| 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 **10/30/2025** |
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| **EVERCARE AT EDWARDSVILLE** | **401 ST MARY DRIVE , EDWARDSVILLE, Illinois, 62025** |

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| S0000 | Initial Comments<br><br>Complaint Investigation 25410332/2650154<br><br>Facility Reported Incident of 10/17/25/2653000 | S0000 | | 11/07/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br><br>300.1210a)<br><br>300.1210b)<br><br>300.1210d)2)3)<br><br>300.3210t)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | 10/31/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>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 3-202.2a of the Act)<br><br>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.<br><br>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:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>Section 300.3210 General<br><br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.<br><br>These requirements were not met as evidenced by:<br><br>Deficiencies at this level require two deficient practice statements.<br><br>A. Based on interview and record review the facility failed to ensure residents were free of neglect and failed to ensure coordination of care for a resident to receive medically necessary hemodialysis for 1 of 3 residents (R2) reviewed for neglect and dialysis services in the sample of 16. This failure occurred when (R2) was transferred from another nursing home to the facility on 10/8/25, with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was put into place while the facility was waiting for the new | S9999 | | |

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| S9999 | Continued from page 2<br>provider to perform treatment. R2, who was receiving dialysis 5 days per week prior to her facility admission, subsequently did not receive dialysis services for 12 days, experienced shortness of breath, sweating, weakness, jaundiced eyes, and critical lab levels (potassium levels (6.2 mEq/L - milliequivalents) (normal 3.4-5.0) ; BUN (blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl – milligrams/deciliters) requiring hospitalization.<br><br>B. Based on interview and record review the facility failed to prevent resident-to-resident altercations for 1 of 3 (R7) residents investigated for abuse in a sample of 16.<br><br>Findings include:<br><br>R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Hypoglycemia, unspecified; Hyperlipidemia, unspecified; End stage renal disease; Dependence on renal dialysis; Disorder of kidney and ureter, unspecified; Essential (primary) hypertension; Acquired absence of right leg below knee, type 1 diabetes mellitus without complications. R2's POS does not have an order for dialysis. R2's POS does document, "Monitor dialysis catheter, Twice A Day 6:00 AM- 6:00 PM, 6:00 PM - 6:00 AM."<br><br>R2's POS from the former facility documents R2 was receiving dialysis five days a week but no dialysis order was on the admission physician orders.<br><br>R2's Facesheet documents R2 was admitted to the Facility on 10/8/2025.<br><br>R2's Care Plan with a start date of 10/8/2025 documents, "Problem: I am at risk for alteration in nutrition due to d/x (diagnosis of) hypertension, Chronic systolic (congestive) heart failure, Disorder of kidney and ureter, End stage renal disease." R2's Care Plan does not document R2 was receiving dialysis. R2's Care Plan does not document anything related to waiting on dialysis treatment and or alternate treatment while the facility is waiting for the dialysis provider to accept her.<br><br>R2's Transfer Sheet documents R2 was admitted from another nursing home on 10/8/2025 at 11:40 AM.<br><br>R2's Transfer Physician Orders Sheets (POS) document dialysis five times a week.<br><br>R2's Transfer Care Plan with a date initiated of | S9999 | | |

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| S9999 | Continued from page 3<br>1/30/2025 from the previous facility documents "Dialysis: Resident has potential for impaired renal function secondary to dialysis ESRD (end stage renal disease)."<br><br>R2's Medical Records document (R2) was transferred from another nursing home to the facility on 10/8/25, with no dialysis services set up and/or scheduled prior to her acceptance to the facility. No alternate dialysis treatment was scheduled and or put into place while the facility was waiting for the new provider to perform hemodialysis treatment for R2. R2 did not receive any dialysis services while in the facility for 12 days.<br><br>R2's Progress Notes dated 10/8/2025 at 1: 20 PM, "arrived at facility via facility van with staff x2. Resident a/o (alert and orientated) x3. Wheelchair independent use, and stated she is able to transfer self. Wheelchair is her personal WC (wheelchair). Speech clear and understood. smoking status, vape used. Denied tobacco use. MD (Medical doctor) in house for rounds upon arrival. Medications reconciled. BIMS (Brief interview for mental status) at a 14 (out of 15) with denying depression (cognitively intact for decision making)." R2's Progress Notes do not document R2 was seen by the MD, and R2's Progress Notes do not have any documentation by the Physician.<br><br>R2's Progress Notes from V20, Nursing Home B, document on 10/8/2025 at 11:40 PM, R2 was transferred from their facility to (Facility).<br><br>On 10/28/2025 at 10:12 AM, V6, Licensed Practical Nurse (LPN) stated, "I know (R2) needed an x-ray and some labs when she first got here and she was supposed to have dialysis, but we were waiting on the new dialysis center. I took an x-ray on her chest right before I went on vacation and when I came back (R2) still had not had dialysis but then she was sent out to the hospital. I was not given any additional instructions related to her dialysis and or what to do while she was waiting for dialysis."<br><br>R2's Progress Notes 10/12/2025 at 10:58 AM, "Resident has c/o (complained of) being SOB (short of breath), hot, weak, and is excessively sweating. Resident states she missed dialysis on Friday. MD (Medical Doctor) made aware of the missed dialysis day. Resident's glucose was low at 49. VS (vital signs) are as follows: 97.8, 140/85, 84, 93% on RA (Room air). MD made aware of VS (vital signs) and patient complaints, MD states just to monitor her glucose level in an hour, and send her to dialysis tomorrow, which is her normal dialysis day. Resident currently at lunch table eating a snack to | S9999 | | |

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| S9999 | Continued from page 4<br>bring glucose level up."<br><br>R2's Progress Notes do not document V4, Medical Doctor, was notified the following day when R2 did not receive dialysis treatment. R2's Progress Notes do not document any follow up and/or anything is being put into place to address dialysis. R2's Progress Notes does not document any alternate treatment and or recommendations for addressing R2's dialysis care. R2 was not sent to dialysis and no follow up occurred.<br><br>R2's Progress Notes for the month of October 2025 do not document V4 was aware R2 was not receiving any dialysis treatment while she was in the facility. No plan was documented with regards to what to do while R2 was waiting for dialysis treatment and for a bed to open it. None of R2's Progress Notes document any follow up and/or anything was being put into place to address dialysis treatment for R2.<br><br>R2's October 2025 Progress Notes do not document V4, Medical Doctor was aware R2 went 12 days without receiving dialysis.<br><br>R2's Progress Notes dated 10/20/2025 at 2:02 PM, spoke with resident, sister and ADON (Assistant Director of Nursing) regarding resident need of dialysis. Resident waiting on approval from dialysis clinic this week. Rec'd (received) order to send to ER (Emergency Room) for eval (evaluation) and need of dialysis. Family and resident aware of this and agree as she has not had treatment this week. NP (Nurse Practitioner) in for rounds this day and assessed resident and agreed to send to ER for eval (evaluation) and tx (treatment) if needed. EMS (Emergency Medical Services) here to transport to (nearby hospital). Per wound nurse her skin is intact with no concerns, resident verbalized that she was not in pain.<br><br>R2's Hospital records dated 10/20/2025 document R2 had not had dialysis in about two weeks since coming to the new facility and had elevated potassium levels (6.2 mEq/L) (normal 3.4-5.0); BUN ((blood urea nitrogen (74) (normal 7-25 <=23.0) , and elevated serum creatinine levels 9.17 (normal 0.55-1.02 mg/dl). Patient states she had not underwent hemodialysis and the nursing facility was spoken with this nurse who informed them that they were not able to set up outpatient hemodialysis sessions prior to patient's transfer to their facility unfortunately, patient is asymptomatic but needs dialysis. (R2) states she has not received dialysis since being there. She is unsure why. R2 received dialysis services at the hospital. | S9999 | | |

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| S9999 | Continued from page 5<br>R2's Hospital Records dated 10/25/2025 at 1:17 PM, Medical Problems: Hyperkalemia, End-stage renal disease needing dialysis, Hypertension, Insulin dependent diabetes mellitus and document R2 was discharged back to the facility on 10/25/2025. R2 was admitted to the hospital for five days.<br><br>On 10/23/2025 at 2:59 PM, V12, Family of R2 stated, "My sister is mentally delayed. She does not read, write and is unable to count money. About three weeks ago I went to her former nursing home, and they told me (R2) was no longer there. I was really confused because nobody asked me. I do not know how or why she got to (Facility). When I finally went to the (Facility) (R2) was not doing well at all. Her face was swollen, she was having shortness of breath, and her eyes were yellow like jaundice. I went to find the nurse and ask her when the last time (R2) had dialysis, and the nurse did not even know my sister was supposed to be getting dialysis. I asked them to send her to the hospital which they did, and she was admitted, and she is still there. (R2) did not get one treatment of dialysis while she was there, and she was getting five treatments a week at the other facility. I was so confused and don't know how this could have happened. I know they told me (R2) was to never go more than 2-3 days without dialysis because her fluids would build up and toxics would build up and it could harm her. How did this happen? (R2) has two children, a 7 and a 9-year child. I don't know what we are going to do if something bad happened to her. I feel like she was supposed to get dialysis, how could they wait so long, and not make sure she got dialysis."<br><br>On 10/23/2025 at 1:23 PM, V5, Former Director of Nursing (DON) stated "when staff are receiving a new patient, we review the orders and have them put in the paperwork and leave everything in a black metal mailbox to review for later to make sure nothing was missed and/or overlooked. Typically, this is something the DON would do. I cannot say who is reviewing the paperwork now. I would look at the medication to make sure no medications are forgotten, and for example if they were on dialysis, I would make sure they have that set up already and notify transportation, so they do not miss any appointments. If a resident is coming from another facility and is already on dialysis, then we already know they are going to need dialysis and that should have already been set up before they even got into the facility. Then we make sure our driver knows when the appointments are so they can ensure they do not miss any of their appointments."<br><br>On 10/23/2025 at 1:37 PM, V13, Social Service Director | S9999 | | |

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| S9999 | Continued from page 6<br>(SSD) stated, “Normally if a resident is on dialysis that is something we would look at before admitting them and make sure all of that is set up before they arrive, so they do not miss any appointments. I am not sure what happened with (R2).”<br><br>On 10/23/2025 at 1:42 PM, V13 provided R2’s transfer paperwork which included her POS and Care Plan from the previous facility.<br><br>On 10/23/2025 at 1:46 PM, V3, Assistant Director of Nursing (ADON) stated, “When we get a new admit normally the DON would review the admitting nurse’s notes and ensure there are no errors. The communication papers are put in a mailbox and then the DON reviews them. Since the DON is no longer working here, me and V14, Registered Nurse (RN) review everything to make sure there are no errors. As far as (R2), I did call the dialysis provider. (R2) was getting dialysis five times a week at the other facility in house. We do not do dialysis in house and use several contractors. I did call the (V15, Contractor A). (V15) wanted a chest x-ray and blood work on (R2) before they would admit her. Then they need a chair and space for her. (R2) was not getting dialysis from the provider because we were waiting for approval from them before we could send her. I am not aware of any other plans in place for dialysis until we heard back from the dialysis contractor (V15).”<br><br>On 10/23/2025 at 4:30 PM, V4, Medical Doctor stated, “If a resident is coming from another nursing home facility and they are receiving dialysis, he would expect for coordination of care for the new nursing home to put things in place to assure dialysis services would be provided, with the least interruption possible, and for policy to be followed and coordinated. Any interruption from this schedule could have the potential for harm, and if the resident was having symptoms he would expect to be notified and would send them out to the hospital for missed appointments of over two days depending on labs. A resident missing dialysis and exhibiting symptoms would more than likely experience fluid overload, they usually will have SOB (shortness of breath), chest pain, other things and a lot of things. Usually fluid overload. Skipping dialysis can lead to fluid overload where the fluid builds up in the body leading to symptoms such as shortness of breath (SOB), swelling. This can result in emergency situations requiring hospitalization. It can lead to elevated potassium levels in the blood which can affect the heart and toxic buildups as the body is not able to remove waste products from the blood. If left untreated it can cause | S9999 | | |

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| S9999 | Continued from page 7<br>harm and possible death."<br><br>On 10/29/2025 at 9:22 AM, V21, Nephrologist (Kidney Specialist) stated, "It is critical that if a resident who is receiving dialysis and goes to another facility that dialysis is set up ahead of time and no treatments are missed. No treatments should be missed. ESRD (End stage renal disease) depends in dialysis. A resident may not even be having symptoms because a lot of these things are silent killers and can affect the heart and cause death. If a resident does not have dialysis set up, I would expect them to be sent the ER to get treatments until they are able to get treatments from the new facility. Any resident missing 10 treatments I would absolutely consider that neglect. This could cause serious harm and death the body is depending on the dialysis treatment."<br><br>On 10/28/2025 at 3:59 PM, V19, Transportation stated, "I had a referral out to (V15, Dialysis Center) regarding (R2) receiving dialysis. I had faxed them twice and had a referral out to them, but I guess they did not get it, so it did not go through. I guess my fax was not going through and I followed up with them on Friday and today was (R2's) first day of getting dialysis treatment. I tried to set something up when she was first admitted. (R2) is set up now and today was her first dialysis treatment since admission."<br><br>On 10/28/2025 at 4:11 PM, LPN V18, LPN stated, "I remember when (R2) was a new resident and she came from (Nursing Home B). I do not know anything about her needing dialysis when she first arrived. I know (R2) was sent out to the hospital. I was not told what to look for and or send her out if she had any of those symptoms from not having dialysis. I know when she just came back from the hospital, she is on dialysis now and it is all set up."<br><br>The Facility Abuse Prevention and Prohibition Program Policy undated documents, "To ensure that facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. 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. Staff must not permit anyone to engage in | S9999 | | |

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| S9999 | Continued from page 8<br>verbal, mental, sexual, or physical abuse, neglect, mistreatment. Or misappropriation of resident property. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems."<br><br>The Facility Change of Condition Policy undated documents, "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. The facility will inform the resident, consult with the resident'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: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the residents' physical, mental, or psychosocial status (i.e., 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., the use of any medical procedure, or therapy that has not been used on that resident before).A decision to transfer or discharge the resident from the facility."<br><br>B. R7's EMR (Electronic Medical Records) undated documents that the resident was admitted to the facility on 5/20/24.<br><br>R7's EMR dated 5/20/24 documents "Complete traumatic amputation of right great toe, subsequent encounter" | S9999 | | |

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| S9999 | Continued from page 9<br>and “Type 2 diabetes mellitus with foot ulcer.”<br><br>R7’s EMR dated 1/20/25 documents “anxiety disorder, unspecified.”<br><br>R7’s Care Plan dated 2/7/25 documents “Problem: (R7) has a behavior problem r/t descriptive accounts of occurrence involving her and/or others.”<br><br>R7’s Care Plan dated 10/21/25 documents “Problem: I have conflicts with other residents as evidenced by altercations verbally and being aggressive towards them verbally.”<br><br>R7’s MDS (Minimum Data Set) dated 8/18/25 documents a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS documents That the resident requires substantial/maximal assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident is dependent for sit to stand, chair/bed to chair transfer, and toilet transfer. The MDS documents that the resident has not exhibited any behaviors.<br><br>The facility’s “Serious Injury Incident and Communicable Disease Report” dated 9/16/25 documents “(R8) is a 75-year-old female who resides at (Facility) with a BIMS that is unable to be scored. Diagnosis included but are not limited to: Generalized Anxiety Disorder, Essential Primary Hypertension, Bipolar Disorder Unspecified. (R7) is a 63-year-old female who also resides at (Facility) with a BIMS of 13. Diagnosis include but are not limited to: Anxiety Disorder, Unspecified, Type II Diabetes, Essential (primary) Hypertension. On 9/16/2025 around 5:00 pm staff witnessed an alleged resident to resident interaction between (R7) and (R8). Both residents separated immediately and placed on enhanced supervision. MD (Medical Director), POA's (Power of Attorney), Administration and Ombudsman made aware. Both residents placed on 15-minute checks. Investigation initiated. Initial Interventions: 1) Residents were separated immediately and placed on 15-minute checks for 48 hours. 2) (R7) assessed for injuries, skin and pain assessment completed, no new findings. 3) Staff and resident interviews initiated. 4) In-service on abuse policy initiated. Investigation: (R8) denies making any contact with (R7). (R7) stated that (R8) hit her on the arm, but also states she "did not care, it did not hurt" Staff members were interviewed and stated that they heard the residents verbally arguing and that they were seated within proximity of each other. Other residents were interviewed that were present at the alleged incident, report no knowledge of any alleged | S9999 | | |

| 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 10/30/2025 |
|---|---|---|---|

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

| (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 |
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| S9999 | Continued from page 10<br>abuse and feel safe and wish to remain at (Facility). Conclusion: This allegation is unsubstantiated due to no physical evidence on residents skin assessments indicating that physical contact was made, no certain eyewitnesses saw contact made, and both residents deny wrongdoing. A verbal altercation occurred, both residents feel safe and did not feel threatened, it was more of a disagreement. Final Interventions: 1) 15-minute checks completed. No further incidents. 2) SSD (Social Services Designee) to follow up and ensure that residents remain feeling safe. 3) Behavior tracking updated. 4) Investigation completed. 5) In-service on behaviors/ abuse & neglect completed. 6) Final sent to IDPH (Illinois Department of Public Health)."<br><br>Facility's Serious Injury Incident and communicable Disease Report" dated 10/23/25 documents "(R8) is a 75-year-old female who resides at (Facility) with a BIMS that is unable to be scored. Diagnosis included but are not limited to: Generalized Anxiety Disorder, Essential Primary Hypertension, Bipolar Disorder Unspecified. (R7) is a 63-year-old female who also resides at (Facility) with a BIMS of 13. Diagnosis include but are not limited to: Anxiety Disorder, Unspecified, Type II Diabetes, Essential (primary) Hypertension. On 10/17/2025 around 5:00 pm staff witnessed an alleged resident to resident interaction between (R7) and (R8). Both residents separated immediately and placed on enhanced supervision. MD, POA's, Administration and Ombudsman made aware. Investigation initiated. Initial Interventions: 1) Residents separated immediately. 2) Both residents placed on enhanced monitoring. 3) Skin and pain assessment completed on (R7). 4) Investigation initiated. (R7) was allegedly speaking with another resident in the dining room when (R8) rolled up behind her to grab her hair and made contact with her back side. (R7) acknowledges feeling safe in the facility and wishes to remain at (Facility). (R8) states that she reacted after being called a derogatory name by (R7). (R8) suggested that (R7) was also blocking her from getting past. (R11) interviewed and states that she did witness (R7) rolling back to block (R8) but she did not hear any name calling. (R11) acknowledges feeling safe in the facility and wishes to remain at (Facility). Other residents that were present at the time of this alleged incident report seeing (R7) and (R8) interacting but feel safe in the facility and wish to remain at (Facility). (R7) had a small bruise noted on her back, noted on a skin check from 10/17. On 10/22 another skin check was completed and noted no bruising on (R7's) back. This investigation is unsubstantiated due to this being repeated behaviors that both | S9999 | | |

| 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 10/30/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **EVERCARE AT EDWARDSVILLE** | **401 ST MARY DRIVE , EDWARDSVILLE, Illinois, 62025** |

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| S9999 | Continued from page 11<br>resident's display. Neither resident was harmed in this alleged interaction, and both wish to remain at (Facility). Final Interventions: 1) Care plans reviewed and updated for both residents. 2) Staff in-serviced on facility abuse prevention and policy. 3) Psychosocial follow ups completed, no changes. Both residents wish to remain at (Facility). 4) Both residents' care plans reviewed and updated accordingly. 5) Final sent to IDPH. "<br><br>R7's Weekly Skin Assessment dated 10/18/25 documents "quarter size bruise noted to residents left upper back area bluish in color."<br><br>On 10/28/25 at 12:22 PM, R7 stated that she does not recall exactly what happened during the altercation in September, she just remembers that (R8) hit her. She stated that the week ago altercation, (R8) hit her twice and pulled her hair.<br><br>On 10/28/25 at 12:45 PM, R13 stated he witnessed (R8) hit (R7) in the stomach in September. He stated that (R7) did not hit her back and told him to get a CNA (Certified Nursing Aid).<br><br>On 10/28/25 at 12:59 PM, R12 stated that she witnessed (R8) hit (R7) in the dining room last week.<br><br>On 10/28/25 at 1:00pm, R10 stated she witnessed (R8) hit (R7) but she does not remember when and where.<br><br>Facility policy "Abuse Prevention and Prohibition Program" undated documents "To ensure that facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.<br><br>(A) | S9999 | | |