

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  06/11/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to notify resident's representatives of a fall in 1 of 4 residents (R3) reviewed for accidents in the sample of 4.</p> <p>Findings include:</p> <p>1.R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including osteoporosis, pain and dementia. V4, R3's Family, is listed as R3's Emergency Contact and Durable Power of Attorney.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documented R3 was severely cognitively impaired and required partial assistance with bed mobility and transfer.</p> <p>R3's Fall Report dated 5/27/25 documents R3 had an unwitnessed fall.</p> <p>R3's Progress Note dated 5/27/25 at 10:31 AM by V5, Licensed Practical Nurse (LPN), documents R3 was found on the floor with a hematoma (bruise) on the right side of (her head).</p> <p>R3's Progress Note dated 5/28/25 at 4:07 PM by V6, Social Services Director, documents V4, R3's family, was not notified of R3's fall, and it was determined that the contact number for V4 was incorrect.</p> <p>On 6/10/25 at 11:20 AM, V1, Administrator, stated V5 tried to call V4 when R3 fell, but the voicemail box was not set up. V4 came to the Facility later and noticed R3's face was bruised and was upset that nobody had contacted her. V1 followed up with V5, and they discovered the phone number V5 used was not correct.</p> <p>On 6/10/25 at 1:18 PM, V5 stated she tried to contact R3's family after her fall, but the number she dialed was not the correct number.</p> <p>On 6/10/25 at 1:24 PM, V6, Social Services Director, stated V4's contact number was not listed correctly, so V4 was not aware of R3's fall until she came to the Facility to visit.</p> <p>On 6/10/25 at 2:35 PM, V4 stated when she came to visit R3, the entire side of her face and eye were black and blue. She was shocked and upset that the Facility did not contact her regarding R3's fall.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 12:30 PM, V2, Director of Nursing (DON), stated she expects staff to notify resident representatives of falls and would expect them to ensure the contact information is accurate.</p> <p>The Facility's Undated Change of Condition Policy documents medical care problems will be communicated to the resident's family or responsible party in a timely, efficient and effective manner, and the Facility will inform the resident's legal representative when there has been an accident involving the resident.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility failed to completed physician's ordered wound care for 1 of 3 residents (R2) reviewed for wound care in the sample of 4.</p> <p>Findings include:</p> <p>1. R2's Face Sheet documents R2 resides in the Facility with diagnoses including paraplegia, pressure ulcer, and acquired absence of both left and right leg below the knee.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively intact, dependent for mobility, and had two pressure ulcers that were present on admission.</p> <p>R2's Care Plan dated 6/8/21 documents R2 is at risk for impaired skin integrity. R2's Care Plan dated 5/29/24 documents R2 has wounds to left thigh/buttock region and right thigh.</p> <p>R2's Wound Consultant Company Report dated 5/27/25 documents R2 had a wound to left posterior thigh measuring 17 cm (centimeters) x 8.9 cm x 0.3 cm. The previous treatment prescribed by V8, Wound Nurse Practitioner, was continued which consisted of cleansing with normal saline or wound cleanser, applying collagen and silver alginate, covering with silicone superabsorbent foam, and changing daily and as needed.</p> <p>R2's Physician Order with start date of 4/10/25 documents cleanse left posterior upper thigh with normal saline or wound cleanser, apply collagen sheet and silver alginate with silicone bordered foam, and change daily and as needed, if soiled.</p> <p>R2's Treatment Administration Record (TAR) does not document R2 received the treatment to the left posterior upper thigh on 5/16/25, 5/20/25, 5/26/25, 6/1/25, 6/3/25, or 6/4/25.</p> <p>R2's Physician Order starting 4/3/23 documents skin prep to bilateral stumps daily.</p> <p>R2's TAR does not document skin prep to bilateral stumps was completed on 4/5/25, 4/6/25, 4/11/25, 4/19/25, 4/20/25, 4/28/25, 5/16/25, 5/19/25, 5/20/25, 5/26/25, 6/1/25, 6/3/25, or 6/4/25.</p> <p>On 6/11/25 at 8:10 AM, V2, Director of Nursing (DON), stated complete treatments should be documented in the TAR.</p> <p>R2's Wound Consultant Company Note, dated 5/14/25 documented new surgical wounds to abdomen measuring 2 cm x 2 cm x 0.2 cm and 1 cm x 1 cm x 0.2 cm. The treatment V8 prescribed for both areas were cleanse with normal saline or wound cleanser, apply silver alginate, and cover with dry dressing daily and as needed.</p> <p>R2's Physician Orders dated 6/10/25 do not document any treatments for abdominal wounds.</p> <p>R2's TAR reviewed since 5/14/25 and does not document any treatments for abdominal wounds.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 9:30 AM, V8, Wound Nurse Practitioner, stated R2 does not have any orders for wound treatments to his abdomen, but should. She ordered silver alginate on her last visit, but the order was never entered by nursing.</p> <p>On 6/11/25 at 12:30 PM, V2 stated V9, Former Wound Nurse, would have been responsible for entering V8's wound care orders. She would expect nurses to enter orders in a timely fashion, provide treatments as ordered, and document treatments as given, when completed.</p> <p>The Facility's Undated Documentation - Nursing Policy documents the purpose is to provide documentation of resident status and care given by nursing staff. Documentation will be concise, clear, pertinent and accurate. Treatment administration records are completed with each treatment completed and are completed and documented per physician order.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility failed to treat resident's pressure ulcers per physician's orders for 1 of 3 residents (R2) reviewed for pressure ulcers in the sample of 4.</p> <p>Findings include:</p> <p>1.R2's Face Sheet documents R2 resides in the Facility with diagnoses including paraplegia, pressure ulcer, and acquired absence of both left and right leg below the knee.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively intact, dependent for mobility, and had two pressure ulcers that were present on admission.</p> <p>R2's Care Plan dated 6/8/21 documents R2 is at risk for impaired skin integrity. R2's Care Plan dated 5/29/24 documents R2 has wounds to left thigh/buttock region and right thigh.</p> <p>R2's Wound Consultant Report dated 5/27/25 documents R2 had a Stage 3 pressure ulcer to left proximal thigh measuring 2.9 centimeters (cm) x 1.9 cm x 0.2 cm. The previous treatment prescribed by V8, Wound Nurse Practitioner, was continued which consisted of cleansing with normal saline or wound cleanser, applying collagen and silver alginate, covering with silicone superabsorbent foam, and changing daily and as needed.</p> <p>R2's Physician Order, PO, starting 2/12/25 documents cleanse proximal thigh with normal saline, apply gentamycin and silver alginate, and cover with silicone bordered foam dressing daily and as needed.</p> <p>R2's Treatment Administration Record (TAR) does not document R2 received treatment to the left proximal thigh on 3/10/25, 3/28/25, 3/29/25, 5/16/25, 5/20/25, 5/26/25, 6/1/25, 6/3/25, or 6/4/25.</p> <p>On 6/11/25 at 8:10 AM, V2, Director of Nursing (DON), stated complete treatments should be documented in the TAR.</p> <p>On 6/11/25 at 12:30 PM, V2 stated V9, Former Wound Nurse, would have been responsible for entering V8's wound care orders. She would expect nurses to enter orders in a timely fashion, provide treatments as ordered, and document treatments as given, when completed.</p> <p>The Facility's Undated Documentation - Nursing Policy documents the purpose is to provide documentation of resident status and care given by nursing staff. Documentation will be concise, clear, pertinent and accurate. Treatment administration records are completed with each treatment completed and are completed and documented per physician order.</p> <p>The Facility's Undated Medication Administration Policy documents the time and type of treatment administered to the resident will be recorded.</p>