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	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	401 St Mary Drive Edwardsville, IL 62025

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to use the required equipment (gait belt) during transfer and appropriately use the full mechanical lift to prevent falls in 2 of 3 residents (R3, R29) reviewed for accidents and hazards in the sample of 38. These failures resulted in R3 sustaining a left femur fracture and R29 sustaining a hematoma to her head and requiring emergency care. Findings include: 1. R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including muscle weakness, lack of coordination, and abnormalities of gait and mobility. R3's Minimum Data Set (MDS) dated [DATE] documented R3 was moderately cognitively impaired and was dependent with transfers from chair to bed or bed to chair. R3's Care Plan initiated 8/30/25 documents R3 requires extensive assistance for transfers related to weakness and impaired mobility. R3's Progress Note by V34, Licensed Practical Nurse (LPN), dated 1/12/25 at 10:01 PM documents at approximately 6:55 PM, an unnamed Certified Nursing Assistant (CNA) reported R3 was on the floor. The CNA stated R3 became weak during transfer and shifted weight to her left side where she had an amputated leg. The CNA stated she fell with R3, and R3 reported pain to left hip. R3's 1/12/26 Fall Report by V34 documents R3 became anxious during transfer from wheelchair to bed and placed all weight on left below the knee amputation, causing her to lose balance. The CNA lowered R3 to the floor, placing herself under R3 to break the fall. R3 was sent to the Emergency Room. R3's Hospital Record dated 1/13/26 documents R3 sustained a complete acute transverse fracture to left humeral neck after sustaining a fall at the nursing facility. On 3/20/26 at 10:40 AM, V33, CNA, stated she was putting R3 back into bed from her wheelchair on 1/12/26 when R3 fell. R3 stated she felt like her right side was weak, so she put some weight on the left side where she had an amputation. V33 tried to break R3's fall, but both V33 and R3 fell on the floor. V33 stated she was previously told by other CNA's that R3 liked staff to use a bear hug method when transferring her, so she was not using a gait belt on R3 at the time. On 3/20/26 at 12:45 PM, V1 stated she would expect staff to follow the Facility's transfer policy and use gait belts for transfers. (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 0689 Level of Harm - Actual harm Residents Affected - Few	2. R29's Undated Face Sheet documents R29 was admitted to the facility on [DATE] and has a medical diagnosis of Type 2 Diabetes Mellitus, Abnormalities of Gait and Mobility, Muscle Weakness, Altered Mental Status, Chronic Pain Syndrome, Osteoarthritis, Alzheimer's Disease, and Hypertension. R29's Minimum Date Set (MDS) dated [DATE] documents R29 is moderately cognitively impaired, uses a wheelchair, and is dependent on staff for sitting to standing, toilet transfers, and chair/bed to chair transfers. R29's Care Plan Start Date 12/27/2025 documents Falls: R29 had a fall on 12/27/2025. Intervention Start Date 12/27/2025 documents staff educated on the proper use of (full mechanical lift) to ensure that all sling attachments are secure before all transfers. R29's Care Plan Start Date 8/30/2025 documents ADLs (Activities of Daily Living) Functional Status/Rehabilitation Potential: R29 requires extensive assist for ADLs related to immobility, range of motion (rom) and pain. Intervention Start Date 8/30/2025 documents R29 needs total assist with transfers with the use of the (full mechanical lift) and 2 staff. R29's Progress Note dated 12/27/2025 at 8:38 AM documents This nurse called to resident room resident found laying on floor beside (full mechanical lift) Certified Nursing Assistant (CNA) replies she was transferring resident and hook on (full mechanical lift) unhooked resident started to slide out CNA replies she assisted resident to floor. Staff educated to make sure (full mechanical lift) sling is properly secured before transfer. Resident has a small hematoma noted to back of head 1 centimeter (cm) skin intact no bleeding noted. Resident denies any discomfort besides she replies her head hurts a little. 911 placed to pick resident up and transport to Local hospital for evaluation. R29's Progress Note dated 12/27/2025 at 8:45 AM documents Date/time of incident: 12/27/25 0838. Details: res was being lifted with (full mechanical lift) pad to wheelchair by staff when (full mechanical lift) strap came off of (full mechanical lift). Staff member held strap up while resident was lowered to the floor. Assessed resident did sustain a small hematoma to back of head. Root cause: strap not securely in place. R29's Fall Investigation Worksheet dated 12/28/2025 documents date of fall: 12/27/2025, time of fall 8:38 AM. Fall witnessed, location of fall: resident room. Was resident using an assistive device: yes, (full mechanical lift). Was resident injured: hematoma and scratch. Root cause of fall: improper placement of hook. R29's Local Hospital Records Dated 12/27/2025 documents Emergency Department (ED) Adult Initial Assessment Triage Note Patient (Pt) to the ED via Emergency Medical Service (EMS) for evaluation after a fall. Pt was in the (full mechanical lift) when a strap broke, causing the pt to fall 4 feet. Pt striked her head, and is complaining of neck pain. R29's Local Hospital Records Dated 12/27/2025 documents ED Triage Note Arriving to ED from Nursing Home with complaint of being transferred from bed to wheelchair via (full mechanical lift) the hook of the (full mechanical lift)) came undone or broke. Nursing Home staff states they lowered her to the floor but she struck the back of her head. On 3/19/2026 at 10:59 AM V20, Licensed Practical Nurse (LPN), stated the CNA came to her and stated she was transferring R29 using the (full mechanical lift) when the hook of the lift pad came unhooked from the (full mechanical lift) and R29 was assisted to the ground. V20 stated she assessed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R29 and R29 had a small hematoma to her head and was sent to the local hospital for evaluation. On 3/19/2026 V2, Director of Nursing (DON), stated during R29's transfer, the hook was not completely on the (full mechanical lift), and when R29 went up in the air the hook came off. V2 stated the staff member held R29 and R29 was lowered to the ground. V2 stated the staff member was transferring R29 by herself. On 3/19/2026 at 1:06 PM R29 stated she remembers being put into the (full mechanical lift) sling by staff and does not know how she slipped out of the sling. R29 stated she is unsure if she slipped out of the pad due to the fault of the CNA. R29 stated she slipped out of the (full mechanical lift) pad and hit the top of her head on the floor. R29 stated it was a bummer that she fell and hit her head because it hurt really bad. R29 stated she was sent to the hospital and had her head scanned and it did not show anything. On 3/19/2026 at 1:26 PM V24, Nurse Practitioner, V24 stated she was notified of R29's fall and is unsure of the particulars of the fall and transfer because she was not in the room at the time the incident occurred. V24 stated she assessed R29 on 12/30/2025 and R29 was alert and oriented and able to follow commands. V24 stated she does not recall if R29 had a hematoma to her head and was not told by staff if R29 had one. V24 stated she excepts the facility to be following their fall and transfer policy. V24 stated she would except staff to be trained on how to properly use the facility's mechanical lift. On 3/19/2026 at 1:38 PM V25, CNA, stated on 12/27/2025 the facility was extremely short staffed, and she asked multiple staff members to help her use the (full mechanical lift) on R29 and no one would help her. V25 stated she used the (full mechanical lift) by herself to get R29 up to her chair from the bed. V25 stated the (full mechanical lift) sling hook had broken when she was lifting R29 and V25 caught R29 using her leg and lowered R29 to the ground. V25 stated she screamed for staff to come help her when the (full mechanical lift) sling strap broke and no one came into the room. V25 stated the facility allows staff to use the (full mechanical lift) with one person. The Facility's Transfers-Manual Gait Belt and Mechanical Lifts Policy Date Reviewed 6/1/2025 documents Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer techniques. The transferring needs of resident will be assessed on an ongoing basis and designated into one of the following categories: 0=independent, 1=1 person transfer (25% or less assistance from the caregiver) with gait belt, 2= 2 person transfer with gait belt (ONLY when use of mechanical lift is not possible), SS=sit to stand lift with 1 caregivers, H=mechanical lift (Hoyer) with 2 caregivers. Use of gait belt for all physical assist transfers is mandatory. The Facility's Fall Evaluation and Prevention Policy Date Reviewed 6/1/2025 documents Purpose: to ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the Facility failed to ensure food was stored in a manner that prevents foodborne illness. This has the potential to affect all 91 residents living in the Facility.Findings include:On 3/17/26 at 6:55 AM, in the standing freezer there were two boxes of uncooked beef patties stored directly on top of a box of cookie dough.On 3/17/26 at 7:00 AM, in the deep freeze there were multiple bags of food in plastic gallon storage bags. There were three bags labeled bone in chicken that had red frozen liquid inside. These bags were stored directly on top of bags labeled pound cake and brown sugar pineapple. V5, Cook, stated this freezer is primarily used for leftovers and asked if the chicken should be moved. She verified the chicken was uncooked and the beef in the other freezer was also uncooked.On 3/18/26 at 10:18 AM, V1, Administrator, stated she expects the Facility to follow its food storage policies.The Facility's Food and Supply Storage Policy dated 8/1/25 documents food and supply storage areas shall be maintained in a clean, safe, and sanitary manner.The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/17/26 documents there are 91 residents living in the Facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that medication administration protocols were followed in 4 of 4 residents (R11, R21, R32, and R74) when reviewed for pharmacy services in the sample of 38.Findings include: 1. R74's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnosis: wedge compression fracture of T11-T12 vertebra and low back pain. R74's Quarterly Minimal Data Set, dated 12/23/2025 documents R74 was cognitively intact, high-risk drugs: opioid, pain management: resident received scheduled and PRN (when needed) pain medication regimen, pain last 5 days: yes, pain frequency: occasionally, pain interference with day-to-day activities: occasionally, pain intensity: 3 out of 10. R74's Care Plan, dated 3/30/2025 documents resident has chronic pain r/t (related to) T-12 compression fracture, chronic back pain, depression, long history of pain medication use, GERD, and head injury as a child. Approaches documented include: report to nurse my complaint of pain or requests for pain treatment, report to nurse loss of appetite, refusal to eat and weight loss, report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx (signs/symptoms) or c/o (compliant of) pain or discomfort, record/report to Nurse any s/sx of non-verbal pain, observe/record pain characteristics (FREQ) and PRN as needed): quality (e.g. sharp, burning); Severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors; relieving factors, observe/document for side effects of pain medication, observe the effectiveness of pain interventions, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care, notify physician if interventions are unsuccessful or if current complaint is a significant change from my past experience of pain, administer analgesia (pain medication) as per orders. R74's Physician Order Sheet (POS), dated 10/27/2025 documents a new physician's order for Hydrocodone 7.5 milligrams (mg) four times a day at 5:00 AM, 11:00 AM, 5:00 PM and 11:00 PM for low back pain. R74's Electronic Medical Record no documentation of Hydrocodone incident. On 3/17/2026 at 7:55 AM R74 was lying in bed and stated he committed a felony last week. R74 stated he is prescribed a pain medication, Hydrocodone 7.5 mg four times a day. R74 stated the nurses leave his medications at bedside and sometimes he doesn't need the pain medication, so he places the tablet in a secret place in his room. Last week a CNA (certified nurse assistant) named V6 wore a boot because she had recently fractured her ankle, and she was in a lot of pain. R74 stated he told V6 that if she hurt he had pain medication that would help with that and she said OK. R74 stated a few minutes later V6 came back to his room and stated she would like the pain medications. R74 stated he gave V6 2 Hydrocodone 7.5 mg tablets and a few hours later the Administrator and the Director entered his room and started asking him 100 questions. R74 stated management insisted he give them all the medications he had, and he did. R74 stated he had about 10 tablets of Hydrocodone in his secret stash and staff took them. On 3/17/2026 at 1:05 PM V6, CNA stated she entered R74 room one day last week and he asked her if (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her foot hurt because she's wearing a medical boot. V6 stated she told R74 that she was ok and R74 told her he has something that would handle that pain if she needs it. V6 reported what R74 said to the nurse V10, Licensed Practical Nurse, (LPN) and V10 told her to go back in R74's room a few minutes later and tell him she was hurting to see what he gives her. V6 stated she reentered R74's room a few minutes later and asked for pain relief and R74 handed her 2 white pills in a medication cup. V6 stated she took the pills directly to V10 who was sitting at the nurse's station and reported these pills were given to her by R74. V10 went directly to the DON's (Director of Nurses) office and the Administrator, DON, ADON (Assistant Director of Nurses) and V10 went to R74's room to start an investigation. V6 stated V10 told her later that they found over 26 Hydrocodone in his room that he was hoarding. V6 stated she had not observed any pills in a medication cup in R74's room nor had she observed a nurse place the medication cup of pills in R74's room without him taking them in front of the nurse. On 3/18/2026 at 8:33 AM V10, LPN stated she works day shift, and she has observed pills in a medication cup at R74's bed side in the past when she arrives to the facility she does rounds and she has observed pills in a medication cup on R74's table in his room a few times. V10 stated when she saw the medications in R74's room she gave them back to the night shift nurse to dispose of. V10 stated she couldn't recall what night shift nurses left the medications in R74's room and she recalled it occurred over a couple of times. V10 stated she always ensures all residents take their medications in front of her because that's nursing standard of practice. On day last week V10 stated V6, CNA came to her and told her R74 offered her pain medication, and she told her to go back in R74's room to see what medication he had. V6 returned to the nurse's station a few minutes later and gave her 2 Hydrocodone 7.5 mg tablets and stated R74 gave them to her. V10 stated she immediately took the medication to V1, Administrator and V2, Director of Nurses (DON) and the Assistant Director of Nurses (ADON) and an investigation was initiated at that time. On 3/18/2026 at 10:42 AM V2, DON stated one day last week V10 came to her and stated they had a situation regarding R74's Hydrocodone. V10 reported that R74 gave V6 2 Hydrocodone tablets for her foot pain and V6 gave both tablets to V10 and her, V1 and V3 went to R74's room and asked him why he gave Hydrocodone to V6 and V74 stated because V6 had recently broke her ankle and she was hurting. V2 stated she asked R74 for the other pills he had in his room, and he reached under his bed and got a black case that had 12 Hydrocodone in it. V2 asked R74 to leave his room so they could search it and staff found 14 more Hydrocodone, 2 Ibuprofen tablets and 2 Depakote capsules. R74 told V2 that sometimes night shift nurses drop off his medications on his bedside table while he's sleeping and when he wakes up he stashes them for a rainy day pain. R74 didn't state any specific nurses that drop his medications off in his room. R74 stated he hadn't given any medication to any other staff other than V6 and he didn't give medications to other residents. V2 stated R74 doesn't ever leave his room and doesn't have any visitors either. V2 stated she expected staff to report to her when they observe medications left in a resident's room so she can address that because narcotics are to be stored under a double lock and no residents, including R74's POS have an order to have Hydrocodone at bedside. On 3/18/2026 at 12:50 PM V2, DON stated R74's physician's order was for one Hydrocodone tablet four times a day scheduled during this time and the nurses must have left the medication with the resident over a period of time for R74 to have 26 Hydrocodone in his room. V2 clarified the nurses must have left the medication in R74's room [ROOM NUMBER] different times over a period of time for him to have that many tablets stashed. The Facility's Medication Administration Policy, reviewed 6/1/2025 documents purpose: to provide (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practice standards for safe administration of medications for residents in the facility. Policy: medications will not be left at bedside, medications will be administered by licensed nursing staff and the licensed nurse will remain with the resident until the medicine is actually swallowed. 2. R11's Face Sheet, undated, documents R11 has the following diagnoses: Unspecified Dementia, Osteoarthritis, Developmental Disorder, Borderline Intellectual Disorder, Obsessive Compulsive Disorder, Major Depressive Disorder, Bipolar Disorder, Borderline Personality Disorder, Autistic Disorder, and Attention Deficit Hyperactivity Disorder. R11's POS (Physician Order Sheet), documents the following physician orders: Acetaminophen 325mg (milligrams) 2 tablets every 4 hours as needed, dated 12/18/24, and Trazadone 100mg at bedtime, dated 6/26/25. R11's MDS (Minimum Data Set), dated 2/20/26, documents R11 is cognitively intact. R11's Care Plan, dated 11/10/25, documents R11 is at risk for medication noncompliance due to resident hoarding, with an intervention that staff will observe resident taking medication to ensure they are swallowed and not pocketed. R11's Progress Note, dated 11/10/25 at 11:11 AM, documents the following: Going into room noted resident had 4 pills in her hand and A.M (Morning) medication had not been given. When questioned resident said it was pills from the last two day that she hadn't taken 2 oblong white pills resident said was pain pills and 2 round white pills were trazadone. Resident stated while she feels great body wise, she feels she is falling apart in her mind that she was in a very dark place. Resident said she was having suicidal thoughts of killing herself. Resident began crying, I was able to calm resident down with reassuring words that I would get her help. The N.P (Nurse Practitioner) was walking by, I called her over and informed her of conversation I was having with Resident. (R11) repeated the thoughts of self-harm her and I informed her that resident was hording pills. (V24, Nurse Practitioner, NP) said to send resident to hospital. for Psych Eval (Psychiatric Evaluation). (R11's Family) was called and informed of resident hording pills and expressing wanting to kill herself. Also informed (R11's Family) that we have and order to send resident to the hospital for a psychiatric evaluation, agreed and stated (R11) has been going back and forth with that idea for a couple of days. Resident placed on one-on-one monitoring. Psychiatry called, information given on resident Spoke with (R11's Doctor), informed him of resident hording pills and wanting to kill self. Order was given to send resident to the (local psychiatric hospital). Hospital notified and informed them of resident's plan to commit suicide 911called to transport resident to hospital.) R11's Nurse Practitioner Progress Note, dated 11/10/25 at 9:50 AM, documents, in part, the following: Suicidal ideations: HPI (History of Present Illness): Patient is a [AGE] year old female with a PMH (Past Medical History) of Dementia, Hypertension, Dyslipidemia, Insulin-Dependent Diabetes, Hypothyroidism, Chronic Kidney Disease, Anemia, Osteoporosis, Autism, Depression, Anxiety, Bipolar Disorder and Attention Deficit Disorder, being seen today for complaints of suicidal ideations and hoarding medications. Patient found to have 4 medications in a pouch at her bedside, identifying them as trazadone and acetaminophen. States that she feels that she does not need them and is sleeping alright. States that she is feeling better than I ever have while also feeling like my body is telling me to kill myself. Patient states that she is very sorry for hording medications and denies any additional meds being kept. Call placed to patient sister who indicates that she feels the patient has been making these statements for a few days and that her emotional stability has been vacillating between very high and very low. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's Progress Note, dated 11/10/25 at 4:42 PM, documents the following: Called (Psychiatric Hospital) to check status of resident. Resident admitted to adult behavior unit with Major Depressive Disorder. On 3/20/26 at 9:40AM, R11, stated, she doesn't know why she was keeping those medications, she was depressed, had thoughts of suicide but would not have attempted suicide by taking those pills. R11 stated they were two sleeping pills and two pain pills. R11 stated she went to the psychiatric hospital and was better. R11 stated she sees a psychiatrist and counselor regularly and denied thought of suicide at this time. R11 stated if she did have suicidal thoughts, she would alert the staff. R11 stated the nurses stay with her until she takes it, they will not leave her with it to take on her own. 3. R21's Undated Face Sheet documents R21 was admitted to the facility on [DATE] and has a medical diagnosis of Major Depressive Disorder, Chronic Pain, Diastolic Congestive Heart Failure, Type 2 Diabetes Mellitus, Paroxysmal Atrial Fibrillation, Hypothyroidism, Chronic Obstructive Pulmonary Disease, and Hypertension. R21's Minimum Data Set (MDS) dated [DATE] documents R21 is cognitively intact. On 3/17/2026 at 9:08 AM R21 stated medications are late almost every evening and night. R21 stated the facility can give medications 1 hour before and after the medications are due and the facility is passing medications at least 2 hours late. R21 stated unless the nurse starts on your hall, your medications will be late. 4. R32's Undated Face Sheet documents R32 was admitted to the facility on [DATE] and has a medical diagnosis of Type 2 Diabetes Mellitus, Systolic Congestive Heart Failure, Dysphagia, Peripheral Vascular Disease, Hyperlipidemia, Chronic Kidney Disease Stage 3, and Hypertension. R32's MDS dated [DATE] documents R32 is cognitively intact. On 03/17/2026 at 8:44 AM R32 stated the facility runs late on passing medications. R32 stated medications are passed late often and will be a couple hours late. R32 stated night medications are always late and have been passed around 11:30 PM or later. On 3/18/2026 at 10:37 AM V9, Ombudsman, stated residents have complained to her that their medications are being administered late frequently. On 3/18/2026 at 12:54 PM V2, Director of Nursing, stated acceptable medication administration times include medications passed 1 hour before or 1 hour after medications are due. V2 stated it is not acceptable for medications to be passed more than 1 hour after a medication is due. The Facility's Resident Council minutes dated 12/8/2025 documents Nursing: meds are late. The Facility's Resident Council Memorandum dated 12/8/2025 documents Department: Nursing. Issue: Medicine being passed late at night and not at the right time. The Facility's Resident Council minutes dated 1/5/2026 documents Nursing: Meds not being passed on time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Medication Administration Policy Reviewed 6/1/2025 documents Medications may be administered one hour before or after the scheduled medication administration time. Medications will not be left at bedside. Medications and treatments will be administered only by licensed medical or licensed nursing staff. The licensed nurse will remain with the resident until the medicine is actually swallowed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the Facility failed to provide palatable meals for 4 of 4 residents (R4, R24, R34, R50) reviewed for food and nutrition services in the sample of 38.Findings include:1.R4's Face Sheet documents R4 was admitted to the facility on [DATE].R4's Minimum Data Set (MDS) dated [DATE] documented R4 was cognitively intact.R4's Diet Order dated 2/25/25 documents R4 is on a regular diet.On 3/17/2026 9:50 AM, R4 stated, The food is nasty, just ultimately nasty. We have complained and complained and complained and nothing changes. I think people in prison get better food than (we do) in here. The steam table doesn't work and the food is usually cold.2.R24's Face Sheet documents R24 was admitted to the facility on [DATE].R24's MDS dated [DATE] documented R24 was moderately cognitively impaired.R24's Diet Order dated 9/30/25 documents R24 is on a regular diet with no added salt.On 3/17/26 at 7:28 AM, R24 stated the food is terrible, has no taste, and is cold much of the time.3.R34's Face Sheet documents R34 was admitted to the facility on [DATE].R34's MDS dated [DATE] documented R34 was cognitively intact.R34's Diet Order dated 2/16/25 documents R34 is on a regular diet with no added sweets.03/17/2026 7:11 AM, R34 stated the food is terrible.4.R50's Face Sheet documents R50 was admitted to the facility on [DATE].R50's MDS dated [DATE] documented R50 was cognitively intact.R50's Diet Order dated 10/27/25 documents R50 is on a regular diet with double portions.On 3/17/26 at 7:15 AM, R50 stated the food is not good. The menu is terrible, and the food is usually cold.The Facility's Resident Council Meeting Minutes dated 12/8/25 document cold food as an issue.The Facility's Resident Council Meeting Minutes dated 1/5/26 document cold food and gross food as issues.The Facility's Resident Council Meeting Minutes dated 2/9/26 document food is not palatable.On 3/17/25 at 8:30 AM, test tray temperatures were obtained with a metal calibrated thermometer on the B Hall after the last resident hall tray was passed. The scrambled eggs measured 117 Fahrenheit (F).On 3/18/26 at 10:18 AM, V1, Administrator, stated the Facility used to have more homestyle cooking and more options before the new company took over, and the residents were accustomed to that. V1 would expect the Facility to follow its policies regarding food service.The Facility's Undated Food Preparation: Taste-Testing documents food items will not be served unless palatable and pleasing to the eye.

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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** Based on observation, interview, and record review, the facility failed to prevent abuse for 2 (R4, R10) of 6 residents reviewed for abuse in the sample of 38. This failure resulted in R4 being tearful and scared of staff. Findings include:R4's Face Sheet documents she was initially admitted on [DATE].R4's Quarterly Minimal Data Set (MDS) dated [DATE] documents R4 is alert and cognitively intact with diagnoses included: anxiety, depression, malnutrition, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease (COPD) and anemia.R4's Care Plan did not address abuse.R10's Face Sheet documents she was initially admitted on [DATE].R10's Quarterly MDS dated [DATE] documents R10 is alert and cognitively intact with diagnoses included: anxiety, malnutrition, respiratory failure, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease, cancer, anemia and renal insufficiency. Received scheduled and PRN pain medication regimen. Pain was present occasionally. Pain interference with day-to-day activities occasionally. Pain intensity 3 out of 10.R10's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse staff to resident.R10's Care Plan did not address abuse.On 3/18/2026 at 1:15 PM during resident council meeting residents were asked how staff treat them and if they have experienced abuse at the facility and R4 stated there was an agency nurse (V23, Licensed Practical Nurse, LPN) that cursed her and her roommate (R10) out and got in her face and flipped her the middle finger several times one day and then V23 had the nerve to return to work at the facility again a few days later and R4 stated, Oh h*ll no she is not working here! R4 stated her and V23 got into it because she wouldn't give her roommate (R10) her pain medication. R4 didn't know what day or shift this occurred on.On 3/19/2026 at 11:35 AM R4 stated she needed to clarify what occurred between her and V23. R4 stated V23 was mean and abusive to her and her roommate, (R10). R4 opened her notebook and read her notes regarding what occurred between her, V23 and R10. R4 stated it was a Saturday day shift, and she was upset with V23 because she wouldn't give her roommate, R10 her pain medications and she was hurting badly. R4 clarified what she meant by mean and abusive she stated V23 yelled and cursed at her and R10 and then got in her face and flipped her off using her middle finger in her room and then V23 stepped into the hallway and flipped her and R10 off again. R4 stated she was in shock when it occurred because no one has ever treated her like that before. R4 stated she dropped the ball because it was a weekend, and she didn't report what occurred until she saw V23 was passing medications on her hall that Monday and that infuriated her. R4 stated when she saw V23 working again that Monday she was on her way to the nurse's station and V23 said to her, Hey you, you want your medications now? and R4 stated V23 snickered as she said it. R4 stated she didn't answer V23, and she went to the nurse's station and told V26, LPN that that nurse shouldn't be here and that she needed to leave because she abused her and R10 a few days ago. R4 stated V26 went to V23, and she walked her to the front of the building and then walked her out of the building shortly after that. R4 stated she was very upset that V23 treated her that way and she felt it was abuse, R4 stated she was scared of V23 because she was a nurse and she was in charge of her and other residents lives. R4 stated she is not a [NAME] but when she saw V23 was working at the facility again she was enraged and was very upset and she cried because she didn't want V23 to yell at, curse, or get in her and other residents faces or give other residents the middle finger. R4 stated it was her fault V23 came to work again to the facility because she didn't report what occurred to anyone that shift because it was a weekend and no management was here so they wouldn't have been able to help her.On 3/19/2026 at 2:40 PM R10 was observed laying in bed. R10 stated she recalled the agency nurse (V23) who snapped on her and her roommate at the time, R4 sometime last month (date unknown) and stated V23 refused to administer her pain medication to her and her roommate R4 was standing up to V23 and telling her to administer the pain medication to me because I was hurting badly and V23 snapped on her and R4 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cursing saying f*** you and go f*** yourselves to her and R4. R10 stated V23 flipped her and R4 off with her middle finger multiple times. R10 stated she was upset about how V23 treated her and R4 and she felt it was abusive and after V23 left their room that day her and R4 barricaded their door with their shelfs and were fearful V23 would come back in their room and hurt them. R10 stated her and R4 talked about what to do and they didn't know what to do and they didn't want to leave their room because they didn't know what V23 would do. R10 stated V23 never gave her pain medication that night and she laid in the fetal position all night because she was scared of V23 and didn't want to deal with V23 anymore. R10 stated no staff spoke to her about what occurred with her, R4 and V23. R10 stated she was surprised no one spoke to her and she felt this was all brushed under the rug as if it didn't even happen. R10 stated she was very grateful she didn't see V23 working at the facility again like R4 did because she would have lost it because she was very fearful of V23.V23's Written Statement, dated 2-23-2026 documents it was about the med that she wanted me to give R10. She was mad that the lady wasn't getting her medicine, she was still hurting, I asked if she needed anything. R4 started yelling at me that I had to give her her medicine. The next time I worked she walked up to nurse station and made the allegation that I put my finger in her face and then a lady walked me out.On 3/19/2026 on 1:02 PM V23, LPN stated she worked night shift (date unknown) and R4 was upset with her because she wouldn't give her roommate, R10 her pain medication but it wasn't time for them to be administered and she let both residents know she would administer the pain medication to R10 as soon as she could per the POS (physician order set) and R4 yelled because was upset because R10 was in pain. V23 denied flipping R4 or R10 off with her middle finger and denied cursing at either resident. V23 stated she came to work the next day shift and was passing medications on R4's and R10's hall and she saw R4 on the hall and she asked her if she wanted her medications and R4 stated she didn't want anything from her and a few minutes later a nurse told her to write a statement and she did and staff walked her out. V23 stated she didn't know why she was told to leave the facility because she didn't do anything wrong.On 3/19/2026 at 11:20 AM V26, LPN stated she works day shift and gets to the facility to work at approximately 6:00 AM. V26 stated she recalled R4 came to the nurse's station really upset one morning (date unknown.) R4 was physically shaking, yelling and crying pointing to V23 and stated, You get that nurse out of here right now! She shouldn't be here! Why is she here? Why is she here? I am not going back to my room until she (V23) leaves! She (V23) flipped me off over medications the other day and she cursed me and my roommate (R10) out. V26 stated she immediately went to V23 who was passing medications on R4's hall at that time and instructed her to lock her medication cart and to come with her to the front of the facility. V26 stated she called V1, Administrator and V1 told V26 to have V23 write a statement and then escort her out of the building. V26 stated after V23 was escorted out of the facility R4 was still shaking, crying and very upset and she sat at the nurse's station for 20 minutes telling her that a few days ago V23 cursed at her and R10 and got in her face and flipped her off several times and she was trying to intimidate her and R10. V26 stated she didn't interview any other residents including R10 regarding what occurred.On 3/19/2026 at 10:55 AM V3, Assistant Director of Nurses (ADON) stated she didn't know the exact date of the incident but she recalled V26 called her one morning and stated R4 was very upset because an agency nurse, V23 was working on R4's hall and she shouldn't be working here because V23 had recently cursed at R4 and her roommate R10 and also flipped them off with her middle finger. V3 stated she instructed V26 to pull V23 off the hall and have her write a statement. V3 stated she arrived to the facility about 10 minutes after V26 called her and she observed V23 writing a statement in the employee breakroom. V23 denied flipping residents off and denied flipping them off with her middle finger. V3 stated her and V26 walked V23 out of the facility a few minutes later. V3 stated she spoke to R4 and R4 told her V23 was in her face yelling, cursing and flipping her and R10 off regarding R10 getting her pain medication. V3 stated she didn't document the interview with R4, she didn't interview R10 and she didn't interview other staff or residents regarding what was told to her.On 3/19/2026 at 10:44 AM V2, Director of Nurses (DON) stated she wasn't at the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility (date unknown) when whatever occurred between the agency nurse V23, R4 and R10. V2 arrived to work on day (day unknown) and all heck broke loose with R4 because a nurse that she had an incident with a few days prior was working at the facility again and R4 was very upset about it. V2 stated she didn't know anything occurred between V23, R4 and R10 prior to that day (day unknown.) V2 stated R4 and R10 came to her office and both of them stated the agency nurse, V23 cursed at them over pain medications and got in R4's face yelling and cursing at her and flipped her middle finger off to both residents. V2 stated she didn't know what shift R23 worked when the incident occurred, and she didn't interview other residents or staff about the incident. At one-point R4 went to V26 and told her V23 shouldn't be working here because of how V23 treated her and R10 and V26 walked V23 out. V2 stated V1, Administrator is the abuse coordinator at the facility. On 3/19/2026 at 12:45 PM V1, Administrator stated she didn't know exactly what occurred between V23, R4 and R10 but it was reported to her one morning (date unknown) that R4 reported to staff that an agency nurse, V23 shouldn't be working here anymore and R4 was very upset. V1 stated V26 called her and reported that R4 was upset V23 was still working at the facility and staff immediately escorted V23 out of the building and she was not to return working here. V1 stated the situation was squashed immediately.On 3/19/2026 at 1:26 PM V24, Nurse Practitioner stated she wasn't aware of abuse or mistreatment of residents. V24 stated she expects the facility to follow abuse policy to prevent abuse from occurring.The Abuse Prevention and Prohibition Policy, with a review date of 12/2/25, documents, in part, the following: Each resident has the right to be free from mistreatment and abuse. Staff must not permit anyone to engage in verbal abuse or mistreatment. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems.

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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 observation, interview and record review the facility failed to follow the facility's abuse policy regarding abuse for 2 (R4, R10) of 6 residents investigated for abuse in the sample of 38.Findings include: R4's Face Sheet documents she was initially admitted on [DATE].R4's Quarterly Minimal Data Set (MDS) dated [DATE] documents R4 is alert and diagnoses included: anxiety, depression, malnutrition, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease (COPD) and anemia.R4's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse or mistreatment staff to resident.R4's Care Plan did not address abuse.R10's Face Sheet documents she was initially admitted on [DATE].R10's Quarterly MDS dated [DATE] documents R10 is alert and diagnoses included: anxiety, malnutrition, respiratory failure, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease, cancer, anemia and renal insufficiency. Received scheduled and PRN pain medication regimen. Pain was present occasionally. Pain interference with day-to-day activities occasionally. Pain intensity 3 out of 10. R10's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse or mistreatment staff to resident.R10's Care Plan did not address abuse.On 3/18/2026 at 1:15 PM during resident council meeting residents were asked how staff treat them and if they have experienced abuse at the facility and R4 stated there was an agency nurse (V23, Licensed Practical Nurse, LPN) that cursed her and her roommate (R10) out and got in her face and flipped her the middle finger several times one day and then V23 had the nerve to return to work at the facility again a few days later and R4 stated, Oh h*ll no she is not working here! R4 stated her and V23 got into it because she wouldn't give her roommate (R10) her pain medication. R4 didn't know what day or shift this occurred on.On 3/19/2026 at 12:45 PM V1, Administrator stated she didn't know exactly what occurred between an agency nurse V23, R4 and R10. V26, LPN called her one morning and stated that R4 was very upset that agency nurse, V23 was passing medication on her hall and stated she shouldn't be working at the facility because she mistreated R4 and R10. V1 stated staff immediately escorted V23 out of the building and she was not to return working here. V1 stated the situation was squashed immediately and there was no full investigation completed. V1 stated there was no reason a full investigation was not completed, once staff were aware of the situation the nurse was pulled from the hall, she wrote a statement and she was escorted from the facility, not to return. V1 stated she didn't interview any other residents other than R4 and she didn't interview staff either. No statements other than V23's was documented.On 3/19/2026 at 1:26 PM V24, Nurse Practitioner stated she wasn't aware of abuse or mistreatment of resident. V24 stated she expects the facility to follow the facility's abuse policy.The Abuse Prevention and Prohibition Policy, with a review date of 12/2/25, documents, in part, the following: Each resident has the right to be free from mistreatment and abuse. Staff must not permit anyone to engage in verbal abuse or mistreatment. 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 and mistreatment. The Administrator will provide initial and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies.

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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 observation, interview and record review the facility failed to report an allegation of abuse for 2 (R4, R10) of 6 residents reviewed for abuse in the sample of 38.Findings include:R4's Face Sheet documents she was initially admitted on [DATE].R4's Quarterly Minimal Data Set (MDS) dated [DATE] documents R4 is alert and cognitively intact with diagnoses: anxiety, depression, malnutrition, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease (COPD) and anemia.R4's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse or mistreatment staff to resident.R4's Care Plan did not address abuse.R10's Face Sheet documents she was initially admitted on [DATE].R10's Quarterly MDS dated [DATE] documents R10 is alert and cognitively intact and diagnoses: anxiety, malnutrition, respiratory failure, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease, cancer, anemia and renal insufficiency. Received scheduled and PRN pain medication regimen. Pain was present occasionally. Pain interference with day-to-day activities occasionally. Pain intensity 3 out of 10.R10's POS, dated 2/2026 a physician's order dated 12/6/2025 Hydrocodone 10-325 mg 1 tablet every 8 hours for pain three times a day (TID) at 6:00 PM, 2:00 AM and 10:00 AM.R10's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse or mistreatment staff to resident.R10's Care Plan did not address abuse.On 3/18/2026 at 1:15 PM during resident council meeting residents were asked how staff treat them and if they have experienced abuse at the facility and R4 stated there was an agency nurse (V23, Licensed Practical Nurse, LPN) that cursed her and her roommate (R10) out and got in her face and flipped her the middle finger several times one day and then V23 had the nerve to return to work at the facility again a few days later and R4 stated, Oh h*ll no she is not working here! R4 stated her and V23 got into it because she wouldn't give her roommate (R10) her pain medication. R4 didn't know what day or shift this occurred on.On 3/19/2026 at 12:45 PM V1, Administrator stated she didn't know exactly what occurred between an agency nurse V23, R4 and R10. V26, LPN called her one morning and stated that R4 was very upset that agency nurse, V23 was passing medication on her hall and stated she shouldn't be working at the facility because she mistreated R4 and R10. V1 stated staff immediately escorted V23 out of the building and she was not to return working here. V1 stated the situation was squashed immediately and there was no full investigation completed. V1 stated there was no reason a full investigation was not completed, once staff were aware of the situation the nurse was pulled from the hall, she wrote a statement and she was escorted from the facility, not to return. V1 stated she didn't interview any other residents other than R4 and she didn't interview staff either. No statements other than V23's was documented.On 3/19/2026 at 1:26 PM V24, Nurse Practitioner stated she wasn't aware of abuse or mistreatment of resident. V24 stated she expects the facility to follow the facility's abuse policy and report the allegations of abuse to appropriate agencies.The Abuse Prevention and Prohibition Policy, with a review date of 12/2/25, documents, in part, the following: Each resident has the right to be free from mistreatment and abuse. Staff must not permit anyone to engage in verbal abuse or mistreatment. 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 reports 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 observation, interview and record review the facility failed to investigate abuse for 2 (R4, R10) of 6 residents investigated for abuse in the sample of 38.Findings include:R4's Face Sheet documents she was initially admitted on [DATE].R4's Quarterly Minimal Data Set (MDS) dated [DATE] documents R4 is alert and diagnoses included: anxiety, depression, malnutrition, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease (COPD) and anemia.R4's Care Plan did not address abuse.R10's Face Sheet documents she was initially admitted on [DATE].R10's Quarterly MDS dated [DATE] documents R10 is alert and diagnoses included: anxiety, malnutrition, respiratory failure, debility, cardiorespiratory conditions, chronic obstructive pulmonary disease, cancer, anemia and renal insufficiency. Received scheduled and PRN pain medication regimen. Pain was present occasionally. Pain interference with day-to-day activities occasionally. Pain intensity 3 out of 10.R10's POS, dated 2/2026 a physician's order dated 12/6/2025 Hydrocodone 10-325 mg 1 tablet every 8 hours for pain three times a day (TID) at 6:00 PM, 2:00 AM and 10:00 AM.R10's Nurse Progress Notes, dated 2/2026 no documentation of allegations of abuse staff to resident.R10's Care Plan did not address abuse.On 3/18/2026 at 1:15 PM during resident council meeting residents were asked how staff treat them and if they have experienced abuse at the facility and R4 stated there was an agency nurse (V23) that cursed her and her roommate (R10) at her and got in her face and flipped her the middle finger several times one day and then V23 had the nerve to return to work at the facility again a few days later and R4 stated, Oh h*ll no she is not working here! R4 stated her and V23 got into it because she wouldn't give her roommate (R10) her pain medication. R4 didn't know what day or shift this occurred on.On 3/19/2026 at 11:35 AM R4 stated she needed to clarify what occurred between her and V23. R4 stated V23 was mean and abusive to her and her roommate, (R10.) R4 opened her notebook and read her notes regarding what occurred between her, V23 and R10. R4 stated it was a Saturday day shift, and she was upset with V23 because she wouldn't give her roommate, R10 her pain medications and she was hurting badly. R4 clarified what she meant by mean and abusive she stated V23 yelled and cursed at her and R10 and then got in her face and flipped her off using her middle finger in her room and then the V23 stepped into the hallway and flipped her and R10 off again. R4 stated she was in shock when it occurred because no one has ever treated her like that before. R4 stated she dropped the ball because it was a weekend, and she didn't report what occurred until she saw V23 was passing medications on her hall that Monday and that infuriated her. R4 stated when she saw V23 working again that Monday she was on her way to the nurse's station and V23 said to her, Hey you, you want your medications now? and R4 stated V23 snickered as she said it. R4 stated she didn't answer V23, and she went to the nurse's station and told V26, LPN (Licensed Practical Nurse) that that nurse shouldn't be here and that she needed to leave because she abused her and R10 a few days ago. R4 stated V26 went to V23, and she walked her to the front of the building and then walked her out of the building shortly after that. R4 stated she was very upset that V23 treated her that way and she felt it was abuse, R4 stated she was scared of V23 because she was a nurse and she was in charge of her and other residents' lives. R4 stated she is not a [NAME], but when she saw V23 was working at the facility again she was enraged and was very upset and she cried because she didn't want V23 to yell at, curse or get in her and other residents faces or give other residents the middle finger. R4 stated it was her fault V23 came to work again to the facility because she didn't report what occurred to anyone that shift because it was a weekend and no management was here so they wouldn't have been able to help her.On 3/19/2026 at 2:40 PM R10 was observed lying in bed. R10 stated she recalled the agency nurse (V23) who snapped on her and her roommate at the time, R4 stated sometime last month (date unknown) V23 refused to administer her pain medication to her and her roommate R4 was standing up to V23 and telling her to administer the pain medication to me because I was hurting badly and V23 snapped on her and R4 (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cursing saying f*** you and go f*** yourselves to her and R4. R10 stated V23 flipped her and R4 off with her middle finger multiple times. R10 stated she was upset about how V23 treated her and R4 and she felt it was abusive and after V23 left their room that day her and R4 barricaded their door with their shelves and were fearful V23 would come back in their room and hurt them. R10 stated her and R4 talked about what to do and they didn't know what to do and they didn't want to leave their room because they didn't know what V23 would do. R10 stated V23 never gave her pain medication that night and she lay in the fetal position all night because she was scared of V23 and didn't want to deal with V23 anymore. R10 stated no staff spoke to her about what occurred with her, R4 and V23. R10 stated she was surprised no one spoke to her and she felt this was all brushed under the rug as if it didn't even happen. R10 stated she was very grateful she didn't see V23 working at the facility again like R4 did because she would have lost it because she was very fearful of V23.V23's Written Statement, dated 2-23-2026 documents it was about the med that she wanted me to give R10. She was mad that the lady wasn't getting her medicine, she was still hurting I asked if she needed anything. R4 started yelling at me that I had to give her (R10) her medicine. The next time I worked she walked up to nurse station and made the allegation that I put my finger in her face and then a lady walked me out.On 3/19/2026 on 1:02 PM V23, LPN stated she worked night shift (date unknown) and R4 was upset with her because she wouldn't give her roommate, R10 her pain medication but it wasn't time for them to be administered and she let both residents know she would administer the pain medication to R10 as soon as she could per the POS (Physician Order Set) and R4 yelled because R4 was upset because R10 was in pain. V23 denied flipping R4 or R10 off with her middle finger and denied cursing at either resident. V23 stated she came to work the next day shift and was passing medications on R4's and R10's hall and she saw R4 on the hall and she asked her if she wanted her medications and R4 stated she didn't want anything from her and a few minutes later a nurse told her to write a statement and she did and staff walked her out. V23 stated she didn't know why she was told to leave the facility because she didn't do anything wrong.On 3/19/2026 at 11:20 AM V26, LPN stated she didn't interview any other residents other than R4 including R10 or staff regarding what occurred and she didn't write a statement regarding what occurred and she only spoke to R4 regarding what occurred, V26 didn't interview R10 or any other residents or staff regarding the incident.On 3/19/2026 at 10:55 AM V3, Assistant Director of Nurses (ADON) stated she didn't know the exact date of the incident, but she recalled V26 called her and reported that R4 was very upset that an agency nurse, V23 was still working at the facility and passing medications on her hall. V3 stated she interviewed R4 regarding what occurred, but she didn't interview R10 and she didn't interview any other residents or staff regarding the incident.On 3/19/2026 at 10:44 AM V2, Director of Nurses (DON) stated she didn't know anything occurred between V23, R4 and R10 prior to that day (day unknown.) V2 stated R4 and R10 came to her office and both of them stated the agency nurse, V23 cursed at them over pain medications and got in R4's face yelling and cursing at her and flipped her middle finger off to both residents. V2 stated she didn't document the interviews with R4 and R10 and she didn't interview other residents or staff about the incident. V2 stated V1, Administrator is the abuse coordinator at the facility, and she would be the one to conduct abuse investigations. On 3/19/2026 at 12:45 PM V1, Administrator stated she didn't know exactly what occurred between an agency nurse V23, R4 and R10. V26, LPN called her one morning and stated that R4 was very upset that agency nurse, V23 was passing medication on her hall and stated she shouldn't be working at the facility because she mistreated R4 and R10. V1 stated staff immediately escorted V23 out of the building and she was not to return working here. V1 stated the situation was squashed immediately and there was no full investigation completed. V1 stated there was no reason a full investigation was not completed, once staff were aware of the situation the nurse was pulled from the hall, she wrote a statement and she was escorted from the facility, not to return. V1 stated she didn't interview any other residents other than R4 regarding the incident, and she didn't interview staff either. No statements other than V23's was documented.On 3/19/2026 at 1:26 PM V24, Nurse Practitioner (continued on next page)

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	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Edwardsville	401 St Mary Drive Edwardsville, IL 62025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she wasn't aware of abuse or mistreatment of residents. V24 stated she expects the facility to follow the abuse policy and to investigate allegations of abuse. The Abuse Prevention and Prohibition Policy, with a review date of 12/2/25, documents, in part, the following: Each resident has the right to be free from mistreatment and abuse, 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 and mistreatment.