

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054908		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2025	
NAME OF PROVIDER OR SUPPLIER EVERCARE AT UNIVERSITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1095 UNIVERSITY 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	
S0000	Initial Comments		S0000				
	Facility Reported Incident of 10-6-25/ 2641670						
S9999	Final Observations		S9999				
	Statement of Licensure violations:						
	300.610a)						
	300.1210b)						
	300.1210d)4)						
	300.3210t)						
	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 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. : Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview, observation, and record review, the Facility failed to ensure residents were protected from sexual abuse and failed to follow its abuse policy for preventing, reporting, and investigating allegations of abuse for 1 of 3 residents (R2) reviewed for abuse in a sample of 6. This failure resulted in R2 being sexually abused by R3 on 10/5/25 and again on 10/6/25. On 10/5/25 at approximately 5:30 PM, V7, Certified Nursing Assistant (CNA), witnessed R3 sexually abusing R2; however, the Facility did not report or investigate the allegation, and no protective measures were implemented to ensure R2's safety. On 10/6/25 at approximately 9:00 AM, R3 entered R2's room without staff supervision and sexually abused R2 again. The Facility did not provide adequate supervision or timely intervention following the initial allegation, resulting in continued exposure to harm for R2. 1-R2's Face Sheet documents R2 was admitted to the Facility on 8/21/25 with diagnoses including frontal lobe and executive function deficit following cerebral infarction and unspecified psychosis. R2's Minimum Data Set (MDS) dated 10/15/25 documented R2 was severely cognitively impaired, dependent with mobility and ambulated by wheelchair. R2's Care Plan does not address risk of abuse and neglect. On 10/16/25 at 1:30 PM, R2 was sleeping in bed in her room on a specialty mattress with a fall mat to the right side of her bed. R2 did not respond to verbal	S9999					

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S9999	Continued from page 2 stimuli. 2-R3's Face Sheet documents R3 was admitted to the Facility on 9/17/25 with diagnoses including cerebral infarction, major depressive disorder, and generalized anxiety disorder. R3's MDS dated 9/24/25 documented R3 was cognitively intact and ambulated via wheelchair. R3's Care Plan initiated 9/29/25 documents R3 has a history of inappropriate contact with peers and staff. The Care Plan does not address any interventions for these behaviors until 10/6/25. On 10/16/25 at 1:30 PM, R2 was sleeping in bed in her room on a specialty mattress with a fall mat to the right side of her bed. R2 did not respond when spoken to. On 10/15/25 at 11:41 AM, V6, Certified Nursing Assistant (CNA), stated she was doing rounds on the hall and noticed R3 was in R2's room and was trying to get in bed with R2. R2 is non-verbal and cannot consent to sexual relations On 10/15/25 at 2:10 PM, V7, CNA, stated on 10/5/25 around 5:30 or 6:00 PM, R2 was sitting in her reclining wheelchair in the dining room with her legs in the air. R3 was in his wheelchair sitting next to and facing toward R2 moving his arm back and forth repeatedly V7 walked closer and saw R2's lower buttocks exposed with R3's hand in her diaper. R3 stated he was checking her diaper. V7 told R3 to stop and moved him away from R2, then asked V18, Licensed Practical Nurse (LPN), and V19, LPN, for help. V19 told R3 to go to his room, and V7 took R2 to her room. R2's incontinent brief fell off when staff were transferring her to her bed because the fasteners on the briefs were torn apart. R2 was agitated and resistive when staff were trying to clean her. V18 never came down to the room to check on R2, and when V7 was finished providing care, she was told V18 left the Facility. V7 then told V20, LPN, who notified V1, Administrator. V7 stated R2 is non-verbal and not able to communicate or consent, and this was a sexual assault. If someone had done something about this, the incident the following day would never have happened. On 10/16/25 at 9:43 AM, V18 stated on 10/5/25 V7 reported R3's hand came out from under R2's blanket. V18 watched the Facility cameras with V19, LPN, and did not see anything happen.	S9999					

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S9999	Continued from page 3 On 10/16/25 at 9:51 AM, V19, LPN, stated V7 told her R3 had his hand under R2's blanket in the dining room. V19 reviewed the camera with V18 and did not see anything happen. V19 stated they contacted V1 about this. On 10/16/25 at 11:09 AM, V1 stated she was notified about V7's allegation on 10/5/25. She watched the video surveillance and did not see anything, so she did not investigate it further. Unfortunately, something happened the following day. but V7 was determined it happened. V1 had no idea why V7 would say that, but unfortunately, something happened the next day. V1 stated the original videos have been deleted, but did have one saved video from her phone for surveyors to review. R3's Progress Note by V2 dated 10/6/25 at 9:00 AM documents, "Resident was found in another resident's room. Resident was removed from female resident's room and moved to another hallway." R3's Psychiatry Note by V24, Nurse Practitioner (NP) note dated 10/9/25 documents, "Per staff patient entered into female peer room, got into her bed remove(d) her (incontinent brief) and put shaving cream on her. Admits to going into peer room states he wanted to have sex." On 10/15/25 at 11:41 AM, V6, CNA, stated she was doing rounds on the hall and noticed R3 was in R2's room and was trying to get in bed with R2. On 10/17/25 at 11:09 AM, the Facility video footage was reviewed with the following noted: The video was dated 10/5/25 and was time stamped with footage from 5:59 PM to 6:03 PM. The video showed R2 sitting in her chair on the far lower left corner of the screen. R2's legs were not in full view the entire time. R2 was moving around and moving her legs up and down. R2 was wearing dark colored pants and a blanket. The blanket was covering R2's left leg, and the lower right leg of R2's pants was pushed up due to movement. R2 had wiggled her way around in the chair, and some of her incontinent brief was exposed on the right side. The video did not fully capture R3 in the frame, and the times did not encompass the entire time frame reported by V7. On 10/16/25 at 11:42 AM, V25, Wound Nurse/LPN, stated he was asked to fill out involuntary hospital paperwork R3 on 10/6/25 for inappropriate behavior. V25 stated he was told R3 was putting shaving cream on R2's buttock and needed to be sent out to the hospital.		S9999				

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S9999	Continued from page 4 On 10/16/25 at 2:07 PM, V26, Psychiatrist, stated staff told him R3 was being sexually inappropriate, getting into another residents bed and smearing feces in the Facility, so he ordered to have him sent to the hospital. V26 reviewed R3's Progress Note and stated R3 entered in another resident's room, removed her incontinent brief, put shaving cream on her, and said he wanted to have sex. On 10/16/25 at 2:45 PM, V2, Director of Nursing (DON), stated R3 was trying to get into R2's bed. V2 called V26 who wanted R3 to be sent to the hospital for a medical evaluation. Apparently R3 put his hands on R2 on 10/5/25. That is all V2 knew because V1 handles the abuse allegations. V7 was very upset and calling everyone. We told staff to report all allegations to V1 and not discuss with anyone else. R3 was discharged to a men's unit. We felt more comfortable that way. On 10/16/25 at 2:54 PM, V20 stated when she arrived at work she was informed by V7 that R3 was observed with his hands in R2's incontinent brief. V20 was told V1 had not been notified, so she notified V1 who stated she would take care of it. V20 stated R3 was not placed on any enhanced supervision and was able to move about the facility independently. V20 stated the staff often place R2 in her reclining wheelchair at the nurse's station. V20 stated R3 would propel himself in the hallway, and when he got near R2 he would slow down and look at her. On 10/16/25 at 2:57 PM, V24 stated staff reported R3 went into R2's room, pulled down her (incontinent brief), took his pants down and put shaving cream on her. We had him sent out to the hospital. V24 would expect the facility to keep residents free from abuse. Residents need to be in a safe environment. R3 admitted to V24 that he wanted to have sex. V24 stated that is not ok for him, and she let him know that. R2 is non-verbal and not very engaged or conversational, and V24 does not think she has the ability to consent. There is always potential for psychosocial harm with sexual abuse because that is a violation of personal space and overall safety. On 10/16/25 at 3:14 PM, V1, Administrator, stated on 10/6/25 V6 was rounding and saw R3 in R2's room. Someone said R3 had shaving cream in there. When V1 went to R2's room, R2 was lying in bed on her left side curled up in a ball. She was not wearing a brief because she was in bed and sometimes staff just put the incontinent pad underneath them. Due to fact R3 attempted, we contacted V26 who ordered him to go to the hospital. We wanted to find a (different) Facility		S9999				

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S9999	Continued from page 5 for R3, because usually if they do it once they are going to do it again. Allegations of abuse should be reported immediately and residents should be separated to make sure they are safe. She did not report the allegation on 10/5/25 to law enforcement or the Department. She stated it just did not cross her mind because nothing happened. On 10/17/25 at 8:30 AM, V6 stated when she found R3 in R2's room, he was not in the bed with her but looked like he was going to get in the bed his with her. R3's pants were pulled down and he had shaving cream on his hands. R2 was wearing a brief and gown, but her blanket was pulled back. V6 notified V2. On 10/17/25 at 9:17 AM, V27, R2's Family, stated R2 is not able to make her own decisions and does not communicate. On 10/17/25 at 9:26 AM, V28, R2's Family, stated R2 is not alert, oriented, or able to make her own decisions. R2 does not communicate. R2's Face Sheet documents R2 was admitted to the Facility on 8/21/25 with diagnoses including frontal lobe and executive function deficit following cerebral infarction and unspecified psychosis. R2's Minimum Data Set (MDS) dated 10/15/25 documented R2 was severely cognitively impaired, dependent with mobility and ambulated by wheelchair. R2's Care Plan does not address risk of abuse and neglect. R3's Face Sheet documents R3 was admitted to the Facility on 9/17/25 with diagnoses including cerebral infarction, major depressive disorder, and generalized anxiety disorder. R3's MDS dated 9/24/25 documented R3 was cognitively intact and ambulated via wheelchair. R3's Care Plan initiated 9/29/25 documents R3 has a history of inappropriate contact with peers and staff. R3's Progress Note by V2 dated 10/6/25 at 9:00 AM documents, "Resident was found in another resident's room. Resident was removed from female resident's room		S9999				

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S9999	Continued from page 6 and moved to another hallway." R3's Psychiatry Note by V24, Nurse Practitioner (NP) note dated 10/9/25 documents, "Per staff patient entered into female peer room, got into her bed remove(d) her (incontinent brief) and put shaving cream on her. Admits to going into peer room states he wanted to have sex. Local Police Report printed 10/16/25 documents on 10/6/25 at 10:56 AM, dispatch forwarded an anonymous caller regarding an alleged rape occurring today at (Facility). The caller stated multiple incidents were happening at the facility, but the administrators were not reporting them to the police. The caller stated a resident staying at the facility was sexually assaulting another individual by the name of (R2) but did not know the suspect's name. The caller stated the facility administrators were not doing anything about the incidents. V1 had been made aware of the alleged occurrence and stated than an incident had occurred. V1 showed surveillance video which showed R3 moving his wheelchair down the hallway and entering R2's room at 8:59 AM on 10/6/25. V7 was seen entering R2's room and calling for V18. At 9:04 AM on 10/6/25, R3 was seen wheeling himself out of the room. V18 stated V7 entered the room to find R3 out of his chair and lying in bed with R2. V18 said R3 had shaving cream on R2's right butt check and heard him say, "You stopped me before I started." V18 said R2 was found lying on her left side, facing the facility wall, and had shaving cream on her right butt cheek. The Facility's Abuse Prevention and Prohibition Program Reviewed 6/1/25 documents "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 verbal, mental, sexual, or physical abuse., neglect, mistreatment." "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." "The Administrator is responsible for coordinating and implementing the facility abuse prevention policies, procedures, training programs, and systems." "The			S9999			

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S9999	Continued from page 7 Facility promptly and thoroughly investigates reports or resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts." A		S9999				