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	09/06/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 - Based on the interview and record review, the Facility failed to document necessary assessments of wound conditions per its policy, complete treatments as prescribed by a physician, and ensure the resident was assessed in a timely manner after a referral for one of three residents (R2) reviewed for wound management in the sample of 8. Findings include: On 8/29/2024 at 9:05 AM, R2 stated he had been at the Facility for a month and had not been seen by a doctor about his foot wound. R2 stated his foot bandage was changed on 8/28/2024, but prior to that, it had not been changed since the Thursday before. R2 stated his wound should be getting better, but it is not. R2's Face Sheet dated 9/3/2024 documents that R2 has a diagnosis of Stiff Man Syndrome, Cerebral Palsy, Tinea Pedis (fungal infection), Cellulitis (unspecified part of limb), and an open foot wound. It further documents that R2 was admitted to the facility on [DATE]. R2's Care Plan dated 7/20/2024 does not address the monitoring of R2's foot wound but does document that R2 has potential for pain/discomfort related to his wound to his Right Great toe. R2's Treatment Administration Record (TAR) dated 8/1/2024-8/30/2024 documents, Cleanse R (Right) Great toe lateral area with wound cleanse or normal saline. Apply xerofoam gauze and cover with dry dressing. Change on Monday, Wednesday, Friday, and PRN (as needed). R2's TAR is missing documentation that R2's treatment was completed on 8/9/2024, 8/12/2024, 8/14/2024, 8/16/2024 and 8/23/2024. On 9/3/2024 at 9:20 AM, V2, Director of Nursing (DON), verified that several days on the TAR were missing the required documentation of R2's foot treatment being performed. V2 stated she changed R2's dressing on 8/19/2024 because R2 asked her to. V2 stated, It looked angry (inflamed), so she referred R2 to Wound Management because she did not think R2's current order was working/effective for healing. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/2024 at 2:48 PM, V21, a Licensed Practical Nurse (LPN), stated that the Facility does not have a steady wound nurse, but they are working on hiring one. V21 stated she was unsure what type of wound R2 had, and the Wound Log is the only documentation regarding R2's foot wound. V21 stated that R2 had not yet been seen by Wound Management but would be on 9/4/2024. On 9/3/2024 at 3:01 PM, V2 stated R2 was referred to Wound Management on 8/22/2024, but they did not get the referral, so V10 (Assistant Director of Nursing) sent them an email for R2 to be seen by Wound Management on 9/4/2024. V2 continued to state that the wound log was lacking documentation such as: onset date, how the wound was acquired, and classification of the wound. V2 stated that R2 had not seen a doctor related to his foot wound; it is not getting better and will probably need to be debrided. V2 added, It's more than what we (Facility staff) can do. The Facility's Wound Report for Quality Assurance, dated 8/4/2024- 8/10/2024, documents that R2 has a wound to his right great toe measuring 0.8 cm by 0.2 cm by 0.1 cm and is being treated with xeroform three times a week. The Facility's Wound Report for Quality Assurance, dated 8/16/2024, documents that R2 has a wound to his right great toe measuring 0.8 cm by 0.2 cm by 0.1 cm and is being treated with xeroform three times a week. The Facility's Wound Report for Quality Assurance, dated 8/24/2024, documents that R2 has a wound to his right great toe measuring 0.7 cm by 0.7 cm by 0.0 cm and is being treated with xeroform three times a week. The Facility's Wound Report for Quality Assurance, dated 8/30/2024, documents that R2 has a wound to his right great toe measuring 0.7 cm by 0.7 cm by 0.0 cm and is being treated with Xeroform three times a week. R2's Wound Management visit note dated 9/4/2024 documents, Initial consult of (R2), who was admitted to the facility on ,d+[DATE] (2024) and noted to have a right great toe wound, origin unknown, but his hospital H&P (History and Physical) suggests that the wound is secondary to tinea. It continues to document the measurements 1.5 cm (centimeters) by 1.5 cm by 0.3 cm with moderate serosanguineous (a light pink to red color. It's a combination of blood and serum, a clear yellow liquid found in the body) drainage and mechanical debridement of the area was completed with normal saline and gauze. It further documents the goal is to complete adequate wound hygiene with dressing changes to prevent infection and display healing by a reduction in measurement/characteristic every 2 weeks of modify the plan of care. The visit note also documents the treatment was changed to silver alginate. The Facility's Wound Management Policy, dated October 24th, 2022, documents, Purpose: To provide a system for the treatment and management of residents with wounds including pressure and non-pressure areas. A resident who has a wound will receive necessary treatment and services to promote healing and prevent infection. It further documents the documentation should include the appearance of the wound base, drainage amount, appearance of wound edges, description of the peri-wound condition, presence of absence of new epithelium at wound rim and presence of pain. IDT (Inter-Disciplinary Team) will document discussion and recommendation for: wounds that do not respond to treatment.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 - Based on observation, interview, and record review, the Facility failed to ensure medications were readily available for administration per physician's orders to ensure residents' highest well-being, comfort, and pain control for 3 of 7 residents (R1, R4, and R8) reviewed for medications in the sample of 8. Findings include: 1. On 8/29/2024 at 10:00 AM, R1 stated she was admitted to the Facility after having a back surgery. R1 stated she went without her pain and sleep medications. R1 stated she had staff tell her several different stories about why she did not receive her medications. R1 stated a nurse (unknown) asked R1 if R1 had called the pharmacy about her medication. R1 stated, I thought they were supposed to do that. R1 stated it finally got straightened out when the facility staff got a handwritten prescription for the doctor. R1 stated she did experience quite a lot of pain. R1 stated she went from Tuesday (8/20/2024) until Friday (8/23/2024) without her pain and sleep pills. R1's Facesheet dated 9/5/2024 documents R1 had a diagnosis of acute pain due to trauma as well as a wedge compression fracture of the T11-T12 vertebra (mid back) and was admitted to the facility on [DATE] at 5:55 PM. R1's Progress Notes dated 8/22/2024 document R1 had Major orthopedic surgery: repair of fracture and rated her pain at a 5 on the 1-10 pain scale, indicating a moderate pain level. R1's Baseline Care Plan dated 8/21/2024 documents that R1 is cognitively intact. R1's Pain observation for Cognitively Aware dated 8/21/2024 documents, Is resident currently expressing pain? No- analgesics currently in use to control pain. Have you had pain or hurting at any time in the last 5 days? Yes. Location of pain- back. It further documents that R1's frequency of pain is occasional and is classified as moderate aching that comes and goes in the evening. It continues, Over the past 5 days, has pain made it hard for you to sleep at night? Yes. It further documents analgesics as an intervention to alleviate the pain. R1's Medications Administration History, dated 8/20/2024-8/30/2024, documents, Oxycodone 5 mg every 6 hours for pain-start date 8/20/2024. It further documents that R1 received the first dose for back pain on 8/23/2024 at 9:32 AM. R1's Packing Slip (Form documenting medications were delivered) dated 8/21/2024 does not include Oxycodone. On 9/3/2024 at 3:00 PM, V2, Director of Nursing (DON), stated that R1 came from the hospital with a prescription for Oxycodone due to having recently had back surgery. V2 stated that the nurse should have contacted the doctor and got a prescription sent to the pharmacy right away and documented that they did. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2024 at 10:30 AM, V9, Regional Consultant, provided an electronic mail message dated 9/3/2024 documenting the pharmacy's delivery of Oxycodone on 8/23/2024 at 12:07 AM. V9 confirmed this was R1's medication and wrote R1's name on the email. 2. On 9/3/2024 at 12:00 PM, V22, a Licensed Practical Nurse (LPN) stated that R4 was out of her scheduled pain medication and did not receive it that morning when it was due. V22 stated she had to hold it while they waited for a script. V22 stated she called V20 (the Medical Director) and left him a voicemail. On 9/3/2024 at 1:40 PM, R4 stated she was experiencing pain in her right shoulder but didn't know how she would rate it. She was not aware of missing any pain medication doses. R4's Face Sheet, dated 9/5/2024, documents that R4 has a diagnosis of arthritis and cervical spinal stenosis. R4's Care Plan, dated 3/4/2020, documents that R4 has the potential for pain related to R4's diagnosis. If further documents, Administer analgesia (pain medication) as per orders. R4's MAR dated 8/5/2024-9/5/2024 documents R4's Hydrocodone is ordered to be given twice daily (7 AM-10 AM and 7 PM-10 PM). It further documents R4's Hydrocodone was Not administered: Drug/Item Unavailable on 8/25/2024, 8/26/2024, 8/27/2024, 8/28/2024, 8/29/2024, 8/30/2024, 8/31/2024, 9/1/2024, 9/2/2024, 9/3/2024, and 9/4/2024. R4's Prescription Order dated 4/24/2024 documents R4's doctor ordered Hydrocodone 5/325 mg one tablet twice a day. It further documents this prescription was filled on 7/26/2024. On 9/5/2024 at 2:33 PM, V2 stated she was not aware R4 was out of her scheduled Hydrocodone, but after being informed and checking on it, she confirmed R4 did not have her medication. V2 stated medications should be given as prescribed, and R4's pain medication was scheduled to be given twice a day. V2 stated even PRN (as needed) medications should be here and available. 3. On 9/4/2024 at 9:30 AM, V23, a Licensed Practical Nurse (LPN), stated that R4 and R8 were out of their pain medications during her morning med pass. V23 stated that she gave R8 one of the last pain pills they had at the Facility for him on August 16th because R8's wife requested he have it. V23 stated that R8 complains about pain all over, mostly his legs. R8's Face Sheet, dated 9/4/2024, documents that he has chronic pain and an old tear/injury to his knee. R8's Prescription Order dated 5/7/2024 documents R8's doctor (V20) Hydrocodone 5/325 mg one tablet as needed every 8 hours as needed for pain. It further documents this prescription was filled on 7/9/2024. R8's Care Plan dated 1/26/203 documents that R8 has the potential for pain related to R8's diagnosis. If further documents, Administer analgesia (pain medication) as per orders. R8's MAR dated 8/6/2024-9/5/2024 documents V23 administered R8 his Hydrocodone on 8/16/2024 for a pain level of 7. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/2024 at 10:05 AM, V10, the Assistant Director of Nursing (ADON), stated that sometimes getting controlled medications (e.g., Oxycodone, Clonazepam, and Hydrocodone) is difficult because the doctor has to send a handwritten script. On 9/3/2024 at 10:28 AM, V9, Regional Consultant, stated, Part of the issue is (R1) was supposed to come with a hard script, and we were going back and forth with the hospital. We just went through starting a new process with our Medical Director (V20). We initiate getting the prescription filled 7 days prior to running out. On 9/5/2024 at 2:22 PM, V10 stated she would expect all medications, including those ordered as needed, to be available. V10 stated if a resident is out of medication, she would notify the doctor for a script and pull the medication out of the Ekit (Emergency Medication Kit). V10 stated that someone post-surgical should have something stronger than Tylenol for pain. The Facility's Pain Management Policy dated 6/2020 documents, Purpose: to ensure accurate assessment and management of the resident's pain. It continues, 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. It further documents, The licensed nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR). It continues, Nursing staff will implement timely interventions to reduce the increase in severity of pain.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40701 Based on observation, interview, and record review, the Facility failed to ensure medications were readily available for administration per physician's orders for 3 of 7 residents (R1, R4, and R8) reviewed for medications in the sample of 8. Findings include: 1. On 8/29/2024 at 10:00 AM, R1 stated she was admitted to the Facility after having a back surgery. R1 stated she went without her pain and sleep medications. R1 stated she had staff tell her several different stories about why she did not receive her medications. R1 stated a nurse (unknown) asked R1 if R1 had called the pharmacy about her medication. R1 stated, I thought they were supposed to do that. R1 stated it finally got straightened out when the facility staff got a handwritten prescription for the doctor. R1 stated she did experience quite a lot of pain. R1 stated she went from Tuesday (8/20/2024) until Friday (8/23/2024) without her pain and sleep pills. R1's Facesheet dated 9/5/2024 documents R1 had a diagnosis of acute pain due to trauma as well as a wedge compression fracture of the T11-T12 vertebra (mid back) and was admitted to the facility on [DATE] at 5:55 PM. R1's Progress Notes dated 8/22/2024 document R1 had Major orthopedic surgery: repair of fracture and rated her pain at a 5 on the 1-10 pain scale, indicating a moderate pain level. R1's Baseline Care Plan dated 8/21/2024 documents that R1 is cognitively intact. R1's Pain observation for Cognitively Aware dated 8/21/2024 documents, Is resident currently expressing pain? No- analgesics currently in use to control pain. Have you had pain or hurting at any time in the last 5 days? Yes. Location of pain- back. It further documents that R1's frequency of pain is occasional and is classified as moderate aching that comes and goes in the evening. It continues, Over the past 5 days, has pain made it hard for you to sleep at night? Yes. It further documents analgesics as an intervention to alleviate the pain. R1's Medication Administration Record (MAR) dated 8/1/2024-8/31/2024 documents Clonazepam 1 mg (milligram) once a day 7:00 PM-10:00 PM- start date 8/21/2024. It further documents, Not administered: Drug/item unavailable on 8/21/2024 and 8/22/2024. R1's Progress Note dated 8/23/2024 2:30 PM documents, Spoke with (Pharmacy) regarding Clonazepam order, Pharmacist states no script was received, therefore medication cannot be dispensed. R1's Progress Note dated 8/23/2024 at 03:02 PM documents, Spoke with (V20's Nurse). She states the script for Clonazepam was sent to (pharmacy) electronically on 8/22/24. States she will send script again. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Note dated 8/23/2024 at 3:06 PM documents, Spoke with (Pharmacy). They have received the script for Clonazepam and will E-Run (Emergency- Run) the medication so patient will receive evening dose. R1's Medications Administration History, dated 8/20/2024-8/30/2024, documents, Oxycodone 5 mg every 6 hours for pain-start date 8/20/2024. It further documents that R1 received the first dose for back pain on 8/23/2024 at 9:32 AM. R1's Packing Slip (Form documenting medications were delivered) dated 8/21/2024 does not include Clonazepam or Oxycodone. R1's Packing Slip dated 8/23/2024 documents 14 pills of Clonazepam were delivered. On 9/3/2024 at 3 PM, V2, Director of Nursing (DON), stated that R1 came from the hospital with a prescription for Oxycodone due to having recently had back surgery. V2 stated she was not aware that R1 did not have Clonazepam and did not come to the Facility with a hard script for it. V2 stated that the nurse should have contacted the doctor and got a prescription sent to the pharmacy right away and documented that they did. On 9/5/2024 at 10:30 AM, V9, Regional Consultant, provided an electronic mail message dated 9/3/2024 documenting the pharmacy delivered Oxycodone on 8/23/2024 at 12:07 AM and Clonazepam on 8/23/2024 at 6:26 PM. V9 confirmed this was R1's medication and wrote R1's name on the email. 2. On 9/3/2024 at 12:00 PM, V22, a Licensed Practical Nurse (LPN) stated that R4 was out of her scheduled pain medication and did not receive it that morning when it was due. V22 stated she had to hold it while they waited for a script. V22 stated she called V20 (the Medical Director) and left him a voicemail. On 9/3/2024 at 1:40 PM, R4 stated she was experiencing pain in her right shoulder but didn't know how she would rate it. She was not aware of missing any pain medication doses. R4's Face Sheet, dated 9/5/2024, documents that R4 has a diagnosis of arthritis and cervical spinal stenosis. R4's Care Plan, dated 3/4/2020, documents that R4 has the potential for pain related to R4's diagnosis. If further documents, Administer analgesia (pain medication) as per orders. R4's MAR dated 8/5/2024-9/5/2024 documents R4's Hydrocodone is ordered to be given twice a day (7 AM-10 AM and 7 PM-10 PM). It further documents R4's Hydrocodone was Not administered: Drug/Item Unavailable on 8/25/2024, 8/26/2024, 8/27/2024, 8/28/2024, 8/29/2024, 8/30/2024, 8/31/2024, 9/1/2024, 9/2/2024, 9/3/2024, and 9/4/2024. R4's Prescription Order dated 4/24/2024 documents R4's doctor ordered Hydrocodone 5/325 mg one tablet twice a day. It further documents this prescription was filled on 7/26/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2024 at 2:33 PM, V2 stated she was not aware R4 was out of her scheduled Hydrocodone, but after being informed and checking on it, she confirmed R4 did not have her medication. V2 stated medications should be given as prescribed, and R4's pain medication was scheduled to be given twice a day. V2 stated even PRN (as needed) medications should be here and available. 3. On 9/4/2024 at 9:30 AM, V23, a Licensed Practical Nurse (LPN), stated that R4 and R8 were out of their pain medications during her morning med pass. V23 stated that she gave R8 one of the last pain pills they had at the Facility for him on August 16th because R8's wife requested he have it. V23 stated that R8 complains about pain all over, mostly his legs. R8's Face Sheet, dated 9/4/2024, documents that he has chronic pain and an old tear/injury to his knee. R8's Prescription Order dated 5/7/2024 documents R8's doctor (V20) Hydrocodone 5/325 mg one tablet as needed every 8 hours as needed for pain. It further documents this prescription was filled on 7/9/2024. R8's Care Plan dated 1/26/203 documents that R8 has the potential for pain related to R8's diagnosis. If further documents, Administer analgesia (pain medication) as per orders. R8's MAR dated 8/6/2024-9/5/2024 documents V23 administered R8 his Hydrocodone on 8/16/2024 for a pain level of 7. On 9/3/2024 at 10:05 AM, V10, the Assistant Director of Nursing (ADON), stated that sometimes getting controlled medications (e.g., Oxycodone, Clonazepam, and Hydrocodone) is difficult because the doctor has to send a handwritten script. On 9/3/2024 at 10:28 AM, V9, Regional Consultant, stated, Part of the issue is (R1) was supposed to come with a hard script, and we were going back and forth with the hospital. We just went through starting a new process with our Medical Director (V20). We initiate getting the prescription filled 7 days prior to running out. On 9/5/2024 at 2:22 PM, V10 stated she would expect all medications, including those ordered as needed, to be available. If a resident is out of medication, she would notify the doctor for a script and pull the medication out of the Ekit (Emergency Medication Kit). V10 stated that someone post-surgical should have something stronger than Tylenol for pain. The Facility's Receiving Controlled Substances Policy, dated 10/25/2014, states, Controlled substances are reordered when a four-day supply remains to allow for transmittal of the required written prescription to the pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Controlled Substance Prescriptions Policy dated 10/25/2024 documents, New Controlled Substance Prescriptions: If prescriptions are written by the prescriber while present in the Facility or sent with the resident from an office visit, emergency room visit, or upon hospital discharge, the prescriber is encouraged to document on separate paperwork the fact that a prescription has been provided to ensure accountability on the receiving end. For written prescriptions received by the Facility: If the prescription is from a prescriber other than the attending physician, the order is verified with the current attending physician. The nurse communicates that verification to the pharmacy prior to dispensing. The prescription is faxed to the pharmacy by the prescriber or prescriber's agent. It continues to document, Refill Requests: If one or more refills or a partial quantity remains and medications are not automatically refilled by the pharmacy, refills are: Written on a medication order form and the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and requires from the pharmacy four days in advance of need to assure an adequate supply is on hand. It further documents if a refill is needed, the pharmacy will contact the Facility to verify the medication is necessary and proactively seek out a new complete prescription from the prescriber for future use. It continues, If a new prescription is not obtained by the pharmacy before the medication would be 'due' again, the Facility is notified. In this situation, the Facility may be asked to contact the prescriber for a new prescription prior to the medication running out. -