STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145628	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Nursing & Rehab Center	1115 North Wenthe Effingham, IL 62401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify a residents Physician and resident representative of a medication error for 1 of 3 residents (R1) reviewed for notification of changes in the sample of 9.Findings include:R1's Face Sheet documented an admission Date of 6/6/25 and listed diagnoses including Diabetes Type 2 and Hypertension. The Face Sheet also identified V11 as R1's Power of Attorney.R1's Minimum Data Set, dated [DATE] documented that R1 has no deficits in cognition.R1's Care Plan dated 8/25/25 documented a problem area, Resident is at risk for complications due to Diabetes diagnosis, with corresponding intervention, administer meds (medications) as ordered and/or sliding scale. R1's September 2025 Physicians Order Sheet documented orders for Tresiba Flextouch U-100 (insulin degludec) (long acting) insulin pen 100/u (units) per ml (milliliter) administer 30u subcutaneously at bedtime, 7pm to 10pm, and Insulin Aspart (rapid acting) u100 pen give 10 u with meals.R1's Medication Administration Record (MAR) for September 2025 documented that on 9/30/25, R1 received Tresiba Flextouch 30u at bedtime from 7pm to 10pm, with V5, Licensed Practical Nurse, signing off on the administration. The MAR documented that the insulin aspart 3pm to 6pm dose was not administered as R1 refused it. There was no further documentation of the insulin aspart on 9/30/25.R1's Nursing Progress Notes documented the following:10/1/25, 1:04am. Blood sugar alarm at 70. Cranberry sauce given per patient request. Will recheck. A/O (Alert and oriented) x 4 (to person, place, time, and purpose).10/1/25, 1:22am: BS (Blood Sugar) 108. Resident states she is tired. Laying in bed call light in reach. PWD (Pink, Warm, Dry Skin), A/O x4. Resident stated, maybe she gave me too much insulin. Insulin charted as ordered on previous shift. Will continue to monitor.10/1/25, 2:09am: BS 179. Pt (patient) resting comfortably in bed. Arouses easily. PWD. Call (light)in reach.10/1/25, 3:03am: BS 144 currently. Resident resting comfortably in bed with call light in reach. PWD. Arouses easily. will continue to monitor.10/1/25, 4:42am: BS 156 resting comfortably, rouses easily. PWD. Call light in reach.10/1/25, 5:55am: BS 114. Resident resting in bed, arouses easily. PWD. Call light in reach.10/1/25, 9:08am: (V4, Physician) office called a short while ago and updated of resident condition and the thought of resident probably receiving wrong insulin last night at bedtime. Spoke to nurse at office that will pass to (V4). Nurse updated of resident BS and checked every hour and resident remained stable.10/1/25, 1:29pm: Medical Director also made aware and updated earlier as well this morning. Also, (V11, Power of Attorney) was here this morning and updated as well. Resident remains stable at this time and no issues noted. No new orders received from (V4) either at this time. Will continue to monitor.There were no Nursing Progress Notes in R1's chart for 9/30/25.An Incident Report dated 10/1/25 documented, Detailed incident summary: Resident notified staff of not feeling well around 1am. Once checking blood sugar, blood sugar level was 70. Resident was given cranberry juice and checked several times throughout the night. Resident stated to the nurse that came on at midnight that maybe she got the wrong dose of insulin. Staff nurse who is (V5) is unable to recall which insulin she gave. Resident was closely monitored and did not appear to be in any distress. Resident is alert and oriented during this entire situation. (V4) was notified, Medical Director was notified, (V2, Director of Nurses) and (V1, Administrator) notified and (V11) notified and texted to notify. Nurse was wrote up and educated. A written statement from V5 in this investigation documented, Approximately 10pm on 9/30/25 I was at the medication cart getting meds (medications) together for (R1) she was to also get insulin, Tresiba 30u which is a long-acting insulin. During the time of getting medications together, I was interrupted by CNA (Certified Nursing Assistant) multiple times. I got (R1) medications ready along with the insulin. Went into room to get CBG (Capillary Blood Glucose), according to her (trade name continuous monitoring glucose system) her blood sugar was 296, resulting in resident receiving scheduled Tresiba 30u, I then gave her medications. I proceeded to gather the other residents' medications and administer, when I got to (R3), he also received Tresiba at bedtime at this time it triggered a memory that I believed I gave (R1) the wrong insulin. At approximately 11:30pm I asked to see her blood sugar again and it had dropped to 135, I became concerned. At 12am, (V10, Registered Nurse) came in to relieve me and I informed her of what I believed I had done. (V10) then went into (R1) room and checked blood sugar and it had fallen to 70. I had checked it at approximately 11:40pm and it was 75. Her sugar was dropping significantly, as a nursing measure because resident refused to eat, I gave her a glucagon pen to bring sugar up. At 1am her sugar had risen to 125, when I left facility at 1:30am her sugar was 141. I spoke with (V10) to contact me at home if resident became worse and

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer insulin according to physicians' orders for 1 of 9 residents (R1) reviewed for medication errors in the sample of nine.The findings include:R1's Face Sheet documented an admission Date of 6/6/25 and listed Diagnoses including Diabetes Type 2 and Hypertension. The Face Sheet also identified V11 as R1's Power of Attorney.R1's Minimum Data Set, dated [DATE] documented that R1 has no deficits in cognition.R1's Care Plan dated 8/25/25 documented a problem area, Resident is at risk for complications due to Diabetes Diagnosis, with corresponding intervention, Administer meds(medications) as ordered and/or sliding scale.R1's September 2025 Physicians Order Sheet documented orders for Tresiba Flextouch U-100 (insulin degludec) (long acting) insulin pen 100/u (units) per ml (milliliter) administer 30u subcutaneously at bedtime, 7pm to 10pm, and Insulin Aspart (rapid acting) u100 pen give 10 u with meals.R1's Medication Administration Record (MAR) for September 2025 documented that on 9/30/25, R1 received Tresiba Flextouch 30u at bedtime from 7pm to 10pm, with V5, Licensed Practical Nurse, signing off on the administration. The MAR documented that the insulin aspart 3pm to 6pm dose was not administered as R1 refused it. There was no further documentation of the insulin aspart on 9/30/25.R1's Nursing Progress Notes documented the following:10/1/25, 1:04am. Blood sugar alarm at 70. Cranberry sauce given per patient request. Will recheck. A/O (Alert and oriented) x 4 (to person, place, time, and purpose).10/1/25, 1:22am: BS (Blood Sugar) 108. Resident states she is tired. Laying in bed call light in reach. PWD (Pink, Warm, Dry Skin), A/O x4. Resident stated, maybe she gave me too much insulin. Insulin charted as ordered on previous shift. Will continue to monitor.10/1/25, 2:09am: BS 179. Pt (patient) resting comfortably in bed. Arouses easily. PWD. Call (light)in reach.10/1/25, 3:03am: BS 144 currently. Resident resting comfortably in bed with call light in reach. PWD. Arouses easily. will continue to monitor.10/1/25, 4:42am: BS 156 resting comfortably, rouses easily. PWD. Call light in reach.10/1/25, 5:55am: BS 114. Resident resting in bed, arouses easily. PWD. Call light in reach.10/1/25, 9:08am: (V4, Physician) office called a short while ago and updated of resident condition and the thought of resident probably receiving wrong insulin last night at bedtime. Spoke to nurse at office that will pass to (V4). Nurse updated of resident BS and checked every hour and resident remained stable.10/1/25, 1:29pm: Medical Director also made aware and updated earlier as well this morning. Also, (V11, Power of Attorney) was here this morning and updated as well. Resident remains stable at this time and no issues noted. No new orders received from (V4) either at this time. Will continue to monitor.There were no Nursing Progress Notes in R1's chart for 9/30/25. An Incident Report dated 10/1/25 documented, Detailed incident summary: Resident notified staff of not feeling well around 1am. Once checking blood sugar, blood sugar level was 70. Resident was given cranberry juice and checked several times throughout the night. Resident stated to the nurse that came on at midnight that maybe she got the wrong dose of insulin. Staff nurse who is (V5) is unable to recall which insulin she gave. Resident was closely monitored and did not appear to be in any distress. Resident is alert and oriented during this entire situation. (V4) was notified, Medical Director was notified, (V2, Director of Nurses) and (V1, Administrator) notified and (V11) notified and texted to notify. Nurse was wrote up and educated. A written statement from V5 in this investigation documented, Approximately 10pm on 9/30/25 I was at the medication cart getting meds together for (R1) she was to also get insulin, Tresiba 30u which is a long-acting insulin. During the time of getting medications together, I was interrupted by CNA (Certified Nursing Assistant) multiple times. I got (R1) medications ready along with the insulin. Went into room to get CBG (Capillary Blood Glucose) according to her (trade name continuous monitoring glucose system) her blood sugar was 296, resulting in resident receiving scheduled Tresiba 30u I then gave her medications. I proceeded to gather the other residents' medications and administer, when I got to (R3), he also received Tresiba at bedtime at this time it triggered a memory that I believed I gave (R1) the wrong insulin. At approximately 11:30pm I asked to see her blood sugar again and it had dropped to 135, I became concerned. At 12am, (V10, Registered Nurse)) came in to relieve me and I informed her of what I believed I had done. (V10) then went into (R1) room and checked blood sugar and it had fallen to 70. I had checked it at approximately 11:40pm and it was 75. Her sugar was dropping significantly, as a nursing measure because resident refused to eat, I gave her a glucagon pen to bring sugar up. 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