| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Complaint Investigation:<br><br>2542316/IL188368 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>300.610a)<br>300.1010e)<br>300.1210d)3)<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 300.1010 Medical Care Policies<br><br>e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

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:
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.

These Requirements were not met as evidenced by:

Based on interview, observation and record review the facility failed to ensure timely assesment for continuity of care for 1 of 3 residents (R1) reviewed for continuity of care in the sample of 3. This failure resulted in R1 with known epilepsy with seiziures, not receiving anti seizure medications for 4 days and being sent out for emergency treatment and had a seizure.

Findings include:

R1's Facesheet undated documents an admission date of 11/12/2024 and pertinent medical diagnoses of Epilepsy, unspecified., not intractable without status Epilepticus, Localization-related (Focal) (Partial) Symptomatic Epilepsy and Epileptic Syndromes with Complex Partial Seizures, Not Intractable Without Status Epilepticus, Major Depressive Disorder, Single Episode, Unspecified and Unspecified. Unspecified Atrial Fibrillation.

R1's Physician Order Summary (POS) dated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

March 2025 documents R1's pertinent medications as Lacosamide 100 milligrams (mg) twice a day (Epilepsy), Fluoxetine 10 milligrams (mg) daily (Major Depressive Disorder), Metoprolol 1 tablet every 12 hours (Primary Hypertension) Amlodipine 10 milligrams (mg) (Unspecified Atrial Fibrillation), Levetiracetam 1000 milligrams (mg) twice a day all with a Start Date of 1/22/25 and Hold date from 3/14/25 to 3/17/25, Tradjenta 5 milligrams (mg) (Type 2 Diabetes Mellitus) 1 tablet daily Start Date of 2/5/25 and Hold date from 3/14/25 to 3/17/25.

R1's Electronic Medication Administration Record (eMAR) dated March 2025 documents R1's 8:00 PM medications were held on 3/14/25, 3/15/25 and 3/16/25 for both 8:00 AM & 8:00 PM doses. The 8:00 AM dose on 3/17/25 was held.

On 3/12/25 at 9:51 PM Nurse's Progress notes documents R1 was requesting her new pill. V17 Licensed Practical Nurse documents that R1 was overheard talking to her daughter (V5) about the new pill that she takes 3 times /day and then question as to if the daughter will bring it to her. V17 Licensed Practical Nurse documents that without an order for medication the medication could not be administered.

On 3/14/25 at 1:51 PM Nurse's Progress notes documents (V4) Social Service Director addressed the daughter in regards to her giving resident medication while she is on a Leave of Absence (LOA) with her. (V5) daughter was stated that she hasn't given resident any medications , but she did display a bottle of Antibiotics that was suppose to be given from a local pharmacy. The directions for administration were 1 tablet twice a day and there was a total of 10 pills given, but she (R1) only had 4 pills left.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 3<br>(V5) repeatedly stated that she had not given resident (R1) any medications.<br><br>On 3/14/2025 an email from V7 Nurse Practitioner to V2, Diretor of Nursing, documented an order to hold the medication of R1 due to a report from facility nursing staff that it was a possibility that R1 was being double or tripled dose by V5, her daughter.<br><br>On 3/20/25 at 9:37 AM V16 Licensed Practical Nurse ( LPN) stated she was the one that was passing medications to R1 when she requested "her new pill". As she (V16) was explaining to her that she did not have a new pill. R1 kept repeating that she had a new pill. R1 called her daughter (V5) and the conversation between the two of them was (R1) telling (V5) her daughter that she was not being given the new pill. (V5) R1's daughter came to the facility with a bottle of medicine and wanted it to be given to her mother. (V5) was advised that we could not give the medicine and we would need to obtain an order for the medication.<br><br>On 3/20/25 at 11:31 AM V17 Nurse Practitioner stated she was on vacation for 2 weeks and V7 Psychiatric Nurse Practitioner (NP) was covering for her. V17 stated she was aware that (R1) was being followed by specialists but do not have any interactions with the specialists. V17 stated she was unaware of the labs ordered by the nephrologist. When she returned from vacation she did have an email from V7 advising that there was a possibility that R1 was receiving double dosages of a medicine thought to be an antibiotic. The move to hold the medication was based on not having any information as to why R1 was on any medication besides what was prescribed. V17 stated the expectation was for the specialist | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

to contact us if they have any concerns. If she had any concerns she would contact them.

On 3/20/25 at 11:43 AM V7 Psychiatric Nurse Practitioner stated she was not the regular provider for (R1). The nurse practitioner (V17) was on vacation and she (V7) was just covering for (V17). V7 stated she went with the information that was provided from the staff. The staff assumed (R1) was receiving double or triple doses of some type of medication. She (V7) did not know what the medication was and the staff did not specify the medication because they did not know. What was reported was (V5) the daughter was providing the medication to her mother (R1).

On 3/20/25 at 12:25 V4 Social Service Director stated when (V5) daughter of R1 returned her mother (R1) to the facility she (V5) did not bring the medication or share that her mother was on a prescribed medication. We became aware of some medication only after the mother (R1) began asking about her new pill.

On 3/20/25 at 4:20 PM V2 Director of Nursing stated we did what we were supposed to do. The staff continued to give prescribed medication until able to contact a provider. The order was via email dated 3/14/25 to Hold medications and to monitor (R1). Staff continued to monitor R1 until she was sent to the emergency room 3/17/25.

R1's medical records from a local hospital dated 3/17/25 documents residents seizure medications were stopped few days ago per the order of nursing home staff after they had negative interactions with (V5) patient's daughter . While in Triage patient had a tonic seizure lasting less

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007496 | A. BUILDING: _____ B. WING _____ | C 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERCARE OF COLLINSVILLE | 614 NORTH SUMMIT COLLINSVILLE, IL 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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 5<br>than 1 minute. Patient was postictal and had a nasal trumpet inserted.<br><br>On 3/21/25 at 10:26 AM V22 Medical Director stated the Nurse Practitioner's should be having contact with the specialist.<br><br>On 3/21/25 at 2:30 PM V26 pharmacist stated the nurse practitioner dropped the ball, the nurse practitioner should have reviewed the medication before 3 days. It is definitely concerning because Lacosamide has a half-life of 13 hrs and Keppra has a half life of 6-8 hrs. Those meds are significant, while overdosing might be a concern, review of the medication and further assessment was warranted. Do not feel the facility was at fault, the problem lies with the nurse practitioner as a provider not reviewing or assessing the resident sooner.<br><br>The facility did not have a policy on Continuity of Care.<br>(B) | S9999 | | |