

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  11/18/2024
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>32874</p> <p>--</p> <p>Based on observation, interview, and record review, the facility failed to implement fall interventions for 1 of 3 residents (R2 ) reviewed for falls in the sample of 9.</p> <p>Findings include:</p> <p>R2's progress notes, dated 11/1/2024 at 6:16 pm, document that R2 arrived at the facility by ambulance on a stretcher. The notes document that R2 is alert and orientated x4. R2 uses a manual lift with all transfers, is able to let needs be known, has no skin issues, and has a history of CVA. The notes document weakness on the left side due to the previous stroke.</p> <p>R2's progress notes dated 11/2/2024 at 6:54 pm document the Certified Nursing Assistant (CNA) notifying the nurse resident was lying on the ground next to his bed. R2's progress notes document that the nurse observed the resident lying on the left side of the floor with his left hip propped up on the bedside table. R2's notes document resident stated was trying to pick up his phone off the floor when he lost his balance on his weaker side (left). R2's notes document that upon inspection, there was no bleeding. The right hip has some bruising from falling on the bedside table and also on the left elbow. R2's notes document on blood thinners, ambulance called and en route. R2's notes document R2 alert and oriented times 4. R2's notes document that R2 has a limited Range Of Motion (ROM).</p> <p>There is no fall event available for this fall, and no interventions documented in place after this fall.</p> <p>R2's progress notes dated 11/3/2024 at 10:37 am document that the nurse called down to the resident's room. R2's notes document resident noted to be lying on left side, no c/o of pain, no active bleeding. resident takes blood thinners. sending out to hospital 911 notified of transfer.</p> <p>R2's event report, dated 11/3/2024 at 10:40 a.m., documents a fall out of bed and immediate interventions: fall mats.</p> <p>R2's general admission information, provided to the surveyor as the initial care plan, is undated and blank. R2's general admission information failed to document the musculoskeletal history and physical observation, which would include any type of extremity weakness or any risks for falls.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/2024 at 10:15 am, V2 Director of Nursing (DON) stated she did not see any fall interventions in place for R2.</p> <p>On 11/14/2024, at 12:06 p.m., the V2 Director of Nursing stated that no fall event/investigation was completed for R2's fall on 11/2/2024.</p> <p>The facility policy Fall Evaluation and Prevention, undated documents the purpose is to ensure that the resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance to prevent accidents. The policy documents the facility will evaluate residents for their fall risk and develop interventions for prevention. The policy documents 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 policy documents the goal is to prevent falls if possible and avoid any injuries related to falls. The policy documents that 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. The policy documents that following a fall, the following steps should be undertaken: evaluate the environment where the fall occurred, nothing about any factors that may have contributed to the fall, and ask the resident what happened prior to the fall or what may have caused the fall. Root Cause. The policy documents to complete the accident /incident report and notify the physician.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>32874</p> <p>Based on observation, record review, and interview, the facility failed to assess and provide medication for pain management for 2 of 3 residents (R4 and R7) reviewed for pain in the sample of 9. This failure resulted in R4 being in pain and R7 being unable to participate in therapy.</p> <p>Findings include:</p> <p>1. On 11/13/2024 at 1:17 PM, R4 stated he did not receive pain medication for several days after admission. R4 stated, That was not good for me, as my pain was at an 8. R4 stated they were administered Tylenol, but that was not effective.</p> <p>R4's Medication Administration Record(MAR) History dated 11/1/2024-11-13-2024 documents Hydrocodone -acetaminophen -Schedule 2 table 5-325 Milligram (mg) administer 1 tablet every 8 hours as needed (prn). R4's MAR history documents start date 11/1/2024. R4's MAR history does not document R4 receiving pain medication until 11/8/2024.</p> <p>R4's Face sheet dated 10/29/2024 documents a diagnosis in part of low back pain, and pressure ulcer of sacral region stage 4.</p> <p>R4's progress notes dated 10/29/2024 at 10:51 AM document R4 arrived at the facility per ambulance. R4's progress notes dated 10/30/2024 at 1:53 PM documents a call placed to the hospital regarding the hard script required for the Norco order that was sent with R4 upon discharge. R4's progress notes document the hospitalist that discharged R4 on 10/29/2024 is not available. R4's progress notes document order will be entered once a hard script is provided or hospital escribes. R4's progress notes dated 11/1/2024 at 1:10 PM document a call placed to the hospital about the Norco script.</p> <p>2. On 11/13/2024 at 2:21 PM, R7 was sitting in the dining room in a wheelchair, moaning. R4 stated being in pain. R4 described pain at a 7 on a scale of 1-10. R7 indicated his pain was in his belly. R7 said he gets pain medication once in a while.</p> <p>On 11/13/2024 at 2:50 PM, R7 was being pushed into the therapy room in a wheelchair, moaning. 2:54 PM, V9, COTA (Certified Occupational Therapy Aid) has a heat pack on his abdomen in the therapy room. Stated trying to relieve cramping stated they gave him pain medication before I brought him down. R7 continues to moan in pain. On 11/13/2024 at 2:55 PM, V9 pushed out of the therapy room to his room R7, continually moaning in pain. On 11/13/2024 at 2:58 PM, V9 reported to the nurse R7 reported pain 7 out of 10. the nurse enters the room and asks if in pain R7 says belly. And asks if R7 needs to go to the Bathroom or wants a drink. No type of abdominal assessment was performed when the surveyor asked if the nurse had done any assessment and stated that I had been in there a couple of times. I gave him Tylenol 30 minutes ago. 3:03 PM remains up in wheelchair in room moaning in pain. The nurse then goes to the nurses' station where (V16), the Medical Director, is across from the station. nurse is V11, LPN. 3:12 PM placed in bed by mechanical lift by V12, Certified Nursing Assistant (CNA), V13 CNA, V12, and V14 CNA. V13, CNA stated, He is yelling for no apparent reason.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R7's care plan dated 1/26/2023, documents R7 has the potential for pain related to diagnosis of polyneuropathy, interstitial pulmonary disease, venous insufficiency, Gastroesophageal Reflux Disease (GERD), Pulmonary Vascular Disease (PVD), old meniscus bucket tear, derangement of unspecified lateral meniscus due to an old tear or injury, and chronic. R7's Care plan documents the following interventions 10/27/2024 administer pain medications as per orders 10/27/2024 Assess for pain every shift and document results, observe and report to the nurse changes in the usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care, record/report to nurse any signs/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, aggressiveness, squirmy, constant motion, refer to physician for adjustment in pain management as needed.</p> <p>R7's undated medication list documents hydrocodone0acetaminophen 5-325mg i tab twice daily, starting on 11/8/2024. However, the list fails to document the last dose administered.</p> <p>R7's prescription order Norco 5/325 one by mouth twice a day script documents faxed 11/13/2024 with note at top of script please fil.</p> <p>On 11/13/2024 at 2:15 PM, V2, DON stated (R7's) pain medication was not available as the script had not been received from a physician.</p> <p>On 11/13/2024 at 1:20 PM, V2, the Director of Nursing (DON), stated she expected residents to have pain medication as ordered.</p> <p>The facility policy for pain management undated policy documents the purpose of ensuring accurate assessment and management of the resident's pain. The policy documents that 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. The policy documents the licensed nurse will administer pain medication as ordered, and documents medication administered on the Medication Administration Record (MAR). The policy documents that if there is a new onset of pain or if the pain has changed, the licensed nurse will notify the physician to review the medication. The policy documents that nursing staff will implement timely interventions to reduce the increase in the severity of pain.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>32874</p> <p>-</p> <p>Based on observation interviews and record reviews, the facility failed to provide medications as ordered for 2 of 3 residents (R4 and R7) who were reviewed for medications in the sample of 9.</p> <p>Findings include:</p> <p>1. On 11/13/2024 at 1:17 PM, R4 stated he did not receive pain medication for several days after admission. R4 stated, That was not good for me, as my pain was at an 8. R4 stated the was administered Tylenol but that was not effective.</p> <p>R4's Medication Administration Record (MAR) History dated 11/1/2024-11-13-2024 documents Hydrocodone -acetaminophen -Schedule 2 table 5-325 Milligram (mg). Administer 1 tablet every 8 hours as needed (prn). R4's MAR history documents stator date 11/1/2024. R4's MAR history does not document R4 receiving pain medication until 11/8/2024.</p> <p>R4's Face sheet dated 10/29/2024 documents a diagnosis in part of low back pain, and pressure ulcer of sacral region stage 4.</p> <p>R4's progress notes dated 10/29/2024 at 10:51 AM document R4 arrived at the facility per ambulance. R4's progress notes dated 10/30/2024 at 1:53 PM document a call placed to the hospital regarding the hard script required for the Norco order sent with R4 upon discharge. R4's progress notes document the hospitality that discharged R4 on 10/29/2024 is not available. R4's progress notes document order will be entered once a hard script is provided or hospital escribes. R4's progress notes dated 11/1/2024 at 1:10 PM document a call placed to the hospital about the Norco script.</p> <p>2. On 11/13/2024 at 2:15 PM, V2 2 DON stated that R7's pain medication was not available because the script had not been received from the physician.</p> <p>On 11/13/2024 at 1:20PM V2, the Director of Nursing (DON) stated she expected residents to have pain medication as ordered.</p> <p>The facility policy medication administration, undated documents to provide practice standards for safe administrating of medication for residents in the facility. The policy documents medication will be administered per the order of attending physician or licensed independent practitioner or as consistent with the law.</p>		