

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 01/24/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42834</p> <p>Based on interview and record review the facility failed to locate and/or replace missing clothing for 1 of 1 resident reviewed for loss of property in the sample of 17.</p> <p>On 1/22/2025 at 1:40PM V19, R10's family member, stated Dad lost clothes, jackets, a brand-new pair of white leather shoes, hearing aids, and two blankets. I took him a blanket and the blanket disappeared. I took him another blanket and the next day that blanket was gone. It was unbelievable.</p> <p>On 1/22/2025 at 2:00PM V16, Social Services Director, stated I don't know anything about R10's missing clothes. I thought we found everything and returned it.</p> <p>On 1/22/2025 at 2:30PM V1, Administrator, stated I thought his items were found. I'm not sure. I don't think they filed a grievance.</p> <p>On 1/23/2025 at 2:00PM V19 stated We didn't get any missing items back from the facility. They have not contacted us for reimbursement either.</p> <p>On 1/23/2025 at 3:00PM V1 stated We have a grievance filled out for the missing items. A family member picked the items up, but I don't know who it was. Grievances for the past 3 months were asked for and the grievance regarding R10's missing items was not given by facility.</p> <p>Grievance records dated 1/7/2025 documents Resident's daughter stated that resident had some clothes missing. Gray zip up jacket, gray and white fleece blanket, socks. Steps of Investigation: checked laundry and resident's room. Summary/findings: Resident's items were found in laundry. Returned to resident's room.</p> <p>Grievance records dated 1/17/2025 documents Resident's daughter stated that her dad's white shoes were missing. Steps of Investigation: Checked laundry and resident's room. Checked all other rooms in facility. Summary/Findings: Shoes were not located. Informed resident's daughter to get receipt or information regarding cost of shoes.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy undated states The facility recognizes and respects the resident's ability to keep personal belongings within reason during their stay at the facility. Report missing items directly to the Social Service Department or appropriate charge nurse or manager. If necessary, the resident visitor or employee shall fill out a Concern Report. These forms should be available at the reception desk or at each nursing station on each floor. The concern Report shall be sent to the Administrator or Designee by the Reception or appropriate floor. After receiving the report of the missing item, the facility will proceed to address the issues brought to their attention.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156</p> <p>Based on interview and record review the Facility failed to ensure abuse did not occur for 1 of 3 residents (R9) reviewed for abuse in the sample of 17.</p> <p>Findings include:</p> <p>R9's Physician Order Sheet for January 2025 documents a diagnosis of aftercare following joint replacement surgery, acute osteomyelitis, left ankle and foot, bipolar disorder, anxiety disorder, type 2 diabetes, diabetes mellitus without complications, unspecified protein calorie malnutrition, morbid obesity due to excess calories, hyperlipidemia, gangrene, not elsewhere classified, chronic viral hepatitis, hyperglycemia, neuropathy, frost bite of the foot.</p> <p>R9's Minimum Data Set (MDS) dated [DATE] documents R9 was cognitively intact for decision making of activities of daily living.</p> <p>R9's Progress Notes dated 11/15/2024 at 8:00 PM, Resident and staff member arguing in dining room. Resident and staff member separated, and resident went to room. Resident feels safe. MD (Medical Doctor) notified.</p> <p>On 1/22/2025 at 2:43 PM, R9 stated, Last month that Dietary Aid (V10) was foul to me, and I mean foul. She had an attitude, and she was coming at me, screaming at me, calling me names, telling me to shut up. She kept coming and coming and then she picked up a glass and was going to throw it in my face, but staff stopped her. I should not have to worry about staff trying to hurt me. No staff should try and hurt anybody living here. At that time, I was fearful. I know I have an attention deficit, and some issues but no staff should be trying to hurt anybody. She no longer works here. They fired her.</p> <p>On 1/22/2025 at 3:03 PM, V12, Licensed Practical Nurse (LPN) stated, I remember the Dietary Aid was screaming at (V9) and they were both upset, and I told her to clock out and go home and she ignored me. I found out later she had quit that same day. I don't remember anything else. She no longer works here.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's Incident Report: Date of occurrence 11/15/2024, (R9) was in the dining room when (R9) and (V10, Dietary Aid) got into an alleged verbal disagreement. (R9) was interviewed and stated that he had arrived in the dining room and informed (V10) that he was in the dining room and not in his room. (R9) stated that (V10) proceeded to get an attitude and told me that I will have to wait. (R9) stated that he started getting upset because he just wanted to inform the staff he was in the dining room. (R9) and (V10) proceeded to start arguing. Staff came and intervened. (R9) stated he feels safe. (V10, Dietary Aid) stated that (R9) had entered the dining room and came up and asked for his food. I let (R9) know that he would need to wait. (R9) told me you do not talk to me like that and told me to shut up. I then told (R9) he needed to stop we were aware he was here. (R9) continued to get loud with me and I told him I was just doing my job. (R9) told me to shut up and go home and I told him he needs to stop speaking about the situation and to stop speaking to me about the situation and to stop speaking to me. He called me a bitc* and I told him he doesn't need to speak to me like that. Other staff members were interviewed and stated they had heard commotion coming from the dining room and saw (R9) and (V10) speaking very loudly in close proximity of each other, the dining room table was placed between the two. Staff intervened and removed (R9) from the dining room with his permission and staff member was asked to leave the dining room, which she did without hesitation. Staff members reported in a timely manner and when further questioned knew who to report allegations of abuse and neglect. Other residents were interviewed, they stated they have never been yelled at or threatened by (V10) nor by any other member of the staff. Conclusion: We have concluded that this allegation of abuse was unsubstantiated based off the interview process with (R9), other residents and staff members, The facility has concluded that the verbal disagreement was initiated due to (R9's) behavior towards staff members, we have also concluded that (V10) would benefit from customer service education and how to handle confrontational residents.</p> <p>A statement by V12, Licensed Practical Nurse (LPN) dated 11/15/2024 documents, Resident and Dietary staff got into an argument in the dining room. Resident asked the Dietary Aid if he could have his tray early and the dietary aid replied with a smart remark. Both dietary and Resident was going back and forth with words. Dietary Aid began to call resident out to his name and threatening to hit the resident with a glass. I as the nurse asked the dietary aid to clock out for the day and she refused.</p> <p>A statement made undated by R9's statement documents, I come in from being outside about 5 PM. I asked if she can tell them I am here. She got an attitude saying I will have to wait. I was getting upset because I just wanted to have my food sent to my table and not my room. We started yelling at each other and I smacked my hand on the table. Staff came and intervened. I called her a bitc*. I feel safe, I just wanted my food.</p> <p>V10's (Dietary Aid) statement dated 11/15/2024 documents, I was serving trays and (R9) came up and asked for food. I let him know he would need to wait. (R9) said you don't talk to me like that and told me to shut up, I said no, you need to shut up, I am doing my job. He told me to stop talking about the situation and if he wants respect he needs to give it. I told him to stay over there and stop talking to me. He was calling me a bitc* and I told him don't talk to me like that.</p> <p>A statement from R11 undated documents, I saw the dietary aid and (R9) yelling at each other. Staff came and separated them.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Statement from V14, Licensed Practical Nurse (LPN) undated documents, I heard commotion coming from the dining room. When I went out the aide and resident were yelling at each other. I intervened and separated the two.</p> <p>On 1/22/2025 at 3:39 PM, R11 stated, This all happened in the cafeteria and (R9) and (V10) were both screaming at each other it was a big blow out. They were both yelling at shouting at each other. It was not nice at all.</p> <p>The Abuse Prevention and Prohibition Program undated documents, The ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35156</p> <p>Based on interview and record review the facility failed to initiate and thoroughly investigate alleged violations of abuse for 1 of 3 residents (R9) reviewed for abuse in the sample of 17</p> <p>Findings include:</p> <p>On 1/22/2025 at 2:43 PM, R9 stated, Last month that Dietary Aid (V10) was foul to me, and I mean foul. She had an attitude, and she was coming at me, screaming at me, calling me names, telling me to shut up. She kept coming and coming and then she picked up a glass and was going to throw it in my face, but staff stopped her. I should not have to worry about staff trying to hurt me. No staff should try and hurt anybody living here. At that time, I was fearful. I know I have an attention deficit, and some issues but no staff should be trying to hurt anybody. She no longer works here. They fired her.</p> <p>On 1/22/2025 at 3:03 PM, V12, Licensed Practical Nurse (LPN) stated, I remember the Dietary Aid was screaming at (V9) and they were both upset, and I told her to clock out and go home and she ignored me. I found out later she had quit that same day. I don't remember anything else. She no longer works here.</p> <p>R9's Incident Report: Date of occurrence 11/15/2024, (R9) was in the dining room when (R9) and (V10, Dietary Aid) got into an alleged verbal disagreement. (R9) was interviewed and stated that he had arrived in the dining room and informed (V10) that he was in the dining room and not in his room. (R9) stated that (V10) proceeded to get an attitude and told me that I will have to wait. (R9) stated that he started getting upset because he just wanted to inform the staff he was in the dining room. (R9) and (V10) proceeded to start arguing. Staff came and intervened. (R9) stated he feels safe. (V10, Dietary Aid) stated that (R9) had entered the dining room and came up and asked for his food. I let (R9) know that he would need to wait. (R9) told me you do not talk to me like that and told me to shut up. I then told (R9) he needed to stop we were aware he was here. (R9) continued to get loud with me and I told him I was just doing my job. (R9) told me to shut up and go home and I told him he needs to stop speaking about the situation and to stop speaking to me about the situation and to stop speaking to me. He called me a bitc* and I told him he doesn't need to speak to me like that. Other staff members were interviewed and stated they had heard commotion coming from the dining room and saw (R9) and (V10) speaking very loudly in close proximity of each other, the dining room table was placed between the two. Staff intervened and removed (R9) from the dining room with his permission and staff member was asked to leave the dining room, which she did without hesitation. Staff members reported in a timely manner and when further questioned knew who to report allegations of abuse and neglect. Other residents were interviewed, they stated they have never been yelled at or threatened by (V10) nor by any other member of the staff. Conclusion: We have concluded that this allegation of abuse was unsubstantiated based off the interview process with (R9), other residents and staff members, The facility has concluded that the verbal disagreement was initiated due to (R9's) behavior towards staff members, we have also concluded that (V10) would benefit from customer service education and how to handle confrontational residents.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A statement by V12, Licensed Practical Nurse (LPN) dated 11/15/2024 documents, Resident and Dietary staff got into an argument in the dining room. Resident asked the Dietary Aid if he could have his tray early and the dietary aid replied with a smart remark. Both dietary and Resident was going back and forth with words. Dietary Aid began to call resident out to his name and threatening to hit the resident with a glass. I as the nurse asked the dietary aid to clock out for the day and she refused.</p> <p>A statement made undated by R9's statement documents, I come in from being outside about 5 PM. I asked if she can tell them I am here. She got an attitude saying I will have to wait. I was getting upset because I just wanted to have my food sent to my table and not my room. We started yelling at each other and I smacked my hand on the table. Staff came and intervened. I called her a bitc*. I feel safe, I just wanted my food.</p> <p>V10's (Dietary Aid) statement dated 11/15/2024 documents, I was serving trays and (R9) came up and asked for food. I let him know he would need to wait. (R9) said you don't talk to me like that and told me to shut up, I said no, you need to shut up, I am doing my job. He told me to stop talking about the situation and if he wants respect he needs to give it. I told him to stay over there and stop talking to me. He was calling me a bitc* and I told him don't talk to me like that.</p> <p>A statement from R11 undated documents, I saw the dietary aid and (R9) yelling at each other. Staff came and separated them.</p> <p>A Statement from V14, Licensed Practical Nurse (LPN) undated documents, I heard commotion coming from the dining room. When I went out the aide and resident were yelling at each other. I intervened and separated the two.</p> <p>On 1/22/2025 at 3:24 PM, V2, Director of Nursing stated, I was not in the building when this incident occurred. When I came back, I know (V10) was put on suspension. I am not sure if she still works here. I think she was a no show and never came back to work after this incident. I only did the initial report. I cannot tell you why it was not substantiated.</p> <p>On 1/22/2025 at 3:39 PM, R11 stated, This all happened in the cafeteria and (R9) and (V10) were both screaming at each other it was a big blow out. They were both yelling at shouting at each other. It was not nice at all.</p> <p>On 1/22/2025 at 3:49 PM, V1, Administrator stated, I did not substantiate this because I felt it was more of any issue with customer service. I reviewed the cameras and (V10) never had a cup in her hand. She was arguing in the dining room, (R9) and (V10) were both separated but no harm occurred. We felt it was more of an issue with customer service than abuse. (R9) stated he felt safe, and no glass was thrown at him. (V10) was pulled aside and was in the break room so she did not clock out until later, but she was not around any resident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Abuse Prevention and Prohibition Program undated documents, The ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834</p> <p>Based on Interview and Record Review, the facility failed to administer ordered medications to 1 of 1 resident reviewed for medications in the sample of 17.</p> <p>R2's Facesheet documents an admitted [DATE]. Diagnosis include Osteomyelitis, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Acquired absence of other right toe(s), Chronic Kidney Disease, Acute Embolism and Thrombosis of unspecified deep veins of left lower extremity, Type 2 Diabetes.</p> <p>R2's Minimum Data Set, MDS, dated [DATE] documents R2 has no cognitive deficits.</p> <p>R2's Care Plan updated 10/24/2024 documents I have chronic pain related to Gastroesophageal Reflux Disease, Neuropathy, and Idiopathic gout. Interventions include: Report to Nurse my complaints of pain or requests for pain treatment. Pain Assessments quarterly and as needed.</p> <p>R2's order sheet dated 9/12/2024 documents oxycodone - Schedule II tablet; 5 mg; amount: 1 tab; oral Twice A Day. Open ended. 7:00AM-10:00AM, 4:00PM-6:00PM.</p> <p>R2's medication administration sheets dated 10/1/2024-10/31/2024 document Oxycodone -Schedule II tablet 5mg. Amount to administer1 tablet, oral. Time 7:00AM-10:00AM. 4:00PM-6:00PM. MAR documents oxycodone not administered on the following dates: 10/2/2024 PM dose, 10/3/2024 AM and PM dose, 10/4/2024 PM dose, 10/5/2024 AM and PM dose, 10/6/2024 PM dose, 10/7/2024 PM dose, 10/8/2024 AM and PM dose, 10/9/2024 AM and PM dose, 10/10/2024 PM dose, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/17/2024 AM and PM doses. Comment sections lists reasons as Item unavailable, Medical Doctor, MD, to send prescription to pharmacy, waiting on prescription, medication not in.</p> <p>On 1/22/2025 at 7:30AM V7, Registered Nurse, stated most medications are in our stock medication. Occasionally there will be a medication that is not in stock, and it takes a little longer to get here. I remember R2 had an insurance issue with pain meds.</p> <p>On 1/22/2025 at 3:00PM V2, Director of Nursing, DON, stated most medications are in stock medications. If a medication is not in the ekit then we would put a rush to pharmacy. Most pain medications are in the ekit. I do not know why R2 did not get her oxycodone. I had just started working here when that happened. We have new policies and procedures in place now that would prevent medications from getting missed.</p> <p>Facility's undated Medication Administration policy states Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner or as consistent with state law.</p>		