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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to notify the physician for 1 of 3 residents (R2) reviewed for notification in the sample of 16. This failure resulted in R2's Physician not being notified when R2 did not receive dialysis for 12 days resulting in R2 being hospitalized . Findings include: R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Hypoglycemia, unspecified; Hyperlipidemia, unspecified; End stage renal disease; Dependence on renal dialysis; Disorder of kidney and ureter, unspecified; Essential (primary) hypertension; Acquired absence of right leg below knee, type 1 diabetes mellitus without complications. R2's POS does not have an order for dialysis. R2's POS does document, Monitor dialysis catheter, twice a day 6:00 MA-6:00 PM-6:00 PM - 6:00 AM.R2's Facesheet document R2 was admitted to the facility on [DATE]. R2's Care Plan with a start date of 10/8/2025 Problem: I am at risk for alterations in nutrition due to d/x (diagnosis of) hypertension, Chronic systolic (congestive) heart failure, Disorder of kidney and ureter, End stage renal disease. R2's Care Plan does not document R2 was receiving dialysis and or was waiting for approval for potential dialysis treatments. R2's Progress Notes dated 10/8/2025 at 1:20 PM, arrived to facility via facility van with staff x2. Resident a/o (alert and orientated) x3. Wheelchair independent use, and stated she is able to transfer self. Wheelchair is her personal WC (wheelchair). Speech clear and understood. smoking status, vape used. Denied tobacco use. MD (Medical doctor) in house for rounds upon arrival. medications reconciled. BIMS (Brief interview for mental status) at a 14 (out of 15) with denying depression (cognitively intact for decision making). (Author V3). R2's Progress Notes do not document R2 was seen by the MD.R2's Progress Notes 10/12/2025 at 10:58 AM, Resident has c/o (complained of) being SOB (short of breath), hot, weak, and is excessively sweating. Resident states she missed dialysis on Friday. MD (Medical Doctor) made aware of the missed dialysis day. Resident's glucose was low at 49. VS (vital signs) are as follows 97.8, 140/85, 84, 93% on RA (Room air). MD made aware of VS and patient complaints, MD states just to monitor her glucose level in an hour and send her to dialysis tomorrow, which is her normal dialysis day. Resident currently at lunch table eating a snack to bring glucose level up. R2's Progress Notes does not document V4, Medial Doctor was notified the following day when R2 did not receive dialysis treatment. R2's Progress Notes do not document V4 was aware R2 was not receiving any dialysis treatment while she was in the facility. R2's Progress Notes do not document V4 was aware R2 went 12 days without receiving dialysis.On 10/28/2025 at 1:32 PM, V4, Medical Director stated, On the day (R2) arrived he saw her, but he has not yet uploaded his physician notes (date of service 10/8/2025). He knows (R2) missed some dialysis, but he was under the impression that (R2) was coming from home not from another facility. The following week when (R2) was having issues he was notified but he was not notified that she did not receive dialysis the next day as recommended, and they (Facility) should have notified him, and he does not know what the issue was they were having. He reviewed her labs on her first day and her labs were good considering she was on dialysis. He can say he was not informed of her situation. If he would have known (R2) did not get her dialysis treatment he would have sent her to the hospital for treatment.R2's Hospital records dated 10/20/2025 document R2 had not had dialysis in about two weeks since coming to the new facility, and had elevated potassium levels (6.2 mEq/L - milliequivalents/Liter) (normal 3.4-5.0); BUN (blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl - milligrams/deciliter). Patient states she had not underwent hemodialysis and the nursing facility was spoken with this nurse who informed them that they were not able to set up outpatient hemodialysis sessions prior to patient's transfer to their facility unfortunately, patient is asymptomatic but needs dialysis. (R2) states she has not received dialysis since being there. She is unsure why. R2 received dialysis services at the hospital. R2's Hospital Records dated 10/25/2025 at 1:17 PM, Medical Problems: Hyperkalemia, End-stage renal disease needing dialysis, Hypertension, Insulin dependent diabetes mellitus and document R2 was discharged back to the facility on [DATE]. R2 was admitted to the hospital for five days. The Facility Change of Condition Policy undated documents, To ensure that medical care problems are communicated to the attending physician or authorized designee and family/ responsible party in a timely, efficient, and effective manner. The facility will inform the resident, consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the residents' physical, mental, or psychosocial

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Deficiencies at this level require two deficient practice statements.A. Based on interview and record review the Facility failed to ensure residents were free of neglect for 1 of 3 residents (R2) reviewed for neglect in the sample of 16. This failure occurred when (R2) was transferred from another nursing home to the facility on [DATE], with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was put into place while the facility was waiting for the new provider to perform treatment. R2, who was receiving dialysis 5 days per week prior to her facility admission, subsequently did not receive dialysis services for 12 days, experienced shortness of breath, sweating, weakness, jaundice eyes, and critical lab levels (potassium levels (6.2 mEq/L - milliequivalents/Liter) (normal 3.4-5.0) ; BUN (blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl - milligrams/deciliters) requiring hospitalization.B. Based on interview and record review the facility failed to prevent resident-to-resident altercations for 1 of 3 (R7) residents investigated for abuse in a sample of 16. Findings include: The Immediate Jeopardy was presented and called on 10/29/2025 at 1:12 PM, with V1, Administrator, V22, [NAME] President of Clinical Operations and V23 Regional Director of Operations. The Immediate Jeopardy began on 10/8/2025 at 1:20 PM when R2 arrived at the facility. The first abatement plan dated 10/29/2025 was not accepted. The fourth abatement plan on 10/30/2025 at 9:03 AM was accepted. The surveyor confirmed by observation, interview, and record that the Immediate Jeopardy was removed on 10/30/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the facility's policies and procedures and in-service training. R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Hypoglycemia, unspecified; Hyperlipidemia, unspecified; End stage renal disease; Dependence on renal dialysis; Disorder of kidney and ureter, unspecified; Essential (primary) hypertension; Acquired absence of right leg below knee, type 1 diabetes mellitus without complications. R2's POS does not have an order for dialysis. R2's POS does document, Monitor dialysis catheter, Twice A Day 6:00 AM- 6:00 PM, 6:00 PM - 6:00 AM. R2's POS from the former facility documents R2 was receiving dialysis five days a week but no dialysis order was on the admission physician orders. R2's Facesheet documents R2 was admitted to the facility on [DATE]. R2's Care Plan with a start date of 10/8/2025 documents, Problem: I am at risk for alteration in nutrition due to d/x (diagnosis of) hypertension, Chronic systolic (congestive) heart failure, Disorder of kidney and ureter, End stage renal disease. R2's Care Plan does not document R2 was receiving dialysis. R2's Care Plan does not document anything related to waiting on dialysis treatment and or alternate treatment while the facility is waiting for the dialysis provider to accept her. R2's Transfer Sheet documents R2 was admitted from another nursing home on [DATE]. R2's Transfer Care Plan with a date initiated of 1/30/2025 from the previous facility documents Dialysis: Resident has potential for impaired renal function secondary to dialysis ESRD (end stage renal disease). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Medical Records document (R2) was transferred from another nursing home to the facility on [DATE], with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was scheduled and or put into place while the facility was waiting for the new provider to perform hemodialysis treatment for R2. R2 did not receive any dialysis services while in the facility for 12 days. R2's Progress Notes dated 10/8/2025 at 1: 20 PM, arrived at facility via facility van with staff x2. Resident a/o (alert and orientated) x3. Wheelchair independent use, and stated she is able to transfer self. Wheelchair is her personal WC (wheelchair). Speech clear and understood. smoking status, vape used. Denied tobacco use. MD (Medical doctor) in house for rounds upon arrival. Medications reconciled. BIMS (Brief interview for mental status) at a 14 (out of 15) with denying depression (cognitively intact for decision making). R2's Progress Notes do not document R2 was seen by the MD, and R2's Progress Notes do not have any documentation by the Physician. R2's Progress Notes from V20, Nursing Home B, document on 10/8/2025 at 11:40 PM, R2 was transferred from their facility to (Facility). On 10/28/2025 at 10:12 AM, V6, Licensed Practical Nurse (LPN) stated, I know (R2) needed an x-ray and some labs when she first got here and she was supposed to have dialysis, but we were waiting on the new dialysis center. I took an x-ray on her chest right before I went on vacation and when I came back (R2) still had not had dialysis but then she was sent out to the hospital. I was not given any additional instructions related to her dialysis and or what to do while she was waiting for dialysis. R2's Progress Notes 10/12/2025 at 10:58 AM, Resident has c/o (complained of) being SOB (short of breath), hot, weak, and is excessively sweating. Resident states she missed dialysis on Friday. MD (Medical Doctor) made aware of the missed dialysis day. Resident's glucose was low at 49. VS (vital signs) are as follows: 97. 8, 140/85, 84, 93% on RA (Room air). MD made aware of VS (vital signs) and patient complaints, MD states just to monitor her glucose level in an hour, and send her to dialysis tomorrow, which is her normal dialysis day. Resident currently at lunch table eating a snack to bring glucose level up. R2's Progress Notes do not document V4, Medical Doctor, was notified the following day when R2 did not receive dialysis treatment. R2's Progress Notes do not document any follow up and/or anything is being put into place to address dialysis. R2's Progress Notes does not document any alternate treatment and or recommendations for addressing R2's dialysis care. R2 was not sent to dialysis and no follow up occurred. R2's Progress Notes for the month of October 2025 do not document V4 was aware R2 was not receiving any dialysis treatment while she was in the facility. No plan was documented with regards to what to do while R2 was waiting for dialysis treatment and for a bed to open it. None of R2's Progress Notes document any follow up and/or anything was being put into place to address dialysis treatment for R2. R2's October 2025 Progress Notes do not document V4, Medical Doctor was aware R2 went 12 days without receiving dialysis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Progress Notes dated 10/20/2025 at 2:02 PM, spoke with resident, sister and ADON (Assistant Director of Nursing) regarding resident need of dialysis. Resident waiting on approval from dialysis clinic this week. Rec'd (received) order to send to ER (Emergency Room) for eval (evaluation) and need of dialysis. Family and resident aware of this and agree as she has not had treatment this week. NP (Nurse Practitioner) in for rounds this day and assessed resident and agreed to send to ER for eval (evaluation) and tx (treatment) if needed. EMS (Emergency Medical Services) here to transport to (nearby hospital). Per wound nurse her skin is intact with no concerns, resident verbalized that she was not in pain. R2's Hospital records dated 10/20/2025 document R2 had not had dialysis in about two weeks since coming to the new facility and had elevated potassium levels (6.2 mEq/L) (normal 3.4-5.0); BUN ((blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl). Patient states she had not underwent hemodialysis and the nursing facility was spoken with this nurse who informed them that they were not able to set up outpatient hemodialysis sessions prior to patient's transfer to their facility unfortunately, patient is asymptomatic but needs dialysis. (R2) states she has not received dialysis since being there. She is unsure why. R2 received dialysis services at the hospital. R2's Hospital Records dated 10/25/2025 at 1:17 PM, Medical Problems: Hyperkalemia, End-stage renal disease needing dialysis, Hypertension, Insulin dependent diabetes mellitus and document R2 was discharged back to the facility on [DATE]. R2 was admitted to the hospital for five days. On 10/23/2025 at 1:46 PM, V3, Assistant Director of Nursing (ADON) stated, When we get a new admit normally the DON would review the admitting nurse's notes and ensure there are no errors. The communication papers are put in a mailbox and then the DON reviews them. Since the DON is no longer working here, me and V14, Registered Nurse (RN) review everything to make sure there are no errors. As far as (R2), I did call the dialysis provider. (R2) was getting dialysis five times a week at the other facility in house. We do not do dialysis in house and use several contractors. I did call the (V15, Contractor A). (V15) wanted a chest x-ray and blood work on (R2) before they would admit her. Then they need a chair and space for her. (R2) was not getting dialysis from the provider because we were waiting for approval from them before we could send her. I am not aware of any other plans in place for dialysis until we heard back from the dialysis contractor (V15). On 10/23/2025 at 4:30 PM, V4, Medical Doctor stated, If a resident does not receive dialysis and/or misses a dialysis appointment I would expect to be notified. I am not sure which resident you are referring to and I am not aware of a resident coming from another facility with dialysis and not receiving dialysis while at the facility. I would expect to be notified if a resident missed an appointment. On 10/29/2025 at 9:22 AM, V21, Nephrologist (Kidney Specialist) stated, It is critical that if a resident who is receiving dialysis and goes to another facility that dialysis is set up ahead of time and no treatments are missed. No treatments should be missed. ESRD (End stage renal disease) depends in dialysis. A resident may not even be having symptoms because a lot of these things are silent killers and can affect the heart and cause death. If a resident does not have dialysis set up, I would expect them to be sent the ER to get treatments until they are able to get treatments from the new facility. Any resident missing 10 treatments I would absolutely consider that neglect. This could cause serious harm and death the body is depending on the dialysis treatment. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Abuse Prevention and Prohibition Program Policy undated documents, To ensure that facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment. Or misappropriation of resident property. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. The Immediate Jeopardy that began on 10/8/2025 when R2 was admitted without any hemodialysis treatment scheduled and or given for 12 days while she was in the facility was removed on 10/30/2025 after the facility took the following actions to remove the Immediacy: 1. The Administrator and Assistant Director of Nursing (ADON) were in-serviced by the VP of clinical services on neglect r/t (related to) coordination of care by not setting up dialysis treatments. 2. All department heads on abuse and neglect policy and procedure and no staff was allowed to work until they were in-serviced on abuse and neglect. 3. 24-hour report sheet was made up starting 11/1/2025. It was made to ensure that there were no dialysis residents that missed/ needed set up for treatment. 4. A quality assurance tool was implemented: On-going audit of the 24-hour report will be completed daily x 4 weeks to ensure that no resident missed dialysis or needed dialysis set up and a Root cause analysis was completed for neglect r/t coordination of care for all new residents and dialysis treatment. B. R7's EMR (Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE]. R7's EMR dated 5/20/24 documents Complete traumatic amputation of right great toe, subsequent encounter and Type 2 diabetes mellitus with foot ulcer. R7's EMR dated 1/20/25 documents anxiety disorder, unspecified. R7's Care Plan dated 2/7/25 documents Problem: (R7) has a behavior problem r/t descriptive accounts of occurrence involving her and/or others. R7's Care Plan dated 10/21/25 documents Problem: I have conflicts with other residents as evidenced by altercations verbally and being aggressive towards them verbally. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's MDS (Minimum Data Set) dated 8/18/25 documents a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS documents That the resident requires substantial/maximal assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident is dependent for sit to stand, chair/bed to chair transfer, and toilet transfer. The MDS documents that the resident has not exhibited any behaviors. The facility's Serious Injury Incident and Communicable Disease Report dated 9/16/25 documents (R8) is a [AGE] year-old female who resides at (Facility) with a BIMS that is unable to be scored. Diagnosis included but are not limited to: Generalized Anxiety Disorder, Essential Primary Hypertension, Bipolar Disorder Unspecified. (R7) is a [AGE] year-old female who also resides at (Facility) with a BIMS of 13. Diagnosis include but are not limited to: Anxiety Disorder, Unspecified, Type II Diabetes, Essential (primary) Hypertension. On 9/16/2025 around 5:00 pm staff witnessed an alleged resident to resident interaction between (R7) and (R8). Both residents separated immediately and placed on enhanced supervision. MD (Medical Director), POA's (Power of Attorney), Administration and Ombudsman made aware. Both residents placed on 15-minute checks. Investigation initiated. Initial Interventions: 1) Residents were separated immediately and placed on 15-minute checks for 48 hours. 2) (R7) assessed for injuries, skin and pain assessment completed, no new findings. 3) Staff and resident interviews initiated. 4) In-service on abuse policy initiated. Investigation: (R8) denies making any contact with (R7). (R7) stated that (R8) hit her on the arm, but also states she did not care, it did not hurt Staff members were interviewed and stated that they heard the residents verbally arguing and that they were seated within proximity of each other. Other residents were interviewed that were present at the alleged incident, report no knowledge of any alleged abuse and feel safe and wish to remain at (Facility). Conclusion: This allegation is unsubstantiated due to no physical evidence on residents skin assessments indicating that physical contact was made, no certain eyewitnesses saw contact made, and both residents deny wrongdoing. A verbal altercation occurred, both residents feel safe and did not feel threatened, it was more of a disagreement. Final Interventions: 1) 15-minute checks completed. No further incidents. 2) SSD (Social Services Designee) to follow up and ensure that residents remain feeling safe. 3) Behavior tracking updated. 4) Investigation completed. 5) In-service on behaviors/ abuse & neglect completed. 6) Final sent to IDPH (Illinois Department of Public Health). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility's Serious Injury Incident and communicable Disease Report dated 10/23/25 documents (R8) is a [AGE] year-old female who resides at (Facility) with a BIMS that is unable to be scored. Diagnosis included but are not limited to: Generalized Anxiety Disorder, Essential Primary Hypertension, Bipolar Disorder Unspecified. (R7) is a [AGE] year-old female who also resides at (Facility) with a BIMS of 13. Diagnosis include but are not limited to: Anxiety Disorder, Unspecified, Type II Diabetes, Essential (primary) Hypertension. On 10/17/2025 around 5:00 pm staff witnessed an alleged resident to resident interaction between (R7) and (R8). Both residents separated immediately and placed on enhanced supervision. MD, POA's, Administration and Ombudsman made aware. Investigation initiated. Initial Interventions: 1) Residents separated immediately. 2) Both residents placed on enhanced monitoring. 3) Skin and pain assessment completed on (R7). 4) Investigation initiated. (R7) was allegedly speaking with another resident in the dining room when (R8) rolled up behind her to grab her hair and made contact with her back side. (R7) acknowledges feeling safe in the facility and wishes to remain at (Facility). (R8) states that she reacted after being called a derogatory name by (R7). (R8) suggested that (R7) was also blocking her from getting past. (R11) interviewed and states that she did witness (R7) rolling back to block (R8) but she did not hear any name calling. (R11) acknowledges feeling safe in the facility and wishes to remain at (Facility). Other residents that were present at the time of this alleged incident report seeing (R7) and (R8) interacting but feel safe in the facility and wish to remain at (Facility). (R7) had a small bruise noted on her back, noted on a skin check from 10/17. On 10/22 another skin check was completed and noted no bruising on (R7's) back. This investigation is unsubstantiated due to this being repeated behaviors that both resident's display. Neither resident was harmed in this alleged interaction, and both wish to remain at (Facility). Final Interventions: 1) Care plans reviewed and updated for both residents. 2) Staff in-serviced on facility abuse prevention and policy. 3) Psychosocial follow ups completed, no changes. Both residents wish to remain at (Facility). 4) Both residents' care plans reviewed and updated accordingly. 5) Final sent to IDPH. R7's Weekly Skin assessment dated [DATE] documents quarter size bruise noted to residents left upper back area bluish in color. On 10/28/25 at 12:22 PM, R7 stated that she does not recall exactly what happened during the altercation in September, she just remembers that (R8) hit her. She stated that the week ago altercation, (R8) hit her twice and pulled her hair. On 10/28/25 at 12:45 PM, R13 stated he witnessed (R8) hit (R7) in the stomach in September. He stated that (R7) did not hit her back and told him to get a CNA (Certified Nursing Aid). On 10/28/25 at 12:59 PM, R12 stated that she witnessed (R8) hit (R7) in the dining room last week. On 10/28/25 at 1:00pm, R10 stated she witnessed (R8) hit (R7) but she does not remember when and where. Facility policy Abuse Prevention and Prohibition Program undated documents To ensure that facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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	145555	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure coordination of care for a resident to receive medically necessary hemodialysis for 1 of 3 residents (R2) reviewed for dialysis services in the sample of 16. This failure occurred when (R2) was admitted to the facility on [DATE] and did not receive dialysis services for 12 days. R2 was sent to the hospital per family request where she was found with critical lab values, shortness of breath and had a 5 day hospital stay.Findings include:The IJ (Immediate Jeopardy) was presented and called on 10/29/2025 at 1:12 PM, with V1, Administrator, V22, [NAME] President of Clinical Operations and V23 Regional Director of Operations. The Immediate Jeopardy began on 10/8/2025 at 1:20 PM when R2 arrived at the facility. (R2) was transferred from another nursing home to the facility on [DATE], with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was put into place while the facility was waiting for the new provider to perform treatment. R2, who was receiving dialysis 5 days per week prior to her facility admission, subsequently did not receive dialysis services for 12 days, experienced shortness of breath, sweating, weakness, jaundiced eyes, and critical lab levels (potassium levels (6.2 mEq/L - milliequivalent/Liter) (normal 3.4-5.0) ; BUN (blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl - milligrams/deciliters) requiring hospitalization. The first abatement plan dated 10/29/2025 was not accepted. The fourth abatement plan on 10/30/2025 at 9:03 AM was accepted. The surveyor confirmed by observation, interview, and record that the Immediate Jeopardy was removed on 10/30/2025, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the facility's policies and procedures and in-service training.R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Hypoglycemia, unspecified; Hyperlipidemia, unspecified; End stage renal disease; Dependence on renal dialysis; Disorder of kidney and ureter, unspecified; Essential (primary) hypertension; Acquired absence of right leg below knee, type 1 diabetes mellitus without complications. R2's POS does not have an order for dialysis. R2's POS does document, Monitor dialysis catheter. Twice a day 6:00 AM-6:00 PM- 6:00 PM- 6:00 AM.R2's Facesheet documents R2 was admitted to the facility on [DATE].R2's Care Plan with a start date of 10/8/2025 Problem: I am at risk for alteration in nutrition due to d/x (diagnosis of) hypertension, Chronic systolic (congestive) heart failure, Disorder of kidney and ureter, End stage renal disease. R2's Care Plan does not document R2 was receiving dialysis and or waiting to set up hemodialysis treatments.R2's Transfer Sheet documents R2 was admitted from another nursing home on [DATE] at 11:40 AM. R2's Transfer Physician Orders Sheets (POS) document dialysis five times a week. R2's Transfer Care Plan with a date initiated of 1/30/2025 documents, Dialysis: Resident has potential for impaired renal function secondary to dialysis ESRD (End State Renal Disease).R2's Progress Notes document (R2) was transferred from another nursing home to the facility on [DATE], with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was scheduled and or put into place while the facility was waiting for the new provider to perform hemodialysis treatment for R2. R2's Progress Notes do not document R2 received any dialysis services while in the facility for her first 12 days. (10/8/2025-10/20/2025).R2's Progress Note dated 10/8/2025 at 1: 20 PM, arrived to facility via facility van with staff x2. Resident a/o (alert and orientated) x3. Wheelchair independent use, and stated she is able to transfer self. Wheelchair is her personal wc (wheelchair). Speech clear and understood. Smoking status, vape used. Denied tobacco use. MD (Medical doctor) in house for rounds upon arrival. medications reconciled. BIMS (Brief interview for mental status) at a 14 (out of 15) with denying depression (cognitively intact for decision making). R2's Progress Notes do not document any dialysis appointments and/or address any alternate treatments if R2 was not able to get into dialysis right away. R2's Progress Notes 10/12/2025 at 10:58 AM, Resident has c/o (complained of) being SOB (short of breath), hot, weak, and is excessively sweating. Resident states she missed dialysis on Friday. MD (Medical Doctor) made aware of the missed dialysis day. Resident's glucose was low at 49. VS (vital signs) are as follows: 97.8, 140/85, 84, 93% on RA (Room air). MD made aware of VS and patient complaints MD states just to monitor her glucose level in an hour, and send her to dialysis tomorrow, which is her normal dialysis day. Resident currently at lunch table eating a snack to bring glucose level up.R2's Progress Notes does not document R2 received dialysis on 10/13/2025 (next day). R2's Progress Notes do not address anything related to where or what company she is to receive dialysis treatment, and/or any alternate plan to receive dialysis. R2 was not sent to dialysis and