

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Evervella of White Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 620 West Bridgeport White Hall, IL 62092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain secure medical records for 1 of 4 (R11) reviewed for privacy / confidentiality of records in the sample of 13. Findings include: R11's Face Sheet, print date of 11/20/25, documents R11 was admitted on [DATE] with diagnosis of Dementia. R11's Minimum Data Set, dated [DATE], documents R11 is severely cognitively impaired. R11's Nurses Note, dated 11/16/25, documents R11 passed away under hospice care. On 11/20/25 at 8:10 AM, V33, Licensed Practical Nurse, (LPN), stated I was present when V34 LPN was upset because the narcotic count sheet for R11 was wrong. V34 went through and figured out that it was a math error not an actual drug divergence. V34 took it to V2, Director of Nurses, and wanted him to fix it. V34 was upset because V2 wouldn't fix it immediately. V2 told her he had to do an investigation into it. V34 told me she took a photo on her phone of the narcotic count sheet, a printed copy of the Medication Administration Record (MAR), and a printed copy of the narcotic count sheet. I did not see her leave the building with them, but I did here the printer going off to print the records. On 11/20/25 at 8:14 AM, V34 LPN, stated R11's morphine narcotic count sheet was off. I brought it up to V2. He wanted me to reach out to the nurse that worked prior to me. I called that nurse and told her she needed to come in and fix her mistake. She had made a math error. The amount of morphine in the bottle was correct it was just the narcotic count sheet was off. V2 told me I needed to write a statement for his investigation that he was doing. I took a photo of the narcotic count sheet on my phone. I wanted it to help me write my statement, so I had all the details. This happened on a Friday, and I told V2 I would bring my statement in on Monday. When I got home, I wrote my statement and then I deleted the photo on my phone. The photo did not have R11's name on it. I did not make any paper copies of R11's record and take them home. On 11/20/25 at 8:34 AM, V1, Administrator, stated she is unable to provide the complete investigation because it is in storage since the facility has new owners. When the new owners came in everything previously was boxed up and hauled away. The previous owners tell me they can locate the record and mail a copy to me. On 11/20/25 at 8:34 AM, V2, Administrator, stated staff should not be taking photos of residents' medical record on their phone or copies of the medical record and taking the record home. On 11/20/25 at 11:00 AM, V38, Director of Clinical Operations, stated no employee should take a picture of medical records on their personal phone. The Final Report - Potential HIPAA (Health Insurance Portability and Accountability), dated 9/29/25, documents, On 9/23/25, (V33) reported to (V2) that on 9/12/25 (v34) was observed to make a phot copy of resident (R11's) narcotic sheet and that (V34) stated, I am going to make a copy of the narc (narcotic) count sheet for that patient and keep it for my records. (V33) reported she also observed her printing and making a copy of the MAR and that (V34) stated to (V33), I am saving that too in case I need proof. It continues, (V34) was notified on 9/23/25 to bring any medical records back to the facility that was allegedly taken. (V34) was interviewed on 9/23/25 and reported that she did not take any paper copies of records from the facility but only took a photo and that no information including residents name was on the photo or was exposed. It continues, At this time we do not believe there was a violation of HIPAA as (V34) stated there was no patient information on the photo, information was not exposed, and the photo was deleted immediately. The policy Workforce Training - (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Privacy & Security Of Protected Health Information, undated, documents, Policy: All employees will receive appropriate training, regarding the policies and procedures for ensuring the secure and confidential receipt, transmission, storage, use and / or disclosure of protected health information.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist 1 of 4 residents (R3) reviewed for feeding assistance in the sample of 13. Findings include: R3's Face Sheet, print date of 11/20/25, documents R3 was admitted on [DATE] with diagnoses of Parkinson's Disease with Dyskinesia and Major Depressive Disorder with severe psychotic symptoms. R3's Minimum Data Set, dated [DATE], documents R3 has moderate cognitive impairment, requires set up clean up assistance for dining, requires supervision touch assist for toileting, partial to moderate assist with hygiene, sitting to standing position change, toilet transfer, and is occasionally incontinent of urine. On 11/16/25 at 7:34 AM R3 is sitting in the dining room. R3 has a plate of scrambled eggs, a muffin, a bowl of fruit loops, both juice and water, a Coke can, and both white and chocolate milk. R3 is attempting to grab and use her spoon. R3 is unable to manipulate the spoon. R3's left arm and hand are extremely shaky. At 7:42 AM, R3's plate is pushed aside. The plate remains untouched. At 7:48 AM, V6, Registered Nurse, asked R3, why are you not eating? R3 stated, I can't get my silverware. V6 put R3's spoon in the cereal bowl. At 7:55 AM R3's food remains untouched. R3 is sitting fidgeting with the Coke can and her water glass. She is not drinking either just touching them attempting to grab them. At 7:57 AM, V7, Human Resource / Certified Nurse Assistant, asked R3 to eat and could she get her something else. V7 asked if R3 would like a banana and V7 walked away. V7 returned with a banana, cut it in half and put it on R3's plate. At this time, R3 is holding the spoon that is in the cereal bowl attempting to utilize the spoon. R3 is holding the spoon straight up and down in the bowl and unable to scoop up the cereal. V7 walks away without helping R3. At 8:09 AM R3 is holding the spoon straight up and down in the cereal bowl. R3's plate remains untouched. R3 has not been able to get a bite of cereal. At 8:13 AM R3 grabs the banana half, R3 leans over her plate, R3 pushes the banana against the plate, and R3 manages to take 2 bites of the banana. At 8:21 AM R3 has a portion of the muffin in her hand and takes one bite. At 8:24 AM, V1, Administrator, encourages R3 to eat, but offers no physical assist. At 8:25 AM, V6 sits with R3 and offers physical assistance for R3 to eat the cereal. On 11/20/25 at 8:34 AM, V1, Administrator, stated if someone needs assistance with eating staff should assist them. On 11/20/25 at 8:36 AM, V6, stated if someone is struggling to eat staff needs to assist the resident. The policy Activities of Daily Living (ADL) Supporting, dated 7/15/25, documents, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance: d. dining (meals and snacks).		