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 02/21/2025
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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50840 Based on interview and record review, the facility failed to prevent resident to resident abuse for 3 of 3 residents (R71, R77, R78, R80) reviewed for abuse in the sample of 44. This failure resulted in R80 being pushed by R40 causing R80 to be sent out to the hospital. Finding include: 1.) R80's Face Sheet, undated, documents R80 has the following diagnoses: Unspecified dementia, unspecified severity, with other behavioral disturbance, Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Generalized anxiety disorder. R78's Face Sheet, undated, documents R78 has the following diagnosis: anxiety disorder. R80's MDS (Minimum Data Set), dated 2/11/25, documents R80 is severely cognitively impaired. R78's MDS, dated [DATE], documents R78's cognition is intact. R80's Care Plan, date initiated 2/7/25, documents R80 has a potential for physical harm towards others related to personal space, dementia and poor impulse control. R78's Care Plan, date initiated 2/7/25, documents R78 has a behavior problem related to descriptive accounts of occurrence involving her and/or others. R80's Progress Note dated 2/5/25 at 4:31 PM documents This nurse was standing at the nurses' station when R80 was observed striking R78 in the face in the dining room. This nurse separated residents immediately and placed R80 on one-on-one monitoring. R78 who was struck has a reddened area to her left eye and states she was just sitting at the table when R80 approached her and struck her in the eye. Medical Psychiatrist notified of event and ordered R80 to be sent to hospital for evaluation. Emergency Medical Services and family contacted at this time. R78's Progress Note, dated 2/5/25 at 4:55 PM, documents R78 sitting in dining room, another resident (R80) walked up to her and struck her in the left eye, Redness noted. Nurse Practitioner in facility assessed R78. No new orders received. POA (Power of Attorney) and Medical Doctor aware. IDPH (Illinois Department of Public Health) notified. (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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	145555	A. Building B. Wing	02/21/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Final Report, dated 2/5/25 at 4:45 PM, documents the following, Investigation: R78 was observed sitting at the dining room table, she was approached by R80. R80 was observed wandering. R80 was observed near R78. Staff stated it appeared that R80 had struck R78 near the eye, slight redness noted to area, no other discoloration noted. R80 was removed immediately from the dining area and placed one on one. R78 stated she was sitting at her table and R80 had struck her. When asked if R78 knew who R80 was, she did not. When asked if R78 had any issues with R80 prior, R78 stated no. When asked if R78 feels safe in the facility R78 stated she does. R78 denied pain. R80 when questioned denied the incident, there was noted confusion on assessment. Medical psychiatrist was notified of incident and change of condition. Orders given to send R80 to hospital for evaluation for new onset of behaviors/confusion. Conclusion: Due to the nature of R80's diagnosis it has been concluded that this was an isolated incident and not an act of aggression/targeting. R80 has not displayed aggressive physical behaviors in the past as his baseline is pleasantly confused. 2.) R77's Face Sheet, undated, documents R77 has the following medical diagnoses: Unspecified dementia, unspecified severity, with other behavioral disturbance, Aphasia, Cerebrovascular disease, and Depression. R71's Face Sheet, undated, documents R71 has the following medical diagnoses: Wernicke's encephalopathy, Dementia, Alzheimer's Disease, Major depressive disorder, Generalized Anxiety disorder. R77's MDS, dated [DATE], documents R77 is severely cognitively impaired. R71's MDS, dated [DATE], documents R71 is mildly cognitively impaired. R77's Care Plan, date initiated 1/20/25, documents R77 was in an altercation with another resident due to a misunderstanding. R71's Care Plan, date initiated 1/20/25, documents R71 as a history of inappropriate contact and becoming agitated with peers. R71 became upset with another resident causing harm to him, staff removed me from him, placing me on one-on-one in my room. R77's Progress Note, dated 1/20/25 at 7:05 AM, documents Administration notified of incident with another resident (R71). R77 was observed approaching dining room table where 2 other residents were present, started to interrupt them and was attempting to take something off the table. R77 was told to stop by R71 at the table and then continued to try and remove items from the table. R71 that was sitting at the table then swung his cup at R77 attempting to throw his iced tea on him. During this R77 was struck by the cup resulting in a small abrasion to right cheek. R71 and R77 immediately separated and placed on one-on-one monitoring. Both parties POA (Power of Attorney) notified of event as well as MD (Medical Doctor). Event reported to IDPH (Illinois Department of Public Health) R71's Progress Note, dated 1/20/25 at 7:05 AM, documents R71 involved in incident with another resident, R77. R71 was sitting at dining room table when another resident, R77 approached the table and attempted to take some items from the table. R71 told other resident, R77 to stop trying to take his things. R77 did not listen and continued trying to remove items from the table. R71 then took his cup of iced tea and struck R77, resulting in a small abrasion to R71's right cheek. R71 and R77 separated immediately and placed on one-on-one monitoring, POA and MD notified of event. Event reported to IDPH. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Final Report dated 1/20/25 at 7:00 AM, documents R71 was sitting at dining room table when R77 approached the table and attempted to take some items from the table. R71 told R77 to stop trying to take his things. R77 did not listen and continued trying to remove items from the table. R71 then took his cup of iced tea, while trying to dump the iced tea on R77, contact was made with the cup resulting in a small abrasion to R77's right cheek. R71 and R77 were separated and placed on one-on-one monitoring, POA and MD notified of event. R77 has the diagnosis of dementia and behaviors of wandering/bother others property. R71 also has the diagnosis of dementia with behaviors. R71's story had changed a few times during the interview process, however it remains the same that R71 did not premeditate or target R77. R77 does not recall what happened to full capacity. Both have remained behavior free and staff acted appropriately. In an abundance of precaution both R71 and R77 were monitored for 24 hours. Frequent monitoring of the dining room while multiple residents are in the area. On 2/21/25 at 11:32 AM, V9, Certified Nursing Assistant Coordinator, stated R71, R77, R78, and R80 usually do not have aggressive behaviors. V9 stated R80 does need to be re-directed sometimes in the evenings. V9 stated R77 can be resistant with care and aggressive during care at times, but just needs re-approached and is usually fine. V9 stated R77 does wander at times, and she thinks some people may think he is being intimidating or aggressive. V9 denied hearing of any other altercations or incidents involving R71, R77, R78, or R80. V9 stated she did not personally see either incident that happened on 1/20/25 or 2/5/25 but if she would see an incident of abuse, she would make sure all residents are safe, remove the residents involved, and then report the incident to the administration. On 2/21/25 at 12:27 PM, V2, Director of Nursing, stated R78 and R80 have never had any prior aggressive behaviors towards anyone before the incident on 2/5/25. V2 stated R78 was immediately seen by the Nurse Practitioner that was in the facility at the time of the incident. V2 stated R80 was removed from the dining area after incident, the psychiatrist was then contacted, and R80 was sent to the hospital for evaluation. V2 stated R71 has not had any previous aggressive behaviors before incident on 1/20/25 and after incident R71 was placed on one-on-one in his room. V2 stated R80 does not have aggressive behaviors, however he does get a little more agitated in the afternoon and can be harder to re-direct. V2 stated R77 was placed in his room after incident and monitored one-on-one. V2 stated both R71 and R77 saw the psychiatrist the next day following the incident. 44953 3.) R40's Face Sheet undated documents his pertinent diagnosis as Other Specific Personality Disorder, Alzheimer's Disease with late Onset, Unspecified Psychosis not due to a substance or known Physiological Condition; Unspecified Mental disorder due to known Physiolocal Condition and Unspecified Dementia with Behavioral Disturbance. R40's Minimum Data Set (MDS) dated [DATE] documents he is cognitively intact and has not exhibited any verbal or physical behaviors toward others. R40's Care Plan dated 12/27/24 documents R40 has the potential to be physically aggressive r/t anger, depression and poor impulse control. The interventions place are 1:1 with male staff, social service worker to visit with R40 2 times a week for 3 weeks and prn; move room closer to the nurses desk for closer monitoring for aggressive behaviors and request the psych medical providers to include R40 in their rotation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/21/25 at 11:25 AM Facility Reported Incident (FRI) dated 12/27/24 documents R40 pushed a resident (R80) as (R80) stopped in his (R40's) doorway. (R80) lost his balance and fell to his buttocks, into a sitting position. (R80) was transferred to an area hospital. The abuse was Unsubstantiated due to R40's Personality disorder and Alzheimers. On 2/18/25 at 9:30 AM Licensed Practical Nurse (LPN) stated R40 is a loner does not bother anyone, and does not want anyone in his room. (R40) does come out of his room to walk the halls for exercise and to eat in the dining room but he sits away from everyone and eats alone. R40 is not a problem until you try to provide care, give him medication or go in his room. Stated she was not in the facility the day of the incident . On 2/21/25 at 1:45 PM V1 (Administrator) stated the incident was not viewed as abuse as R40 just has peculiar ways. Even though his behavior was viewed as inappropriate, it was not viewed as with malicious intent. The facility attempts to protect all its residents, R40 has never had a roommate because of of his isolationist behavior, but he does not have a history of being aggressive with anyone. On 2/21/25 at 2:30 PM V2 Director of Nursing (DON) stated staff monitor all the residents but pay particular attention to R40 because he does like being alone, does not like being touched and avoids all activities. R40 has his rights and we honor that. R80's Face Sheet undated documents his diagnosis as Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Unspecified dementia, unspecified severity, with other behavioral disturbance and Generalized anxiety disorder. R80's Minimum Data Set (MDS) dated [DATE] documents severe cognitive impairment and wandering behavior occurs daily. R80's Hospital Records dated 12/27/24 documents R80 was seen at an area hospital for a ground level fall abdominal pain and head injury. R80's Computed Tomography (CT) scan of cervical spine without contrast dated 12/27/24 documents no fracture but severe spondolysis. R80's Computed Tomography (CT) scan of brain without contrast documents right posterior soft tissue swelling but normal aging brain. On 2/21/25 at 1:48 V1 (Administrator) stated R80 just wanders around the building trying to be friendly. (R80) is not a problem but does require monitoring to prevent someone from harming him. This was the first time I have known him to go into anyone's room. Both (R40) and (R80) have been Care Planned and are on Behavior Tracking. The facility's Abuse and Neglect Prohibition Policy dated 3/1/2020 documents All residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation