STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF COLLINSVILLE	614 NORTH SUMMIT , COLLINSVILLE, Illinois, 62234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2549219/2627054 25410753/2659261 25411133/2667652	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A)6) 300.3240a) 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 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	S9999		

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

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S9999	Continued from page 1 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by: 1A. Based on interview, observation, and record review, the facility failed to ensure a resident was free from neglect when they failed to monitor, assess, and put forth interventions for resident safety with a disregard for resident care, comfort or safety for 1 of 6 residents (R2) reviewed for Resident Neglect in the sample of 9. The facility also failed to provide effective fall prevention and supervision for 1 of 3 residents (R2) reviewed for falls in the sample of 9. R2 is documented as experiencing 50 falls in the facility from 4/8/25 through 12/1/25. This failure resulted in R2 being left saturated in urine and feces with no staff checking on him and R2 experiencing an injury on 4/11/25, 5/29/25, 6/15/25, 6/23/25, 7/4/25, 8/7/25, 8/13/25, 9/13/25, 10/14/25, 10/29/25, 11/7/25, 11/13/25, and 12/1/25 with R2 being sent to the Emergency Room on 8/7/25 with fall/contusion, 8/13/25	S9999		

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S9999	Continued from page 2 with fall/head injury with laceration, 10/14/25 with questionable fall/laceration of finger, 10/29/25 with fall/abrasion to face, and 11/7/25 with fall/closed head injury. The Findings Include: 1. R2's Admission Record, dated 11/18/25, documents R2 was admitted to the facility on 2/10/25 with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 1/28/25, documents R2 is at Risk for Falls. Interventions: If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. R2's Care Plan, dated 11/10/25, documents R2 has had an actual fall: 4/8/25 witnessed fall with no injury - Intervention: No new interventions. 4/11/25 witnessed fall with small re-open area to left chin and lump on back of head - no new interventions. 4/19/25 unwitnessed fall with no injury - Staff educated to place roommate wheelchair on the outside of room when not in use. 4/23/2025 unwitnessed fall - Educated staff to walk to and from meals. 5/9/25 unwitnessed fall with no injury - Staff to assist 1:1 during residents increased agitation episodes/periods. 5/26/25 unwitnessed fall with no injury - Staff to ensure resident has on non-skid socks. 5/29/2025 unwitnessed fall with hematoma - Intervention: Sent to ER (emergency room) for eval. 5/31/2025 unwitnessed fall with no injury - Intervention: Educate staff to be within arm's reach of resident during 1:1. 6/10/25 fall with no injury - Intervention: Resident made 1:1 for remainder of shift. 6/11/25 witnessed fall w/ no injury - Intervention:	S9999		

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S9999	Continued from page 3 Pharmacy contacted for medication review. 6/15/2025 unwitnessed fall w/no injury - Intervention: Keep in visual when out of bed. 6/15/2025 unwitnessed fall w L hematoma to elbow - Intervention: Reeducate staff on 1:1. 6/17/25 witnessed fall no injury - Intervention: Staff to assist with seating to a chair with arms. 6/21/25 witnessed fall - Intervention: Staff to ensure that entryways are clear of clutter/residents. 6/23/25 witnessed fall no injury - Intervention: Staff to ensure chair is up against wall before resident sits down. 6/23/25 witnessed, skin tear to left knee - Intervention: Staff to increase toileting rounding with resident. 7/4/25 unwitnessed, with minor injury - Intervention: Staff to remove nightstand from room. 7/14/25 witnessed fall, no injury - Intervention: Staff educated not to put their hands on his back. 7/26/25 witnessed fall - Intervention: Staff to assist resident to bed after evening snack. 7/27/25 unwitnessed fall, no injury - Intervention: Staff to ensure that resident remote is kept within reach. 8/5/25 witnessed fall, no injury - Intervention: Staff will keep pitchers of liquid out of reach. 8/7/25 witnessed fall - Intervention: Sent to hospital for eval/treatment. 8/12/25 unwitnessed fall no injury - Intervention: Resident is to be placed in bed at lowest position. 8/13/25 unwitnessed fall with injury - Intervention: Encourage resident to utilize wheelchair for mobility. 8/16/25 unwitnessed fall, no injury - Intervention: Staff reeducated to frequently toilet resident. 8/18/25 witnessed fall - Intervention: Staff to add (non-slip pad) to wheelchair. 8/26/25 witnessed fall - Intervention: No new	S9999		

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S9999	Continued from page 4 interventions. 9/2/25 unwitnessed fall with no injury - Intervention: Staff to keep door to room open for frequent visual checks. 9/4/25 unwitnessed fall with no injury - Intervention: Overnight staff to assist resident to chair in Tv room for AM activities. 9/7/25 witnessed fall - Intervention: Staff reeducated not to place hands on resident back. 9/11/25 witnessed fall - Intervention: No new interventions. 9/13/25 unwitnessed fall - Intervention: Scheduled Care Plan meeting with (Local Hospice) to discuss frequent falls. 9/13/25 unwitnessed fall - Intervention: Reeducate overnight staff to assist resident to chair in TV room for AM activities. 9/13/25 unwitnessed fall - Intervention: Provide an early morning snack. 9/15/25 unwitnessed fall - Intervention: Contacted (Local Hospice) to get prn medications scheduled. 9/19/25 witnessed fall - Intervention: No new intervention 9/19/25 witnessed fall - Intervention: No new intervention 9/21/25 unwitnessed fall - Intervention: No new intervention 9/21/25 unwitnessed fall - Intervention: No new intervention 9/22/25 unwitnessed fall w/o injury - Intervention: Staff to allow resident to sit on floor as he desires. 10/29/25 unwitnessed fall no injury - Intervention: Staff to check on resident more frequently during wake hours. 11/7/25 unwitnessed fall with hematoma to head - Intervention: Continue with plan of care. Other Interventions: Be sure the resident's call light is within reach and encourage the resident to use it	S9999		

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S9999	Continued from page 5 for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. Anticipate and meet the resident's needs. R2's Minimum Data Set (MDS), dated 8/16/25, documents R2 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R2 is always incontinent of both bowel and bladder. R2's Fall Risk Assessment, dated 3/29/25, documents R2 is a High Fall Risk. The facility's fall log, dated September, October, and November 2025, documents R2 has had more falls that were not addressed in the Care Plan. These falls occurred on 9/24/25 x 2, 9/25/25, 11/1/25, 11/7/25, 11/13/25, and 12/1/25. There are missing Fall Risk Assessments that were not completed after each fall. R2's Hospital Record, dated 8/7/25, documents in part patient is a 64-year-old male who presents ER due to fall at his facility. Patient has catatonic schizophrenia and is a very poor historian. He has old bruising to the face. He denies any pain but will not answer orientation questions. He has old bruising to the face. Facility is concerned he may have internal bleeding due to his blood thinning agent. A Head CT (cat scan) was performed with impression: No acute intracranial hemorrhage or suspicious mass effect. Clinical Impression: Bruise to face. R2's Hospital Record, dated 8/13/25, documents in part this is a 64-year-old male presenting for ground level fall. Patient is nonverbal due to catatonic schizophrenia and cannot answer questions. Per EMS (emergency medical service) he fell from his chair and struck his head. Patient is on Eliquis. Patient can move 4 extremities to command although function is severely limited. CT was performed with impression: No acute intracranial hemorrhage or suspicious mass effect. Patient re-evaluated with any acute concerns, and his laceration was repaired. Bleeding controlled. Discharge: Clinical Impression: CHI (closed head injury), Catatonic Schizophrenia, Forehead Laceration. R2's Hospital Record, dated 10/14/25, documents in part Patient is a 64-year-old male with past medical history of catatonia, diabetes, hypertension who presents with a fall and laceration. Patient was found after having a fall. Patient has catatonia and intermittently does not answer any questions. For me patient says that he has no pain. He can shake his head no to say that he does not feel sick today. Physical Exam: Head: External	S9999		

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S9999	Continued from page 6 signs of trauma to head. Patient has well-healed laceration including left forehead with sutures still in place that were removed by myself. Musculoskeletal: On patient's left fifth digit there is a 1 CM (centimeter) laceration on palmar aspect overlying proximal phalanx. X-Ray of finger shows no acute fracture of dislocation. Laceration was repaired with 3 sutures. R2's Hospital Record, dated 10/15/25, documents in part R2 is a 64-year-old male presents to the ED by EMS from (Facility) for evaluation. Patient was evaluated at this facility yesterday for laceration to his left pinky. He received sutures at this time. Per EMS, staff found patient bleeding from his left pinky this morning and sent to the ED (emergency department). No other complaints. Clinical Impression: Visit for wound check. R2's Hospital Record, dated 10/29/25, documents in part R2 is a 64-year-old male presenting to the emergency department following a ground level fall. Patient is nonverbal with limited mobility at baseline. He was apparently walking behind a nurse and fell to the ground injuring his left knee. Shortly thereafter, the patient tripped over something on the ground and fell striking his head. Patient shakes his head when asked if he has any pain though does nod yes when palpating his back. A laceration to the corner of the right eyebrow. A CT of his head, cervical spine, thoracic, and lumbar spine was completed with negative results. Medical Management: The patient is a nursing home resident where ongoing medical care and assistance with activity of daily living will be provided. The fall was purely mechanical in nature by the patient's description, and the patient had no preceding dizziness, chest pain, or shortness of breath and has none of those symptoms now. The patient did not have any suggestion of a change in mental status during or following the event. This description of the events makes syncope or seizure exceedingly unlikely. A syncope work-up (labs, EKG) considered is deemed unnecessary due to the mechanical nature of the fall. Clinical Impression: Ground-level fall, knee abrasion, eyebrow laceration. R2's Hospital Record, dated 11/7/25, documents in part patient is a 64-year-old male arriving via EMS from SNF (skilled nursing facility) presenting after a witnessed ground level fall. Patient is A&O (alert and oriented) x3 but demonstrates variable cognitive function. Patient states that he tripped and sustained a head injury. Med list indicates he is on Eliquis. CT of head and neck demonstrated no acute abnormalities. CXR (chest x-ray) demonstrated no acute cardiopulmonary	S9999		

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S9999	Continued from page 7 disease. CT pelvis showed moderate arthritis of left hip. Lab work WNL. Vitals remained stable throughout visit. Traumatic injury ruled out. Discharged back to nursing home. Discharge instructions: Fall Prevention. R2's Fall Risk Assessment, dated 3/29/25, documents R2 is a High Fall Risk. R2's Incident Note, dated 8/8/25 at 9:43 AM, documents "IDT (interdisciplinary team) met to review residents witnessed fall. Care plan updated. Resident at risk for falls related to schizophrenia, anxiety, hypertension, subacute dyskinesia, frequent falls, malnutrition, and antihypertensive and psychotropic medications. Previous interventions include: Recent medication adjustment related to increased anxiety, staff instructed to check on resident more frequently during wake hours, treated for an acute illness, staff educated walk resident to and from the dining room for meals, and staff instructed to ensure resident is wearing appropriate footwear at all times, and pharmacy consulted for medication review, staff re-educated on 1:1 procedure, staff to assist with seating by ensuring chair has arms for support, staff educated on keeping entry ways clear of clutter/residents, increased staff rounding to offer toileting, staff educated not to place their hand on his back while ambulating, staff will keep pitchers of liquid out of reach, staff will ensure resident's remote is within reach when he is in bed, facility removed side table from room, and staff to ensure chairs are pushed up against the wall for support before resident sits. Root cause: Resident became weak and fell. Intervention: Sent to the ER for evaluation and treatment." R2's Social Determinants of Health Note, dated 10/14/25 at 12:11 PM, documents "This writer went to assist resident out of the doorway when this writer noted blood on the floor. This writer observed this resident's hand to see where the blood was coming from. This writer noted a skin tear about 2.5 CM long at the base of this resident's 5th digit right above the metatarsal. Resident noted to be on Eliquis and ASA (Aspirin) bleeding is not stopping. No one witnessed this resident fall as he has been in the floor most of the time he has been awake this shift. Resident unable to tell this writer what happened. Pressure applied to site. Resident sent to (local hospital) for further evaluation. Resident left this facility via stretcher accompanied by 3 paramedics. Hospice Aware. This writer attempted to notify this residents brother. This writer called this residents brother from line 1 per brothers request no answer at this time."	S9999		

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S9999	Continued from page 8 R2's Social Determinants of Health Note, dated 10/29/25 at 9:58 PM, documents "This writer was at the nurse's station on the phone with the DON (Director of Nursing) to report this resident's fall when this resident approached and fell at the nurses station. Resident noted to fall on his knee hitting his head on the bookshelf. Resident left this facility via ambulance on a stretcher accompanied by 2 paramedics in route to (local hospital). This writer attempted to call hospice back to inform them of second fall no answer at this time. This writer left a message for this resident's brother." R2's Incident Note, dated 11/7/25 at 9:02 PM, documents "This nurse was sitting at the nursing station resident had just walked by and went into dining area and then I there was a loud sound. Immediately I walk into dining area resident was observed lying on his left side on the floor, head against the wall with the chair next to him. Resident was assessed then assisted from floor to chair. Resident alert, BP (blood pressure) 104/71, T (temperature) 97.8, P (pulse) 93, R (respirations) 20, O2 (oxygen saturation) 97% RA (room air), and all ext. (extremities) WNL (within normal limits). Resident denies pain. Hematoma to left back side of head and redness to the left front side of head. Hospice and DON notified. Hospice orders to send resident out to hospital for evaluation and treatment." R2's Fall Risk Assessment, dated 11/13/25, documents R2 is a High Fall Risk. R2's Fall Risk Evaluation Note, dated 11/13/25 at 11:31 AM, documents "Fall Risk: History of falls (past 3 months): 3 or more falls in past 3 months. Resident is ambulatory / incontinent. Systolic blood pressure: No noted drop between lying and standing. Predisposing disease: 1-2 present. Resident did not have a change in condition in the last 14 days. Recent hospitalization history in last 30 days: No. Gait / balance: Balance problem while walking. Gait / balance: Decreased muscular coordination. Gait / balance: Change in gait pattern when walking through doorway. Gait / balance: Jerking or unstable when making turns. Gait / balance: Balance problem while standing. Medication: Takes 3-4 these medications (or medication classes) currently and / or within last 7 days. Fall Risk Score: 19.0." If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. The following fall interventions were put in place after R2 experienced falls, however, they are not being	S9999		

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S9999	Continued from page 9 followed: Staff to increase toileting rounding with resident, Staff reeducated to frequently toilet resident, Staff to remove nightstand from room, Staff to ensure that resident remote is kept within reach, Staff to keep door to room open for frequent visual checks, Staff to check on resident more frequently during wake hours, and Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 11/13/25 at 2:30 PM, R2 was seen lying on the floor in small dining room across from nurse's desk, rolling side to side, sitting up, then lying back down. Other residents were in dining room during this time with both staff and residents seen walking past and around R2 while he was on the floor. On 11/13/25 at 2:35 PM, V9, Licensed Practical Nurse (LPN), stated that R2 is care planned to be on the floor. V9 stated they tried everything to keep him from doing that but if staff tries to get him up, he becomes upset and has behaviors. V9 stated staff keep an eye on him and if he scoots too far, they will intervene to assist him to a chair. V9 stated she has worked with R2 for five years now and R2 can talk and tell you about his needs at times. On 11/17/25 at 8:17 AM, R2 was seen lying in bed with his call light on a nightstand in the middle of the room and not within reach of R2. R2 was seen with his blanket off him and to the side of the bed. There is a noticeable wet spot on R2's sheet underneath his buttocks. The door to his room is closed with staff unable to watch R2. No other visible fall precautions noticed. On 11/17/25 at 10:25 AM, R2 still seen lying in bed, unchanged from earlier with his call light still on the nightstand and not in reach, and his door to the room remains closed with R2 not visible to staff. R2 still seen lying in bed in the same position, unchanged from earlier, still has visible wet spot on his sheet. On 11/17/25 at 12:10 PM, R2 still lying in bed and in same position as earlier. When asked if he has gotten up today R2 nodded his head no. When asked if he has been cleaned up yet, R2 nodded his head no. The sheets under R2 appeared saturated in urine with a brownish stain around the wet area. R2's call light remains on the nightstand and not in reach of R2. R2's door remains closed with R2 not visible from hallway. On 11/17/25 at 12:24 PM, V12, Certified Nursing Assistant (CNA), and V14, Licensed Practical Nurse	S9999		

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S9999	Continued from page 10 (LPN), both walked up to R2's door, opened it and looked inside, then closed the door and walked on down the hall without actually checking on R2. On 11/17/25 at 12:43 PM, V14, LPN, took a lunch tray into R2's room to assist in feeding him. On 11/17/25 at 12:50 PM, V14 walked out of R2's room with R2's lunch tray and placed it in cart in the hall. On 11/17/25 at 1:00 PM, R2 was still lying in bed now with his blanket pulled up and over him. When asked if he was cleaned up yet, R2 nodded no, when asked if he was still wet, R2 nodded yes. R2 pulled back his blanket showing that his sheet was still saturated and now with the brownish stain and his pants and shirt were also saturated. On 11/17/25 at 1:05 PM, V14 returned and was sitting at R2's bedside assisting R2 with his drinks. On 11/17/25 at 1:15 PM, V14 left after assisting R2 to eat and drink while R2 was saturated with urine/feces in bed. V14 failed to clean him or have CNAs clean him and instead covered R2 up with his blanket and left the room while closing the door behind him. On 11/17/25 at 1:35 PM, V16, CNA, stated "(R2) was up when I came on this morning and I helped to put him in his bed after breakfast, maybe around 9:00 AM. The other CNA on this hall left and I was the only one on the hall. I have been everywhere, and I did open (R2's) door to see if he was still breathing, but I didn't have the time to check for anything else. They called in (V15) to help me today." On 11/17/25 at 1:40 PM, V15, CNA, stated "I hate to see him (R2) like this. It's too bad that I didn't know he was sitting like this earlier." On 11/17/25 at 1:42 PM, V15 and V16 assisted R2 to stand by the side of his bed with each CNA holding onto one of R2's arms. V16 held onto R2 by under his arm while he stood by side of his bed during peri-care with his pants saturated and down around his ankles. V15 put a clean incontinence brief between R2's legs and fastened it, walked to his recliner and pushed the recliner over to R2 and while still unlocked, had R2 pivot and sit into the unlocked recliner with no gait belt used. On 11/17/25 at 1:55 PM, V15 stated "(R2) is a very high fall risk but if he knows you, he will cooperate with you and stand there during care."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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S9999	Continued from page 11 On 11/18/25 at 8:20 AM, R2 resting in bed with his call light on a nightstand and not within reach. On 11/19/25 at 12:45 PM, V2, DON, stated "(R2) has a lot of interventions in place for his falls. We have been working with his hospice team and our Psych physician to see what things may work for him and what things don't. We have had a care plan meeting with his family to discuss these things as well." 2. R3's Admission Record, dated 11/18/25, documents R3 was originally admitted to the facility on 2/23/18 with diagnosis of Type 2 DM, Anemia, Atherosclerotic Heart Disease (ASHD), Bipolar disorder, Left below knee amputation (BKA), Morbid obesity, Hernia, Peripheral Vascular Disease (PVD), Major depressive disorder, Anxiety disorder, Falls, HTN, Myalgia of muscles, non-pressure chronic ulcer of skin, Chronic Obstructive Pulmonary Disease (COPD), and Schizophrenia. R3's Care Plan, dated 6/24/25, documents R3 is high risk for falls related to left leg amputee. Interventions: Anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, follow facility fall protocol, review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. R3's MDS, dated 10/23/25, documents R3 is cognitively intact and is dependent on staff for ADLs. R3 is always incontinent of both bowel and bladder. On 11/17/25 at 11:35 AM, V11, CNA, and V12, CNA, rolled R3 over and placed a full body mechanical lift sling under him. V11 brought in R3's wheelchair and stood behind it at the foot of his bed while V12 attached R3's sling to lift device and lifted R3 off the bed, then pulled R3 from his bed over to his wheelchair in the middle of the room (approximately 4 feet) with no one holding onto R3 and R3 was freely swinging in the air. V11 then changed position and controlled the lift device while V12 went behind R3's wheelchair and held him while lowering him to the wheelchair. 3. R1's Admission Record, dated 11/18/25, documents R1 was originally admitted to the facility on 2/19/22 with diagnosis of Dementia, Alzheimer's Disease, Anemia, Glaucoma, Pulmonary Embolism, Malnutrition, HTN, DVT,	S9999		

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S9999	Continued from page 12 Arthritis, and Asthma. R1's Care Plan, dated 6/2/25, documents R1 is at risk for falls related to confusion, gait/balance problems, unaware of safety needs. Interventions: Anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, follow facility fall protocol. R1's MDS, dated 10/21/25, documents R1 has a severe cognitive impairment, is dependent on staff for all ADLs, and is always incontinent of both bowel and bladder. R1's Fall Risk Assessment, dated 6/3/25, documents R1 is a High Fall Risk. On 11/13/25 at 2:55 PM, R1 was seen lying in bed with the bed raised up, bilateral side rails up, and her call light on a recliner approximately 3 feet away from the bed and is not reachable. On 11/18/25 at 9:00 AM, R1 lying in bed raised about mid height with her call light on the recliner and not in reach. On 11/19/25 at 11:10 AM, V21, Regional Director of Operations, stated "I would expect all staff to monitor fall risk residents and provide the interventions that are listed in the care plans to ensure resident safety. I would expect any staff transferring a resident using a (full body mechanical lift) to have continuous hold onto the resident during the transfer. I would expect all staff who are assisting a resident in transferring to use a gait belt during the transfer for resident safety." On 11/19/25 at 12:20 PM, V22, CNA, stated "When we are transferring a resident using (full body mechanical lift), there needs to be two people with one person controlling the device while the other is standing by the resident. I did not know we are supposed to be holding onto the resident the entire time, I thought we just stood by them in case something happened." On 11/19/25 at 12:30 PM, V18, CNA, stated "For resident falls, I would look in the care plan or on the clipboard for interventions. The nurses will usually let us know what to do or how to work with a particular resident. For transfers, I always use a gait belt on the resident (has one around her waist) and if using a (full body mechanical lift) we must have two people and	S9999		

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S9999	Continued from page 13 always hold onto the resident." On 11/19/25 at 12:50 PM, V3, Assistant Director of Nursing (ADON), stated "I would expect staff to keep the resident's call light in reach at all times, even if they are not cognitive enough to use it, they should have it available. I went through each of (R2's) fall interventions and realized that he did still have his nightstand in his room. I have removed that this morning. I also noticed that his call light was not in reach and does not have a clip on it to attach to his bed, so we will have to order some. I did make sure he has his call light now. I am not comfortable with (R2) lying on the floor in the dining room and have asked staff to help him with that. To me that is almost a dignity thing." On 11/19/25 at 12:35 PM, V2, DON, stated "I would expect staff to use a gait belt when transferring a resident and to hold onto the resident at all times while transferring using a (full body mechanical lift). I would expect all staff to follow a resident's fall interventions to maintain resident safety. I would expect staff to keep the resident's call light in reach at all times." On 12/1/25 at 8:35 AM, Upon investigation, R2 was seen lying on the floor by the side of his bed with his call light coiled up on the floor and not within reach, no staff was seen stopping to assist. V3, Assistant Director of Nursing (ADON), was notified and had V14, LPN, assist R2 to get up and then assisted R2 to the restroom. V26, CNA, assisted R2 from restroom to the dining room while walking besides R2 with no gait belt around R2. On 12/2/25 at 8:50 AM, V27, MDS Coordinator, stated "I was told by corporate to get rid of anything old in the resident's Care Plan. I was told to do this quarterly, so anything older than 3 months was deleted." When asked about the interventions that were put in place for falls older than 3 months ago, V27 stated "I would say those are discontinued because they are no longer in the Care Plan." On 12/2/25 at 9:00 AM, V28, Nurse Practitioner (NP), stated "I have been working with (R2) for years now and he is a complicated resident. We have had meetings where we sat down with Hospice, Psych, and the facility staff to discuss him. I think it is a combination of things going on with him and he is declining and gets manic episodes at times and will take off with a fast walk and loses his balance. We have tried altering his medications to see what would work but he absolutely	S9999		

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S9999	Continued from page 14 needs his psychotropic meds, or he will have behaviors. We stopped his Eliquis because it was of no benefit for him at this point. I know he has had numerous falls, but some of them might not have been falls, he has a tendency to sit himself down on the floor. I would always expect the staff to keep him safe and to follow the interventions put into place in order to keep him safe." On 12/2/25 at 10:03 AM, V28, NP, stated "Anytime anyone falls and hits their head, there is a chance that they could have a head bleed and could even die from it. (R2) has fallen numerous times and hit his head and he hasn't had a brain bleed, however, it could happen, you just don't know. It is always a possibility. It is very tough to keep him down. We can't stop him and hold him down. The only thing we can do is to keep him safe and avoid an injury if possible." On 12/2/25 at 12:58 PM, V28, NP, stated "I would expect the staff to check on the residents every two hours and change them when needed. That is the standard of care. It is not standard of care to leave them sitting in incontinence without cleaning them up." On 12/2/25 at 1:21 PM, V29, Facility Medical Director, stated "I have been called numerous times for (R2). Your observations are serious, but we must be objective here. I would have to look at both sides. We have discussed (R2) at the QA meetings, and we had interventions put in place. If the facility did not follow the interventions, then that is one thing, because by regulation, all interventions should be put in place and followed. With all (R2's) falls, a lot of things could have happened. They must investigate what was observed and if they cannot justify why things were not done, and the resident is at risk, then that would be a neglectful act. Any resident who is incontinent and I see them like that, I would ask the staff why, what was their reason for not taking care of that resident and tell them they are doing a bad job and need to improve. If I was looking from your angle, then I would say it was neglectful period. To be fair, I have to see the other side first." On 12/2/25 at 1:21 PM, V29, Facility Medical Director, stated "If the facility did not follow the interventions, and if they cannot justify why things were not done, with the resident at risk, then that would be a neglectful act. Any resident who is left sitting in their incontinence and I was looking from your angle, then I would say it was neglectful period." On 12/2/25 at 1:35 PM, V30, Hospice Medical Director,	S9999		

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S9999	Continued from page 15 was advised of this investigation and its findings and stated "We had a team meeting about a month ago with everyone involved to discuss (R2) and interventions to protect him from further falls or minimize his falls. I know (R2) has had a huge number of falls and it is very concerning to everyone. Luckily, he has not had any bleed from his falls, but we removed his Eliquis due to the risk of a bleed with his falls. When asked about staff not following the fall interventions put in place, V30 stated "I would expect the staff to be following his fall interventions and to put further fall interventions in place to minimize the number of falls. If all those observations are happening, then that is definitely a neglectful act. I assumed that things were going to be taken care of with (R2) after our meetings. I am not in the facility much and not involved with (R2's) day to day care." When advised of R2 sitting in his urine/feces for five hours, V30 stated "I 100% agree that he should have been cleaned up. No one should be sitting in their urine or feces at all. That should not be happening at all and is not acceptable." The Facility's "Fall Evaluation and Prevention" Policy, dated 6/1/25, documents in part "Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. Residents should be evaluated for their fall risk on admission/re-admission to the home, following any change of status that may affect balance, mobility, or safety, following a fall, and quarterly." The Facility's "Transfers-Manual Gait Belt and Mechanical Lifts" Policy, undated, documents in part "In order to protect the safety and wellbeing of the staff and residents, and to promote quality of care, this facility will use mechanical lifting devices for the lifting and movement of residents. Guidelines: 2. Refer to Manufacturer's Guide for proper instructions for use of equipment for transfer and weighing. 9. Use	S9999		

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S9999	Continued from page 16 of a gait belt for all physical assistant transfers is mandatory." The Facility's "Abuse Prevention and Prohibition Program" Policy, dated 6/1/25, documents in part "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. Identification: Physical Neglect: a. Malnutrition and dehydration. b. Poor hygiene. f. Inadequate provision of care. g. Caregiver indifference to resident's personal care and needs. i. Leaving someone unattended who needs supervision." 1B. Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care for 2 of 3 residents (R2, R3) reviewed for incontinent care in the sample of 9. This failure resulted in R2 lying in urine and feces for hours and any reasonable person would not like to sit in their urine or feces with staff not checking on them or cleaning them up timely. The findings include: 1. R2's Admission Record, dated 11/18/25, documents R2 was admitted to the facility on 2/10/25 with diagnosis of Malnutrition, Schizophrenia, Anxiety disorder, Hypertension (HTN), Deep Vein Thrombosis (DVT), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), and Major depressive disorder. R2's Care Plan, dated 3/3/25, documents R2 has FUNCTIONAL bladder incontinence r/t catatonic schizophrenia. Interventions: Clean peri-area with each incontinence episode, ensure the resident has unobstructed path to the bathroom, limit fluids 2-3 hours prior to bedtime, monitor and document intake and output as per facility policy, monitor/document for signs/symptoms UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. R2's Minimum Data Set (MDS), dated 8/16/25, documents R2 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R2 is always incontinent of both bowel and bladder. On 11/17/25 at 8:25 AM, R2 was seen lying in bed,	S9999		

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S9999	Continued from page 17 awake, with blanket off him and to the side of the bed. There is a noticeable wet spot on R2's sheet underneath his buttocks. The door to the room is closed. On 11/17/25 at 10:25 AM, R2 still seen lying in bed in the same position, unchanged from earlier, still has visible wet spot on his sheet, and the door to room remains closed. On 11/17/25 at 12:10 PM, R2 was seen lying in bed, appears to be same as earlier. When asked if he has gotten up today R2 nodded his head no. When asked if he has been cleaned up yet, R2 nodded his head no. The sheets under R2 appeared to be even more saturated in urine with a brownish stain around the wet area with a foul odor. R2's door remains closed. On 11/17/25 at 12:24 PM, V12, Certified Nursing Assistant (CNA), and V14, Licensed Practical Nurse (LPN), both walked to R2's door, opened it and looked inside, then closed the door and walked on down the hall without checking on R2. On 11/17/25 at 12:43 PM, V14, LPN, took a lunch tray into R2's room to assist in feeding him. On 11/17/25 at 12:50 PM, V14 walked out of R2's room with R2's lunch tray and placed it in cart in the hall. On 11/17/25 at 1:00 PM, R2 was still lying in bed now with his blanket pulled up and over him. When asked if he was cleaned up yet, R2 nodded no, when asked if he was still wet, R2 nodded yes. R2 pulled back his blanket showing that his sheet was still saturated with the brownish stain, his clothes were also saturated, and still with a foul odor. On 11/17/25 at 1:05 PM, V14 returned and was sitting at R2's bedside assisting R2 with his drinks. On 11/17/25 at 1:15 PM, V14 left after assisting R2 to eat and drink while R2 was saturated with urine/feces in bed. V14 failed to clean him or have CNAs clean him and instead covered R2 up with his blanket and left the room while closing the door behind him. On 11/17/25 at 1:35 PM, V16 stated "(R2) was up when I came on this morning and I helped to put him in his bed after breakfast, maybe around 9:00 AM. The other CNA on this hall left and I was the only one. I have been everywhere, and I did open (R2's) door earlier to see if he was still breathing, but I didn't have the time to check for incontinence."	S9999		

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S9999	Continued from page 18 On 11/17/25 at 1:40 PM, V15 stated "I hate to see him like this. It's too bad that I didn't know he was sitting like this earlier." On 11/17/25 at 1:42 PM, V15 and V16 entered to provide incontinent care on R2, both donned gloves with no hand hygiene seen done. Both CNAs pulled R2's shirt off, which was also saturated in urine. Both assisted R2 to stand by the side of his bed with each CNA holding onto R2's arm and no gait belt used. R2's pants were dropped to the floor and his saturated incontinence brief removed with both urine and feces inside. V16 held onto R2 while he stood by side of his bed during peri-care with R2's pants remaining wet and around his ankles. V15 had same soiled gloves on and reached in to get a wet washcloth, from a few washcloths inside a plastic measuring container with water, grabbed a washcloth, then put it back in the water, changed her gloves, then got a wet cloth again, sprayed peri-cleaner on the cloth, and began wiping R2's buttocks, and anal area. V15 changed gloves with no hand hygiene done, then repeated wiping R2 with wet cloths including down his legs, groins, and peri-area. There was no wiping or cleaning of R2's penis or testicles. V15 put a clean incontinence brief between R2's legs and fastened it, walked to his recliner and pushed the recliner over to R2 and while still unlocked, had R2 pivot and sit into the recliner. V16 then removed R2's wet pants and socks, then using same gloves, searched for pants in R2's closet. On 11/19/25 at 10:25 AM, When asked if R2 remembers lying in his wet bed yesterday, saturated in urine/feces, R2 nodded yes. When asked if he would rather be checked on and cleaned up quickly, R2 nodded his head yes. When asked if he likes lying in a wet bed, R2 nodded no, then stated "They cleaned me up already." 2. R3's Admission Record, dated 11/18/25, documents R3 was originally admitted to the facility on 2/23/18 with diagnosis of Type 2 DM, Anemia, Atherosclerotic Heart Disease (ASHD), Bipolar disorder, Left below knee amputation (BKA), Morbid obesity, Hernia, Peripheral Vascular Disease (PVD), Major depressive disorder, Anxiety disorder, Falls, HTN, Myalgia of muscles, non-pressure chronic ulcer of skin, Chronic Obstructive Pulmonary Disease (COPD), and Schizophrenia. R3's Care Plan, dated 6/24/25, documents R3 has functional bladder incontinence related to physical limitations, poor toileting habits. Interventions: Clean peri-area with each incontinence episode, encourage fluids during the day to promote prompted	S9999		

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S9999	Continued from page 19 voiding responses, monitor and document intake and output as per facility policy, monitor/document for signs/symptoms UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. It continues R3 has bowel incontinence related to immobility, poor diet. Interventions: Check resident every two hours and assist with toileting as needed, provide bedpan/bedside commode, provide loose fitting, easy to remove clothing, provide peri-care after each incontinent episode." R3's MDS, dated 10/23/25, documents R3 is cognitively intact and is dependent on staff for ADLs, including toileting. R3 is always incontinent of both bowel and bladder. On 11/17/25 at 11:20 AM, V11, CNA, and V12, CNA, entered to do incontinent care on R3. Supplies were already on a bedside table with both CNAs having gloves on. R3's incontinence brief unfastened and open, V12 sprayed R3's peri-area with peri-care, obtained a wet washcloth and wiped the top of R3's peri-area, wiped down each groin, then testicles while folding washcloth between areas. V12 wiped the tip of R3's penis but failed to pull back the foreskin to wash his entire penis. V11 rolled R3 to his right side and held him while V12 obtained wet cloth and wiped R3's buttocks and anal area (feces noted). R3 was rolled to his left side and V12 cleaned R3's right buttock. There was no drying of R3 during incontinence care. On 11/17/25 at 11:00 AM, V10, Ombudsman, stated the residents are complaining to her about improper incontinent care. On 11/19/25 at 11:10 PM, V21, Regional Director of Operations, stated "I would expect the staff to check on the residents at least every two hours for incontinence and to provide timely and complete incontinence care when needed." On 11/19/25 at 12:20 PM, V22, CNA, stated "I check on my residents every two hours and some I will check every hour that way I don't have to do complete incontinent care. For males, I pull back the foreskin and will clean the penis." On 11/19/25 at 12:30 PM, V18, CNA, stated "I check my residents at least every two hours and do complete incontinent care to all areas. For the uncircumcised	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF COLLINSVILLE	614 NORTH SUMMIT , COLLINSVILLE, Illinois, 62234

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S9999	Continued from page 20 male, I would pull back the foreskin, wipe the penis in circular motion, then replace the foreskin." On 11/19/25 at 12:35 PM, V2, Director of Nursing (DON), stated "I would expect the staff to check on the residents for incontinence care at least every two hours and to provide timely and complete incontinent care, including pulling back the foreskin on uncircumcised males." The facility's "Incontinence Care" Policy, dated 6/17/25, documents in part "Purpose: to prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. 2. Perform hand hygiene and put on non-sterile gloves. 4b. Do not place soiled soapy cloths back in clean basin water until procedure completed. In the male resident, wash the penis first, turn the resident to the side, then wash perineal area. 6. Gently pat area dry with towel from anterior to posterior. 9. Change gloves and perform hand hygiene." The facility's "Hand Hygiene" Policy, undated, documents in part "When to wash hands with soap and water only: after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. If hands will be moving from a contaminated body site to a clean body site during patient care. Before glove placement. After glove removal." (A)	S9999		