| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628<br><br>Based on the interview and record review, the facility failed to notify the physician of changes in condition related to weight loss and blood glucose readings for 1 of 3 residents (R2) reviewed for change in condition in the sample of 14.<br><br>Findings include:<br><br>R2's undated Face Sheet documents she was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, vascular dementia, diabetes, and unspecified calorie protein malnutrition.<br><br>R2's weight record, dated 9/12/24, documented her weighing 170 pounds. On 10/12/24, she weighed 168 pounds. On 10/28/24, she weighed 2 pounds. On 11/6/24, she weighed 152 pounds, and on 12/5/24, she weighed 136 pounds. These weights calculate a 20 % weight loss in three months from 9/ 2/24 to 12/5/24 and a 10.5 % weight loss over the last month from 11/6/24 to 12/5/24.<br><br>There was no documentation in R2's medical record that V22, R2's Physician, was notified of R2's significant weight loss.<br><br>On 2/13/25 at 11:25 AM, V2, Director of Nursing, DON, stated that once the weights are obtained and these fluctuate from the Resident's normal, either she or the nurse caring for the Resident will notify the physician.<br><br>R2's Care Plan, dated 8/12/24, documents, Problem: I have a diagnosis of diabetes mellitus which places me at risk for medical complications. The goal for this care plan documents, I will experience no medical complications related to their diabetes through the next review. Interventions for this care plan include HgbA1C as ordered by a physician, follow protocol per facility for low blood sugars, administer my medications as ordered MD (medical doctor), and accuchecks as ordered by a physician.<br><br>R2's Progress Note, dated 12/8/24 at 4:33 PM, documents, Resident was sent out to the (local) hospital at 4:33 PM for Change of condition. The Resident was not responding to verbal cues. Vitals 98% (oxygen saturation), 86 (pulse), 86/56 (blood pressure), 2 (respirations). POA (Power of Attorney) notified, Left message with (V22's, Medical D ctor) on-call nurse. There was no documentation that R2's blood sugar level was obtained.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's Emergency Medical Services (EMS) report printed on 2/18/25 documents that EMS arrived at the facility on 12/8/24 at 4:41 PM to find R2 unresponsive with an altered level of consciousness (LOC). Per this report, EMS obtained R2's vital signs and noted her blood glucose level was 24. The report also documented that EMS administered Glucagon to treat R2's critically low blood glucose level and transported R2 to the local hospital.<br><br>R2's hospital records dated 12/8/24 - 12/12/24 document under Assessment and Plan, Type 2 Diabetes Mellitus with hypoglycemia-long term (current) use of insulin: Status: acute; Assessment and Plan: HgBA1C 5.6, blood sugar in the 20s in nursing home, 60 on arrival to the ER (emergency room ), currently trending 70-100. Hold insulin for now; she may need insulin with her A1C.<br><br>R2's Physi Ian's Order, dated 8/12/2024, documented that R2 is to receive Humalog (lispro) insulin 20 units subcutaneously before meals three times per day.<br><br>R2's Medication Administration Record (MAR), dated 12/1/24-12/27/24, documented that she did not receive the scheduled insulin ordered by the physician 13 times in a six-day span including 12/1/24 (morning), 12/1/24 (afternoon), 12/1/24 (evening), 12/2/24 (morning), 12/2/24 (afternoon), 12/2/24 (evening), 12/3/24 (morning), 12/5/24 (morning), 12/5/24 (afternoon), 12/5/24 (evening), 12/6/24 (morning), 12/6/24 (afternoon) and 12/6/24 (evening). The reason documented that these insulins were not given is reported as Not Administered: Other or Not Administered: another comment with the blood glucose level documented. R2 also did not receive her scheduled insulin on 12/7/24 (morning), and the reason was that R2 was sleeping.<br><br>R2's Progress Notes did not document that R2's physician was not notified when R2's insulin was not given as ordered on the above dates.<br><br>On 2/13/25 at 11:15 AM, V10, Registered Nurse (RN), stated that the physician was made aware of a resident's blood sugar by the staff calling him. If a resident is to receive insulin, there should be a range of blood sugars, such as when the insulin should be given and when it should be held. If there is not a range of blood sugars listed, V10 stated that the physician should be called.<br><br>On 2/13/25 at 11:20 AM, V11, a Licensed Practical Nurse (LPN), stated that she remembered R2's blood sugars being fine. V11 stated that R2 typically did not receive her scheduled insulin because her blood sugars weren't high enough. V11 stated that she would document this, but the physician wasn't always notified.<br><br>On 2/18/25 at 8:50 AM, V2, Director of Nursing, DON, stated that if a resident's blood glucose is out of range or if the Resident's insulin is not given as ordered, the nurse should call or text the physician. V2 stated that she would expect this to be documented in the progress notes. V2 stated that staff are not good at documenting this in the progress notes, but she said that they are getting better.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/18/2025 at 2:00 PM, V11 was shown a copy of R2's December 2024 MAR documentation regarding R2's insulin administration. V11 reviewed R2's original insulin order in the presence of surveyors and stated that there were not any parameters included in the insulin order of when the insulin should be held. V11 stated that she uses nursing judgment when deciding to hold a resident's insulin. V11 stated that she was not comfortable giving that amount of insulin with a blood sugar that was 90-100. V11 stated that each time she holds the insulin is very situational and dependent on the individual Resident and the amount of insulin they are supposed to receive. V11 stated anytime a resident's insulin is held, the physician should be notified. V11 stated she did not notify the physician when she held R2's insulin, but she should have. V11 stated that she had not had any conversation with any physician or nurse practitioner regarding the frequency with which she held R2's insulin on the days prior to R2 being sent to the hospital with low blood sugars. V11 stated that she never saw any real change in R2's condition that he recalled. V11 stated that the physician should be notified when the insulin is held, especially when it is being held as often as R2's was being held.<br><br>On 2/19/25 at 8:23 AM, V21, Nurse Practitioner (NP), stated that she was not aware that R2's insulin was held 13 times in a six-day span from 12/1/24 to 12/6/24 due to the nurse determining R2's blood sugar was too low to receive that much insulin. V21 stated she did remember receiving a couple of texts from the nurse caring for R2 informing her that she had held the dose of insulin, and V21 stated she told the staff that it was okay. V21 stated that the nurses should notify her every time a dose of insulin is held. V21 stated that she had seen R2 in October, and no changes were made to her insulin. V21 stated that if she is notified that the insulin is being held frequently and is aware of this, she can make the necessary changes to the ordered insulin dose. V21 stated that R2 should have had an HgBA1C in November, three months after she was admitted , but there was no HgbA1C result found in R2's EMR for November 2024. V21 stated she would have adjusted the current insulin dose based on a recent A1C result. She also stated that if she had been made aware of multiple insulin doses being held, she would have ordered an HgbA1C. V21 stated if a HgbA1C had been done as ordered in November 2024, the results may have resulted in a decreased insulin dose if appropriate. V21 stated that if the HgbA1C result had been lower, there was no way she would have continued the current insulin dose. V21 added that she could not adjust the Resident's insulin based on a couple of texts or calls that a nurse had held the insulin. Still, if she had been aware that they had held the insulin 13 times in six days, she would have ordered an HgbA1C and adjusted R2's insulin according to the results. A V21 stated that the standing orders provided to the facility are based on current evidence-based practice and recommendations for diabetic and heart health issues, as well as specific diagnoses. The standing orders are reviewed annually according to these guidelines. The labs in the standing orders are important because they are based on these guidelines. V21 expects that pertinent standing orders should b entered for each Resident on admission. V21 stated she couldn't guestimate (guess/estimate) what is happening when they have only received a couple of notifications that insulin has been held on the Resident. V21 stated that when they are in the facility, she and V22 review the physician order sets for the last couple of months and any available lab results. V21 stated that they depend on the staff to notify them if the blood glucose results are abnormal. V21 also stated it should be documented in progress notes every time a nurse contacts the physician/ nurse practitioner. V21 was asked if she was aware that R2 had a significant weight loss from 170 pounds to 136 pounds in a four-month period. V21 stated she was not aware of the weight loss, and if V22 was aware of it, he would have addressed it in his progress notes. V21 stated she last saw R2 in October 2024. V21 stated that this weight loss would have influenced hypoglycemia, as weight loss directly affects the metabolic system. There was no documentation in R2's EMR that she was seen by V21 or 22 after October 2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's undated policy, Change of Condition, documents Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/ responsible party in a timely, efficient, and effective manner. Guidelines: The facility will inform the Resident, consult with the R sident's physician or authorized designee such as Nurse Practitioner; and if known, notify the Resident's legal representative or an interested family member when there is: A significant change in the residents' physical, mental, or psychosocial status (i.e., (for example) a deterioration in health, mental, or psychosocial status in either life- threatening conditions or clinical complications); Life-threatening conditions are such things as a heart attack or stroke; Clinical complications are such things as development of a stage 2 pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression; A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., (example) the use of any medical procedure, or therapy that has not been used on that Resident before).<br><br>The facility's undated policy, Significant Weight Gain or Loss documents, If weight loss noted: family and resident will be notified in addition to physician. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628<br><br>Based on the interview and record review, the facility failed to monitor and assess blood sugar levels for residents with diabetes, for 1 of 3 residents (R2) were reviewed for quality of care in the sample of 14. This failure resulted in R2 requiring emergency intervention for blood glucose level 24 and hospitalization .<br><br>Findings include:<br><br>R2's Face Sheet, undated, documents she was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, vascular dementia, diabetes, and unspecified calorie protein malnutrition.<br><br>R2's Minimum Data Set (MDS) dated [DATE] documented that she was cognitively alert and oriented. R2 has an active diagnosis for diabetes.<br><br>R2's Care Plan, dated 8/12/24, documents, Problem: I have a diagnosis of diabetes mellitus, which places me at risk for medical complications. The goal for this care plan documents, I will experience no medical complications related to their diabetes through the next review. Interventions for this care plan include HgbA1c (Hemoglobin A1c is a blood test that measures the average blood sugar level over the past 2-3 months) as ordered by a physician, follow protocol per facility for low blood sugars, administer my medications as ordered MD (medical doctor), and accu checks as ordered by a physician.<br><br>R2's Physician's Order, dated 8/12/2024, documented that R2 is to receive Humalog (lispro) insulin 20 units subcutaneously before meals three times per day.<br><br>R2's Medication Administration Record (MAR), dated 12/1/24-12/27/24 documented R2 did not receive the scheduled insulin ordered by the physician 13 times in a six-day span including 12/1/24 (morning), 12/1/24 (afternoon), 12/1/24 (evening), 12/2/24 (morning), 12/2/24 (afternoon), 12/2/24 (evening), 12/3/24 (morning), 12/5/24 (morning), 12/5/24 (afternoon), 12/5/24 (evening), 12/6/24 (morning), 12/6/24 (afternoon) and 12/6/24 (evening). The reason documented that these insulins were not given is documented as Not Administered: Other or Not Administered: another comment with the blood glucose level documented. R2 also did not receive her scheduled insulin on 12/7/24 (morning), and the reason was that R2 was sleeping.<br><br>R2's Progress Notes did not document that R2's Physician, V22, was not notified when R2's insulin was not given as ordered on the above dates.<br><br>R2's Progress Note, dated 12/8/24 at 4:33 PM, documents, Resident was sent out to the (local) hospital at 4:33 PM for Change of condition. The resident was not responding to verbal cues. Vitals 98% (oxygen saturation level), 86 (pulse), 86/56 (blood pressure), 20 (respirations). POA (Power of Attorney) notified, Left message with (V22's, medical doctor) on-call nurse. R2's progress notes and December 2024 Medication Administration Record (MAR) did not document that R2's blood glucose level was checked at the time of condition change.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2's Emergency Medical Services (EMS) report printed on 2/18/25 documents that EMS arrived at the facility on 12/8/24 at 4:41 PM to find R2 unresponsive with an altered level of consciousness (LOC). Per this report, EMS obtained R2's vital signs and noted her blood glucose level was 24. The report also documented that EMS administered Glucagon to treat R2's critically low blood glucose level and transported her to the local hospital.<br><br>R2's Hospital Record, dated 12/8/24 - 12/12/24, document under Assessment and Plan, Type 2 Diabetes Mellitus with hypoglycemia- long term (current) use of insulin: Status: acute; Assessment and Plan: HgbA1c 5.6%, blood sugar in 20's in nursing home, 60 on arrival to the ER (emergency room ), currently trending 70-100. Hold insulin for now; she may not need insulin with her A1C.<br><br>On 2/18/25 at 10:30 AM, V2, Director of Nursing (DON), provided a document that she stated was V22's standing order for his residents in the facility. This document stated that for residents with the following diagnoses/conditions: Endocrine: Diabetes Mellitus. The standing orders documented that glycated hemoglobin (HgbA1C) is to be drawn every three months, hold insulins if blood sugar levels are below 80 (Recheck in one hour), call provider for any blood sugar above 350, and hypoglycemic protocol: May use fingerstick glucose checks as needed (PRN) for signs and symptoms of hypoglycemia. Give a glass of orange juice (OJ) with sugar or glucose gel, 1 ounce, squeezed into mouth PRN hypoglycemia. If unable to give OJ, give one glucagon injection subcutaneously (SQ) or intramuscularly (IM).<br><br>On 2/13/25 at 11:15 AM, V10, Registered Nurse (RN), stated that the physician was made aware of a resident's blood sugar by the staff calling him. V10 noted that if a resident is to receive insulin, there should be a range of blood sugars for when the insulin should be given and when it should be held. If there is not a range of blood sugars listed, V10 stated that the physician should be called.<br><br>On 2/13/25 at 11:20 AM, V11, a Licensed Practical Nurse (LPN), stated that she remembers R2's blood sugars being fine. V11 stated that R2 typically did not receive her scheduled insulin because her blood sugars weren't high enough. V11 stated that she would document this, but the physician was not always notified.<br><br>On 2/13/25 at 2:50 PM, V13, LPN, stated that she had only worked at the facility for two weeks. V13 does not remember taking R2's blood sugar prior to sending her out with emergency services. She stated that she kind of remembers that R2 was seated in a high-back reclining chair. V13 stated that she did remember the EMS checking R2's blood sugar.<br><br>On 2/13/25 at 3:09 PM, V14, LPN, stated that she was vaguely familiar with R2. V14 stated that she usually worked on the B hall, and R2 resided on the C hall. V14 remembered working with the nurse who sent her out. V14 thought she may have been an agency nurse, and she remembers printing the face sheet for her. V14 doesn't remember R2 being unresponsive or any blood sugars that may have been taken.<br><br>On 2/18/25 at 8:50 AM, V2 stated that if a resident's blood glucose is out of range or if the Resident's insulin is not given as ordered, the nurse should call or text the physician. V2 would expect this to be documented in the progress notes. V2 stated that staff are not good at documenting this in the progress notes, but she said they are getting better.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/18/2025 at 2:00 PM, V11 was shown a copy of R2's December 2024 MAR documentation regarding R2's insulin administration. V11 reviewed R2's original insulin order in the presence of surveyors and stated that there were not any parameters included in the insulin order of when the insulin should be held. V11 stated that she uses nursing judgment when deciding to hold a resident's insulin. V11 stated that she was not comfortable giving that amount of insulin with a blood sugar that was 90-100. V11 stated that each time she holds the insulin is very situational and dependent on the individual Resident and the amount of insulin they are supposed to receive. V11 stated anytime a resident's insulin is held, the physician should be notified. V11 stated she did not notify the physician when she held R2's insulin, but she should have. V11 stated that she has not had any conversation with any physician or nurse practitioner regarding the frequency with which she held R2's insulin on the days prior to R2 being sent to the hospital with low blood sugars. V11 stated that she had never seen any real change in R2's condition, which she had recalled. V11 stated that the physician should be notified when the insulin is held, especially when it is being held as often as R2's was being held.<br><br>On 2/18/25 at 2:30 PM, V2 was shown the hard copy of the standing orders that she had provided. V2 stated that these orders are entered into the computer when the nurses need to use them. She stated that the nurses all have access to these at the desk. V2 stated that standing orders are not entered until the physician says to use them. V2 stated that these orders can be used as soon as the Resident is admitted .<br><br>On 2/18/25 at 3:00 PM, V11 was shown V22's standing orders and asked if she was familiar with these. V11 stated that she was and that they were available in the nursing binder at the desk. V11 stated that if a resident's blood sugar is low, she would pull out the standing orders and follow them. She stated she would hold the insulin based on the standing order. Still, she would not necessarily enter that standing order into the resident's orders into their Electronic Medical Record (EMR) because she has the standing order hard copy to follow.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/19/25 at 8:23 AM, V21, Nurse Practitioner (NP), stated that she was not aware that R2's insulin was held 13 times in a six-day span from 12/1/24 to 12/6/24 due to the nurse determining R2's blood sugar was too low to receive that much insulin. V21 stated she remembered receiving a couple of texts from the nurse caring for R2 informing her that she had held the dose of insulin, and V21 stated she told the staff that it was okay. V21 added that she is aware that sometimes a resident may not eat and will have random low blood sugar. V21 stated that the nurses should notify her every time a dose of insulin is held. V21 stated that she had seen R2 in October, and no changes were made to her insulin. V21 stated that if she is notified that the insulin is being held frequently and is aware of this, she can make the necessary changes to the ordered insulin dose. V21 stated that R2 should have had a HgbA1C in November, three months after she was admitted , but there was no HgbA1C result found in the R2's EMR for November 2024. V21 stated she would have adjusted the current insulin dose based on a recent A1C result. She also stated that if she was made aware of multiple insulin doses being held, she would have ordered an HgbA1C. V21 stated that if an HgbA1C had been done as ordered in November 2024, the results may have resulted in a decreased insulin dose if appropriate. V21 stated that if the HgbA1C result had been lower, there was no way she would have continued the current insulin dose. V21 added that she cannot adjust the Resident's insulin based on a couple of texts or calls that a nurse had held the insulin. Still, if she had been aware that they had held the insulin 13 times in six days, she would have ordered an HgbA1C and adjusted R2's insulin according to the results. V21 stated that the standing orders provided to the facility are based on current evidence-based practice and diabetic, heart health, and specific diagnoses recommendations. The standing orders are reviewed annually according to these guidelines. The labs in the standing orders are essential because they are based on these guidelines. V21 expects that on admission, the pertinent standing orders should be entered for each Resident. V21 stated she couldn't guestimate (guess/estimate) what is happening when they have only received a couple of notifications that insulin has been held on the Resident. V21 stated that when they are in the facility, she and V22 review the physician order sets for the last couple of months, along with any lab results available. V21 stated that they depend on the staff to notify them if the blood glucose results are abnormal. V21 also stated it should be documented in the progress notes every time a nurse contacts the physician/ nurse practitioner. V21 was asked if she was aware that R2 had a significant weight loss from 170 pounds to 136 pounds in a four-month period. V21 stated she was not aware of the weight loss, and if V22 was aware of it, he would have addressed it in his progress notes. V21 stated she last saw R2 in October 2024. V21 stated this weight loss would have most definitely influenced the hypoglycemia as the weight loss has a direct effect on the metabolic system.<br><br>There was no documentation in R2's EMR that R2 was seen by V21 or V22 after October 2024.<br><br>The facility's undated policy, Medication Administration, documents, Purpose: To provide practice standards for safe administration of medications for residents in the facility. Whenever a medication is held for any reason, the licensed nurse will initial the appropriate area on the MAR and circle their initials. The licensed nurse will document the reason the medication was held on the back of the Mar. If medication is not given, licensed personnel should document the medication was not given, notify the MD (medical doctor), and make a note in the resident's chart. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628<br><br>Based on the interview and record review, the facility failed to implement interventions to address a significant weight loss for 1 of 3 residents (R2) who were reviewed for weight loss in a sample of 14. This failure resulted in R2 experiencing a significant weight loss of 20% over a four-month period.<br><br>Findings include:<br><br>R2's Face Sheet, undated, documents she was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, vascular dementia, diabetes, and unspecified calorie protein malnutrition.<br><br>The R2 medical record did not document how the facility obtained R2's initial weight upon admission on 8/12/24.<br><br>R2's Care Plan, dated 8/12/2024, documents the problem: Adult failure to thrive related to anorexia. The goal for this care plan documents (R2) will not exhibit signs of malnutrition or dehydration. The interventions for this care plan include assess for dehydration (dizziness on sitting/standing change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation fever, infection, electrolyte imbalance), encourage and record intake of food and fluids, monitor and record output, monitor for signs of malnutrition (pale skin; dull eyes; swollen lips; swollen and/or dry tongue with [NAME] or magenta hue; poor skin turgor; cachexia; bilateral edema; muscle wasting. R2's care plan was not updated to address her significant weight loss.<br><br>R2's Physician's Order (PO), dated 8/13/2024, documented an order for pureed diet with thin liquids.<br><br>R2's Nutrition Assessment, dated 9/12/2024, documented R2 being observed turning her head as staff attempted to feed her oral intake of less than 50% at most meals. R2 is taking fluids well. Her weight and body mass index (BMI) indicate obesity. Recent glycated hemoglobin (HgbA1C) is at a good level for diabetes. R2 is at high risk for weight loss. Continue the Pureed diet. Recommend Health Shake with all meals.<br><br>R2's weight record, dated 9/12/24, documented her weighing 170 pounds. On 10/12/24, she weighed 168 pounds. On 10/28/24, she weighed 162 pounds. On 11/6/24, she weighed 152 pounds, and on 12/5/24, she weighed 136 pounds. These weights calculate a 20 % weight loss in three months from 9/12/24 to 12/5/24 and a 10.5 % weight loss over the last month from 11/6/24 to 12/5/24.<br><br>R2's PO, dated 10/18/24, documented that R2 should receive health shakes with all meals. This was 36 days after V23; the Dietician recommended that R2 receive health shakes.<br><br>R2's PO, dated 11/21/24, documented monthly weights to be performed on the fifth of the month to monitor weight loss.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2's meal intake record from 8/20/24 to 12/1/24 documented that of the 52 meals where the intake was recorded, 30 meals had an intake of none to 25%.<br><br>There was no documentation in R2's medical record that the Dietician assessed R2 after the initial assessment of 9/12/25 or that the facility implemented any interventions to address R2's insidious weight loss after 10/18/24.<br><br>On 2/13/25 at 11:25 AM, V2, Director of Nursing, DON, stated once the weights are obtained and these fluctuate from the normal for the resident, either herself or the nurse caring for the resident will notify the physician. V2 stated that they have until the tenth month to obtain the weights. V2 stated she would pull a weight report and review back to when the resident was admitted , and if there were any variations, she would notify the physician. V2 stated that the dietitian can obtain the report and view the weights.<br><br>On 2/18/25 at 12:12 PM, V19, a Certified Nursing Assistant (CNA), stated that R2 was fed her meals, and she would usually eat about 25% of the meal. V19 stated that R2 liked her health shakes and would drink all of them.<br><br>On 2/18/25 at 1:10 PM, V20, the CNA, stated she remembered assisting R2 with eating her meals and that she ate horrible. V20 stated that R2 always ate less than 25%, but she would always drink her health shakes or any beverage offered.<br><br>On 2/19/25 at 8:23 AM, V21, Nurse Practitioner (NP), was asked if she was aware R2 had a significant weight loss from 170 pounds to 136 pounds in a four-month period. V21 stated she was not aware of R2's weight loss, but she only saw her in October and did not see her again. She stated that V22, R2's medical doctor, was aware of R2's weight loss; he would have addressed it in his progress notes. A review of R2's electronic medical record (EMR) did not include documentation that R2 was seen by V21 or V22 after V21 saw her on October 23, 2024. There was no documentation or plan in V21's progress notes regarding R2's weight loss, and there was no documentation in R2's progress notes that V21 or V22 had been notified of R2's significant weight loss. V21 stated this weight loss would have most definitely influenced the hypoglycemia as the weight loss has a direct effect on the metabolic system.<br><br>On 2/20/25 at 11:19 AM, V23, the Registered Dietitian, stated she is rarely notified by the facility when a resident needs to be seen. She stated that she would run her own reports- like tube feedings and weight records, which tell her a lot. V23 stated that a resident should be weighed 24-48 hours after admission. She stated that she has not been contacted regarding new admissions or significant weight changes but figured it out herself. V23 stated that if a resident has a substantial weight change, they should notify her. V23 reviewed the initial nutritional assessment performed on 9/12/24 for R2. V23 stated she didn't know why R2 did not receive orders for the recommended health shake until over a month later. V23 stated that the process followed her recommendation to V1, Administrator; V2, Director of Nursing; and V5, Dietary Manager. From there, the recommendation should be sent to the physician for an order, placed in the resident's physician's orders, and implemented by the dietary staff. V23 stated this process should not take over a month. V23 stated she doesn't know why R2 was not seen and reviewed regarding her weight loss at the facility. V23 added she could not explain it. She doesn't understand why she missed it. V23 added that in comparison to her other facilities, this facility does not reach out to her with concerns.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145985 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evercare at University | 1095 University Drive<br>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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility's undated policy, Significant Weight Gain or Loss, documents, Purpose: To ensure that insidious/significant weight gain or loss will be identified so that nutritional needs can be evaluated, and appropriate intervention provided. Standards: All admissions will have a baseline weight obtained. If weight loss is noted, the family and resident will be notified in addition to the physician. Interdisciplinary Team (IDT) team will review monthly to assure appropriate plan of care and interventions for those with significant weight gain or loss. |