

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Evercare of Swansea		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 North Second Street Swansea, IL 62226	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834</p> <p>Based on interview, and record review, the facility failed to physically assess a resident (R2) after a fall. This failure resulted in R2 sustaining a tibial plateau fracture on 11/22/2024 and not being sent to hospital for evaluation until 11/26/2024.</p> <p>Findings include:</p> <p>R2's Facesheet documents an admitted [DATE]. Diagnosis include Dementia, Cerebrovascular Accident, Seizures, Hypothyroidism, Hypertension.</p> <p>R2's Minimum Data Set, MDS, dated [DATE] documents R2 has no cognitive deficits. R2 requires substantial/maximum assist with chair to bed transfers.</p> <p>R2's Care Plan dated 11/26/2024 documents R2 is at risk for falls. R2 does not understand mobility limits due to cognitive limitations related to dementia and Alzheimer's disease. Actual fall 11/26/2024.</p> <p>R2's Fall investigation dated 11/27/2024 at 3:00PM documents fall with physical harm/injury. Detailed incident summary documents R2 is a [AGE] year-old female resident with cognitive impairments.</p> <p>R2's Fall investigation/Findings: R2 when interviewed stated that she fell but could not provide details of when or how she fell . When asked if it was recent, she stated Yes. R2 stated she feels safe at facility. Staff members who were interviewed stated that R2 runs her wheelchair into doors and doorways. Staff try to redirect her, but she continues to have behaviors. A Certified Nursing Assistant, CNA, stated that 11/22/2024 R2 needed to be lowered to the floor via gait belt but that she was lowered to her bottom without incident. When asked about the incident the CNA stated R2 was holding onto the arms of the chair and not letting go during the transfer, so the CNA was going to sit her back into her wheelchair when R2 locked her arms and legs and had to be lowered to the floor.</p> <p>R2's Nurse's notes dated 11/25/24 at 8:00PM documents left leg swollen, bruised, warm to touch. Reported via secure communication. New order received. Negative Holman's sign bilaterally. No signs/symptoms of pain when active range of motion performed. Call light within reach.</p> <p>R2's Nurse's notes dated 11/25/24 at 10:00PM documents radiology company notified of X-ray and Doppler order.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Nurse's notes dated 11/26/24 at 1:49AM documents result of X-rays of left femur, left knee and left tibia and fibula sent to secure communication.</p> <p>R2's Nurse's notes dated 11/26/24 at 6:30PM documents R2 left facility via ambulance with 2 emergency medical technicians, EMTs, to local hospital.</p> <p>R2's X-ray report dated 11/26/2024 documents frontal and lateral views of the left femur submitted. Tibial lucency can be evaluated with tibial imaging. Impression no acute fracture visualized femur. Impression Age indeterminate tibial plateau fracture.</p> <p>On 12/12/2024 at 3:20PM V3, Certified Nursing Assistant, CNA, stated, on 11/22/2024 in the evening, I went into R2's room to put here to bed. I had not been here very long, so I didn't know R2 well. I was told R2 was a one person assist, but she needed to be a 2 person assist. When I began to transfer her after I put the gait belt on her, she locked her arms on the wheelchair and would not let go. I set her down in the wheelchair and talked to her and told her she has to let go of the wheelchair to be able to get in bed. I tried to transfer her again and again she locked her arms on the wheelchair and would not let go. This time she was out further from the wheelchair, and I was unable to get her back in the wheelchair. R2 then slid to the floor. Her legs were bent against her dresser in what looked to be an uncomfortable angle. I left the room to get another CNA to help me. We got her up off the floor and into bed. R2 denied being in pain. I told the nurse I was working with what had happened. I don't know the nurse's name.</p> <p>On 12/13/2024 at 2:00PM V13, Licensed Practical Nurse, LPN, stated she was working the evening of 11/22/2024 and was R2's nurse. V13 denies being told R2 was lowered to the floor or R2 having any incident at all.</p> <p>On 12/13/2024 at 2:25PM V15, Certified Nursing Assistant, CNA, stated I helped V3 with R2 when R2 was lowered to the floor. When I went in the room R2 was sitting with her bottom on the floor and her hands were still holding the arms of the wheelchair. Her legs were straight. We got her off the floor and onto the bed. She did not complain of pain.</p> <p>On 12/17/2024 at 9:45AM V16, Nurse Practitioner, stated I would've expected R2 to have been assessed at the time of her fall on 11/22/2024. When I was notified about R2's leg appearing red and swollen was on 11/25/2024. I then ordered a Doppler and x rays.</p> <p>There is no documentation of R2's fall or any assessments on file for 11/22/2024.</p> <p>Facility's undated fall policy states The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>34964</p> <p>Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 40 residents who reside in the facility.</p> <p>Findings include:</p> <p>On 12/12/24 at 3:30 PM V2, Regional Nurse, stated the facility's Director of Nursing (DON) walked out on 11/15/24 without notice and no new DON has been hired V2 stated she is not here everyday and admitted there is not Registered Nurse (RN) coverage everyday because V4, RN is the only other RN working in the facility and she only works 3 days a week. V2 stated they are trying to hire more RNs but do not use agency RNs just for RN coverage and only use agency if there is need for an RN to do intravenous (IV) medications.</p> <p>The facility's schedule dated November 2024 documents there was no RN coverage on November 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 25th, 26th, 28th or 30th.</p> <p>The facility's schedule dated December 2024 documents there was no RN coverage on December 1st, 3rd, 6th, 9th, 12th, 14th or 15th.</p> <p>On 12/17/24 at 1:45 PM V2 stated the facility does not have a policy for RN staffing, but just try to follow the regulations.</p> <p>The facility's Room Roster dated 11/12/24 document there are 40 residents residing in the facility.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834</p> <p>Based on interview and record review the facility failed to administer ordered medications to 4 of 4 residents in the sample of 12.</p> <p>Findings include:</p> <p>On 12/17/2024 at 10:00AM R8 stated We did not get our meds on Sunday morning (12/15/2024). The nurse down here did not show up and the nurse on the other end refused to give us our meds. I have heart issues and some people have mental illness and should not go without meds.</p> <p>R8's Facesheet documents an admitted [DATE]. Diagnosis include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Essential Hypertension.</p> <p>On 12/17/2024 R8's medication administration records dated 12/1/2024-12/31/2024 show the following medications not signed out as administered on 12/15/2024 at 8:00AM: Brillinta 90mg, Acidophilus, Aspirin 81mg, Escitalopram 10mg Escitalopram 5mg, Glipizide 5mg, Lisinopril 2.5mg, Loratadine 10mg, Potassium 10meq, Vitamin D 3 5000 units, Ferrous Sulfate 325mg, Metoprolol 25mg, Cyclobenzaprine 5mg, Gabapentin 100mg, Symbicort inhaler, insulin LisiPro 5 units.</p> <p>R9's Facesheet documents an admitted [DATE]. Diagnosis include Type 2 Diabetes, Hypertension.</p> <p>On 12/17/2024 R9's medication administration records dated 12/1/2024-12/31/2024 show the following medications not signed out as administered on 12/15/2024 at 8:00AM: Amlodipine 5mg Aspirin 81mg, Hydrochlorothiazide 25mg, Losartan pot 100mg, Metformin 500mg, Pentoxifylline 400mg, Acetaminophen 500mg, Gabapentin 100mg, Levetiracetam 500mg, Metoprolol 25mg, finger stick blood glucose monitoring.</p> <p>R7's Facesheet documents an admitted [DATE]. Diagnosis include Hypertension, Adult Failure to Thrive.</p> <p>On 12/17/2024 R7's medication administration records dated 12/1/2024-12/31/2024 show the following medications not signed out as administered on 12/15/2024 at 8:00AM: Aspirin 81mg, Certavite tablet, Loratadine 10mg, Vitamin D3, Eliquis 5mg, Famotidine 20mg, Metoprolol 25mg, Prednisone 10mg.</p> <p>R5's Facesheet documents an admitted [DATE]. Diagnosis include Type 2 Diabetes, Hypertension.</p> <p>On 12/17/2024 R5's medication administration records dated 12/1/2024-12/31/2024 show the following medications not signed out as administered on 12/15/2024 at 8:00AM: Vitamin D3, insulin Aspart 5 units, Omeprazole 20mg, Acidophilus, Certavite tablet, Ferrous Sulfate 325mg, Lisinopril 5mg, Loratadine 10mg, Metformin 100mg, Dicyclomine 20mg, Gabapentin 300mg, fingerstick blood glucose.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/17/24 at 10:30 AM V1, Administrator stated she did receive a call from V18, Licensed Practical Nurse(LPN) on Sunday, 12/15/24 to let her know that there was no nurse working on the 200 Hall. V1 stated she was not aware until Sunday evening that the residents on the 200 Hall did not receive their morning medications on Sunday. She stated another agency nurse came in to work the 200 Hall at 10:00 AM. V1 stated the agency nurse should have administered the morning medications when she got to the facility or V18 should have administered them when she got done with her medication pass.</p> <p>On 12/17/24 at 10:45 AM V18 stated she worked on the 100 Hall on Sunday, 12/15/24 and she received a call from pharmacy regarding a resident on the 200 hall and when she went to inform that nurse, she discovered there was no nurse working on the 200 hall. V18 stated she called and notified V1 that there was no nurse working on the 200 Hall and she (V18) assisted the pharmacy with what they needed and then went back to her own hall to finish passing medications to the residents on the 100 Hall. V18 stated she finished her own medication pass around 9:30 AM and then went over to the 200 hall to start passing medications, but by then there was another agency nurse who had come in to work that hall. V18 stated she informed the agency nurse that the residents on the 200 hall still needed their morning medications but that nurse told her she was not going to pass the morning medications. V18 stated the agency nurse already had the keys to the cart so she (V18) also did not give the 200 hall residents their morning medications. V18 stated the agency nurse was very snotty to her so she went back to the 100 hall around 10:00 AM and called V1 and informed her the agency nurse was refusing to pass the morning medications. V18 stated she stayed on her own hall after that because of the other nurse's attitude. V18 stated she knows it is important that residents receive their medications, but the agency nurse just refused to pass them.</p> <p>Undated facility policy states Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner or as consistent with state law. No medication will be used for any resident other than the resident for whom it was prescribed. Medications must be given to the resident by the Licensed Nurse to prepare the medication, to as consistent with state law. Medications may be administered one hour before or after the scheduled medication administration time.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834</p> <p>Based on Observation, Interview, and Record Review, the facility failed to administer ordered medications, resulting in 4 of 4 residents missing medications in the sample of 12.</p> <p>Findings include:</p> <p>On 12/17/2024 at 10:00AM R8 stated We did not get our meds on Sunday morning (12/15/2024). The nurse down here did not show up and the nurse on the other end refused to give us our meds. I have heart issues and some people have mental illness and should not go without meds.</p> <p>On 12/17/2024 at 10:15AM R9 stated On Sunday (12/15/2024) no one gave us our meds. The nurse down on the other end refused and we didn't get any.</p> <p>R8's Facesheet documents an admitted [DATE]. Diagnosis include Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Essential Hypertension.</p> <p>R8's order sheet dated 10/2/2024 documents Insulin Lispro 100 units/ml inject 5 units subcutaneous, subq, 3 times daily at 8:00AM, 12:00PM, 4:00PM. R8's medication administration sheet dated 12/15/2024 does not have documentation that Insulin Lispro 5 units was administered at 8:00AM</p> <p>R8's order sheet dated 1/30/2024 documents Glipizide 5milligram, mg, tablet. Take 1 tablet by mouth daily at 8:00AM. R8's medication administration sheet dated 12/15/2024 does not have documentation for Glipizide 5mg tablet was administered at 8:00AM.</p> <p>R8's order sheet dated 11/12/2024 documents finger stick blood glucose monitor at 7:00AM, 11:00AM, 4:00PM, 8:00PM. R8's medication administration sheet dated 12/15/2024 does not have documentation that finger stick blood glucose was performed at 7:00AM and no result documented.</p> <p>R8's medication administration sheet dated 12/15/2024 documents R8's accucheck at 12:00PM was 275.</p> <p>R8's undated care plan documents R8 is diagnosed with diabetes. Administer diabetes medication as ordered.</p> <p>R10's Facesheet documents an admission date of 6/14/2023. Diagnosis include Chronic Atrial Fibrillation, Type 2 Diabetes, History of Cerebral Infarction.</p> <p>R10's order sheets dated 8/5/2024 document Diltiazem capsule 120mg Extended Release, ER. Take 1 capsule daily at 8:00AM. R10's medication administration sheets dated 12/15/2024 does not have documentation that Diltiazem capsule 120mg ER was administered at 8:00AM.</p> <p>R10's order sheets dated 10/2/2024 document Isosorbide Mononitrate tablet 30mg ER. Take 1 tablet by mouth daily at 8:00AM. R10's medication administration sheets dated 12/15/2024 does not have documentation that Isosorbide 30mg tablet was administered at 8:00AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R10's order sheets undated documents accucheck three times daily every meal at 8:00AM, 12:00PM, 4:00PM. R10's medication administration sheets dated 12/15/2024 does not have documentation that accucheck was performed at 8:00AM.</p> <p>R10's order sheets dated 8/5/2024 document Metoprolol Tartate 25mg half tablet (12.5mg) by mouth twice daily at 8:00AM and 4:00PM. R10's medication administration sheets dated 12/15/2024 does not have documentation that Metformin Tartate 25mg half tablet was administered at 8:00AM.</p> <p>R10's order sheets dated 11/5/2024 document Insulin Lispro 3 units subq three time daily at 8:00AM, 12:00PM, 4:00PM. R10's medication administration sheets dated 12/15/2024 does not have documentation that Insulin Lispro 3 units subq were administered at 8:00AM.</p> <p>R10's care plan updated 5/28/2024 documents R10 is diagnosed with diabetes medication as ordered. R10 is diagnosed with heart failure give nitrates as ordered.</p> <p>R11's Facesheet documents an admitted [DATE]. Diagnosis include Congestive heart failure, Type 2 Diabetes, Hypertension.</p> <p>R11's order sheets dated 5/8/2024 documents Insulin Aspart injection flex pen. Inject 12 units three times daily with meals at 8:00AM, 12:00PM, 4:00PM. R11's medication administration sheets dated 12/15/2024 does not have documentation that Insulin Aspart 12 units were administered at 8:00AM.</p> <p>R11's order sheets dated 9/11/2024 documents Metformin tablet 500mg. Take 1 tablet by mouth twice daily at 8:00AM and 4:00PM. R11's medication administration sheets dated 12/15/2024 does not have documentation that Metformin was administered at 8:00AM.</p> <p>R11's medication administration sheet dated 12/15/2024 documents R11's accucheck at 12:00PM was 351.</p> <p>R11's care plan updated 5/28/2024 documents diabetes medication as ordered.</p> <p>R12's Facesheet documents an admitted [DATE]. Diagnosis include Hypertension, Type 2 Diabetes.</p> <p>R12's order sheets dated 8/21/2024 document Basaglar Kwik pen inject 30 units every 12 hours at 8:00AM and 8:00PM. R12's medication administration sheet dated 12/15/2024 does not have documentation for Basaglar Kwik pen 30 units was administered at 8:00AM.</p> <p>R12's order sheets dated 5/9/2024 document Glipizide tablet 5mg. Take 1 tablet once daily at 8:00AM. R12's medication administration sheet dated 12/15/2024 does not have documentation for Glipizide 5mg tablet was administered at 8:00AM.</p> <p>R12's medication administration sheet dated 12/15/2024 documents R12's accucheck at 12:00PM was 314.</p> <p>R12's order sheets dated 5/9/2024 document Losartan Potassium tablet 50mg. Take 1 tablet once daily at 8:00AM. R12's medication administration sheet dated 12/15/2024 does not have documentation for Losartan Potassium tablet 50mg tablet was administered at 8:00AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R12's Care Plan updated 5/28/2024 documents R12 has hypertension. Administer antihypertensives as ordered. R12 has diabetes. Administer diabetes medications as ordered.</p> <p>On 12/17/24 at 10:30 AM V1, Administrator stated she did receive a call from V18, Licensed Practical Nurse (LPN) on Sunday, 12/15/24 to let her know that there was no nurse working on the 200 Hall. V1 stated she was not aware until Sunday evening that the residents on the 200 Hall did not receive their morning medications on Sunday. She stated another agency nurse came in to work the 200 Hall at 10:00 AM. V1 stated the agency nurse should have administered the morning medications when she got to the facility or V18 should have administered them when she got done with her medication pass.</p> <p>On 12/17/24 at 10:45 AM V18 stated she worked on the 100 Hall on Sunday, 12/15/24 and she received a call from pharmacy regarding a resident on the 200 hall and when she went to inform that nurse, she discovered there was no nurse working on the 200 hall. V18 stated she called and notified V1 that there was no nurse working on the 200 Hall and she (V18) assisted the pharmacy with what they needed and then went back to her own hall to finish passing medications to the residents on the 100 Hall. V18 stated she finished her own medication pass around 9:30 AM and then went over to the 200 hall to start passing medications, but by then there was another agency nurse who had come in to work that hall. V18 stated she informed the agency nurse that the residents on the 200 hall still needed their morning medications but that nurse told her she was not going to pass the morning medications. V18 stated the agency nurse already had the keys to the cart so she (V18) also did not give the 200 hall residents their morning medications. V18 stated the agency nurse was very snotty to her so she went back to the 100 hall around 10:00 AM and called V1 and informed her the agency nurse was refusing to pass the morning medications. V18 stated she stayed on her own hall after that because of the other nurse's attitude. V18 stated she knows it is important that residents receive their medications but the agency nurse just refused to pass them.</p> <p>Review of an article dated August 20,2022, titled, Hyperglycemia in diabetes and found at https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631 documented the following: Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL), or 10 to 11.1 millimoles per liter (mmol/L) Recognizing early symptoms of hyperglycemia can help identify and treat it right away.If hyperglycemia isn't treated, it can cause toxic acids, called ketones, to build up in the blood and urine. This condition is called ketoacidosis. To help keep your blood sugar within a healthy range: .Monitor your blood sugar. Depending on your treatment plan, you may check and record your blood sugar level several times a week or several times a day. Careful monitoring is the only way to make sure that your blood sugar level stays within your target range. Note when your glucose readings are above or below your target range. Carefully follow your health care provider's directions for how to take your medication.</p> <p>Review of an article dated February 29, 2024, titled High blood pressure (hypertension) and found at https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/diagnosis-treatment/drc-20373417 documented the following: Always take blood pressure medicines as prescribed. Never skip a dose or abruptly stop taking blood pressure medicines. Suddenly stopping certain ones, such as beta blockers, can cause a sharp increase in blood pressure called rebound hypertension.</p> <p>If you skip doses because of cost, side effects or forgetfulness, talk to your care provider about solutions. Don't change your treatment without your provider's guidance.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility policy undated states Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner or as consistent with state law. No medication will be used for any resident other than the resident for whom it was prescribed. Medications must be given to the resident by the Licensed Nurse to prepare the medication, to as consistent with state law. Medications may be administered one hour before or after the scheduled medication administration time.</p> <p>Facility's undated Glucose Monitoring policy states Nursing will monitor resident's blood glucose to assist in the development of an appropriate medication and treatment regime for residents with a metabolic disorder caused by an imbalance between insulin supply and demand.</p>		