STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146040	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Jerseyville	410 Fletcher St Jerseyville, IL 62052

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop/implement interventions for 1 of 3 residents reviewed for pressure ulcers in the sample of 4. Findings include: R2's face sheet documents an admission date of 4/27/2025. Diagnosis include Hypertensive Heart Disease with Heart Failure, Human Immunodeficiency Virus, Chronic Obstructive Pulmonary Disease, Acute Myocardial Infarction, Cerebral Infarction. On 6/5/2025 at 8:15AM V3, Assistant Director of Nursing, ADON, stated R2 does not have any skin issues. On 6/5/2025 at 8:30AM V3 stated, We just did a skin check on R2 and she does have a new area to her left buttock. We just found it this morning. She recently came back from the hospital. I talked to the nurse who did R2's admission assessment and he denied any skin issues. She was in the hospital quite a while. On 6/5/2025 at 9:30AM V3, Assistant Director of Nursing, ADON, and V4, Licensed Practical Nurse, LPN, performed skin check to R2. Dime size open reddened area noted to left buttock. R2's Minimum Data Set, MDS, dated [DATE] documents R2 has no cognitive deficits. R2's MDS dated [DATE] documents R2 has no unhealed pressure ulcers. R2's Care Plan dated 5/25/2025 documents R2 has potential for pressure ulcer development related to decline in medical, physical, mental status. incontinence. assist with transfers and turning and repositioning. Interventions include: R2 requires the bed as flat as possible to reduce shear. R2 prefers to be repositioned with 2 people, lifter. R2 requires pressure relieving device on bed/chair. R2's Braden scale for pressure ulcer development dated 5/12/2025 documents R2 is at moderate risk for pressure ulcer development. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress notes dated 6/5/2025 at 8:53AM document Skin Issue: #001: New skin Issue. Location: Buttocks - generalized. Laterality / Orientation: Left. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 0.7 Width (cm): 0.7 Depth (cm): 0.1 Undermining: No. Tunneling: No. Skin Issues Note: order for triad paste put in place. R2's Clinical admission dated 5/27/2025 documents no skin issues. R2's Skin Issues assessment dated [DATE] documents new issue, buttocks, pressure ulcer/injury, left. Stage 2, in house acquired. Stage by in house nursing, .7cm x .7cm x .1cm. On 6/5/2025 at 8:30AM R2 stated, I got a pressure ulcer, and they haven't done anything. I have had a pressure ulcer before. I did have a cushion for my chair, but I don't know what happened to it. I like to be up in my chair all day. I like to smoke. On 6/5/2025 at 1:30PM R2 up in wheelchair in smoking area. R2 did not have a cushion or pressure relieving device in chair or on bed. On 6/5/2025 at 1:40PM V2 stated R2 was much more independent when she first came in. She wants to be up most of the day. We encourage her to lay back down in the afternoon or use a pressure relieving cushion. On 6/5/2025 at 1:40PM V3 stated, We encourage R2 to try one of the recliners to sit up in to relieve the pressure and reposition. She may have a cushion. Facility's pressure ulcer policy updated 6/2/2025 states: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse and documented in the resident's clinical record.