STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058776	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE AT EDWARDSVILLE	401 ST MARY DRIVE , EDWARDSVILLE, Illinois, 62025

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S0000	Initial Comments Complaint Investigation 2546725/2566824	S0000		08/06/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section	S9999		08/06/2025

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

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S9999	Continued from page 1 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These regulations were not met as evidenced by: Based on interview and record review the facility failed to provide sufficient nursing staff to assist residents with incontinent needs to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident and failed to perform timely incontinent care for 1 of 3 residents (R3) reviewed for incontinent care in the sample of 3. This failure resulted in R3 feeling embarrassed, ashamed, demeaned, disrespected, unwanted, and less than a man. Findings include: R3's Care Plan, dated 02/11/2025, documents "Problem: I require assist for my ADLs (Activities of Daily Living) r/t (related to) weakness and decreased mobility. Approach: I require extensive assist of 2 staff with toileting tasks for bm (bowel movement) and 1 for urinal use." R3's Minimum Data Set, dated 6/10/2025, documents that R3 is cognitively intact, occasionally incontinent of urine and bowel, and requires Partial/moderate assistance with toileting. R3's Progress Note, dated 07/20/2025 at 09:18 PM, documents "Resident called 911 while CNA (Certified Nurse's Assistant) was in there attending to his roommate. Resident was aware that cna will assist him next. 911 stated that resident called them 5 times within a short span of time. In between resident calling 911, resident was also calling and ordering food for himself. Once food arrived, cna stated resident threw food and wasted drink on his bed after he was cleaned up." The facility Grievance/Complaint Log, dated June 2025, documents on 6/27/2025 R3 filed a grievance regarding call light response. The facility Grievance/Complaint Form, dated 6/27/2025,	S9999		

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S9999	Continued from page 2 documents that R3 feels that nursing staff has poor response time to call light. It documents that the complaint was partially substantiated and corrective actions taken call light response audit. The Police Report, dated 7/2025, documents on 7-20-25 at 7:38 PM V9, Police officer, responded to facility in reference to patient R3 calling the police to get the nursing staff to help him. Upon arrival met with V10, Charge Nurse. V10 stated that R3 is a problem patient and falsely calls for help and uses up resources even though he doesn't need help. V9 explained to V10 why he was called. V10 stated that her staff will get to R3 when they can, because of shift change and other nursing duties. V9 then found R3 in his room. Overwhelming smell of feces, R3 had feces leaking out of R3's diaper all over his waist area. R3 stated that he turns on the patient signal light for help, but staff comes and turns it off but do not help him. V7 (CNA) was present in room helping another patient. V7 seemed overwhelmed and stated that she cannot change R3 by herself. When V7 started her shift, she was supposed to have help, but no one was coming to help her. Advising that the facility was understaffed. After approximately 15 minutes of V9 presence in the room, the staff arrived to help R3. On 7/28/2025 at 11:52 AM R3 stated that he received horrible care at the facility. R3 stated that he laid in urine for 45 minutes. R3 stated that a friend came to visit, and he smelled of strong urine. R3 stated that he was embarrassed and ashamed. R3 stated that he couldn't look his friend in the eyes. R3 stated that he was sitting in his own "crap" for so long that he called the police for help. R3 stated he had a bowel movement. R3 stated that he put the light on and nothing. R3 stated that there have been multiple times that the staff come in and turn the light out and never come back. R3 stated that he was covered with bowel. R3 stated that "I am a man. Who wants to live like that." R3 stated that he felt it was demeaning and disrespectful too. R3 stated that he doesn't deserve that. R3 stated that he felt like he doesn't matter and less than a man. R3 stated that he was treated like a caged animal. R3 stated that he was treated less than a dog. On 7/28/2025 at 11:55 AM V5, R3's friend, stated that she has been at the facility on multiple occasions when R3 had to wait 45 minutes. V5 stated that she was told by the staff that there is only 1 staff on the hall at that time. V5 stated that R3 shouldn't have sit in filth that long that is ridiculous. V5 stated that R3 was embarrassed that he was wet and that she had to say	S9999		

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S9999	Continued from page 3 something for the staff to respond. On 7/28/2025 at 1:17 PM, V6, Licensed Practical Nurse, LPN, stated that she entered R3's room around 8:00 PM and gave R3 his medication. V6 stated at that time R3 said he had an accident and needed to be cleaned. V6 stated that she notified the CNA and was told that she was the only one down on the hall and would have to wait to get someone to help with cleaning up R3. V6 stated that she notified another staff and was informed that they could not go in the room with R3. V6 stated that R3 did call the police. V6 stated that she is not sure of what time approximately 8:15 PM but not for sure. V6 stated that the police did come. V6 stated that she was not sure when the police got to the facility, V6 stated that the police spoke with the resident and the CNA. V6 stated that then the Officer told her that R3 had a bowel movement and needed to be changed. V6 stated that R3 was changed at that time. On 7/28/2025 at 1:54 PM V7, CNA, stated that she was the aide assigned to R3. V7 stated that she is an agency with this being her first time at the facility. Upon entering the facility, she was informed what hall she was on and that she would get help at 6pm from oncoming staff. V7 stated that she was informed to not provide care to R3 alone or you will get in trouble. V7 stated that she did clean R3 prior to supper before 5pm. V7 stated that R3 was incontinent of bowel. V7 stated that she was then informed to feed in the dining room, and she did and stayed in there until about 7:10 PM. V7 stated that she checked her hall, and no lights were on, and she went to lunch returning around 7:40 PM. V7 stated that when she returned the light to R3's room was on. V7 stated that R3 was incontinent of bowel with stool up his side. V7 stated that she left the room to find the other aide that was supposed to have arrived at 6 PM. V7 stated that she was informed that no one came in and no one was scheduled. V7 stated that she could not change R3 at that time because she didn't have help, so she went and helped another resident. V7 stated that by the time someone came to help the police were there. V7 stated that she was interviewed by the police and informed him that she was the only one on the hall. V7 stated that she informed the police that she was informed that she would have help on the hall, but this was not case. V7 stated that she cannot care for R3 alone and had to wait for someone to help her. V7 stated that she was informed that R3 is continent and can ask for help. V7 stated that it is possible that he pushed his button, and it was turned off. V7 stated that she was the only one on the hall and stated that someone could have turned it off and not returned. V7 stated that she was not on the hall from 5:00 PM to	S9999		

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S9999	Continued from page 4 7:40 PM. V7 stated that R3 is alert and oriented and can speak for himself. V7 stated that she would have helped R3 before, but she didn't have any help. On 7/29/2025 at 12:20 PM V2, Director of Nursing, stated that it is the expectation of the staff to round at least every 2 hours and more frequent if needed. V2 stated that if the staff identifies a resident is incontinent, they are to address it immediately. V2 stated that R3 requires 2 CNAs to be in room when providing care. V2 stated that this is to give the staff a witness for allegations. V2 stated that the CNA is to respond to the call light, go ask for help then start gathering supplies and start the process while the other staff is coming. V1 stated that this should take no more than 5 minutes. The facility's Incontinence Policy, dated 6/17/25, documents that the purpose is to prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provide perineal and genital care after each episode. The facility's Staffing Policy, not dated, documents that It is the policy of the (facility) to provide sufficient nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. (B)	S9999		