

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 01/10/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25071</p> <p>Based on interview and record review the facility failed to provide medication as ordered by the Physician. This applies to 1 resident (R1) of three reviewed for medication administration in a sample of three.</p> <p>Findings include:</p> <p>R1's medical diagnosis from the electronic medical record documents R1 as an [AGE] year-old with diagnoses to include Vascular Dementia with severe agitation.</p> <p>On 01/09/2025 at 12:29 PM V2 (Director of Nursing) stated On the second, (01/02/2024) in the afternoon (R1) was having a meltdown. He was striking staff and asking who we are going to murder. The nurse asked me to assist her with drawing up his PRN (as needed) medication. It was an intense situation. Instead of going to the MAR (medication administration record) I asked her what dose of Haldol he was receiving. Her response was 2ml (milliliters). I went to the med cart drew up the 2ml and gave it. It calmed him down eventually. He had a seat and kept busy with adjusting and messing with a wheelchair. There was no drowsiness or sedation. The Physician was present during the interaction and witnessed the resident before and after the medication administration.</p> <p>On 01/09/2025 at 1:59 PM at 10:53 AM V7 (Licensed Practical Nurse/LPN) stated (R1) was very violent and redirection was not changing his demeanor. Once (V2 Director of Nursing) gave him the medication he quit striking us. He remained up on the unit the entire afternoon and evening.</p> <p>The Physician Order for R1 dated 12/31/2024 lists haloperidol lactate solution, 5 mg (milligrams)/mL; amt: 2 MG; injection every six hours as needed. (The drug classification for this medication is miscellaneous antipsychotic agent.)</p> <p>The Medication Administration Record for R1 dated 01/02/2025 at 3:18 PM documents the PRN (as needed) being administered.</p> <p>The Medication Administration policy which is not dated documents under VIII; Compare the licensed practitioners prescription/order with MAR (medication administration record). Listed under iX; Compare the licensed practitioners order with the pharmacy label on the medication package. Listed under X; Compare the pharmacy label and MAR. XI; Any discrepancies identified during the first, second, and /or third check must be resolved prior to the administration of any medication.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2025 at 2:44 PM V13 (Nurse Practitioner) stated Yes, this was a medication error. The doctor was there during (R1's) outburst. He witnessed the entire episode and yes, we did speak of the situation. The amount of Haldol (R1) received was not enough to cause any harm. In fact, it barely slowed his behaviors.</p>		