

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 08/06/2025
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent resident to resident abuse in 1 of 5 residents (R2), reviewed for abuse in the sample of 5. This failure resulted in R2 being hit in the face by R1, which resulted in redness and R2 feeling fearful of R1. Findings Include: On 8/6/25 at 3:35 PM, R1 was observed, when surveyor knocked on his door, R1 cracked the door, the surveyor asked if she could come into his room, he stated no, when asked if she could talk with him, he stated no and shut the door. R1 appeared paranoid. On 8/6/25 at 3:37 PM, R2 was observed in his room, in a wheelchair, calm, and pleasant. R2 stated he had an incident with R1 a while ago, he had opened R1's room door for him, to be nice, and R1 was cussing at him and hit him upside the head in the face and scratched his arms. R2 stated his head bled where R1 had hit him. Stated he feels fairly safe in the facility but doesn't feel safe around R1. R2 stated he is around R1 sometimes and staff are around so he can get them if needed. R1's Face Sheet, undated, documents R1 has the following diagnoses: Obsessive Compulsive Disorder, Alzheimer's Disease, Psychosis, Obsessive Compulsive Personality Disorder, Unspecified Mental Disorder, and Dementia with Behavioral Disturbance. R1's MDS (Minimum Data Set), dated 6/14/25, documents R1 has a BIMS (Brief Interview of Mental Status) score of 13, indicating R1 is cognitively intact and rejects care. R1's Care Plan, dated 6/14/25, documents R1 has a history of inappropriate contact with his peers and staff. R1 had an encounter with another resident. R1 was placed on 15-minute checks with no further occurrence. Social Service Director to follow up and make sure both residents remain feeling safe at the facility. Behavior tracking updated, in-service on behavior, abuse and neglect completed. R1's Care Plan, dated 12/27/24, documents R1 has the potential to be physically aggressive related to anger, depression and poor impulse control. R1's Care Plan, dated 1/15/21, documents R1 becomes easily annoyed by fellow residents and will attempt physical aggression to get his point across, such as raising his fist at them. R1's Care Plan, dated 7/17/19, documents R1 doesn't like his personal space invaded or staff looking at him related to Paranoia. R1's Progress Note, dated 6/16/2025 at 9:03 AM, documents the following: IDT (Interdisciplinary Team) met regarding resident-to-resident allegation. Interviews and investigation initiated. Care plan reviewed and updated. New intervention: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert Attention. R2's Face Sheet, undated, documents R2 has the following diagnoses: Cerebral Infarction, Major Depressive Disorder, Dementia without Behavioral Disturbance, and Alzheimer's Disease. R2's MDS, dated [DATE], documents R2 has a BIMS score of 15, indicating R2 is cognitively intact and doesn't exhibit any behaviors. R2's Care Plan, dated 11/13/24, has no documentation of R2 having any behaviors. R2's Progress Note, dated 6/16/25 at 9:51 AM, documents the following: IDT met to review resident to resident allegation. Skin and pain assessments complete. Interviews and investigation initiated. Care plan reviewed and updated. New intervention: Educate resident to ask for staff assistance when he notices that other residents are needing help. R1 and R2's Abuse Investigation Final Report, dated 6/18/25, documents the following: Incident date of 6/14/25 at 6:30PM, R2 was attempting to open the door for R1, unaware of any behavioral symptoms, which resulted in R1 reacting to reach out of the door and R1 made contact with R2. R1 was confused by R2's actions resulting in R1 reacting to the movement of the door. Redness was noted to R2's left cheek and left arm. R1 and R2 were placed on 15-minute checks with no further incidents. Conclusion: this allegation is unsubstantiated due to the unintentional interaction between the two residents. On 8/6/25 at 4:34 PM, V15, MD, denied concerns regarding abuse, he was in the facility today, 8/6/25, rounding and did not see anything concerning. V15 stated if an allegation of abuse occurred, he would expect the facility to notify him, investigate the allegation, and protect the resident. The Abuse Prevention Policy, dated 3/2025, documents the following: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Resident - to - Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm.</p>		