STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145555	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	401 St Mary Drive Edwardsville, IL 62025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the Facility failed to ensure assessments were accurately completed to reflect the residents' current status for 2 of 3 (R1, R4) residents, reviewed for Resident Assessments, in the sample of 6. Findings include: 1. On 11/26/2024 at 9:20 AM, V4, Licensed Practical Nurse (LPN) stated R1 rates her pain between a 5-10 on the pain scale. On 11/26/2024 at 10:03 AM, R1 stated she takes Oxycodone because her hip deteriorated. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. It further documents R1 had not received scheduled or PRN (as needed) pain medications nor received non-medication interventions for pain. It further documents a Pain Assessment Interview should be conducted. R1's Physician's Orders dated 7/30/2024 documents, Oxycodone 5 mg (milligrams)- take one tablet by mouth twice daily. R1's Care Plan dated 11/13/2024 documents R1 has potential for pain/discomfort and Approach: Observe the effectiveness of pain interventions q (every) shift. Review for compliance alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. R1's Care Plan dated 11/27/2024 documents, (R1) has complaints of chronic pain r/t (related to) right hip and rt (right) knee. Administer analgesic medications as ordered by pcp (primary care physician). R1's Medication Administration History dated 10/27/2024-11/26/2024 documents R1 received Oxycodone 5 mg on 11/17/2024 and rated her pain at 8 on a 1-10 pain scale. It continues to document R1 received her Oxycodone 5 mg on 11/22/2024 and rated her pain at 10 on the 1-10 pain scale. On 11/26/2024 the Facility Matrix was reviewed and R1 was not listed as receiving Opioids. R1's Quarterly Pain assessment dated [DATE] is incomplete. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/2024 at 1:55 PM, V2 Director of Nursing (DON) stated, (R1) doesn't really have a diagnosis for the pain. We've done multiple X-rays of her knee and hip but they don't show much. She had her last quarterly pain assessment in June. It is not complete and she should have had one done again in September. We should probably refer her to pain management. On 11/27/2024 at 2:26 PM, V14, NP (Nurse Practitioner), stated R1 has been on oxycodone long term for neuropathy and chronic pain syndrome. R1's Face Sheet dated 12/2/2024 does not include these diagnoses. On 12/2/2024 at 12:09 PM, V2 (DON) stated, No, that's not right (R1's MDS related to pain). I would definitely expect it to reflect the residents current status. 2. R4's Minimum Data Set (MDS) dated [DATE] documents R4 does not have any potential indicators of psychosis including hallucinations or delusions. It further documents R4 does not reject evaluation or care, nor does R4 wander. R4's Care Plan dated 4/11/2024 documents, I walk throughout facility all day long without purpose. On 11/26/2024 at 11:24 AM, R5 stated, She (R4) has 6 people that she talks to inside her head. On 11/26/2024 at 1:15 PM, R4 was observed walking around anxiously throughout the building with several staff members following her- trying to redirect her. At this time, the anonymous staff member whispered to the surveyor, She's (R4) on the war path. R4's Care Plan and Behavior Tracking documents R4 has the following behaviors: Resident walks through-out the facility cursing to herself and at times at staff as she passes by It further documents, Remind resident her cursing is disruptive to other residents. R4's Behavior Tracking dated November 2024 documents R4 had 4-5 episodes of walking through the facility cursing on 11/20/2024-11/25/2024 on day and evening shift. It further documents the interventions attempted were not successful and the behavior continued. On 12/2/2024 at 10:18 AM, V1 stated the Facility has a behavioral health counsler, but R4 refused to see her. On 12/2/2024 as of 1:17 PM, the Facility had not provided a policy related to accuracy of assessments.

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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 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** 40701 Based on interview and record review, the Facility failed to ensure pain medications were readily available for administration in order to prevent increasing pain/discomfort for 1 (R1) of 3 residents reviewed for opioid medications, in the sample of 6. Findings include: On 11/26/2024 at 9:20 AM, a staff member who wishes to remain anonymous, stated, Sometimes (R1) runs out of pain meds (medication). I am not sure if it's the pharmacy or the doctors fault. It tells you on the card when to re-order so we should all be observant of that. I don't know where the disconnect it. The Nurse Practitioner (NP) can't write those scripts (Controlled substance prescriptions). (R1) was out the other day (pain medication not available). It was 11/22 (2024) and she was out a day or two. She claims her pain is 5-10 on the pain scale. On 11/26/2024 at 10:03 AM, R1 stated she takes Oxycodone because her hip deteriorated. R1 stated, Every month, it's no surprise- I need another script (prescription). They make phone calls. The doctor is either on vacation or whatever else and the nurse practitioner can't write the script, but they put her in charge. I have a history of rehab (rehabilitation) and withdraw. I dry heave, get hot then cold. It's no fun to deal with. I can't even make it from here (the bed) to the bathroom. I don't leave my room. I shut down completely. They don't give me a 'heads up' that I'm going to run out, but every month I'm dealing with it. They go through a whole sheet (medication card) and no one thinks to re-order it- I mean come on! Last week I was out. I just got it back Monday. I went 7 days without it. I told (V2, Director of Nursing, DON) and (V12, Licensed Practical Nurse (LPN). They call and leave messages but still here I sit in agony. I was almost to the point of causing myself 'an accident' just so I could go to the hospital to get my medicine. Not suicide or anything, just a fall or something. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. It further documents R1 had not received scheduled or PRN (as needed) pain medications nor received non-medication interventions for pain. It further documents a Pain Assessment Interview should be conducted. R1's Physician's Orders dated 7/30/2024 documents, Oxycodone 5 mg (milligrams)- take one tablet by mouth twice daily. R1's Care Plan dated 11/13/2024 documents R1 has potential for pain/discomfort and Approach: Observe the effectiveness of pain interventions q (every) shift. Review for compliance alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. R1's Care Plan dated 11/27/2024 documents, (R1) has complaints of chronic pain r/t (related to) right hip and rt (right) knee. Administer analgesic medications as ordered by pcp (primary care physician). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R1's Medication Administration History dated 10/27/2024-11/26/2024 documents R1 did not receive Oxycodone 5 mg on 11/18/2024, 11/19/2024, 11/20/2024, and 11/21/2024 due to Drug/item unavailable. It further documents R1 received Oxycodone 5 mg on 11/17/2024 and rated her pain at 8 on a 1-10 pain scale. It continues to document R1 received her Oxycodone 5 mg on 11/22/2024 and rated her pain at 10 on the 1-10 pain scale. R1's Medication Administration History dated 10/1/2024-10/31/2024 documents, 10/11/2024- not administered: need script for both 7 AM and 7 PM doses. It further documents, 10/12/2024-Drug/Item Unavailable. Awaiting script from M.D (Medical Doctor). It continues to document, 10/18/2024-Drug/Item Unavailable. Awaiting script from M.D. On 11/26/2024 at 2:36 PM, V3, Assistant Director of Nursing (ADON) stated, All I'm going to say is I can't make someone do something. I notified the doctor we needed a script. That's all I can tell you. She (R1) told me she had been without her medicine. I reached out again and finally got her meds (medication) in. On 11/26/2024 at 2:41 PM, V2, stated he was aware R1 was out of her medicine. V2 stated, (V3) reached out to the doctor. I am not sure how many doses she missed. (V13) is our Nurse Practitioner (NP) but she does not have her DEA (Drug Enforcement Agency) number (required to write controlled substance medications). On 11/27/2024 at 8:49 AM, V12, LPN, stated, I know (R1) missed one dose for me, but they told me when I was off for a couple days she had missed some too. I got the script from (V14, NP). We kept calling pharmacy. If the doctor doesn't send the script to pharmacy-they won't send it. They have to have the script re-newed or else we could get it from the Ekit (Emergency medicine kit). It's a script thing. (R1) gets very upset about it. (V3) checks but sometimes it happens. She runs out. It's not right if she didn't get her medicine. R1's Quarterly Pain assessment dated [DATE] is incomplete. On 11/27/2024 at 1:55 PM, V2 stated, (R1) doesn't really have a diagnosis for the pain. We've done multiple X-rays of her knee and hip but they don't show much. She had her last quarterly pain assessment in June. It is not complete and she should have had one done again in September. We should probably refer her to pain management. On 11/27/2024 at 2:26 PM, V14, NP, stated R1 has been on oxycodone long term for neuropathy and chronic pain syndrome. V14 stated. As long as she is not going through withdraw, Tylenol can cover the pain. The relief won't be like receiving an Opioid pain killer, but can provide short term relief. On 12/2/2024 at 10:18 AM, V1, Administrator, stated, I'm sure if (R1) was complaining about pain, staff would have offered her Tylenol. R1's Current (12/2/2024) Physician's Orders does not include an order for Tylenol as needed. On 12/2/2024 at 12:09 PM, V2 Director of Nursing stated, I know she went without her oxy (oxycodone) but she didn't go without completely. She also has a lidocaine patch. She doesn't have PRN Tylenol though. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Facility's Pain Management Policy undated, documents, Purpose: To ensure accurate assessment and management of the resident's pain. Policy: A licensed nurse will assess residents for pain on admission and routinely as indicated by the resident's health and functional status. 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. It further documents, The IDT (Interdisciplinary Team) committee review the pain assessment for each newly admitted resident identified by the licensed nurse to have pain and at least quarterly thereafter. A licensed nurse will reassess the resident for pain quarterly and eventfully. Pain Management: The licensed nurse will administer pain medication as ordered, and document medication administered on the Medication Administration Record (MAR). It further documents, Nursing staff will implement timely interventions to reduce the increase in severity of pain. The licensed nurse will update the care plan for pain management with any change in treatment and/or medication.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the Facility failed to ensure the Pre-Admission Screen Resident Review (PASRR) recommendations were completed for a resident with a qualifying diagnosis and disruptive behaviors, ensure the resident assessments were accurate, as well as ensure the interventions for behaviors were successful for 1 of 3 residents (R4) reviewed for behavioral health services, in the sample of 6. Findings include: R4's Face sheet dated 12/2/2024 documents R4 has a diagnosis of Mild intellectual disabilities, Schizoaffective disorder, and bipolar disorder. R4's Pre-admission Screening and Resident Review (PASRR) dated 12/21/2024 documents, Determination: Short term approval without specialized services. Date of approval ends June 18th 2024. It further documents the nursing Facility should complete a Resident Review when the residents short term approval is ending soon. R4's Minimum Data Set (MDS) dated [DATE] documents R4 does not have any potential indicators of psychosis including hallucinations or delusions. It further documents R4 does not reject evaluation or care, nor does R4 wander. R4's Care Plan dated 4/11/2024 documents, I walk throughout facility all day long without purpose.: R4's Care Plan dated 12/22/2023 documents, My goal is to remain in facility for long-term care. Provide me with care and services based on specific needs. Provide me with services to meet my psychosocial and physical needs. 1. On 11/26/2024 at 11:10 AM, R1 stated, I am concerned about the safety and well-being of other residents. (R4) is out of control. I am afraid she will hurt other residents. She scares the s*** out of them. Feeling safe should be the last of these old (elderly) peoples' worries. The amount of people they are shoving in here (Facility)- It's just too much. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. 2. On 11/26/2024 at 11:24 AM, R5 stated, They (staff) don't tell her (R4) not to use that language. She says all kinds of nasty words. It bothers me. A lot of people haven't heard the kind of language she uses. She says dirty s***. She has 6 people that she talks to inside her head. Also, her a** hangs out. It makes people uncomfortable. R5's MDS dated [DATE] documents R5 is cognitively intact. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/2024 at 12:39 PM, a staff member who wishes to remain anonymous stated, I know you saw (R4). We assumed that's why you were here. She has been sent out (to the hospital) a couple times for behavior issues. We all feel like she doesn't belong here. She walks around cussing. She says some things that are really scary. She's scary. If I was a family member with someone here, I'd definitely be scared. At first I thought she was a CNA (Certified Nursing Assistant) and was mortified and thought, 'They let their staff talk like that?' You never know how she is going to react. You have to tip-toe around her. I don't feel like this is the place for her. This is a nursing home. Her behaviors are scary. She'll say 'What the f*** Bob?' and 'that f****** white b****.' The cops have been here twice to take her away. On 11/26/2024 at 12:48 PM, V5, CNA stated, (R4) will say little things that aggravate the other residents. You never know when she's going to snap. I try to keep the ones that don't know any better away from her. On 11/26/2024 at 1:15 PM, R4 was observed walking around anxiously throughout the building with several staff members following her- trying to redirect her. At this time, the anonymous staff member whispered to the surveyor, She's (R4) on the war path. On 11/26/2024 at 1:47 PM, V7, Registered Nurse (RN) stated, (R4) does use foul language. I have heard multiple residents say, 'Please stop. We don't want to hear that' and she'll (R4) tell them to 'Go to your f****** room'. It's not fair to the other residents. It is not the best placement for (R4). We have sent her out (to local hospital) several times but they just send her back. On 11/26/2024 at 1:50 PM, V10, Activity Director, stated she has heard residents' (R3 and R6) complain about R4's behaviors. 3. On 11/26/2024 at 2:00 PM, R3 stated, The one girl, she's tall and chunky. She calls everyone a b****. Mostly when we are out in the dining room. She scares me. R3's MDS dated [DATE] documents R3 is cognitively intact. 4. On 11/26/2024 at 2:03 PM, R6 stated, One girl, I think her name is (R4). She's a loose cannon. Goes from high to low. She means well, she's just dangerous. Sent her out twice with the cops in two weeks. A lot of people here, especially the elderly, don't know what to do about her. She gets in their face and says, 'Boo' and then 'I love you'. She walks around recklessly all time time, doesn't stop, especially in the dining area. R6's MDS dated [DATE] documents R6 is cognitively intact. On 11/26/2024 at 3:45 PM, V11, CNA stated, I can see how R4's behaviors affect the other residents. She yells at staff. Some residents are sensitive to loud noises and vulgarity. On 11/26/2024 at 2:54 PM, V2, Director of Nursing (DON) stated, Our sister facility in (nearby state) shut down and they had to find placement. We have put out referrals, but no one will accept her. We send her to (local psychiatric facility) and they just send her back. She is care planned for cussing to herself and has other behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/27/2024 at 8:49 AM, V12, LPN (Licensed Practical Nurse), stated, (R1) is new and young. I can see how she would be intimidating to some of the residents. On 11/27/2024 at 11:57 AM, R4 was observed on a stretcher at the nurses station, using the vulgar language (F***). R4 was then observed leaving the Facility with Emergency Medical Technicians. On 11/27/2024 at 1:55 PM, V2 stated, (R4) is gone for good. (Another Facility) accepted her. Honestly, we had to do a lot of 1:1 with her. I tried to keep her away from the general population (other residents). R4's Care Plan and Behavior Tracking documents R4 has the following behaviors: Resident walks through-out the facility cursing to herself and at times at staff as she passes by It further documents, Remind resident her cursing is disruptive to other residents. R4's Behavior Tracking dated Novemeber 2024 documents R4 had 4-5 episodes of walking through the facility cursing on 11/20/2024-11/25/2024 on day and evening shift. It further documents the interventions attempted were not successful and the behavior continued. On 12/2/2024 at 10:18 AM V1 was asked what kind of training staff received related to residents with behavioral issues. V1 responded, We have the behavior tracking. If we receive a resident who has behaviors staff get report on them and their behaviors are in their care plans. We will have a inservices on behaviors. V1 stated she was not the administrator at the Facility when R4 was admitted , therefore, V1 was unsure about R4's PASRR. V1 stated the Facility has a behavioral health counsler, but R4 refused to see her. On 12/2/2024 at approximately 11:45 AM, V1 provided another PASRR dated 6/21/2024. This PASRR documents R4 received short term approval without specialized services for 60 days. On 12/2/2024 at 12:09 PM, when asked about staff training related to behavioral health services, V2 stated, That's a good question. I know we do inservices quarterly, outside of that we don't do behavioral health inservices. We will definitely do one soon for sure. That'll take over what we planned for next month. On 12/2/2024 at 1:11 PM, V1 stated the Facility does not have a policy related to behavioral health services.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on interview and record review, the Facility failed to ensure the availability of scheduled opioid medication for 1 of 3 residents (R1) reviewed for pharmacy services, in the sample of 6. This failure caused R1 to miss several doses of pain medication, resulting in discomfort and experiencing symptoms of withdraw. Findings include: On 11/26/2024 at 9:20 AM, an anonymous staff member stated, Sometimes (R1) runs out of pain meds (medication). I am not sure if it's the pharmacy or the doctors fault. It tells you on the card when to re-order so we should all be observant of that. I don't know where the disconnect it. The Nurse Practitioner (NP) can't write those scripts (Controlled substance prescriptions). (R1) was out the other day (pain medication not available). It was 11/22 (2024) and she was out a day or two. She claims her pain is 5-10 on the pain scale. On 11/26/2024 at 10:03 AM, R1 stated she takes Oxycodone because her hip deteriorated . R1 stated, Every month, it's no surprise- I need another script (prescription). They make phone calls. The doctor is either on vacation or whatever else and the nurse practitioner can't write the script, but they put her in charge. I have a history of rehab (rehabilitation) and withdraw. I dry heave, get hot then cold. It's no fun to deal with. I can't even make it from here (the bed) to the bathroom. I don't leave my room. I shut down completely. They don't give me a 'heads up' that I'm going to run out, but every month I'm dealing with it. They go through a whole sheet (medication card) and no one thinks to re-order it- I mean come on! Last week I was out. I just got it back Monday. I went 7 days without it. I told (V2, Director of Nursing, DON) and (V12, Licensed Practical Nurse (LPN). They call and leave messages but still here I sit in agony. I was almost to the point of causing myself 'an accident' just so I could go to the hospital to get my medicine. Not suicide or anything, just a fall or something. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. R1's Physician's Orders dated 7/30/2024 documents, Oxycodone 5 mg (milligrams)- take one tablet by mouth twice daily. R1's Care Plan dated 11/13/2024 documents R1 has potential for pain/discomfort and Approach: Observe the effectiveness of pain interventions q (every) shift. Review for compliance alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. R1's Care Plan dated 11/27/2024 documents, (R1) has complaints of chronic pain r/t (related to) right hip and rt (right) knee. Administer analgesic medications as ordered by pcp (primary care physician). (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 0755 Level of Harm - Actual harm Residents Affected - Few	R1's Medication Administration History dated 10/27/2024-11/26/2024 documents R1 did not receive Oxycodone 5 mg on 11/18/2024, 11/19/2024, 11/20/2024, and 11/21/2024 due to Drug/item unavailable. It further documents R1 received Oxycodone 5 mg on 11/17/2024 and rated her pain at 8 on a 1-10 pain scale. It continues to document R1 received her Oxycodone 5 mg on 11/22/2024 and rated her pain at 10 on the 1-10 pain scale. R1's Medication Administration History dated 10/1/2024-10/31/2024 documents, 10/11/2024- not administered: need script for both 7 AM and 7 PM doses. It further documents, 10/12/2024-Drug/Item Unavailable. Awaiting script from M.D (Medical Doctor). It continues to document, 10/18/2024-Drug/Item Unavailable. Awaiting script from M.D. R1's Progress Notes dated 10/17/2024 document the medical doctor was made aware of the need for R1's oxycodone prescription. R1's Progress Notes dated 10/18/2024 documents V3 Assistant Director of Nursing (ADON) spoke with the pharmacy regarding the need for R1's oxycodone prescription. On 11/26/2024 at 2:36 PM, V3, (ADON) stated, All I'm going to say is I can't make someone do something. I notified the doctor we needed a script. That's all I can tell you. She (R1) told me she had been without her medicine. I reached out again and finally got her meds (medication) in. On 11/26/2024 at 2:41 PM, V2, stated he was aware R1 was out of her medicine. V2 stated, (V3) reached out to the doctor. I am not sure how many doses she missed. (V13) is our Nurse Practitioner (NP) but she does not have her DEA (Drug Enforcement Agency) number (requires to write controlled substance medications). On 11/27/2024 at 8:49 AM, V12, LPN, stated, I know (R1) missed one dose for me, but they told me when I was off for a couple days she had missed some too. I got the script from (V14, NP). We kept calling pharmacy. If the doctor doesn't send the script to pharmacy-they won't send it. They have to have the script re-newed or else we could get it from the Ekit (Emergency medicine kit). It's a script thing. (R1) gets very upset about it. (V3) checks but sometimes it happens. She runs out. It's not right if she didn't get her medicine. On 11/27/2024 at 2:26 PM, V14 stated she was aware of issues with getting opioid medications refilled. V14 stated there is a special process/protocol and sometimes the pharmacy doesn't get the order. V14 stated the Facility staff will call for refills and she will tell them to contact the pharmacy. V14 stated the pharmacy tells them to contact the doctor. V14 stated sometimes a day or two will go by and the patients still has not received their medication. V14 stated she will start the re-ordering process when the resident is down to a week or two left of the medication, but there is not guarantee the pharmacy will fill it early because they have to follow regulations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145555	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	401 St Mary Drive Edwardsville, IL 62025

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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 0755 Level of Harm - Actual harm Residents Affected - Few	The Facility's Controlled Substance Prescription Policy dated 10/25/2024 documents, Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription. The written prescription may be faxed to the pharmacy for long-term care facility residents. It continues, The prescriber and/or nurse are contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available. It continues, If only one refill remains (C111-Vs?) or only a partial fill quantity remains (C11) the pharmacy will simultaneously dispense the remaining refill, contact the facility to verify the continuation of the medication is necessary and if necessary proactively seek out a new, complete prescription from the prescriber for future use. If a prescription is not obtained by the pharmacy before the medication would be 'due again', the facility is notified. In this situation, the facility may be asked to contact the prescriber for a new prescription prior to the medication running out.