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	12/16/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to follow their abuse policy by reporting and investigating allegations of misappropriation for 1 of 3 residents (R3) reviewed for abuse in the sample of 8. Findings include:R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and Alzheimer's disease.R3's Minimum Data Set (MDS) dated [DATE] documented R3 was severely cognitively impaired and dependent with transfer. R3's Physician Order dated 5/28/25 documents 5 mg (milligrams) oxycodone, given every four hours.On 12/11/25 at 2:59 PM, V1, Administrator, stated V6, R3's Family, reported R3 did not receive any of her medications on 11/21/25. V6 reported she watched the video footage from the video camera in R3's room, and R3's nurse never entered R3's room to give medications. On 12/11/25 at 3:20 PM, V1 stated the Facility did notify her of V6's allegation of missing medications on 11/21/25, and the nurse in question was V20, Licensed Practical Nurse (LPN). V1 stated she came in and watched the Facility's video footage that night and checked R3's Medication Administration Records (MARs) which documented the medications had been given. V1 felt the issue had been resolved and did not report or investigate the allegation.On 12/12/25 at 9:02 AM, V6 stated R3's nurse, whose identity was unknown, never entered R3's room during her shift, and R3 never received her medications. The nurse told V6 the oncoming nurse would give R3 her medications. The oncoming nurse, whose identity was also unknown, told V6 the medications were missing and had been documented as given. One of the Certified Nursing Assistants (CNAs), whose name was unknown, notified V1 of the situation. V1 stated she would be in the next day to talk to V6, but she never showed up or called.On 12/12/25 at 1:58 PM, V1 stated there is a camera at the nurse's station that is aimed down the hall and another camera a couple feet into the hall. The video footage showed V20 going from room to room and entering R3's room, but you cannot see which medications were administered. V1 stated she did not report or investigate this because she watched the video and found it was not substantiated. On 12/12/25 at 2:12 PM, V2, Director of Nursing (DON), stated if diversion is alleged, the Facility would notify her or V7, [NAME] President (VP) of Clinical Operations, and we would investigate it. We would check the counts, check the cards on the cart, and then we would check the signage on the MAR and on the narcotic book. If we found a discrepancy, we would investigate further. V2 stated she was not aware of this allegation and asked V1 if she had notified V7. V1 stated she did not notify V7.The Facility's Abuse Prevention and Prohibition Program Policy reviewed 12/2/25 documents, Each resident has the right to be free from misappropriation of property. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts. The Administrator will provide initial and follow-up written report of the results of all abuse investigations and consequent actions to the appropriate agencies.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to report an allegation of misappropriation for 1 of 3 residents (R3) reviewed for abuse in the sample of 8. Findings include:R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and Alzheimer's disease.R3's Minimum Data Set (MDS) dated [DATE] documented R3 was severely cognitively impaired and dependent with transfer.R3's Physician Order dated 5/28/25 documents 5 mg (milligrams) oxycodone, give 1 tab every four hours.On 12/11/25 at 3:20 PM, V1 stated the Facility notified her that V6 alleged R3 had medications missing on 11/21/25.On 12/12/25 at 9:02 AM, V6 stated R3's nurse, whose identity was unknown, never entered R3's room during her shift and told V6 the oncoming nurse would give R3 her medications. The oncoming nurse, whose identity was unknown, told V6 the medications were missing and had been documented as given. One of the Certified Nursing Assistants (CNAs), whose name was unknown, notified V1 of the situation. V1 stated she would be in the next day to talk to V6, but she never showed up or called. On 12/12/25 at 1:58 PM, V1 stated she did not report this to IDPH or law enforcement.The Facility's Abuse Prevention and Prohibition Program Policy reviewed 12/2/25 documents, Each resident has the right to be free from misappropriation of property. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. The Administrator will provide initial and follow-up written report of the results of all abuse investigations and consequent actions to the appropriate agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to investigate an allegation of misappropriation for 1 of 3 residents (R3) reviewed for abuse in the sample of 8. Findings include:R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and Alzheimer's disease.R3's Minimum Data Set (MDS) dated [DATE] documented R3 was severely cognitively impaired and dependent with transfer.R3's Physician Order dated 5/28/25 documents 5 mg (milligrams) oxycodone, give every four hours.On 12/11/25 at 2:59 PM, V1, Administrator, stated V6, R3's Family, reported R3 did not receive her medications on 11/21/25. On 12/11/25 at 3:20 PM, V1 stated the Facility did notify her of V6's allegation of missing medications on 11/21/25, and her nurse was V20, Licensed Practical Nurse (LPN). V1 came in and watched the Facility's video footage that night and checked R2's Medication Administration Records (MARs) which documented the medications had been given. V1 felt the issue had been resolved and did not investigate the allegation.On 12/12/25 at 9:02 AM, V6 stated R3's nurse, whose identify was unknown, never entered R3's room during her shift. The nurse told V6 the oncoming nurse would give R3 her medications. The oncoming nurse, whose identity was unknown, told V6 the medications were missing and had been documented as given. One of the Certified Nursing Assistants (CNAs), whose name was unknown, notified V1 of the situation.On 12/12/25 at 1:58 PM, V1 stated there is a camera at the nurse's station that is aimed down the hall and another camera a couple feet into the hall. The video footage showed V20 going from room to room and entering R3's room, but one could not see what medications were being administered. V1 stated she did not investigate this because she watched the video and it was unfounded. On 12/12/25 at 2:12 PM, V2, Director of Nursing (DON), stated if diversion is expected, the Facility would notify her or V7, [NAME] President (VP) of Clinical Operations, and they would investigate it. They would check the counts, check the medication cards on the cart, and then check the signage on the MAR and on the narcotic book. If they found a discrepancy they would investigate further. V2 stated she was not aware of this allegation and asked V1 if she had notified V7. V1 stated she did not notify V7 of this.The Facility's Abuse Prevention and Prohibition Program Policy reviewed 12/2/25 documents, Each resident has the right to be free from misappropriation of property. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts. The Administrator will provide initial and follow-up written report of the results of all abuse investigations and consequent actions to the appropriate agencies.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to allow resident to remain at the Facility and failed follow proper procedures for discharge for 1 of 3 residents (R2) reviewed for discharge in the sample of 8.Findings include:R2's Face Sheet documents R2 was initially admitted to the facility on [DATE] with diagnoses including malignant neoplasm of colon and chronic pain.R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively impaired and required substantial assistance with transfer.R2's Care Plan dated 9/2/25 documents, My goal is to remain in the facility for long-term care.R2's Progress Note by V21, Licensed Practical Nurse (LPN), on 10/23/25 at 10:42 PM documents R2 returned to the Facility after being sent out for aggressive behaviors.R2's Progress Note by V25, Registered Nurse (RN), on 10/24/25 at 11:50 AM documents R2 was transferred to (Facility) with medications. On 12/10/25 at 8:53 AM, V9, Ombudsman, stated she received an email stating R2 got into an altercation with another resident. R2 was sent to the hospital for a psychological evaluation, then was transferred to (Facility). V9 went to (Facility) to check on R2, and R2 was very upset because she did not want the transfer. V9 appealed the transfer, and V5, Administrative Law Judge (ALJ) ordered the Facility to take R2 back.On 12/10/25 at 9:38 AM, V4, R2's Family, stated the Facility called her, stating R2 got in an altercation with another resident and would have to be placed in another facility. V4 stated she was not happy about this, but the Facility presented it as their only option. She stated the Facility did not let them know their rights as a family and did not follow the proper steps for discharge.On 12/10/25 at 10:10 AM, V1, Administrator, stated R2 had behavioral problems and it had been discussed previously that if they continued R2 may need to go to a different facility. On 12/11/25 at 1:20 PM, V5 stated the Facility allowed R2 to return, but they never filed the Involuntary Discharge (IVD) paperwork and still need to resolve the hearing regarding the IVD that is scheduled for later this month.On 12/12/25 at 8:55 AM, V18, Social Services Director (SSD), stated something happened with R2 after she had already gone home one day, then the next day she came in and R2 had already transferred to (Facility).On 12/12/25 at 12:26 PM, V19, Restorative Aid, stated he transported R2 to (Facility). R2 did not want to go and said they were putting her out because she did something to another resident. V19 later got a phone call from V1 stating he would have to go get her at (Facility) and bring her back because V4 had not approved of the transfer.On 12/12/25 at 3:35 PM, V25 stated she was not aware R2 was discharging until she was leaving the building with V19. She was R2's nurse and did not even have R2's discharge paperwork ready. On 12/12/25 at 1:58 PM, V1 stated she does not remember the Facility choices that were given to R2 prior to transfer.The Illinois Department of Public Health (IDPH) Involuntary Transfer or Discharge Request for Hearing for R2 dated 10/24/25 documents, No IVD paperwork was given to resident.The IDPH Administrative Law Judge Conference Report and Order dated 12/4/25 documents the Administrative Law Judge (ALJ) and Parties including R2 and the Facility held a Prehearing. The case was ordered to be continued for Emergent Evidentiary Hearing on December 5, 2025. On 12/11/25 at 12:30 PM, V1, Administrator, stated there was no Involuntary Discharge (IVD) paperwork provided to R2.The Facility's Notice of Transfer and Discharge Policy revised 6/1/25 documents prior to discharge, the Facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The notice will be provided 30 days in advance or as soon as practicable.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to communicate required resident information to the receiving provider for 1 of 3 residents (R2) reviewed for discharge in the sample of 8. Findings include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of colon and chronic pain.R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively impaired and required substantial assistance with transfer.R2's Progress Note by V25, Registered Nurse (RN), on 10/24/25 at 11:50 AM documents R2 was transferred to (Facility) with medications. V25 was unable to give report to the receiving (Facility), and there was no documentation that paperwork was sent with R2. On 12/12/25 at 3:35 PM, V25 stated she discharged R2, If you want to call it that (discharge). She was not aware that R2 was being discharged until V19, Restorative Aid, came to tell her as they were getting ready to leave the Facility. V25 stated she did not even have R2's paperwork ready.On 12/10/25 at 9:38 AM, V4, R2's Family, stated the Facility did follow the proper steps when discharging R2.On 12/11/25 at 2:50 PM, V1, Administrator, stated when discharging residents, the Facility will send a medication list, two weeks of progress notes, and the resident's care plan and face sheet. The resident's chart should document that it was sent with them. The Facility's Notice of Transfer and Discharge Policy revised 6/1/25 documents when the facility discharges a resident for any reason, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.