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	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at University	1095 University 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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 50840 -- Based on observation, interview, and record review the Facility failed to implement current interventions and initiate progressive interventions to prevent falls for 4 of 4 (R1, R2, R4, R5) residents reviewed for falls in the sample of 5. Findings include: 1. On 10/03/2024 at 10:40 AM, R2 was observed sitting in the dining room in his wheelchair. R2 states that he had a fall on 09/06/2024 when he was in the bathroom. R2 states he was trying to pull down his pants, and he fell forward and hit his head on the bathtub. R2 states he was sent to the emergency room and received 6 stitches by his right eye. R2 states that he is pretty independent, gets up on his own, and goes to the bathroom. R2 denies any other recent falls. R2 states that he knows how to use his call light when he needs help, has learned his lesson the hard way, and always wears shoes when he gets up. On 10/03/2024 at 10:47 AM, a Call don't fall sign was observed on R2's wall, along with a sign stating transfer 1 assist on R2's side wall. There were no non-skid strips noted on R2's floor. On 10/04/2024 at 7:58 AM, there were still no non-skid strips noted on R2's floor. R2's Minimum Data Set (MDS) dated [DATE] documents that R2 is alert and oriented. The MDS documents that R2 requires substantial/maximal assistance with sitting to standing. R2 is dependent for toilet transfers, tub/shower transfers, and chair/bed to chair transfers. R2's Fall Risk assessment dated [DATE] documents that R2 has a fall risk score of 21 and is at risk for falls. The facility's fall log dated 07/01/2024 thru 10/03/2024 documents R2 had falls on 07/08/2024, 08/16/2024, 08/19/2024, 09/06/2024. R2's fall report dated 09/06/2024 documents that R2 had an unwitnessed fall in the bathroom and sustained a laceration above his right eye, requiring him to be sent to the emergency room and receiving 5 sutures. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's care plan, reviewed/revised 09/30/2024, documents, I have issues with non-compliance with leaving my seatbelt on for my safety. I have experienced an actual fall on 1/21/23, 2/23/23, 2/25/23, 3/3/23, 3/6/23, 3/31/23, 4/19/23, 5/10/23, 5/14/23, 5/18/23, 5/20/23, 5/25/23, 6/4/23, 6/5/23, 6/15/23, 6/28/23, 7/8/23, 8/8/23, 8/21/23, 9/1/23, 9/2/23, 9/8/23, 9/15/23, 9/20/23, 7/10/29/23, 1/21/24, 1/29/24, 2/14/24, 4/8/24, 5/4/24, 7/8/24. Requires assist with activities of daily living. Has balance issues. Has the potential for falls related to balance issues and psychoactive drug use. Needs assistance with transfers. Attempts to fall purposefully and recurrent falls prior to admission. R2's care plan documents that the last intervention was added on 7/10/2024. Interventions include Physical therapy to evaluate for positioning and transfer training. When up, make sure the resident has shoes on with laces, a bed alarm when in bed, and a chair alarm in place when in a wheelchair. Re-education with the resident on call button usage; resident performed return demonstration and verbalized understanding. Call before you fall sign in room as added reminder to use call light and allow staff to assist. Continued education on the use of seatbelts while in a wheelchair. Colored tape around the call light as a reminder to use the call light. Non skid strips applied to floor by bed. There was no documentation of R2's fall on 9/6/24 and no progressive intervention after R2's fall with laceration on 09/06/2024. On 10/03/2024 at 10:50 AM, V8, a Certified Nursing Assistant (CNA), stated that R2 usually uses his call light when he needs help getting up. V8 states that R2 stands with one assist, and staff always likes to have 1 person to help with R2. V8 states that the staff always reminds R2 that he needs to use the call light and wait for help before he gets up, but he does like to take it upon himself and get up on his own. On 10/03/2024, at 11:50 AM, V4 Regional Registered Nurse Consultant discussed R2's care plan with her. When the plan was reviewed, no intervention was in place for the fall that occurred on 09/06/2024. V4 states that she just went into R2's care plan and updated it on 10/03/2024. V4 states that ideally, the care plan needed to be updated at the time of the fall. V4 states that their care plan coordinator is off-site. On 10/03/2024 at 12:40 PM, the V5 licensed practical nurse stated that R2 is usually up and in the dining room at the beginning of her shift, but she is still sitting there when her shift is over. V5 states that R2 usually lets staff know when he needs help using the restroom and that R2 is a 2 assist because he is a heavy guy. 2. R1's MDS dated [DATE] documents R1 is cognitively impaired. MDS documents R1 requires partial/moderate assistance with chair/bed-to-chair transfer and sit-to-stand. R1's Fall Risk assessment dated [DATE] documents that R1 has a total fall risk score of 19 and is at risk for falls. The facility's fall log, dated 07/01/2024 through 10/03/2024, documents R1's falls on 07/04/2024, 07/12/2024, and 09/09/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's care plan, reviewed/revised on 09/30/2024, documents I am at risk for decline in my ability to transfer due to Cerebral infarction due to embolism of left middle cerebral artery, Rheumatoid arthritis, unspecified. I am at risk for a decline in my ability to transfer due to Cerebral infarction due to an embolism of the left middle cerebral artery, Rheumatoid arthritis, unspecified. I have experienced an actual fall on 7/24/23, 8/17/23, 8/20/23, 8/21/23, 8/24/23, 8/29/23, 9/19/23, 9/25/23, 10/20/23, 2/7/24, 6/10/24,7/4/24. The resident is at high risk for falls due to my diagnosis of muscle weakness, a disorder of gait and mobility with muscle weakness, arthritis, Alzheimer's disease, unspecified dementia, and anxiety.R1's care plan documents the last intervention for falls was added on 07/11/2024. Interventions include Physical Therapy and Occupational Therapy to evaluate for bed positioning and safety awareness. Place in a reclining high back wheelchair, keep the bed in the lowest position with brakes locked, keep personal items frequently used within reach, keep call light in reach at all times, mattress to floor next to the bed and encourage resident use of call light for assistance. R1's fall report, dated 06/10/2024, documents that R1 had an unwitnessed fall with no injuries noted. R1's care plan, updated 06/10/2024, documents that R1's bed will be in the lowest position with the brakes locked. R1's fall report, dated 07/04/2024, documents that R1 was lying on the floor next to the bed holding his head, with a right elbow contusion. The report documents that R1 be placed in a reclining high-back wheelchair to promote safe positioning. R1's fall report, dated 09/09/2024, documents that CNA reported R1 on the floor next to his bed on his left side. The report also documents that R1's wheelchair will be kept in the hall at bedtime. On 10/03/2024 at 1:45 PM R1 observed lying in bed. R1's bed was observed not to be in the lowest bed position and there was no floor mat next to R1's bed. R1 had a regular wheelchair in his room and R1 stated that is my wheelchair that I use. There was no reclining high back wheelchair observed in R1's room. 3. R5's MDS, dated [DATE], documents that R5 is cognitively impaired and needs substantial/maximal assistance for lying to sitting on the side of the bed, sitting to stand, and chair/bed-to-chair transfer. R5's care plan, reviewed/revised 09/25/2024, documents I have experienced an actual fall on 07/23/2024. No progressive interventions documented after R5's fall on 07/23/2024. R5's Fall Risk assessment dated [DATE] is incomplete and no fall risk score noted. The facility's fall log dated 07/01/2024 thru 10/03/2024 documents R5 had falls on 07/23/2024 and 09/26/2024. R5's fall report dated 07/23/2024 documents that R5 was found on the bathroom floor. However, the report does not document any interventions for R5's fall on 07/23/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's progress note dated 07/23/2024 at 8:05 AM documents R5 in the bathroom laying supine on the floor with their head near the entrance to his bedroom and feet near the toilet. R5 appears to be coming out of a seizure, moaning softly, blood noted to left elbow. Abrasion noted to left elbow. R5 is not answering questions at this VS 143/77, 76, 18, 96% on RA. Pupils are equal, round and reactive to light and accommodation, responds to touch. R5 is taking aspirin daily. Sending R5 to emergency room . R5's fall report dated 09/26/2024 documents an unwitnessed fall with no injuries. The fall report does not document any updated fall interventions for R5. R5's care plan was not revised after R5's fall on 09/26/2024. On 10/4/2024 at 8:03 AM, R5 was observed lying in bed in a locked and low position. A Call before you fall was observed on R5's wall. A wheelchair and cane were observed next to R5's bed. R5 states that he gets up on his own with the use of his cane. R5's call light found under pillow. 34964 - 4. R4's MDS dated [DATE] documents R4 is alert and oriented and requires partial to moderate assist with sit to standing, lying to sitting on side of bed, chair to bed/bed to chair, and toilet transfers. R4's Care Plan dated 2/28/23 documents: Problem: Resident is at risk for falls due to multiple healed fractures, diagnosis of MDD (Major Depressive Disorder), HTN (Hypertension), and insomnia. 8/20/24- Fall Unwitnessed- Self Reported Fall Unwitnessed- 10/3/24 - self-reported. Last Reviewed/Revised 10/03/2024 03:20 PM. Interventions for this care plan include: 1. 4/24/24: Chair removed from resident room [ROOM NUMBER]. 2/28/23: Provide individualized toileting interventions based on needs/patterns. 3. 2/28/23: Implement an exercise program that targets strength, gait, and balance. 4. 10/3/24: IDT team reviewed and sent to ER due to being on blood thinner; upon return, will refer to therapy. 5. 10/3/24: Resident will have decreased falls when he asks for assistance. Remind resident to use call light for assistance. There was no progressive intervention added to R4's Care Plan after his fall on 8/20/24. R4's Fall Risk assessment dated [DATE] documents a score of 9, indicating he is not at risk for falls. There were no updated fall risk assessments done after R4's falls on 8/20/24 or 10/3/24. On 10/3/24 at 1:40 PM, R4's room was observed (he was not in there due to being sent to the hospital this morning after a fall) with a recliner chair next to his bed. There were multiple books on the seat of the chair. The facility's Fall Log dated 7/1/24 through 10/3/24 documents R4 had falls on 10/3/24 and 8/20/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Fall Report dated 8/20/24 at 11:15 PM documents, res (resident) propelled self in wc (wheelchair). states he fell in bathroom landing on knees and r (right) elbow. states he just lost balance and fell . denies hitting the head. neuro check wdl (within normal limits). is on aspirin and policy dictates a trip to er. patient refused to go to ER. DON (Director of Nursing) and MD (Medical Doctor) aware. neuro checks cont (continue). call light in reach. abrasion cleaned and covered with dry drsg (dressing). no c/o (complaint of) pain R4's Fall Report dated 10/3/24 at 4:02 AM documents, res self reported a fall to the floor. states he fell to his knees and then crawled back to bed. abrasion to r knee. Later states he was on floor trying to do push ups. confused to time and situation. denies pain. ROM (range of motion) wdl. ems (emergency medical services) dispatched to transfer to ER per policy of on blood thinner. ems en route to (local hospital) ER On 10/4/24 at 11:48 AM, V8, CNA, stated there was no toileting plan in place for R4. She stated he was pretty independent and would do his own thing. She stated he used a w/c to come down to the dining room but would be up independently in his room and take himself to the bathroom. However, she did not have a scheduled time or plan for staff to assist him in the bathroom. V8 stated that R4 was not in any exercise programs. She stated he used to get therapy, but that has been done for some time. She stated he would pick and choose what activities to do, which may include some physical activity, but he did not attend routinely. The facility's undated policy, Fall Evaluation and Prevention, 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. Policy: 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 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. Procedure: Residents should be evaluated for their fall risk on admission/re-admission to the home, following any change of status that may affect balance, mobility, or safety, following a fall, and quarterly. Following a fall, the following steps should be undertaken: The IDT (interdisciplinary team) will review the plan of care and update the interventions as appropriate.

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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** 34964 Based on observation, interview and record review, the facility failed to have pain medication available as ordered for one of three residents (R3) reviewed for pain in the sample of 5. This resulted in R3 not receiving his narcotic pain medication as ordered for 10 out of 30 days in September 2024. Findings include: R3's undated Face Sheet documents that R3 was admitted on [DATE] with diagnoses that include Stable Burst Fracture of First Lumbar Vertebra, Unstable Burst Fracture of Second Lumbar Vertebra, Initial Encounter for Closed Fracture, pain, and Unspecified Osteoarthritis. R3's Minimum Data Set (MDS) dated [DATE] documents that R3 is alert and oriented and has moderate difficulty hearing. R3's Care Plan dated 4/7/23 documents: I have potential for pain/discomfort r/t (related to) dx (diagnosis) of non-infective gastroenteritis and colitis, unspecified osteoarthritis, stable burst fracture of first lumbar vertebrae, unstable burst fracture of 2nd lumbar vertebrae and unspecified pain. The goal for this care plan is that I will have no side effects from the use of analgesia through the next review date. Interventions for this care plan include: Record/report to nurse any s/sx (signs or symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Observe the effectiveness of pain interventions q (every) shift. Review for compliance alleviating of symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability, and impact on cognition. R3's Physician Order dated 1/3/24 documents: Hydrocodone-Acetaminophen Schedule 2 (narcotic) tablet 5-325 milligrams (mg) one tablet three times a day at 7:00 AM, 2:00 PM, and 8:00 PM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Medication Administration Record (MAR) dated 9/1/24 to 9/30/24 documents R3's Hydrocodone-Acetaminophen 5/325 mg that was ordered to be given three times a day was not available from 9/1/24 through 9/4/24 and from 9/21/24 at the 8:00 PM dose until 9/26/24 at the 8:00 PM dose. Under Reason as to why this scheduled pain medication was not administered as ordered, it was documented the medication was not available. According to the MAR, R3 also had an order for Acetaminophen 650 every 6 hours PRN (as needed), but this was not administered to R3 while his Hydrocodone-Acetaminophen was not available. R3's Treatment Administration Record (TAR) dated 9/1/24 to 9/30/24 also included an order for Voltaren Arthritic Pain Gel prn, but this was not administered for R3 any time during September either. On 10/2/24 at 1:35 PM, V12, R3's daughter, stated that R3 takes Hydrocodone every day for arthritic pain, and he ran out of the medication. She noted that the staff stated they had to get a script for the medication and were waiting for the doctor to call the facility back. V12 stated she is not sure how long the script was out for but she is frustrated that her father is in pain because they are not giving his pain medication as ordered. V12 stated when she visited R3 on 9/26/24, he was having spasms and jerking motions when she visited him, and he said he was hurting. V12 stated they do give the resident Tylenol but it does not do anything for him. On 10/3/24 at 11:05 AM, R3 was in bed feeding himself breakfast. Due to R3 being very hard of hearing, a communication board was used to communicate with him and ask questions. R3 stated, Yes, a little, when asked if he had any pain. He stated, Yes, a little, that he gets pain meds but stated, I don't know, when asked if the facility has ever told him they don't have his pain medications. On 10/3/24 at 11:33 AM V8, Certified Nursing Assistant (CNA) and V9 CNA transferred R3 from his bed to his high backed wheelchair using a full body mechanical lift. During the transfer R3 did grunt and moan and had facial grimacing with generalized discomfort during transfer. After he was seated in the wheelchair, V8 and V9 placed pillows under R3's legs and head and positioned him for comfort. On 10/3/24 at 8:32 AM, V6 Licensed Practical Nurse (LPN) stated they really don't have any problems with the pharmacy getting medications out for residents, but it is more of an issue of getting the necessary prescriptions from the physician. She stated it is the nurse's responsibility to get medications refilled as needed. V6 stated sometimes they have to call the physician several times and the pharmacy will also help in trying to reach the doctor when a script is needed for a refill. V6 stated they start trying to refill the medications before the resident runs out to give enough time to get it refilled. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 1:05 PM, V4, Regional Nurse Consultant, stated she had addressed R3's Hydrocodone with V11, R3's physician, when it ran out. She stated R3 had been in the hospital, and when he returned, he did not have the appropriate diagnosis for the Hydrocodone, but then when she reminded V11 that R3 is [AGE] years old with osteoarthritis, V11 was agreeable to R3 continuing on Hydrocodone-Acetaminophen for his pain. When it was clarified that per R3's MAR, he received Hydrocodone-Acetaminophen when he was readmitted from the hospital on 9/18/24 until he ran out, and it was not available on 9/21/24, V4 stated she was not sure why he continued to receive the medication if he didn't have the appropriate diagnosis. When asked if there was any documentation of R3's MD notification of the need for a refill, V4 stated she did not document when she talked to him or when he was notified of the need for the refill, but she assumes it was on 9/26/24 because that was when the medication was refilled. V4 stated the facility is working on putting processes in place and educating the nurses because it is not ideal for R3 to have gone so many days without his pain medication. She stated he had regular Tylenol available for pain when he was out of his Hydrocodone-Acetaminophen. The facility's undated policy, Pain Management, documents, Purpose: To ensure accurate assessment and management of resident's pain. Policy: A licensed nurse will assess each resident for pain upon admission and routinely as indicated by the resident's health and functional status. Facility staff is responsible for helping resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Procedure: Pain Management: A. The licensed nurse will administer pain medications as ordered, and document medication administered on the Medication Administration Record (MAR).