STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation and interview the facility failed to allow phone access to facility and residents for 2 of 3 residents reviewed for resident rights. This has the potential to affect all 86 residents in the facility. Findings include: R3's baseline Care Plan, dated 7/9/2024, documents that R3 was admitted to the facility on [DATE] for end of life care. On 7/24/2024 at 7:36 PM surveyor called facility number. Telephone rang 6 times and then went to busy signal; phone was not answered. On 7/24/2024 at 7:45 PM surveyor called the facility phone. Rang 5 times and then went to busy signal. staff did not answer the phone. On 7/25/2024 at 8:00 PM surveyor called facility phone. Telephone rang 5 times. Transferred to answering service. On 7/25/2024 at 9:15 PM surveyor called facility phone. Telephone rang 5 times. Then busy signal. On 7/24/2024 at 12:04PM V10, (R1's wife) stated staff do not answer the phone of an evening. V10 stated there is a camera in her husband's room and if she comes to the facility after 5:00PM the staff know there is a problem of something she saw on the camera as phone is not answered. On 7/31/2024 at 10:00 AM V18, R3's daughter stated that after 7 pm you cannot access the facility by phone. V18 stated that the phone rings and then you are sent to an answering machine or its busy. V18 stated that she made attempts to call the facility to check on her father and to talk with him and was not able to do so. On 7/31/2024 at approximately 1:30 PM V1, Administrator, stated that the facility should always be accessed by phone. V1 stated at this time they do not have a receptionist. V1 also stated that they do not have access to the answering machine to retrieve messages. V1 stated that they do not have a phone policy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Illinois Ombudsman Long-Term Care Program Residents' Rights' for People in Long-Term Care Facilities, dated 11/18, documents As a long-term care resident in Illinois You have the right to make and receive phone calls in private and to have access to the use of a telephone where calls can be made without being overheard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Evercare at University		STREET ADDRESS, CITY, STATE, ZIP CODE 1095 University Drive Edwardsville, IL 62025	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, record review, and interview, the facility failed to ensure wound treatments were completed, physician orders followed and residents repositioned timely for 1 of 3 (R2) residents reviewed for pressure ulcers. Findings include: R2's Care Plan, dated 6/15/2024, documents Last Reviewed/Revised: 07/25/2024 02:44 PM. PROBLEM: I have acquired an unstageable pressure ulcer to right posterior thigh My comorbidities include malnutrition and bed mobility. Approach: Administer treatments as ordered and monitor for effectiveness. APPROACH: Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (physician). APPROACH: Follow facility protocols for the prevention/treatment of skin breakdown. APPROACH: Monitor/document/report to MD PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), and stage. R2's Physician Order Sheet, dated 5/23/24, documents Resident must lie after EVERY meal to reduce pressure on buttocks and then back up to eat next meal. R2's Minimum Data Set, dated dated [DATE], documents that R2 is severely cognitively impaired, totally dependent on staff for all activities of daily living and mobility, and has an unstageable pressure ulcer. R2's weekly Skin Assessment, dated 6/15/2024, documents New Conditions: area to coccyx 0.5x0.5x0.1 and area to posterior right thigh (below buttock) 0.5x0.5xUDT R2's Progress Notes, dated 06/15/2024 at 10:16 AM, documents skin check performed, open area to coccyx noted 0.5x0.5x0.1 scant serous drainage noted, area noted to posterior right thigh (below buttock) 1.3x1. 3xudt, resident denies pain, area cleansed with wound cleanser and covered. hospice notified, nurse coming in to evaluate. hospice stated they will call (V15) once they look at it. pt up in (reclining wheelchair), denies pain. awaiting hospice nurse The facility's Wound Report for Quality Assurance/Risk Management Committee, dated 7/14-7/20/2024, documents R2 wound location: Right posterior thigh, current treatment: Santyl, calcium alginate cove with silicon foam. Measurements 1.8x1.8x0.0. Pressure Redux Interventions: reposition every 2 hours, pericare every 2 hours and as needed. No documentation of 3 open areas to R2's coccyx 7/22-7/28/24 documents R2 wound location: Right posterior thigh, current treatment: Santyl, silver alginate, cover with a foam dressing. Measurements 2.3x3.3x unstageable. Pressure Redux Interventions: reposition every 2 hours, peri care every 2 hours and as needed. No documentation of R2's open areas to coccyx. A sign, not dated, above R2's Head of Bed documents turn and reposition every 2 hours, apply barrier cream if reddened, change briefs q 2 hours even if resident has a foley., utilize pillows for offloading buttocks area, resident should be up for every meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER: Evercare at University		STREET ADDRESS, CITY, STATE, ZIP CODE: 1095 University Drive Edwardsville, IL 62025	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/24/2024 at 9:20 AM R2 sitting, in high back wheelchair, in living area portion of dining room being fed by son. At 10:48 AM R2 in hallway in wheelchair son leaving. At 11:00AM R2 in same position in wheelchair in hallway. At 11:14 AM R2 remains wheelchair in the hallway. At 11:22 AM R2 remains in hallway in same position. At 11:25AM R2 pushed down hall to her room by V4, Wound Nurse, and then left the room. V5, Certified Nurses Assistant (CNA) and V6, CNA, then assisted R2 into the bed. R2's heels were checked and no areas of redness or pressure. R2 adult diaper undid and R2 was not wet as verified by both CNAs. R2 was turned to right side and R2's open area with necrotic center to Right posterior thigh wound was observed and not covered by a dressing and no dressing present in adult diaper as verified by CNAs. Wound approximate size of quarter and deep circular wound with area of black necrotic tissue. V4 never does return. V8, LPN, was asked if the treatment nurse was returning. V8 stated that she would do the treatment and looked up order on the MAR. On 7/24/2024 at 11:57 AM V3, Assistant Director of Nursing, appeared with treatment cart and treatment nurse . V3 stated she was going to do the treatment. V3 put Santyl collagenase ointment in medicine cup, calcium alginate dressing and dressing then entered R2 room cleansed wound with wound cleanser and performed treatment. On 7/24/2024 at 11:57 AM V3 stated that the wound was unstageable. V3 stated that the pressure sores should have dressings on as ordered. On 7/29/2024 at approximately 10:00 AM V2 stated since being notified by surveyor of area and not having a dressing in place the facility completed a Performance Improvement Plan on 7/24/2024. V2 stated that this plan included education provided to the wound nurse, and floor nurses of importance of dcumentation and CNAs of assuring that they notify the nurse when a dressing is removed and not in place. V2 stated that audits were performed as well to assure that the system remained in place. On 8/1/2024 at 7:55 AM V8, stated that when she noted the area it was already necrotic. V8 Stated that she is not sure how the area occurred. V8 Stated that when performing her weekly skin check she noted the area. V8 Stated that the treatment is scheduled for nights but that she has had to perform the treatment on the day shift because the dressing was off. V8 Stated that R2 does scratch and pick. V8 Stated that R2 has not refused the treatment per say but that when trying to remove her pants or perform care sometimes she can swing at you or become combative. V8 Stated that it's not the treatment it's the overall care. On 8/1/2024 at approximately 1:50 PM V4 stated that she started at the facility the week after the fourth. V4 stated that she has been completing and measuring the wounds since starting. V4 stated that she does not have any and have not been able to locate any other other logs or measurements prior to her starting. On 8/5/2024 at approximately 2:15 PM V1, Administrator, stated that she expects the staff follow physician orders and to perform treatments as directed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Wound Management policy, dated 6/2020, documents Purpose: To provide a system for the treatment and management of residents with and non-pressure injury. Policy: A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing. Pressure injury- any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure injury, friction and shear are important contributing factors to the development of pressure injuries. Pressure injuries usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. Ill. Documentation A. New pressure injuries or wounds will be documented on the 24 hour log. B. Wound documentation will occur at a minimum of weekly until the wound healed. Documentation will include: i. Location of wound ii. Length , width, and depth measurements recorded in centimeters iii. Direction and length of tunneling and undermining (if applicable) iv. Appearance of the wound base v. Drainage amount and characteristics including color, consistency, and odor vi. Appearance of wound edges vii. Description of the peri-wound condition or evaluation of the skin adjacent to the wound viii. Presence or absence of new epithelium at wound rim ix. Presence of pain C. IDT will document discussion and recommendations for: i. Pressure injury and wounds that do not respond to treatment. ii. Pressure injuries and wounds that worsen or increase in size. iii. Complaints of increased pain, di comfort or decrease in mobility by a resident. iv. Signs of ulcer sepsis, presence o exudates, odor or necrosis. v. Residents refusing treatment. D. Licensed Nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis. E. Document notifications following a change in the resident's skin condition. F. Update the res dent's care plan as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Evercare at University		STREET ADDRESS, CITY, STATE, ZIP CODE 1095 University Drive Edwardsville, IL 62025	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42108 Based on interview and record review the Facility failed to ensure pain was assessed, recognizing the onset, presence, and duration of pain, and assessing the characteristics of the pain and provide pain management for 1 of 3 residents (R3) reviewed for pain. This resulted in R3 experiencing pain during dying process. Findings include: R3's Baseline Care Plan, dated 7/9/2024, does not address R3's pain. R3's Pain Assessment, dated 7/9/204, documents that R3 was experiencing pain. Review of R3's Vitals report and no vitals noted. On 7/31/2024 R3's pain assessments requested. As of 8/13/2024 12:00 PM the facility had not provided assessments. R3's Hospice Progress Notes, dated 7/11/2024 at 11:29 PM, Worsening Symptoms Call Back for Additional Questions or Concerns, Call Back for Any New, Change or Worsening Symptoms 2320 - call from (V19) at (facility) asking about scheduling the morphine and lorazepam Asked when last doses were given - both were administered at 2130. She did not know when previous doses were given. States family is concerned over muscle spasms. This RN encouraged nurse (V19) to please administer the morphine and lorazepam for the muscle spasms/ twitching. This RN explained that is something that often happens with kidney failure due to the electrolyte imbalances. (V19) states she is not the patient's nurse and the nurse is in another building and is not wanting to administer the medications unless the patient asks for them. This RN asked that the nurse please give the morphine every three hours and the lorazepam every four hours through the night and then let her know that tomorrow we can get the morphine and lorazepam scheduled and also have prn doses available also. It also documents 7/12/2024 Is death imminent: Yes. Reason for imminence: altered breathing pattern, decreased blood pressure, decreased oral intake, decreased to no urinary output, increased fatigue, increased sleeping, respiratory distress, terminal restlessness 7/12/2024 8:54 AM. T96, P98, Resp 40, SPO2 71% (3L), BP 100/54. It also documents that R3 is having pain determined by observations of waxing and waning and restlessness. 7/12/2024 at 3:48 PM This nurse made another visit to (R3) due to facility stating that the facility nurse is not administering the morphine. The facility nurse reported that (R3) comfortable and respirations were fine. Facility nurse stated she held morphine at 1 pm due to nursing judgment and stated she spoke with the administrator regarding. This nurse assessed (R3). He was non-responsive and drooling. Oxygen increased to 95% on 1OL, HR:88, blood pressure was 80/48, respiration were 50. This nurse asked for morphine and hyoscyamine to be administered due to elevated respirations and drooling. All scheduled medications discontinued besides comfort med's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University Drive Edwardsville, IL 62025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/2024 at 10:00 AM, V18, R3's daughter, stated that R3 was admitted to (facility), on hospice because he was dying on 7/9/2024. V18 stated that when her father first came to the facility he had rallied and was more alert and able to verbalize his needs. V18 stated that this did not last long. V18 stated that they were educated by hospice of the medications and that the pain and anxiety medications were to be given as R3 needed them. V18 stated that the following day R3 changed and he became more weak and less talkative. V18 stated that R3 was in pain. V18 stated that the nurse was notified and initially the pain medication was given. V18 stated that as her fathers condition became worse this changed. V18 stated that her father was breathing heavy and having muscle jerking. V18 stated that R3 would scoul and moan. V18 stated that this was told to the nurse and she refused to give the medication. V18 stated that they called the hospice nurse and the nurse informed the nurse to give the medication. V18 stated that the nurse refused and stated that she was not going to loose her license. V18 stated that the nurse from a different hall came down and gave R3 the medication and R3 began to calm. V18 stated that she spoke with the director of nursing and was informed that the nurse was to be educated. V18 stated that her fathers last 8 hours of life he had to experience pain and this is unacceptable. On 8/1/2024 at 1:54 PM V13, RN, stated that she works for hospice and had been assigned to R3. V13 stated that she was made aware of R3 experiencing pain and the nurse not wanting to give R3 pain medication. V13 stated that she spoke with V13 and she stated that she didn't feel comfortable with giving medication. V13 stated that R3 did have signs of discomfort and would benefit from the morphine. V13 stated that she attempted to educate the nurse on the dying process and pain. V13 stated that she was informed by V17 that she was well aware of hospice. V13 stated that after the education the nurse continued to give the medication. V13 stated that another nurse administered the medication. On 8/5/2024 at approximately 1:30 PM V17, LPN, stated that she took care of R3 at the facility. V17 stated that when R3 first came to the facility he was alert and able to move around. V17 stated that he was able to ask for help and communicate verbally. V17 stated that there was a time when the family wanted R3 to have some pain medication. V17 stated that the family told her that R3 was experiencing some pain. V17 stated that she did not think that R3 was in pain. V17 stated at that time R3 was barely responsive. V17 stated that she did not feel comfortable. V17 stated that she was concern that R3 would choke. V17 stated that she spoke with hospice and the administrator. When asked about R3's pain assessments V17 stated that everyone is assess for pain every shift and the completed assessment would be documented in the nurses notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Evercare at University		STREET ADDRESS, CITY, STATE, ZIP CODE 1095 University Drive Edwardsville, IL 62025	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pain Management policy, dated 6/2020, documents Purpose: to ensure accurate assessment and management of the resident's pain. Policy: A Licensed Nurse will asset residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Pain Assessment A. A Licensed Nurse will assess each resident for pain upon admission. B. The Licensed nurse will complete a Pain assessment located in PCC under UDAs.) for residents identified as having pain within 8 hours of admission. i. If the resident cannot verbalize the intensity of their pain, the Licensed Nurse will assess the resident's pain based on non-verbal cues such as facial expressions. Pain Management: A. The Licensed Nurse will administer pain medication as ordered and document medication administered in the Medication Administration Record {MAR). B. The Licensed nurse will assess the resident for pain and document results on the MAR the 1-10 pain scale or Painade scale. i. pain score will indicate the highest pain level that occurred on that shift. C. If there is a new onset of pain, if the pain as changed in nature, or the pain has not been relieved with current medication, the Licensed Nurse will notify the Attending Physician. Documentation: Pain Assessments will be maintained in the resident's medical record. i. Document the explanation to the resident/responsible party of how the pain scale works. B. The Licensed Nurse will document resident's pain and response to interventions in the medical record on the weekly summary and as indicated on the progress notes.