage, undated documents food should be stored and prepared in a clean safe sanitary manner that complies with state and federal guidelines. The policy documents food is stored at least 6 inches from the floor. The policy documents all food not in original containers should be labeled and dated. The policy documents food should be labeled and dated to monitor food safety.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to answer call lights timely for 4 of 24 (R12, R15, R57, R66) residents reviewed for call lights in a sample of 67.Findings include:1. The facility Resident Council Minutes, dated October 15, 2025, July 16, 2025, and May 21, 2025, document concerns about call lights not being answered in a timely manner and staff turning off call lights.2. On 12/17/2025 at 1:40 PM R66 stated that the staff do not answer the call lights. R66 stated that the staff are no where to be found. R66 stated that it's horrible. R66's Fall Risk Evaluation, dated 12/2/2025, documents that R66 is alert and oriented x3. 3. On 12/17/2025 at 1:41 PM R57 stated that the staff do not answer the call lights timely if they answer them at all. R57 stated that you must go and find someone to help you and they may come or not. R57's Minimum Data Set (MDS), dated [DATE], documents that R57 is cognitively intact. 4. On 12/17/2025 at 1:43 PM R12 stated that the staff do not answer the call lights timely if they answer them at all. R12 stated that they are either wrapped in blankets sleep or they are sitting in the TV room. R12 stated that they do not answer the lights. How do you get help.R12's MDS, dated [DATE], documents that R12 is cognitively intact. 5. On 12/17/2025 at 1:45 PM R15 stated that she is the president of resident council. R15 stated that the staff do not answer the call lights timely if they answer them at all. R15 stated that the staff will also come in the room turn the light off and never return. R15's MDS, dated [DATE], documents that R15 is cognitively intact.On 12/18/2025 at 9:16 AM V25, Certified Nurse's Assistant (CNA), stated that it is everyone's responsibility to answer a call light. V25 stated that the call lights should be answered timely and this is about 3 minutes of the light coming on.On 12/18/2025 at 9:18 AM V15, Licensed Practical Nurse (LPN), stated that it is everyone's responsibility to answer call lights. V15 stated that it shouldn't take longer than 5 minutes to answer the call light. V15 stated that the older staff do turn the call lights off. V15 stated that she would expect the staff to return within 10 minutes to perform the care. V15 stated that newer CNAs leave the call light on as a reminder to return.The facility's Call Light policy, not dated, documents Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. 4.Requests shall be responded to in a courteous and professional manner.The Residents' Rights for People in Long-term Care Facilities Booklet, dated 10/20, documents that Your -facility must provide services to keep your physical and mental health, and sense of satisfaction.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide activities for 5 of 5 (R2, R12, R15, R57, R66) residents reviewed for activities in the facility in a sample of 67. Findings include:1 On 12/16/2025 at 11:25 AM R2 stated that there are no activities. Nothing. Just bingo. But what about the people that don't like bingo. I'm bored out of my mind. R2 stated that there is no activity person. So no activities.On 12/17/2025 at 1:30 PM a resident council meeting occurred. During the meeting R66, R57, R12, and R15 stated that they don't have any activities at the facility. R66, R57, R12, and R15 stated that they are bored there is nothing to do.2. On 12/17/2025 at 1:40 PM R66 stated that there are no activities. R66 stated that there is nothing to do. R66 stated that when you get bored you start doing your own thing and that isn't always good.R66's Fall Risk Evaluation, dated 12/2/2025, documents that R66 is alert and oriented x3.3. On 12/17/2025 at 1:41 PM R57 stated that there isn't anything to do around here. R57 stated that since the activity person got sick and quit there hasn't been any the activities. R57 stated that they had another and she didn't stay long. R57 stated that she didn't do any activities. R57 stated that she walks around sometimes but there is nothing to do.R57's Minimum Data Set (MDS), dated [DATE], documents that R57 is cognitively intact.4. On 12/17/2025 at 1:43 PM R12 stated that he is bored at the facility. R12 stated that there are no activities at all.R12's MDS, dated [DATE], documents that R12 is cognitively intact.5. On 12/17/2025 at 1:45 PM R15 stated that they cut out the bingo. R15 stated that since the activity person left, they have not had any consistent activities. R15 stated that they don't have a calendar with the activities on them or nothing.During investigation from 12/15/2025 to12/18/2025 from 8AM to 3PM no activities were observed.On 12/18/2025 at 1:19 PM observed December Activity Calendar on the hall wall.On 12/18/2025 at 1:20 PM When asked where are the activities, listed on the Activity Calendar, occurring V1 stated that the activities are usually done in the dining room. V1 stated that they are not occurring because they do not currently have an activity person. V1 stated that they are actively recruiting and hiring at this time.The facility's Activities Program, dated 12/1/25, documents Purpose: To provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being. Guidelines: The Activity Director, trained staff, or volunteer will: 1. identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs. 2.Enhance the resident's highest practicable level of physical, mental, and psychosocial well-being by offering a program of activities that provides the following: a. A heightened sense of well-being b. Promotion of feelings of self-esteem, pleasure, comfort, education, creativity, success, and independence c. That promotes educational or intellectual thought and requires thinking d. Age and gender-specific e. Produce something useful and provide purpose f. Relate to previous work g. Allow for socializing with visitors and participating in community events h. Allow for opportunities for creativity and creative expression i. Physically active programming j. Produce or teach something k. Religious activities l. Opportunities for activities that contribute to the facility 3. A minimum of 4-7 organized activities will be scheduled daily. 4. Provide programs for residents who will not, or cannot, effectively plan their own activity pursuits. 5. Provide for residents needing specialized or extended programs to enhance their overall daily routine and activity pursuit needs. 6. The program of activities will include a combination of large and small groups, one to one's, and self-directed activities. 7. The program of activities will include a system that allows the activity staff to develop, implement, and evaluate the resident's interests and involvement in the activities provided and adjust the daily programming as needed in order to meet the needs of the residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to change and date humidified Oxygen (O2) water bottles for 4 of 4 residents (R1, R3, R36, R48) reviewed for respiratory care in the sample of 67.The findings include:1. R36's admission Record, dated 12/16/25, documents R36 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Atherosclerotic Heart Disease (ASHD), Major Depressive Disorder, Schizophrenia, Hypertension (HTN), and Mutism.R36's Care Plan, dated 11/19/25, documents R36 has oxygen therapy related to COPD and SOB (shortness of breath), has Emphysema/COPD. 11/24/25: R36 has asthma, and shortness of breath. Interventions: Give medications as ordered, monitor/document side effects and effectiveness, give nebulizer treatments and oxygen therapy as ordered. Oxygen Settings: O2 via nasal cannula (NC) at 2 L (liters).R36's Minimum Data Set (MDS), dated [DATE], documents R36 has a moderate cognitive impairment and requires supervision/touching assistance for Activities of Daily Living (ADLs) and transfers. Section I: Active Diagnosis Debility, Cardiorespiratory Condition. Section O: Special Treatments - Respiratory Treatments: Oxygen Therapy.On 12/15/25 at 10:00 AM, R36 had an oxygen concentrator in his room with the humidified water bottle dated 11/24/25.On 12/17/25 at 9:50 AM, R36 in his room sitting in wheelchair, water bottle still dated 11/24/25. R36 stated he only uses that when he needs it.R36's Physician Order (PO), dated 8/8/25, documents Oxygen 2L/NC Continuous/PRN (as needed), may titrate to keep SPO2 (oxygen saturation) above 90% as needed.R36's PO, dated 8/8/25, documents Humidification with oxygen, one time a day every Sunday and as needed. R36's PO, dated 8/8/25, documents Change oxygen tubing, one time a day every Sunday. R36's MAR (Medication Administration Record) - TAR (Treatment Administration Record), dated December 2025, documents Change oxygen tubing one time a day every Sunday. This was documented as completed on 12/7/25 and 12/14/25. R36's MAR-TAR, dated December 2025, documents Humidification with oxygen one time a day every Sunday. This was documented as completed on 12/7/25 and 12/14/25. 2. R48's admission Record, dated 12/16/25, documents R48 was admitted to the facility on [DATE] with diagnosis of COPD, Type 2 Diabetes Mellitus (DM) chronic kidney disease (CKD), Atrial Fibrillation, HTN, and Neuropathy.R48's Care Plan, dated 7/2/25, documents R48 has COPD with interventions: Oxygen Settings: O2 via nasal prongs at 2 L continuously. R48 has shortness of breath (SOB) related to COPD and Congestive Heart Failure (CHF).R48's MDS, dated [DATE], documents R48 is cognitively intact and requires supervision/touching assistance for ADLs and transfers. Section I: Active Diagnosis Debility, Cardiorespiratory Condition. O: Special Treatments - Respiratory Treatments: Oxygen Therapy.On 12/15/25 at 10:09 AM, R48 was observed on O2 at 2 L/NC with the humidified water bottle undated.On 12/17/25 at 9:54 AM, R48 was observed on O2 at 2 L/NC with bottle still undated. R48's PO, dated 2/3/25, documents O2 at 2l/NC to maintain SpO2 90% or above, every shift for monitoring.R48's PO, dated 1/22/25, documents Change O2 Humidity every 3 days and PRN, one time a day every 3 days related to COPD.R48's PO, dated 1/22/25, documents Change O2 tubing every 6 days, one time a day every 6 days related to COPD.R48's MAR-TAR, dated December 2025, documents Change O2 Humidity every 3 days and PRN, one time a day every 3 days. This was documented as completed on 12/1/25, !2/4/25, 12/7/25, 12/10/25, 12/13/25, and 12/16/25.R48's MAR-TAR, dated December 2025, documents Change O2 tubing every 6 days, one time a day every 6 days. This was documented as completed on 12/1/25, 12/7/25, and 12/13/25. 3. R3's admission Record, dated 12/16/25, documents R3 was admitted to the facility on [DATE] with diagnosis of COPD, Chronic Kidney Disease, Hepatitis C, Pulmonary Nodule, Abdominal Aortic Aneurysm (AAA), Transient Cerebral Ischemic Attack (TIA), Depression, HTN, CHR, Pneumonia, Anemia, and Atrial Fibrillation.R3's Care Plan, dated 1/20/25, documents R3 has Ineffective Airway Clearance. Intervention: Provide oxygen as indicated by Resident condition and / or provider order. It continues R3 is at risk for COPD (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Complication.R3's MDS, dated [DATE], documents R3 is cognitively intact and requires supervision/touching assistance for ADL. Section I: Active Diagnosis: Debility, Cardiorespiratory Condition. Section O: Special Treatments - Respiratory Treatments: Oxygen Therapy.On 12/15/25 at 11:00 AM, R3 sitting on side of his bed on oxygen at 3L NC with the humidified water bottle undated. Nebulizer on table with mask sitting on it and not in bag.On 12/17/25 at 9:45 AM, R3 sitting in wheelchair in his room, on oxygen at 2 L/NC with humidified water bottle undated with approximately half full.R3's PO, dated 2/3/25, documents Oxygen at 2L/NC maintain SpO2 at 92 or above every shift for monitoring.R3's PO, dated 2/3/25, documents Change oxygen humidity bottle Q (every) 3 days and as needed, every night shift, every 3 days related to COPD.R3's MAR-TAR, dated December 2025, documents Change Nasal Cannula Q (every) week and as needed, every night shift, every Tuesday. This was documented as completed on 12/2/25, 12/9/25, and 12/16/25. R3's MAR-TAR, dated December 2025, documents Change Oxygen Humidity Bottle Q 3 days and as needed, every night shift, every 3 days. This was documented as completed on 12/3/25, 12/6/25, 12/9/25, 12/12/25, and 12/15/25. 4. R1's admission Record, dated 12/16/25, documents R1 was admitted to the facility on [DATE] with diagnosis of Dyspnea, Dependence on Oxygen, Type 2 DM, Dementia, Anemia, HTN, Hallucinations, and Psychotic Disorder.R1's Care Plan, dated 1/20/25, documents R1 has an Impaired Gas Exchange. Intervention: Administer oxygen as prescribed or per standing order. R1 is at risk for Ineffective Airway Clearance. Intervention: Utilize humidity (humidified oxygen or humidifier). It continues R1 has SOB related to dyspnea. R1's MDS, dated [DATE], documents R1 has a severe cognitive impairment and is dependent on staff for ADLs. Section O: Special Treatments - Respiratory Treatments: Oxygen Therapy.On 12/15/25 at 11:10 AM, R1 lying in bed on O2 at 3L/NC with the humidified water bottle dated 11/29/25.On 12/17/25 at 9:40 AM, R1 lying in bed on oxygen running at 2 L/NC with humidified water bottle dated 11/29/25.R1's PO, dated 1/31/25, documents Oxygen at 2L/NC, every shift.R1's PO, dated 2/3/25, documents Maintain SpO2 90% or above, every shift, related to Dyspnea.R1's PO, dated 1/15/25, documents Change Oxygen Humidified Bottle every 3 days and PRN, every 72 hours related to Dependence on Supplemental Oxygen.R1's PO, dated 1/15/25, documents Change O2 Tubing every 6 days and PRN, every night shift, every 6 days, related to Dependence on Supplemental Oxygen.R1's MAR-TAR, dated December 2025, documents Change O2 Tubing every 6 days and PRN, every night shift, every 6 days. This is documented as completed on 12/5/25, and 12/11/25.R1's MAR-TAR, dated December 2025, documents Change Oxygen Humidified Bottle every 3 days and PRN, every 72 hours. This is documented as completed on 12/2/25, 12/5/25, 12/11/25, and 12/14/25. On 12/23/25 at 8:20 AM, V23, Licensed Practical Nurse (LPN), stated The nurses are responsible for changing the O2 cannulas and water bottle. It will pop up on the MAR-TAR when it is due to be changed.On 12/23/25 at 8:25 AM, V17, LPN, stated Nurses change the oxygen water bottles and cannulas, it will pop up on the MAR-TAR for us to do. I always check it off and will walk up and down the hall changing them.On 12/23/25 at 8:35 AM, V15, LPN, stated Oxygen water bottles and cannulas are changed by the nurses every Sunday and PRN. I usually don't work the 3rd shift so don't change them, they're supposed to be doing that.On 12/23/25 at 9:20 AM, V2, Director of Nursing (DON), stated I would expect the nurses to be changing the oxygen water bottles weekly as indicated on the MAR-TAR and not just sign them off as completed.The Facility's Oxygen Administration Policy, dated 8/1/25, documents in part Infection Control: A. All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen: i) are for single resident use only. ii) will be changed weekly and when visibly soiled, or as indicated by state regulation. B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide activities for 4 of 4 (R1, R16, R25, R34) residents reviewed for treatment and services for dementia residents in the facility in a sample of 67. Findings include:1. R16's admission Record, print date 12/17/2025, documents admission date of 1/17/2025 and lists dementia with anxiety as diagnosis.R16's Care Plan, dated 11/26/25, documents that R16 is an elopement risk/wanderer r/t (related to) disoriented to place, resident wanders aimlessly. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers:On 12/15/2025 at 11:25 R16 observed sitting in room with head down. R16 stated that he is not invited to any activities but would go if there were any. 2. R1's admission Record, print date 12/16/2025, documents admission date of 12/1/2024 and lists unspecified dementia, severe with psychotic disturbances as diagnosis.R1's Care Plan, dated 1/20/25, documents that R1 has Impaired Social Interaction. Interventions: Consult facility activities coordinator. Provide positive enforcement when Resident participates in activities.3. R25's admission Record, print date 12/17/2025, documents admission date of 12/1/2024 and lists dementia as diagnosis.R25's Care Plan, dated 2/25/2025 documents that R25 has Impaired Social Interaction. Intervention: Consult facility activities coordinator. Encourage Resident to participate in recreational activities.4. R34's admission Record, print date 12/17/2025, documents admission date of 8/18/25 and lists dementia with psychotic disturbances as diagnosis.R34's Care Plan, dated 9/12/25, documents that R34 has Impaired Social Interaction. Interventions: Consult facility activities coordinator. Encourage Resident to participate in social situations. Provide positive enforcement when Resident participates in activities.On 12/17/2025 at 1:30 PM a resident council meeting occurred. During the meeting R66, R57, R12, and R15 stated that they don't have any activities at the facility. R66, R57, R12, and R15 stated that they are bored there is nothing to do.On 12/17/2025 at 1:41 PM R57 stated that there isn't anything to do around here. R57 stated that since the activity person got sick and quit there hasn't been any the activities. R57 stated that they had another and she didn't stay long. R57 stated that she didn't do any activities. R57 stated that she walks around sometimes but there is nothing to do.R57's Minimum Data Set (MDS), dated [DATE], documents that R57 is cognitively intact.On 12/17/2025 at 1:43 PM R12 stated that he is bored at the facility. R12 stated that no activities at all.R12's MDS, dated [DATE], documents that R12 is cognitively intact.On 12/17/2025 at 1:45 PM R15 stated that she is the president of resident council. R15 stated that they cut out the bingo. R15 stated that since the activity person left, they have not had any consistent activities. R15 stated that they don't have a calendar with the activities on them nothing.During investigation from 12/15/2025 to 12/18/2025 from 8AM to 3PM no activities were observed.On 12/18/2025 at 1:19 PM observed December Activity Calendar on the hall wall.On 12/18/2025 at 1:20 PM When asked where the activities are, listed on the Activity Calendar, occurring V1 stated that the activities are usually done in the dining room. V1 stated that they are not occurring because they do not currently have an activity person. V1 stated that they are actively recruiting and hiring at this time.The facility's Activities Program policy, dated 12/1/2025, documents that Purpose: To provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being. Guidelines: The Activity Director, trained staff, or volunteer will: 1. Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs. 2.Enhancethe resident's highest practicable level of physical, mental, and psychosocial well-being by offering a program of activities that provides the following: 3. A minimum of 4-7 organized activities will be scheduled daily. 4. Provide programs for residents who will not, or cannot, effectively plan their own activity pursuits. 5. Provide for residents needing specialized or extended programs to enhance their (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overall daily routine and activity pursuit needs. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to complete a medication review for 1 of 1 resident (R8) reviewed for medications in the sample of 67.R8's Note to attending physician/prescriber dated, printed 7/26/2025 documents consider a gradual dose reduction for the following medication Buspirone 10mg daily. R8's Note to attending physician/prescriber fails to document physician review or signature. R8's Note to attending physician/prescriber dated, printed 8/27/25 documents consider a gradual dose reduction for the following medication: Sertraline 100mg daily the sheet fails to document physician review or signature as sheet is blank. R8's physician order dated 12/18/2025 documents Sertraline 100mg daily, Buspirone 10mg daily. R8's face sheet dated 12/17/2025 documents R8 has a diagnosis of paranoid schizophrenia, major depressive disorder and bipolar disorder, current episode manic without psychotic features. On 12/17/2025 at 11:44AM, V2 Director of Nursing (DON) stated by looking at the blank note to attending physician for consideration of medication reduction, they were not done. The facility policy Medication Regiment Review, undated documents in performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition, to other applicable standards, such as the American Society of Consultant Pharmacists Practice standard and clinical standards. The policy documents recommendations are acted upon and documented by the facility staff and or the prescriber. The policy documents the physician accepts and acts upon suggestion or rejects and provides explanation for disagreeing

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure food was served at palatable temperatures for foods for 4 of 4 (R2, R15, R28, R57) people review for meal services in a sample of 67. Findings include:1. The facility's Resident Council Minutes dated October 15, 2025, documents concern with the food being cold and bland.The facility's Resident Council Minutes dated September 17, 2025; documents concern about food overall.The facility's Resident Council Minutes dated August 20, 2025; documents concern about being cold all the time.The facility's Resident Council Minutes dated June 18, 2025, documents concern with food being bland and cold.2. R2's Minimum Data Set, dated [DATE], documents that R2 is cognitively intact.On 12/16/2025 at 11:20 AM R2 stated that the food is horrible. It's cold. R2 stated that sometimes the food is done and sometimes it's not. R2 stated that If you don't have your own food you will starve. R2 stated that the food comes at different times. R2 stated that sometimes it's late and sometimes it doesn't come at all. 3. R28's MDS, dated [DATE], documents that R28 is cognitively intact.On 12/16/2025 at 11:49 AM R28 stated that the food is cold and delivered late. R28 stated that You don't know when the food is coming just have to wait until it gets there.4. R15's MDS, dated [DATE], documents that R15 is cognitively intact. On 12/17/2025 at 1:45 PM R15 stated that the food is horrible and tasteless. R15 stated that that the food is cold. R15 stated that they don't know when the food will be delivered. R15 stated that breakfast starts at 7 AM. R15 stated that they have had delays up to 2 hours. R15 stated that the food will get to you around 9:30 AM and then it's cold. R15 stated that if you don't eat it then you have nothing.5. R57's Minimum Data Set (MDS), dated [DATE], documents that R57 is cognitively intact. On 12/17/2025 at 1:41 PM R57 stated that the food is cold and late more often than not. R57 stated that it looks horrible and tastes horrible as well.The facility's Food Preparation: Teste-Tasting policy, not dated, documents that Procedure: 4. Food items will not be served unless palatable and pleasing to the eye.The facility's Food & Beverage Temperature Control policy, not dated, documents that Policy: Food temperature are maintained during serving times. Purpose to ensure residents receive safe food served at acceptable temperatures.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to perform appropriate hand hygiene when assisting resident with feedings, when performing wound care, and then proper disposal of contaminated linen for 4 of 12 residents (R6, R11, R63, R77) reviewed for infection control practices in the sample of 67.Findings include:1. On 12/15/25 at 12:15 PM, during lunch observation, R6 was seen sitting in the dining room getting feeding assistance from V11, Certified Nursing Assistant (CNA). V11 was seen getting up, assisting other residents, walking to the kitchen and leaving R6 at the table by himself, picking up lunch trays and putting on cart, then sitting back with R6 to assist in feeding him again, all with no hand hygiene seen done before, during, or after assistance given. 2. On 12/15/25 at 10:50 AM, R63 had a contact isolation sign on the wall outside her door. V10, CNA, was performing peri-care on R63 with a gown, mask, and gloves on. V10 had thrown all the soiled linen and wet brief soaked in urine onto the floor. Upon entrance to the room, V10 then picked up the linen and put it in isolation container in room. There was a bottle of peri-cleaner and a roll of trash bags on the floor where the soiled linen was thrown. V10 picked up the bottle and trash bags and placed on the side table. V10 used the same soiled gloves while handling clean linen and other items in the room. R63 stated she is on isolation and not able to leave her room due to a bad infection. R63 has diagnosis of UTI/ESBL (Urinary Tract Infection/Extended-Spectrum Beta-Lactamases). R63's Care Plan, dated 11/24/25, documents R63 is on antibiotic therapy for ESBL, Macrobid 100 MG (milligram) PO (oral) BID (twice daily) x 10 days until 12/03/25, isolation precautions set up outside of room. R63's Order Note, dated 12/16/25 at 7:37 AM, documents Results rec'd (received) for UA (urinalysis) C/S (culture/sensitivity) notified NP (Nurse Practitioner) with orders for the following: Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for ESBL for 10 days. R63's Health Status Report, dated 12/17/25 at 9:29 PM, documents Resident on Macrobid r/t (related to) ESBL in the urine isolation precautions in effect, skin w/d (warm/dry) resp e/n (even/nonlabored), denies pain or distress, no urinary distress noted, fluids encouraged, 97.9 will continue with plan of care. 3. On 12/18/25 at 9:10 AM, V23, Licensed Practical Nurse (LPN), was observed doing wound care on R11. V23 walked into the room with supplies and then donned gloves with no hand hygiene done. V23 cleaned each area with wound cleaner and 4X4's, with glove changes between each area. V23 put Zinc Oxide ointment followed by anti-fungal cream onto the reddened areas with glove changes between each area. V23 did not do any hand hygiene before, during glove changes, or after care was done. On 12/23/25 at 8:20 AM, V23, LPN, stated I do hand hygiene before and after resident care. I change my gloves when going from dirty to clean areas, then do hand hygiene between glove changes. On 12/23/25 at 8:25 AM, V17, LPN, stated I do hand hygiene before walking into a room and when leaving the room. I change my gloves when they are soiled and will use hand sanitizer between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/23/25 at 8:30 AM, V11, CNA, stated I do hand hygiene anytime I am doing resident care, before and after the care. I change gloves and will use hand sanitizer between glove changes. When feeding a resident, I use gloves and hand sanitizer. On 12/23/25 at 8:35 AM, V15, LPN, stated I do hand hygiene when passing meds and pretty much everything you do around here. When changing gloves, I use hand sanitizer between glove change. On 12/23/25 at 8:45 AM, V21, CNA, stated I do hand hygiene before and after resident care and between glove changes. If I am assisting a resident with feeding, I don't wear gloves but use hand sanitizer before. On 12/23/25 at 9:20 AM, V2, Director of Nursing (DON), stated I would expect all staff to perform hand hygiene before and after resident care, between glove changes, and while assisting residents with feeding. I would expect all staff to change their gloves when going from dirty to clean areas and in between residents. I would expect staff to properly dispose of contaminated linen and not throw them on the floor. 4. On 12/15/2025 at 12:20PM V12, CNA standing up beside R77. V12, CNA then pulls chair up beside R77. V12, CNA then picks up fork and starts feeding R77. V12 did not sanitize her hands prior to feeding R77. On 12.15//2025 at 12:36PM V12, CNA put her hands on her lap then gets spoon and starts feeding R77. V12 did not sanitize her hands. R77's Minimum Data Set (MDS) dated [DATE] documents Severe cognitive impairment with a Brief interview of Mental status (BIMS) if 6. R- MDS documents R77 is dependent on staff for eating. The Facility's Hand Hygiene Policy, undated, documents in part Examples of when to perform Hand Hygiene: Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed). After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. If hands will be moving from a contaminated-body site to a clean-body site during patient care. Before gloves placement. After glove removal. The Facility's Infection Prevention Policy, dated 10/1/25, documents in part It is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of isolation precautions. Standard precautions will be employed by all personnel for all residents at all times. Points to remember: Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Linens soiled with blood, body fluids, secretions, and excretions will not be placed on the floor or other resident equipment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide assistance with eating for 2 of 8 residents (R50 and R70) reviewed for assistance with eating in the sample of 67. Findings include: 1. On 12/15/2025 at 12:08PM trays being passed in 2nd floor dining room. The meal consists of pasta with peas and chicken, cooked carrots, white cake with frosting. On 12/15/2025 at 12:13PM R50 sitting sideways in a regular chair at table with tray in front of R50 with plate with pasta, and cooked carrots, separate plate with cake, glass of water covered with plastic, orange drink covered with plastic, mighty shake (unopened)12:25PM R50 has not taken a bite, just looking at food drinks remain covered with plastic, and mighty shake unopened. On 12/15/2025 at 12:35PM R70 1/2 cake eaten, Casserole and carrots not touched. R70 drank 1/2 glass of drink. R70 is not being provided any cueing or encouragement to eat. At 12:37PM R70 dozing at table, knocks spoon off table to floor, then picks up spoon and places on tray. cake is on saucer on table. R70 is trying to get cake on fork and saucer keeps moving. R70 finally managed to spear cake with fork, then partially falls off onto tray then R70 manages to get some of cake off tray with fork. On 12/15/2025 at 12:40PM, V12 CNA sitting at table with R77 asks R70 if R70 needs anything, and states you too to R50 but did not encourage either one to eat. On 12/25/2025 at 12:45PM R50 continues to sit sideways at table, V12, CNA tells R50 she can drink, glasses remain covered with plastic and mighty shake unopened. At 12:47PM R50 removing plastic from orange drink and sipping drink. On 12/15/2025 at12:48PM V14, Licensed Practical Nurse (LPN) entered dining room and encouraging R70 to eat. V14 also encouraged R50 to eat casserole. On 12/15/2025 at 12:55PM R50 taking bite of casserole with fork. V12, CNA after taking R77 tray to cart asked R50 if wanted mighty shake opened, did not offer to open it for R50. On 12/15 2025 at12:54PM V12 CNA asked R50 if wanted to go to room. R50's glass of water still had plastic covering, mighty shake unopened. few bites of casserole, 100% cake eaten, carrots untouched. On 12/25/2025 at 1:04PM V12, CNA assisted R50 out of dining room. R50's Minimum Data Set (MDS) dated [DATE] documents R50 is cognitively intact with a Behavioral Interview for Mental Status (BIMS) if 15. R50's MDS documents R50 requires supervision or touch assistance for eating (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R50's undated care plan documents R50 is at risk for self-care deficit: Bathing, dressing, and feeding. R50's care plan documents intervention provide assistance with ADLs as needed. R50's face sheet, dated 12/17/2025 documents a diagnosis in part, catatonic schizophrenia 2. R70's MDS dated [DATE] documents R70 has severe cognitive impairment with a BIMS of 6. R70's MDS documents R70 requires supervision or touching assistance for eating. (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity. Assistance may be provided throughout the activity or intermittently. R70's undated care plan documents R70 is at risk for self-care deficit: Bathing, dressing, and feeding. R70's care plan documents intervention provide assistance with ADLs as needed. On 12/18/2025 at 2:31PM V2, Director of Nursing (DON) stated residents who require assistance with eating should be provided assistance as needed.The facility policy Activities of Daily Living (ADL), supporting, dated reviewed 7/15/2025 documents residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal hygiene. The policy documents if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a time or having another staff member speak with the resident may be appropriate.

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	12/23/2025

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 4 residents (R2, R6) observed during medication pass. Fourteen errors were observed during 38 opportunities for errors during medication administration. This resulted in a medication error rate of 36.84 percent. The findings include:1. R6's admission Record, dated 12/17/25, documents R6 was originally admitted to the facility on [DATE] with diagnosis of Malnutrition, Catatonic Schizophrenia, Anxiety Disorder, Hypertension (HTN), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), Major Depressive Disorder, and Pneumonitis.R6's Care Plan, dated 3/3/25, documents R6 has Impaired Coping, has a Self-Care Deficit, Risk for Decreased Cardiac Output, Risk for Impaired Communication, Decreased Cardiac Output, Arrhythmia, Hypertension, Disturbed Sensory Perception: Audible/Visual, Malnutrition. It continues 12/1/25: R6 has a behavior problem related to catatonic schizophrenia, anxiety and depression. examples walking fast for hours without sitting down, attempts at grabbing items not belonging to him and walking up onto others quickly. Interventions: Administer medications as ordered. R6 has Diabetes Mellitus. R6 is on anticoagulant therapy related to atrial fibrillation. Interventions: Administer Anticoagulant medications as ordered by physician. R6 is on diuretic therapy. Interventions: Administer Diuretic medications as ordered by physician. R6 is on pain medication therapy. Interventions: Administer Analgesic medications as ordered by physician. R6 uses antidepressant medication related to Depression Diagnosis. Intervention: Administer Antidepressant medications as ordered by physician. R6 uses anti-anxiety medications. Intervention: Administer Anti-Anxiety medications as ordered by physician. R6 uses psychotropic medications. Intervention: Administer Psychotropic medications as ordered by physician. R6 has fluctuations in mood related to Catatonic Schizophrenia. Interventions: Administer medications as ordered.R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs).R6's Physician Order (PO), dated 12/16/25, documents May crush medication.R6's PO, dated 11/10/25, documents Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (milligram) Give 2 capsule by mouth one time a day for Anticonvulsants.R6's PO, dated 10/1/25, documents Austedo Oral Tablet (Deutetrabenazine) Give 6 MG by mouth every 12 hours for Psychosis.R6's PO, dated 9/30/25, documents Haloperidol Tab 5 MG Give 1 tablet by mouth two times a day for Schizophrenia.R6's PO, dated 2/10/25, documents Carvedilol Oral Tablet 3.125 MG Give 1 tablet by mouth two times a day for HTN Take with meals.R6's PO, dated 8/29/25, documents Furosemide Oral Tablet 20 MG Give 1 tablet by mouth two times a day for diuretic.R6's PO, dated 4/17/25, documents Hyoscyamine Sulfate Oral Tablet Disintegrating 0.125 MG Give 1 tablet by mouth every 4 hours as needed for secretions.R6's PO, dated 3/18/25, documents Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth four times a day.On 12/16/25 at 8:00 AM, V15, Licensed Practical Nurse (LPN), was observed administering medications to R6. V15 obtained all R6's medications from the medication cart. V15 crushed up all medications except for the Depakote capsules which were opened and put in with all the other crushed meds. V15 mixed the crushed medications with a spoonful of oatmeal. After mixing the medications in the oatmeal, V15 put the spoonful of oatmeal mixed with medications in the bowl of oatmeal and delivered it to R6's room where V16, Certified Nursing Assistant (CNA) was sitting assisting R6 with breakfast. V15 placed the bowl of oatmeal with the spoon of medications onto R6's breakfast tray and left the room. V16 attempted multiple times to feed R6 his oatmeal, not knowing that there were medications in the bowl, and each time, R6 refused to eat the oatmeal. On 12/16/25 at 8:50 AM, V16, CNA, stated (R6) did not eat any of his oatmeal this morning. Someone came in and took his breakfast tray out of the room. R6 did not get any of his morning medications.On 12/16/25 at 2:25 PM, V4, Assistant Director of Nursing (ADON), was advised of R6 not receiving his morning medications from V15, LPN. V4 stated Well, that would contribute to some of his behaviors lately.On 12/16/25 at 3:40 PM, V28, Nurse (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practitioner (NP), stated I was not aware of (R6) not getting any of his medications today, only that he was having behaviors this morning and that was probably because he didn't sleep last night. I did stop (R6's) Eliquis, but I did not stop his Plavix or Aspirin. The Depakote DR Sprinkles I believe is approved to sprinkle over food and such, so it is ok for them to open the capsules. I'm not sure what to say about the CNA, but I would not expect the CNA to be given him his medications. (R6) has all his medications ordered and he should be getting them as ordered. If (R6) has missed multiple doses, that could contribute to behaviors.2. R2's admission record, dated 12/17/25, documents R2 was admitted on [DATE] with diagnosis of Peripheral Vascular Disease (PVD), Stenosis of carotid arteries, HTN, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Polyneuropathy, Dorsalgia, Disease of spinal cord, Alcohol abuse, Depression, Generalized Anxiety Disorder, Major Depressive Disorder, Spondylolysis, and Spinal stenosis.R2's Care Plan, dated 9/25/25, documents R2 is cognitively intact and requires supervision/touching assistance for ADLs and transfers.R2's MDS, dated [DATE], documents R2 is cognitively intact and requires supervision or touching assistance for ADLs. R2's PO, dated 3/24/25, documents Calcium Carbonate Oral Tablet Chewable, Give 2 tablets by mouth in the morning.On 12/16/25 at 8:21 AM, V15, LPN, gave R24 his medications in one medicine cup with his Calcium Carbonate tablets in another cup. V15 left the Calcium Carbonate sitting on his bedside table and stated, He will take that when he wants to. and left the room.On 12/23/25 at 8:20 AM, V23, LPN, stated When passing meds, I make sure the resident takes them before I leave the room and would never leave them for a CNA to give them to the resident.On 12/23/25 at 8:25 AM, V17, LPN, stated I stand by the resident to make sure they take the medication and don't choke on them. I would not leave them with a CNA for them to give to the resident.On 12/23/25 at 8:35 AM, V15, LPN, stated I always watch the resident take their meds and would never leave the meds with a CNA for them to give to the resident.On 12/23/25 at 9:20 AM, V2, Director of Nursing (DON), stated . I would expect the nurses to stand by the resident and ensure the resident takes all their medications. They should never leave the medications with a CNA or at the resident's bedside.The Facility's Medication Administration Policy, dated 6/1/25, documents in part . Medications will be administered by a Licensed Nurse per the order of Attending Physician or licensed independent practitioner or as consistent with state law. III. Medications must be given to the resident by the Licensed Nurse to prepare the medication, to as consistent with state law. V. Medications may be administered one hour before or after the scheduled medication administration time. VIII. Medications will not be left at bedside. IX. If the attending physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order. Procedure: VIII. Compare the licensed practitioner's prescription/order with MAR (Medication Administration Record) (first check). XV. Administer the medication to the resident. XVI. The licensed nurse will remain with the resident until the medicine is actually swallowed.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide 80 square feet of floor space per resident bed for 53 of 78 residents (R2, R3, R6, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R19, R21, R25, R26, R29, R31, R33, R34, R35, R36, R38, R41, R42, R43, R45, R46, R47, R48, R51, R52,R53, R54, R55, R56, R59, R61, R62, R63, R65, R67, R69, R70, R73, R74, R75, R76, R77, R82, R83, and R84) reviewed for room size in the sample of 78.Findings include:The Facility has 30 two-bed resident rooms which provide only 75 square feet per resident bed. According to historical data and current room measurements, these rooms measure 12 feet by 12 feet six inches. All these rooms are certified for Medicare and Medicaid. These rooms are as follows: room [ROOM NUMBER], 105, 106, 107, 108, 111, 116, 120, 201, 202, 203, 204, 303, 305, 306, 308, 309, 310, 311, 313, 314, 316, 317, 318, 319, 320, 321, 322 and 323. room [ROOM NUMBER] is now a family visiting room and a telephone room for residents. room [ROOM NUMBER] is now a storage room.The facility has 8 two bed resident rooms which provide only 77.5 square feet per resident bed. According to historical data and current room measurements, these rooms, measure 12 feet one inch by 12 feet six inches with an additional 10 inch by 72-inch offset. These rooms are as follows: Rooms 207, room [ROOM NUMBER], 209, 214, 216 and room [ROOM NUMBER].The Facility has 3 two-bed resident rooms which provide only 76.5 square feet per resident bed. According to historical data and current room measurements, these rooms measure 12 feet by 12 feet six inches with an additional 10 inch by 48-inch offset, These Rooms are as follows: room [ROOM NUMBER] which is now the Break Room, 119 which is now the Activity Room.The facility has 2 two bedrooms which provide only 78.5 square feet per resident bed. According to historical data and current room measurements, these rooms measure 15 feet by 10 feet six inches. There rooms are as follows: rooms [ROOM NUMBERS].During observation from 12/15/2025 through 12/17/2025, the following residents were observed in the above rooms which do not have 80 square feet per resident bed: R2, R3, R6, R8, R9, R10, R11, R12, R14, R15, R16, R19, R25, R26, R29, R31, R34, R35, R36, R41, R42, R43, R45, R46, R47, R48, R51, R53, R55, R56, R59, R61, R62, R63, R67, R69, R70, R73, R74, R75, R76, and R82.Form CMS 671 dated 12/15/25 documents the facility's census is 78.On 12/15/2025 at 9:25 AM V7, Regional Maintenance, stated that the facility has multiple rooms with less than the required square footage.