

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2025
NAME OF PROVIDER OR SUPPLIER  Evercare at Edwardsville		STREET ADDRESS, CITY, STATE, ZIP CODE  401 St Mary Drive Edwardsville, IL 62025	

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 0690  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.  (continued on next page)

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 0690  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to perform timely incontinent care for 1 of 3 residents (R3) reviewed for incontinent care in the sample of 3. This failure resulted in R3 feeling embarrassed, ashamed, demeaned, disrespected, unwanted, and less than a man. Findings include: R3's Care Plan, dated 02/11/2025, documents Problem: I require assist for my ADLs (Activities of Daily Living) r/t (related to) weakness and decreased mobility. Approach: I require extensive assist of 2 staff with toileting tasks for bm (bowel movement) and 1 for urinal use. R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intact, occasionally incontinent of urine and bowel, and requires Partial/moderate assistance with toileting. R3's Progress Note, dated 07/20/2025 at 09:18 PM, documents Resident called 911 while CNA (Certified Nurse's Assistant) was in there attending to his roommate. Resident was aware that cna will assist him next. 911 stated that resident called them 5 times within a short span of time. In between resident calling 911, resident was also calling and ordering food for himself. Once food arrived, cna stated resident threw food and wasted drink on his bed after he was cleaned up. The facility Grievance/Complaint Log, dated June 2025, documents on 6/27/2025 R3 filed a grievance regarding call light response. The facility Grievance/Complaint Form, dated 6/27/2025, documents that R3 feels that nursing staff has poor response time to call light. It documents that the complaint was partially substantiated and corrective actions taken call light response audit. The Police Report, dated 7/2025, documents on 7-20-25 at 7:38 PM V9, Police officer, responded to facility in reference to patient R3 calling the police to get the nursing staff to help him. Upon arrival met with V10, Charge Nurse. V10 stated that R3 is a problem patient and falsely calls for help and uses up resources even though he doesn't need help. V9 explained to V10 why he was called. V10 stated that her staff will get to R3 when they can, because of shift change and other nursing duties. V9 then found R3 in his room. Overwhelming smell of feces, R3 had feces leaking out of R3's diaper all over his waist area. R3 stated that he turns on the patient signal light for help, but staff comes and turns it off but do not help him. V7 (CNA) was present in room helping another patient. V7 seemed overwhelmed and stated that she cannot change R3 by herself. When V7 started her shift, she was supposed to have help, but no one was coming to help her. Advising that the facility was understaffed. After approximately 15 minutes of V9 presence in the room, the staff arrived to help R3. On 7/28/2025 at 11:52 AM R3 stated that he received horrible care at the facility. R3 stated that he laid in urine for 45 minutes. R3 stated that a friend came to visit, and he smelled of strong urine. R3 stated that he was embarrassed and ashamed. R3 stated that he couldn't look his friend in the eyes. R3 stated that he was sitting in his own crap for so long that he called the police for help. R3 stated he had a bowel movement. R3 stated that he put the light on and nothing. R3 stated that there have been multiple times that the staff come in and turn the light out and never come back. R3 stated that he was covered with bowel. R3 stated that I am a man. Who wants to live like that. R3 stated that he felt it was demeaning and disrespectful too. R3 stated that he doesn't deserve that. R3 stated that he felt like he doesn't matter and less than a man. R3 stated that he was treated like a caged animal. R3 stated that he was treated less than a dog. On 7/28/2025 at 11:55 AM V5, R3's friend, stated that she has been at the facility on multiple occasions when R3 had to wait 45 minutes. V5 stated that she was told by the staff that there is only 1 staff on the hall at that time. V5 stated that R3 shouldn't have sit in filth that long that is ridiculous. V5 stated that R3 was embarrassed that he was wet and that she had to say something for the staff to respond. On 7/28/2025 at 1:17 PM, V6, Licensed Practical Nurse, LPN, stated that she entered R3's room around 8:00 PM and gave R3 his medication. V6 stated at that time R3 said he had an accident and needed to be cleaned. V6 stated that she notified the CNA and was told that she was the only one down on the hall and would have to wait to get someone to help with cleaning up R3. V6 stated that she notified another staff and was informed that they could not go in the room with R3. V6 stated that R3 did call the police. V6 stated that she is not sure of what time approximately 8:15 PM but not for sure. V6 stated that the police did come. V6 stated that she was not sure when the police got to the facility, V6 stated that the police spoke with the resident and the CNA. V6 stated that then the Officer told her that R3 had a bowel movement and needed to be changed. V6 stated that R3 was changed at that time. On 7/28/2025 at 1:54 PM V7, CNA, stated that she was the aide assigned to R3. V7 stated that she is an agency with this being her first time at the facility. Upon entering the facility, she was informed what hall she was on and that she would get help at 6pm from oncoming staff. V7 stated that she was informed to not provide care to R3 alone or you will get in</p>		

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F 0725  Level of Harm - Actual harm  Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.  (continued on next page)

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide sufficient nursing staff to assist residents with incontinent needs to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident for 1 of 3 (R3) reviewed for staffing in a sample of 3. This failure resulted in a delay in incontinent care for R3 causing him to feel embarrassment, ashamed, demeaned, disrespected, and unwanted. Findings include:R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intact, occasionally incontinent of urine and bowel, and requires Partial/moderate assistance with toileting. The Police Report, dated 7/2025, documents on 7-20-25 at 7:38 PM V9, Police officer, responded to facility in reference to patient R3 calling the police to get the nursing staff to help him. Upon arrival met with V10, Charge Nurse. V10 stated that R3 is a problem patient and falsely calls for help and uses up resources even though he doesn't need help. V9 explained to V10 why he was called. V10 stated that her staff will get to R3 when they can, because of shift change and other nursing duties. V9 then found R3 in his room. Overwhelming smell of feces, R3 had feces leaking out of R3's diaper all over his waist area. R3 stated that he turns on the patient signal light for help, but staff comes and turns it off but do not help him. V7, CNA, was present in room helping another patient. V7 seemed overwhelmed and stated that she cannot change R3 by herself. When V7 started her shift, she was supposed to have help, but no one was coming to help her. Advising that the facility was understaffed. After approximately 15 minutes of V9 presence in the room, the staff arrived to help R3. On 7/28/2025 at 11:52 AM R3 stated that he received horrible care at the facility. 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V7 stated that she checked her hall, and no lights were on, and she went to lunch returning around 7:40 PM. V7 stated that when she returned the light to R3's room was on. V7 stated that R3 was incontinent of bowel with stool up his side. V7 stated that she left the room to find the other aide that was supposed to have arrived at 6 PM. V7 stated that she was informed that no one came in and no one was scheduled. V7 stated that she could not change R3 at that time because she didn't have help, so she went and helped another resident. V7 stated that by the time someone came to help the police were there. V7 stated that she was interviewed by the police and informed him that she was the only one on the hall. V7 stated that she informed the police that</p>		