

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 08/28/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate and provide progressive interventions to prevent falls for one of 10 residents (R34) reviewed for accidents and supervision in the sample of 62. These failures resulted in R34 sustaining a laceration to the face requiring 5 sutures. Findings include: R34's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, dementia, muscle weakness, difficulty in walking, and need for assistance with personal care. R34's MDS dated [DATE] documented she was rarely/never understood, had a memory problem and her cognitive skills for daily decision-making regarding tasks of daily life were severely impaired. R34's Fall Risk assessment dated [DATE] and 6/12/25 documented she was a high fall risk and to implement high fall risk fall prevention interventions. R34's current Care plan requested and provided by the facility documented she had an actual fall with no injury initiated 11/22/24 with interventions as follow: on 4/23/25 R34 had a fall with minor injury on 4/23/25 and for staff to redirect her from ambulating through crowded space; intervention on 5/19/25 documented she had an actual fall with minor injury and for staff to assist her out of dining room chair after dinner and assist with toileting as tolerated. Care plan initiated on 7/9/25 (24 days after her 6/15/25 fall) documented R34 is a high fall risk related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. Interventions for this care plan were initiated on 7/9/25 to anticipate and meet her needs, ensure proper footwear, and for physical therapy to evaluate and treat as ordered or as needed. R34's Progress note dated 6/15/25 at 2:31 AM, documented, Writer was informed by staff that R34 was on the floor and was bleeding from her head. Writer observed R34 at a 90-degree angle on the floor. Writer observed wound to be actively bleeding, unable to assess the size. Pressure applied. R34 assessed for any additional injuries. R34 noted to have bruising to the back of her right hand. R34's Progress note dated 6/15/25 at 6:35 AM, documented, writer spoke with local ER (emergency room) nurse and was informed that R34 received 5 sutures to her laceration, XR (x-ray) was performed of her right hand and no fx (fracture) has been found: DX (diagnosed) as a contusion. R34 will be returning to the facility via EMS (emergency medical services) per local ER nurse. On 8/27/25 at 9:15 AM, in a joint interview with V12 (LPN) and V26 (CNA), V26 looked up R34's electronic chart and stated R34 was moved closer to the nurse's station but not sure of what other measures are put in place. V26 stated she finds out details on concerns for the residents from the (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 0689 Level of Harm - Actual harm Residents Affected - Few	night shift before starting her shift but could not state who was at a high risk for falls or specific intervention/measures put in place for R34's fall prevention besides moving her closer to the nurse's station. On 8/28/25 at 10:10 AM, V38 (Physical Therapy) stated the last time R34 was evaluated was on 1/7/25. On 8/27/25 at 1:25 PM in a joint interview with V1 (Administrator), V2 DON (Director of Nursing), and V30 (Regional Nurse), V30 stated all residents have a right to fall. V2 stated they have an admission process for fall assessments and fall interventions to be put in place following. The facility's Interdisciplinary Fall Reduction/Injury Prevention Protocol dated 1/2025, documented the intent is an interdisciplinary approach at reducing falls, preventing injury, and increasing safety awareness ultimately resulting in improved quality of care for our residents. The policy continued to document recommendations included nursing to complete a fall risk evaluation up admission, re-admission, quarterly and with significant change. the total score places the resident at risk, determine appropriate interventions. Once selected, implement the interventions and then add to the resident's plan of care and resident Kardex. Consider an icon system for facilities with high fall percentage. Note that this type of system will need close monitoring and need a process owner. Examples, Falling Star and Falling Leaf programs. The policy further documented the environmental checklist to be reviewed monthly on facility round with executive director, maintenance, housekeeping.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on Interview, Observation, and Record Review, the facility failed to dispose of expired medications, properly label medications, and to keep food items out of the medication refrigerator reviewed for medication storage and labeling in the sample of 62. This failure had the potential to affect all residents in the facility. The Findings Include: 1. On 8/26/25 at 2:45 PM, the Rehab Medication Room was assessed with the following findings: Tuberculin (TB) Vial 1 ML (milliliter) had a sticker on the box for when it was opened on 7/15/25, the sticker documents Do Not Use 30 days past above date. Vitamin B-12 100 MCG (micrograms), 100-tab bottle expired on 7/2025. Docusate 100 MG (milligram), 1000-tab bottle expired on 7/2025. On 8/26/25 at 3:05 PM, V25, Registered Nurse (RN)/Nurse Manager/Infection Preventionist (IP), stated The TB vial in the Rehab Med Room is used mainly for all the residents. The TB stored in the med room up front, is used for all of the residents and the staff. On 8/27/25 at 1:00PM, V2, Director of Nursing (DON), stated I would expect the nurses to properly date all medications when opened, to discard any expired medication, to properly label each medication, and to keep food items out of the medication refrigerator. 2. On 08/26/2025 at 2:57 PM, the east west medication room was observed with V7, Licensed Practical Nurse. There was a bottle of Med Pass in the medication refrigerator. There was an undated tubersol vial. On 08/26/2025 at 3:00 PM, V7 stated I am not sure, but I think it was just opened yesterday to give a resident a TB test. I didn't know there was a bottle of Med Pass in there. 3. On 08/25/2025 at 2:00 PM medication cart on East Hall contained an oral inhaler with no label, and not in box. The inhaler had the last name of R9 written on the inhaler. R9's Physician Order (PO) dated 8/2025 documents Trellegy Ellipta (Fluticasone-Umeclidinium-vilanterol AEPB 100-62.5-25mcg inhalation i puff daily for Chronic obstructive pulmonary disease. 4. 08/25/2025 2:17 PM medication cart on rehab unit contained a lispro insulin, unlabeled and sticker on pen documented date of expiration 7/17/2025. V3, Licensed Practical Nurse (LPN) stated I don't know who it belongs to it is expired I will just get rid of it. On 8/28/2025 V32, Registered Nurse (RN) stated she had ordered a new inhaler for R9. The Facility's Medication Storage Policy, dated 11/2010, documents in part 9. Medications in the refrigerator are kept in closed, labeled containers or compartments. Internal and external medications within the refrigerator must also be separated. All of these medications must be separate physically from juices, applesauce, yogurts, shakes, and other foods for medication administration that are kept in this refrigerator. 12. The following medications must be removed from stock and disposed of properly on a continuing basis: outdated, contaminated, recalled, deteriorated, unlabeled medications, or those with soiled or broken/cracked containers. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Medication Labels Policy, dated 1/2015, documents in part Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy or consultant pharmacist can modify or change prescription labels. 1. Each prescription medication label includes: a. Resident's name; b. Specific directions for use, including route of administration; c. Brand or generic drug product name; d. Medication strength; e. Volume of dose needed to achieve dose strength.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to perform hand hygiene, wear gloves, and wear Personal Protective Equipment for 4 of 20 residents (R2, R50, R61, R104) reviewed for infection control in the sample of 62. Findings include: 1. On 8/26/25 at 9:06 AM V29, Certified Nurse Aide, (CNA) and V28 CNA entered R50's room to transfer R50 to bed and check for incontinence. V28 did the incontinent care correctly but during the incontinence care, V28 changed gloves twice without hand hygiene in between. On 8/27/25 at 3:20 PM, V2, Director of Nurses, stated hands should be washed between glove changes. R50's admission Record, print date of 8/27/25, documents R50 was admitted on [DATE] and has a diagnosis of Dementia. 2. On 8/25/205 at 11:45 AM during lunch V4, CNA removed chocolate chip cookie from bag with bare hands and placed on table beside R104's plate. V4 did not sanitize hands prior to handling food or wear gloves. R104's face sheet documents R104 was admitted to the facility on [DATE]. 3. R2's admission Record, dated 8/27/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Type 2 DM, Chronic Kidney Disease, Neuromuscular dysfunction of bladder, Anemia, Diabetic foot ulcer, Osteomyelitis right ankle and foot, Bacteremia, Methicillin Resistant Staphylococcus Aureus (MRSA). R2's MDS, dated [DATE], documents R2 is cognitively intact. On 8/26/25 at 11:20 AM, V18, Registered Nurse/Wound Nurse, did wound care to R2's right heel and right top of foot. There was an Enhanced Barrier Precaution (EBP) sign with Personal Protective Equipment (PPE) available on door. V18 did not don on a gown, just donned gloves, and provide wound care to R2's heel. No other EBP PPE was used. On 8/27/25 at 2:00 PM, V30, RNC, stated Any resident getting wound care should be on Enhanced Barrier Precautions and staff should be wearing appropriate PPE while caring for that resident. This includes peri-care while they have a wound to their backside. 4. R61's admission Record, dated 8/27/25, documents R61 was admitted to the facility on [DATE] with diagnosis of Cerebral infarction, Hemiplegia, Hemiparesis, Aphasia, Acute Kidney Failure, Type 2 Diabetes mellitus (DM), Atrial Fibrillation, Anemia, and Obesity. R61's MDS, dated [DATE], documents R61 has a severe cognitive impairment and requires substantial/maximal assistance for toileting, and transfers. R61 is occasionally incontinent of both bowel and bladder. On 8/25/25 at 9:42 AM, R61 was seen lying in bed, stated she has a sore on her butt and gets dressing changed. R61 stated the staff never put on gowns when they take care of her. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/25 at 11:05 AM, V18, RN/Wound Nurse, provided wound care to R61's right buttock which included cleaning with a wound cleanser, then applying skin prep to the site and leaving it open to air. There was no EBP sign or PPE available at the door. V18 washed hands and donned gloves with no gown or other PPE on, then provided wound care to R61's pressure wound to her buttock. The Facility's EBP sign posted documents Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing Linens, providing Hygiene, changing briefs or assisting with toileting, device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. The Facility's Enhanced Barrier Precautions Policy, dated 4/2024, documents 2. Enhanced Barrier Precautions only require use of gown/gloves when performing high contact resident activities: a) Dressing; b) Bathing/showering; c) Transferring (in room, shower/tub rooms, and therapy gyms); d) AM/PM care; e) Changing linens; f) Changing briefs or assisting with toileting; g) Device care or use: central line, urinary catheter, feeding tube, tracheostomy, or ventilator; h) Wound care: any skin opening requiring a dressing. 3. Duration: Enhanced Barrier Precautions are intended to remain in effect for the duration of the resident stay or until the wound is closed/medical device removed. Equipment: 1. Door sign that reads Enhanced Barrier Precautions or Visitors Must See Nurse Before Entering. 2. Supply of gowns, gloves, and plastic bags.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the failed review a urinalysis, complete a McGreer evaluation before notifying the doctor and starting antibiotics for 4 of 9 residents (R5, R14, R57, R61) reviewed for antibiotic stewardship in the sample of 62. Findings include: 1. R57's admission record, print date of 8/27/25, documents R67 was admitted on [DATE] and has diagnoses of Dementia and a history of a stroke. R57's Nurses Note, dated 8/3/25, documents, Received UA (urinalysis) results, sent to (V37, Medical Director), awaiting culture. Received order for Augmentin 875mg (milligram) BID (twice a day) for 7 days. Orders put in. POA (Power of Attorney) notified. R57's Urinalysis with culture if indicated, resulted date of 8/4/25, document, Organism: (GNR) Gram Negative Rod, no sensitivity will be done. Growth: <10,000 cfu (colony forming unit)/ml (milliliter). R57's Medication Administration Record, August 2025, documents R57 received 16 doses of Amoxicillin-Pot Clavulanate Tablet 875-125 MG from 8/3/25 through 8/11/25. On 08/27/2025 at 12:12 PM, V25, Registered Nurse / Infection Preventionist stated it appears that no one reviewed R57's urine culture and notified the doctor. She should have been taken off the antibiotic. R57's McGreer evaluation, dated 8/3/25, and documents UTI (urinary tract infection) criteria not met. The policy Surveillance for Healthcare Associated Infections, dated 9/19/25, fails to document an antibiotic and culture review. 2. R14's admission Record, print date of 8/27/25, documents R14 was admitted on [DATE] and has a diagnosis of Chronic Kidney Disease. R14's Urine Culture, dated 8/11/25, documents, Results; Mixed genital flora isolated. These superficial bacteria are no indicative of a urinary infection. No further organism identification is warranted on this specimen. R14's Physician Order start date of 8/12/25, documents, Cefuroxime Axetil Oral Tablet 250 mg give 1 tablet by mouth two times a day. R14's August 2025 Medication Administration Record documents R14 received 14 doses of Cefuroxime from 8/12/25 - 8/19/25. R14's McGreer evaluation, undated, and documents UTI criteria not met. On 8/28/25 at 9:00 AM, V25 stated the doctor should have been notified and the antibiotic stopped. 3. R5's admission Record, print date of 8/27/25, documents R5 was admitted on [DATE] and has a diagnosis of Dementia. R5's Urine Culture, result date of 8/4/25 documents Organisms: Providencia Stuartii Growth: >100,000cfu/ml. R5's McGreer Evaluation, undated, and it documents UTI criteria not met. 4. R61's admission Record, print date of 8/27/25, documents R61 was admitted [NAME] 5/19/23 and has a diagnosis of a history of a stroke. R61's Nurse Note, dated 8/4/25, documents, Resident noted to have what appears to be blood in her urine, call placed to MD to update, new orders received for UA C&S (urinalysis and culture / sensitivity), resident aware. R61's McGreer Evaluation, dated 8/7/25, documents UTI criteria not met. On 08/27/2025 at 12:12 PM, V25, Registered Nurse / Infection Preventionist stated I know that the McGreer evaluation should be done even before the doctor is called. I have been trying to get the nurses to do it, but I am the one that does the McGreer evaluation after the fact. Sometimes I am not even sure of the symptoms to fill it out correctly are. The policy Antibiotic Stewardship Program, dated 10/22, documents, Sets standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics. Review antibiotic use data to ensure best practices are followed.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews the facility failed to provide dignity during meals for 2 out of 2 residents, (R49, R96); reviewed for resident rights in a sample of 62. Findings include: 1. R96's admission Record, dated 8/27/25, documents R96 was admitted to the facility on [DATE] with diagnosis of Dementia, Dysphasia, Phobic Anxiety disorders, Seizures, Type 2 Diabetic Mellitus (DM), and Congested Heart Failure (CHF). R96's Care Plan, dated 7/15/25, documents R96 is at increased nutritional risk related to her therapeutic diet, mechanically altered diet nectar (mildly) thickened liquids and Diagnosis of Type 2 DM, Dementia, history of dehydration. resident utilizes adaptive feeding equipment with meals. Interventions: assist with tray set up as needed: opening containers, etc. R96's MDS, dated [DATE], documents R96 has a severe cognitive impairment and requires set-up/clean-up assist for eating. 2. R49's admission Record, dated 8/27/25, documents R49 was admitted to the facility on [DATE] with diagnosis of Major Depressive Disorder (MDD), Type 2 DM, Chronic Kidney Disease (CKD), and Anemia. R49's Care Plan, dated 5/15/25, documents R49 has an individualized plan of care while at the facility. Intervention: Eating: Setup help only. It continues R49 is at nutritional risk related to his therapeutic diet, mechanically altered diet, and diagnosis of Type 2 DM, MDD, CKD. Interventions: Offer assistance with tray set up as needed. R49's MDS, dated [DATE], documents R49 has a severe cognitive impairment and requires partial/moderate assistance for eating. On 8/25/25 at 11:50 AM, V7, LPN, was seen standing next to R96 while feeding her, then walked to the other side of the table and fed R49 bites of his food. V7 then told V8, LPN, to Stand over here and feed R96. so V8 walked over and stood next to R96 and began feeding her bites of her meal. V8 then realized she was being observed and obtained a chair to sit down next to R96. On 8/27/25 at 1:00PM, V2, DON, stated I would expect all staff to sit down while feeding a resident, to perform hand hygiene before and in between feeding residents, and not to use their bare hands to feed a resident a food item. On 8/27/25 at 1:15 PM, V34, CNA, stated When I am assisting a resident with eating, I would sit down between residents and feed one resident with one hand and the other resident with my other hand. I would do hand hygiene before assisting them. I would use utensils to feed them things like bread or rolls and will not use my hands. The Facility's Resident [NAME] of Rights Policy, dated 1/2023, documents in part Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life, regardless of diagnosis, severity of (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition or payment source and to exercise those rights as a citizen of the United States without interference, coercion including those rights specified herein. 32. A safe, clean, comfortable home like environment. 33. To personal privacy and confidentiality in his or her accommodations, person and medical treatments and records, written and telephone communications, personal care, visits and meetings of family and resident groups.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview, Observation, and Record Review, the facility failed to follow through on Pharmacist's recommendations, including notifying the physician for medication review for possible changes to antipsychotic, and antianxiety medications for 3 of 5 residents (R1, R8, R9) reviewed for chemical restraints in the sample of 62. The Findings Include: 1. R1's admission Record, dated 8/27/25, documents R1 was admitted to the facility on [DATE] with Diagnosis of Acute Respiratory Failure, Atrial Fibrillation (A-Fib), Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Osteoarthritis, Obesity, Anemia, Generalized Anxiety Disorder, and Major Depressive Disorder. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact. R1's Physician Order (PO), dated 6/30/25, documents Escitalopram Oxalate Oral Tablet 5 MG Give 1 tablet by mouth in the morning related to Major Depressive Disorder. R1's PO, dated 6/25/25, documents Memantine HCl Oral Tablet 5 MG (milligram), give 1 tablet by mouth two times a day related to Unspecified Dementia. R1's PO, dated 6/25/25, documents Trazodone HCl Oral Tablet 150 MG, give 1 tablet by mouth one time a day related to Insomnia. R1's Pharmacy Note, dated 1/8/25, documents Trazodone 50 MG PO (oral) QHS (every night bedtime), (for insomnia) is due for a hypnotic drug and dose evaluation. Please check all that apply below: [] 1. Medical, environmental and psychosocial stressors have been eliminated as possible causes, and an order change may be harmful to the patient. The benefit vs risk has been considered, and the currently therapy will be evaluated every 90 days hereafter. [] 2. Previous attempts at order change and or reduction have been unsuccessful. Continue the current order. [] 3. A change in this order is felt to be appropriate at this time. See orders written below. NOTE: This review is required quarterly by CMS. Your Response: ___ I agree (please write new order) ___ I disagree (If no change is indicated, please provide reason:) 1) ___ 2) ___ Response Signature/ Date. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or the change in the medication. R1's Pharmacy Note, dated 5/5/25, documents See physician recommendation. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or the change in the medication. 2. R8's admission Record, dated 8/27/25, documents R8 was admitted to the facility on [DATE] with diagnosis of Dementia, Generalized Anxiety Disorder, and Schizophrenia. R8's MDS, dated [DATE], documents R8 is cognitively intact. R8's PO, dated 8/11/25, documents Fluphenazine HCl (hydrochloride) Tab 1 MG, give 2 tablets by mouth two times a day for Schizophrenia. R8's PO, dated 8/11/25, documents Hydroxyzine HCl Tab 10 MG, give 1 tablet by mouth two times a day for anxiety. R8's PO, dated 8/11/25, documents Memantine HCl Tab 5 MG, give 1 tablet by mouth one time a day for mood. R8's Pharmacy Note, dated 1/8/25 at 2:36 PM, documents Please be sure that an abnormal movement evaluation has been completed to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended quarterly. Thank you. R8's Abnormal Involuntary Movement Scale (AIMS) was completed on 5/6/25, several months after pharmacy recommendation. R8's Pharmacy Note, dated 2/5/25 at 1:47 PM, documents Please be sure that the resident has had the following labs in the last 6 months. Thank you. TSH, HbA1c, CMP, CBC. NOTE: If these labs have not been drawn in the recommended time frame, please contact the physician to see if they may be appropriate. Thank you. The facility was unable to provide the Pharmacy's recommendation, the Physician's response. R8's Labs were not drawn until 4/18/25. 3. R9's admission Record, dated 8/27/25, documents R9 was admitted to the facility 10/04/23 with diagnosis of Cerebral Infarction, Hemiplegia, Hemiparesis, Schizophrenia, Anxiety Disorder, Bipolar Disorder, Dementia, and Depression. R9's MDS, dated [DATE], documents R9 is cognitively intact. R9's PO, dated 8/25/25, documents Lorazepam Oral Tablet 1 MG give 1 tablet by mouth one time a day related to anxiety disorder. R9's PO, dated 8/19/25, documents Mirtazapine Oral Tablet 7.5 MG, give 1 (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet by mouth at bedtime for sleep/mood disturbance.R9's PO, dated 12/31/24, documents Olanzapine Oral Tablet 5 MG, give 1 tablet by mouth two times a day for bipolar disorder related to bipolar disorder. R9's PO, dated 12/14/24, documents Hydroxyzine HCl Oral Tablet 25 MG, give 1 tablet by mouth two times a day for anxiety related to bipolar disorder. R9's Pharmacy Note, dated 1/8/25 at 2:10 PM, documents Please be sure that an abnormal movement evaluation has been completed to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended quarterly. Thank you. R9's AIMS was not completed until 8/5/25. R9's Pharmacy Note, dated 1/8/25 at 2:11 PM, documents This resident is receiving Hydroxyzine. This antihistamine is rarely considered the agent of choice due to its strong anticholinergic and sedative properties. If this is clinically relevant, may I suggest: Reference: Centers for Medicare and Medicaid Services. State Operations Manual, Survey Protocol for LTC. Appendix P, Rev. 22, 12/15/2006. In addition, CMS and Beers, et al., consider Hydroxyzine to be inappropriate for use in the elderly. They cite its strong anticholinergic side effects producing confusion, sedation, weakness, increased risk of falls, etc. Please review and assess the risks vs. benefits of the continued, routine use of Hydroxyzine; and document below or in a Progress Note the need for continued therapy and that the risks vs. benefits have been considered. Thank you.Your Response:___ I agree (please write new order)___ I disagree (If no change is indicated, please provide reason:)1)_____2)_____ _____Response Signature/ Date. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or the change in the medication.R9's Pharmacy Note, dated 2/5/25 at 12:56 PM, documents Please be sure that the resident has had the following labs in the last 6 months. Thank you.CMP, HbA1c. Please be sure that the resident has had a Magnesium level in the last 12 months. Thank you. NOTE: If these labs have not been drawn in the recommended time frame, please contact the physician to see if they may be appropriate. Thank you. R9's Labs were drawn on 5/2/25, several months after pharmacy recommendation. R9's Pharmacy Note, dated 6/9/25 at 11:35 AM, documents See physician recommendation. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or any change in the medications. R9's Pharmacy Note, dated 8/8/25 at 1:03 PM, documents See physician recommendation. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or any change in the medications. On 8/27/25 at 10:15 AM, V2, Director of Nursing (DON), provided what he could find for residents MRR. V2 stated These are all that we can find regarding your resident's MRR's. We looked in paper chart and electronic chart and could not find any more.On 8/27/25 at 10:25 AM, V30, Regional Nurse Consultant (RNC), stated The pharmacy was entering MRR's into the residents electronic medical record and we were having to print that out and have physician sign the note. We decided that way was not working well, so we now have the pharmacy doing MRR's on a regular MRR form.On 8/27/25 at 10:27 AM, V2, DON, stated The MRR's are given to the DON, who will review and educate the nurses on the changes. This will be my first time doing them with the physician and will review the recommendations and educate the nurses of any changes.On 8/27/25 at 1:00PM, V2, DON, stated I would expect all Pharmacy Recommendations (MRR's) to be followed through with the notification of the physician, then following the order if changes were made.The Facility's Consultant Pharmacist Services Policy, dated 7/2021, documents in part Facility agrees to allow consultant pharmacist access to resident roster, medical records, medication storage areas, medication destruction records, and facility policy to facilitate an effective medication regimen review. The facility will retain Medication Regimen Review (MRR) reports and documentation of actions taken according to facility policy and/or state federal guidelines. The consultant pharmacist will ensure that the following services are performed: 1. Medication Regimen Review will be conducted monthly, utilizing state/federal guidelines, as well as professional standards of care. The consultant pharmacist generates a report for each resident's medical record. In addition, a summary report indicating that all residents' medication regimen reviews have been conducted, with their findings is to be provided to the Director of Nursing, Executive Director, and (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Director. The report is to contain the resident's name, relevant drug and any irregularities. 4. Communicates to physician any identified problems attributed to drug therapy. Communicates to nursing any identified problems attributed to drug storage, administration, or documentation. The Physician and Director of Nursing will be notified upon identification of an irregularity that requires urgent action. The Facility's Abuse Prevention Policy, dated 1/2025, documents in part The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: Facility staff, other residents, consultants, volunteer, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. The Facility's Behavior Management and Psychopharmacological Medication Monitoring Protocol Policy, dated 6/2025, documents in part Residents who receive antipsychotic, anti-depressant, sedative/hypnotic, or anti-anxiety medications are to be maintained at the safest, lowest dosage necessary to manage the resident's condition. Prior to initiating or increasing a psychotropic medication, the resident must be notified of and have the right to participate in their treatment including the right to accept or decline the medication. Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. There will be an established Behavior Management Committee that will meet routinely to review all resident mentioned above and other as the committee deems appropriate. 4. Psychotropic: a. Within the first year in which a resident is admitted on any psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR (gradual dose reduction) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. Procedure: i) The Committee or Pharmacy Consultant will recommend the initiation, when applicable, of a gradual dose reduction, unless clinically contraindicated, in an effort to maintain the resident at the lowest possible dose or to discontinue the medication.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to document limited range of motion for 2 of 20 residents (R23, R61) reviewed for Minimum Data Set accuracy in the sample of 62. Findings include: 1 R23's admission record, print date of 8/27/25, documents R23 was admitted on [DATE] and has a diagnosis of Cerebral Palsy. R23's Minimum Data Set (MDS), dated [DATE] documents that R23 is cognitively intact and has no limited range of motion. On 8/26/25 at 12:30 PM, R23 stated that he does not get exercises on his arm or hand. R23 stated he has limited movement in his left arm and hand. On 8/26/25 at 12:37 PM, V2, Director of Nurses, stated that he agrees R23 has limited range of motion in both hands. On 8/27/25 at 1:44 PM, V33, Licensed Practical Nurse (LPN)/MDS, stated, I have only been here for a month. I have looked at R23 and I agree that his MDS should indicate that he has limited range of motion. Once the MDS is triggered for limited range of motion it then generates a care plan for range of motion. V33 has one now because I just made him one. On 8/26/25 at 12:30 PM, R23 attempted to open his left hand. R23 has 3 fingers that are curled up into the palm of his hand. R23's right hand has 2 contracted fingers. 2. R61's admission Record, dated 8/27/25, documents R61 was admitted to the facility on [DATE] with diagnosis of Cerebral infarction, Hemiplegia, Hemiparesis, Aphasia, Acute Kidney Failure, Type 2 Diabetes mellitus (DM), Atrial Fibrillation, Anemia, and Obesity. R61's Care Plan, 7/9/25, fails to document any restorative therapy, including Range of Motion (ROM) or exercises to be done on R61. R61's Minimum Data Set (MDS), dated [DATE], documents R61 has a severe cognitive impairment and requires substantial/maximal assistance for toileting, and transfers. R61 is occasionally incontinent of both bowel and bladder. R61's MDS fails to document any limited ROM, with R61 having Hemiplegia/Hemiparesis to her right side. On 8/25/25 at 9:42 AM, R61 stated that she had a stroke and cannot move her right side. R61 stated she does not get Physical Therapy anymore and no one is working with her or doing ROM with her. During this investigation, R61 was seen getting assistance from bed to her wheelchair and at no time was staff performing ROM or exercises with her. R61's PT Discharge summary, dated [DATE], documents in part Discharge Recommendations: Patient would benefit from a restorative program for exercises to maintain strength and ROM of BLE's (bilateral extremities). Restorative Program Established/Trained = Restorative Range of Motion (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Program. Range of Motion Established/Trained: CNA/Nursing staff will perform R (right) [NAME] (lower extremity) PROM (passive range of motion) to AAROM (active assist range of motion) up to 30 reps for hip/knee/ankle and L (left) [NAME] AROM (active range of motion) up to 30 reps in all planes to promote maximal [NAME] strength and flexibility. On 7/27/25 at 1:30 PM, V36, Speech Therapist/Therapy Supervisor, stated They were working with (R61) but she was discharged from therapy on 4/4/25 with instructions to continue a Functional Maintenance program. Once a resident is discharged , we give the instructions to the MDS nurse who will decide if the resident continues on Functional Maintenance or Restorative Therapy. That MDS nurse is no longer here, so I am not sure what was done for (R61). On 8/27/25 at 2:10 PM, V30, Regional Nurse Consultant (RNC), stated Our Corporate Leaders got rid of the Restorative Program here, but I would still think the staff are working with the residents for Range of Motion and things like that. On 8/27/25 at 3:20 PM, V2, DON, stated I just checked and we do not have anything set up for staff to do ROM at this time. We are working on getting things set up to do so. On 8/27/25 at 3:40 PM, V25, Nurse Manager/ IP, stated We used to have a MDS Nurse and two Restorative CNAs who did restorative therapy on residents. We got a new Administrator, and he got rid of all three of them and told us he was going to train the CNAs himself on restorative therapy. Then one day, he cleaned out his office and disappeared and that was the end of that. It has not been started up again. The Facility's MDS Assessment Policy, dated 6/2023, documents in part The facility shall conduct interdisciplinary assessments using the MDS item sets as defined by Federal/State regulation. These assessments provide information on the resident's condition to facilitate development of an individualized plan of care is as a means by which the facility can track changes in a resident's status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to initiate a Care Plan for 2 of 20 residents (R23, R61) reviewed for Care Plans in the sample of 62. Findings include: 1 R23's admission record, print date of 8/27/25, documents R23 was admitted on [DATE] and has a diagnosis of Cerebral Palsy. R23's Minimum Data Set, dated [DATE] documents that R23 is cognitively intact and has no limited range of motion. On 08/26/2025 at 12:44 PM, R23's current electronic Care Plan failed to document any restorative programing or limited range of motion. On 8/26/25 at 12:30 PM, R23 stated that he does not get exercises on his arm or hand. R23 stated he has limited movement in his left arm. On 8/26/25 at 12:30 PM, R23 attempted to open his left hand. R23 has 3 fingers that are curled up into the palm of his hand. R23's right hand has 2 contracted fingers. On 8/26/25 at 12:37 PM, V2, Director of Nurses, further stated that he agrees R23 has limited range of motion in both arms. On 8/27/25 at 1:44 PM, V33, LPN/MDS, stated, I have only been here for a month. I have looked at R23 and I agree that his MDS should indicate that he has limited range of motion. Once the MDS is triggered for limited range of motion it then generates a care plan for range of motion. V33 has one now because I just made him one. On 8/26/25 at 2:30 PM, V2, stated that therapy only recommended that he do self-stretching of his fingers and that he had been educated. 2. R61's admission Record, dated 8/27/25, documents R61 was admitted to the facility on [DATE] with diagnosis of Cerebral infarction, Hemiplegia, Hemiparesis, Aphasia, Acute Kidney Failure, Type 2 Diabetes mellitus (DM), Atrial Fibrillation, Anemia, and Obesity. R61's Care Plan, 7/9/25, fails to document any restorative therapy, including Range of Motion (ROM) or exercises to be done on R61. R61's MDS, dated [DATE], documents R61 has a severe cognitive impairment and requires substantial/maximal assistance for toileting, and transfers. R61 is occasionally incontinent of both bowel and bladder. R61's MDS fails to document any limited ROM, with R61 having Hemiplegia/Hemiparesis to her right side. On 8/25/25 at 9:42 AM, R61 stated that she had a stroke and cannot move her right side. R61 stated she does not get Physical Therapy anymore and no one is working with her or doing ROM with her. R61's PT Discharge summary, dated [DATE], documents in part Discharge Recommendations: Patient (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would benefit from a restorative program for exercises to maintain strength and ROM of BLE's (bilateral extremities). Restorative Program Established/Trained = Restorative Range of Motion Program. Range of Motion Established/Trained: CNA/Nursing staff will perform R (right) [NAME] (lower extremity) PROM (passive range of motion) to AAROM (active assist range of motion) up to 30 reps for hip/knee/ankle and L (left) [NAME] AROM (active range of motion) up to 30 reps in all planes to promote maximal [NAME] strength and flexibility. During this investigation from 8/25/25 through 8/28/25, R61 was seen getting assistance for transfers and at no time was staff performing ROM or exercises with her. On 8/27/25 at 1:30 PM, V36, Speech Therapist/Therapy Supervisor, stated They were working with (R61) but she was discharged from therapy on 4/4/25 with instructions to continue a Functional Maintenance program. Once a resident is discharged , we give the instructions to the MDS nurse who will decide if the resident continues on Functional Maintenance or Restorative Therapy. That MDS nurse is no longer here, so I am not sure what was done for (R61). On 8/27/25 at 2:10 PM, V30, Regional Nurse Consultant (RNC), stated Our Corporate Leaders got rid of the Restorative Program here, but I would still think the staff are working with the residents for Range of Motion and things like that. On 8/27/25 at 3:20 PM, V2, DON, stated I just checked, and we do not have anything set up for staff to do ROM at this time. We are working on getting things set up to do so. On 8/27/25 at 3:40 PM, V25, Nurse Manager/ IP, stated We used to have a MDS Nurse and two Restorative CNAs who did restorative therapy on residents. We got a new Administrator, and he got rid of all three of them and told us he was going to train the CNAs himself on restorative therapy. Then one day, he cleaned out his office and disappeared and that was the end of that. It has not been started up again. The Facility's Comprehensive Person-Centered Care Plans Policy, dated 1/2025, documents in part Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Comprehensive Person-Centered Care Plan (CCP) contains services provided, preference, ability, goals for admission and desired outcomes, and care level guidelines. 5. For each problem, need, or strength a resident-centered goal is developed. Goals should be measurable. 6. Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention. 7. The Comprehensive Person-Centered Care Plan can be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change and annual assessments per the RAI (resident assessment instrument) manual.		

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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 interviews, observation and record reviews the facility failed to provide feeding assistance for 1 out of 1 residents (R34); reviewed for Quality of Life in a sample of 62. Findings include:R34's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, dementia, vitamin deficiency, and abnormal weight loss.R34's Minimum Data Set (MDS) dated [DATE] documented she was rarely/never understood, had a memory problem, and required partial/moderate assistance from staff for eating. R34's Care Plan revised on 11/6/24 documented she was at increased nutritional risk; R34 is assisted at meals and offered encouragement/cueing as needed. Interventions added 11/6/24 documented for staff to offer finger foods also. R34's Progress note dated 8/22/25 at 1:59 PM, documented she is dependent on staff to meet ADLs (activities of daily living) and remains on hospice care services. On 8/25/25 at 11:18 AM R34 was sitting in an upright positioned recliner took her fork and stabbed it into her biscuit then attempted several times to take it out but couldn't. At 11:21 AM R34 was still attempting to get a bite of her biscuit unsuccessfully. At 11:25 AM R34 tried holding the container of orange sherbert but unable to eat it and puts back down. On 8/25/25 at 11:31 AM, R34 put her empty spoon in her mouth.On 8/25/25 at 11:44 AM, R34 took her empty spoon and put in her mouth, attempted to pick up her chicken with the spoon but kept pushing the chicken away. At 11:47 AM, R34 was finally able to get a bite of food into her mouth. At 11:55 AM, R34 took her empty spoon again and put in her mouth.On 8/25/25 at 12:10 PM, R34 got a spoonful of melted sherbert that spilled on the table and on her lap as she tried to eat it. On 8/25/25 at 12:15 PM, R34 tried to take her fork out of her biscuit again but was unable to. At 12:17 PM, R34 still tried to take her fork out of the biscuit, she then brought the entire biscuit to her mouth and tried to take bite of it. At 12:19 PM, R34 was able to get the fork out of her biscuit and then picked up the container of sherbert, which was melted now, and drank it. On 8/25/25 at 12:29 PM, R34 continued to drink her melted sherbert. V10 walked up to R34 talked to her and walked away with no additional assistance. R34 put down her sherbert and picked up her spoon upside down and put it to her mouth. R34's plate was about 5-10% eaten, was taken away without asking her if she was done. At 12:41 PM V14 (activity aide) poured milk into R34's cereal and walked away without assisting. R34 tried to take bites of her cereal with her spoon but dropped the cereal in process. R34 used her fingers to eat the cereal. At 12:44 PM, R34 was able to get a bite of cereal from her spoon. R34 picked up the previously spilled cereal from table and ate it. On 8/26/25 at 11:40 AM, R34 was eating without assistance. R34 took a bite of cereal from her spoon making one piece into her mouth followed by an empty spoonful. At 11:43 AM, R34 spilled some of the milk from her spoon while attempting to take another bite of milk with cereal. R34 proceeded to hold the spoon containing milk and cereal in front of her face without bringing it to her mouth until 11:52 AM when she finally put the spoon down on her plate. R34 then used her fingers to pick up her cereal from the spoon and ate one piece. At 11:54 AM, R34 picked up her spoon again and held it out in front of her face until 11:55 AM and took a bite. On 8/27/25 at 9:15 AM, in a joint interview with V12 (LPN) and V26 (CNA), V26 and V13 stated it is expected that a resident be assisted, cued or prompted when they are having difficulties eating. V26 stated we try to assist as much as possible. On 8/27/25 at 9:35 AM, V27 (staffing coordinator) stated if a resident is having difficulty eating, it is expected that they be assisted. On 8/27/25 at 1:25 PM, in a joint interview with V1 (administrator), V2 DON (director of nursing), and V30 (Regional Nurse), V2 stated residents are expected to be assisted with feeding if they are having difficulties. The facility's Dining Service Seating Policy dated 2016, documented residents who are unable to eat independently or who have special needs will be given individualized attention, assistance and care to help promote adequate food and fluid intakes.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide range of motion for 2 of 2 residents (R23, R61) reviewed for contractures in the sample of 62. Findings include: R23's admission record, print date of 8/27/25, documents R23 was admitted on [DATE] and has a diagnosis of Cerebral Palsy. R23's Minimum Data Set (MDS), dated [DATE] documents that R23 is cognitively intact. On 08/26/2025 at 12:44 PM, R23's Care Plan failed to document any restorative programing or limited range of motion. R23's Occupational Therapy Discharge summary, dated [DATE], documents, Discharge recommendations. Functional Maintenance Program Established / Trained = Range of Motion Program. Range of Motion Program Established / Trained: Therapist instructed staff in PROM program of bilateral shoulder flexion and abduction and ring and little digit extension up to 7x per week and for 2 sets of 10 reps (repetitions). On 8/26/25 at 12:30 PM, R23 attempted to open his left hand. R23 has 3 fingers that are curled up into the palm of his hand. R23's right hand has 2 contracted fingers. On 8/26/25 at 12:30 PM, R23 stated that he does not get exercises on his arm or hand. R23 stated he has limited movement in his left arm and hands. On 8/26/25 at 12:37 PM, V2, Director of Nurses, stated that the Certified Nurse Aides do the restorative exercises, and the therapy department makes up a restorative plan when the resident is discharged from therapy. We just started two restorative programs. V2 further stated that he agrees R23 has limited range of motion in both hands. On 8/26/25 at 2:30 PM, V2, stated that therapy only recommended that he do self-stretching of his fingers and that he had been educated. On 8/27/25 at 9:30 AM, V28, Certified Nurse Aide, (CNA), stated, I do range of motion with him with his normal daily cares, like when I put him on the pot, he has to stretch out his hands. I don't do any formal range of motion with him. On 8/27/25 at 9:45 AM, V29, CNA, stated, When I am on the floor I do range of motion with him on his fingers, but I am not on the floor much with my new position. 2. R61's admission Record, dated 8/27/25, documents R61 was admitted to the facility on [DATE] with diagnosis of Cerebral infarction, Hemiplegia, Hemiparesis, Aphasia, Acute Kidney Failure, Type 2 Diabetes mellitus (DM), Atrial Fibrillation, Anemia, and Obesity. R61's Care Plan, 7/9/25, fails to document any restorative therapy, including Range of Motion (ROM) (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Evervella of White Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 620 West Bridgeport White Hall, IL 62092	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or exercises to be done on R61. R61's MDS, dated [DATE], documents R61 has a severe cognitive impairment and requires substantial/maximal assistance for toileting, and transfers. R61 is occasionally incontinent of both bowel and bladder. R61's MDS fails to document any limited ROM, with R61 having Hemiplegia/Hemiparesis to her right side. On 8/25/25 at 9:42 AM, R61 stated that she had a stroke and cannot move her right side. R61 stated she does not get Physical Therapy anymore and no one is working with her or doing ROM with her. R61's PT Discharge summary, dated [DATE], documents in part Discharge Recommendations: Patient would benefit from a restorative program for exercises to maintain strength and ROM of BLE's (bilateral extremities). Restorative Program Established/Trained = Restorative Range of Motion Program. Range of Motion Established/Trained: CNA/Nursing staff will perform R (right) [NAME] (lower extremity) PROM (passive range of motion) to AAROM (active assist range of motion) up to 30 reps for hip/knee/ankle and L (left) [NAME] AROM (active range of motion) up to 30 reps in all planes to promote maximal [NAME] strength and flexibility. During this investigation from 8/25/25 through 8/28/25, R61 was seen getting assistance from bed to her wheelchair and at no time was staff performing ROM or exercises with her. On 8/27/25 at 1:30 PM, V36, Speech Therapist/Therapy Supervisor, stated They were working with (R61) but she was discharged from therapy on 4/4/25 with instructions to continue a Functional Maintenance program. Once a resident is discharged , we give the instructions to the MDS nurse who will decide if the resident continues on Functional Maintenance or Restorative Therapy. That MDS nurse is no longer here, so I am not sure what was done for (R61). On 8/27/25 at 2:10 PM, V30, Regional Nurse Consultant (RNC), stated Our Corporate Leaders got rid of the Restorative Program here, but I would still think the staff are working with the residents for Range of Motion and things like that. On 8/27/25 at 3:20 PM, V2, DON, stated I just checked, and we do not have anything set up for staff to do ROM at this time. We are working on getting things set up to do so. On 8/27/25 at 3:40 PM, V25, Nurse Manager/ IP, stated We used to have a MDS Nurse and two Restorative CNAs who did restorative therapy on residents. We got a new Administrator, and he got rid of all three of them and told us he was going to train the CNAs himself on restorative therapy. Then one day, he cleaned out his office and disappeared and that was the end of that. It has not been started up again. The Facility's Range of Motion Policy, dated 11/2017, documents in part A range of motion program will be developed for a resident as indicated. Responsibility: Therapist, Restorative Nurse, Nursing Assistant.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview, Observation, and Record Review, the facility failed to follow through with the Pharmacist's Medication Regimen Review (MRR), including notifying the physician and obtaining any medication changes as ordered for 3 of 5 residents (R1, R8, R9) reviewed for resident's MRR in the sample of 62. The Findings Include: 1. R1's admission Record, dated 8/27/25, documents R1 was admitted to the facility on [DATE] with Diagnosis of Acute Respiratory Failure, Atrial Fibrillation (A-Fib), Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Osteoarthritis, Obesity, Anemia, Generalized Anxiety Disorder, and Major Depressive Disorder. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact. R1's Physician Order (PO), dated 6/30/25, documents Escitalopram Oxalate Oral Tablet 5 MG Give 1 tablet by mouth in the morning related to Major Depressive Disorder. R1's PO, dated 6/25/25, documents Memantine HCl Oral Tablet 5 MG (milligram), give 1 tablet by mouth two times a day related to Unspecified Dementia. R1's PO, dated 6/25/25, documents Trazodone HCL Oral Tablet 150 MG, give 1 tablet by mouth one time a day related to Insomnia. R1's Pharmacy Note, dated 1/8/25, documents Trazodone 50 MG PO (oral) QHS (every night bedtime), (for insomnia) is due for a hypnotic drug and dose evaluation. Please check all that apply below: [] 1. Medical, environmental and psychosocial stressors have been eliminated as possible causes, and an order change may be harmful to the patient. The benefit vs risk has been considered, and the currently therapy will be evaluated every 90 days hereafter. [] 2. Previous attempts at order change and or reduction have been unsuccessful. Continue the current order. [] 3. A change in this order is felt to be appropriate at this time. See orders written below. NOTE: This review is required quarterly by CMS. Your Response: ___ I agree (please write new order) ___ I disagree (If no change is indicated, please provide reason:) 1) ___ 2) ___ _____ Response Signature/ Date. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or the change in the medication. R1's Pharmacy Note, dated 5/5/25, documents See physician recommendation. The facility was unable to provide the Pharmacy's recommendation, the Physician's response, or the change in the medication. 2. R8's admission Record, dated 8/27/25, documents R8 was admitted to the facility on [DATE] with diagnosis of Dementia, Generalized Anxiety Disorder, and Schizophrenia. R8's MDS, dated [DATE], documents R8 is cognitively intact. R8's PO, dated 8/11/25, documents Fluphenazine HCl (hydrochloride) Tab 1 MG, give 2 tablets by mouth two times a day for Schizophrenia. R8's PO, dated 8/11/25, documents Hydroxyzine HCl Tab 10 MG, give 1 tablet by mouth two times a day for anxiety. R8's PO, dated 8/11/25, documents Memantine HCl Tab 5 MG, give 1 tablet by mouth one time a day for mood. R8's Pharmacy Note, dated 1/8/25 at 2:36 PM, documents Please be sure that an abnormal movement evaluation has been completed to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended quarterly. Thank you. R8's Abnormal Involuntary Movement Scale (AIMS) was completed on 5/6/25, several months after pharmacy recommendation. R8's Pharmacy Note, dated 2/5/25 at 1:47 PM, documents Please be sure that the resident has had the following labs in the last 6 months. Thank you. TSH, HbA1c, CMP, CBC. NOTE: If these labs have not been drawn in the recommended time frame, please contact the physician to see if they may be appropriate. Thank you. The facility was unable to provide the Pharmacy's recommendation, the Physician's response. R8's Labs were not drawn until 4/18/25. 3. R9's admission Record, dated 8/27/25, documents R9 was admitted to the facility 10/04/23 with diagnosis of Cerebral Infarction, Hemiplegia, Hemiparesis, Schizophrenia, Anxiety Disorder, Bipolar Disorder, Dementia, and Depression. R9's MDS, dated [DATE], documents R9 is cognitively intact. R9's PO, dated 8/25/25, documents Lorazepam Oral Tablet 1 MG give 1 tablet by mouth one time a day (continued on next page)		

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

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviews have been conducted, with their findings is to be provided to the Director of Nursing, Executive Director, and Medical Director. The report is to contain the resident's name, relevant drug and any irregularities. 4. Communicates to physician any identified problems attributed to drug therapy. Communicates to nursing any identified problems attributed to drug storage, administration, or documentation. The Physician and Director of Nursing will be notified upon identification of an irregularity that requires urgent action.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the failed to notify the Physician to clarify the continued need for an antibiotic for 2 of 7 (R14, R57) reviewed for medications in the sample of 62. Findings include: 1. R57's admission record, print date of 8/27/25, documents R67 was admitted on [DATE] and has diagnoses of Dementia and a history of a stroke. R57's Nurses Note, dated 8/3/25, documents, Received UA (urinalysis) results, sent to (V37, Medical Director), awaiting culture. Received order for Augmentin 875mg (milligram) BID (twice a day) for 7 days. Orders put in. POA (Power of Attorney) notified. R57's Urinalysis with culture if indicated, resulted date of 8/4/25, document, Organism: (GMR) Gram Negative Rod, no sensitivity will be done. Growth: <10,000 cfu (colony forming unit)/ml (milliliter). R57's Medication Administration Record, August 2025, documents R57 received 16 doses of Amoxicillin-Pot Clavulanate Tablet 875-125 MG from 8/3/25 through 8/11/25. On 08/27/2025 at 12:12 PM, V25, Registered Nurse / Infection Preventionist stated it appears that no one reviewed R57's urine culture and notified the doctor. She should have been taken off the antibiotic. 2. R14's admission Record, print date of 8/27/25, documents R14 was admitted on [DATE] and has a diagnosis of Chronic Kidney Disease. R14's Urine Culture, dated 8/11/25, documents, Results; Mixed genital flora isolated. These superficial bacteria are no indicative of a urinary infection. No further organism identification is warranted on this specimen. R14's Physician Order start date of 8/12/25, documents, Cefuroxime Axetil Oral Tablet 250 mg give 1 tablet by mouth two times a day. R14's August 2025 Medication Administration Record documents R14 received 14 doses of Cefuroxime from 8/12/25 - 8/19/25. On 8/28/25 at 9:00 AM, V25 stated the doctor should have been notified and the antibiotic stopped. The policy Surveillance for Healthcare Associated Infections, dated 9/19/25, fails to document an antibiotic and culture review. The policy Antibiotic Stewardship Program, dated 10/22, documents, Sets standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics. Review antibiotic use data to ensure best practices are followed.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide 80 square feet of floor space per resident in eight, 3-bed resident rooms for 19 of 19 residents (R3, R22, R24, R25, R27, R34, R36, R45, R51, R66, R71, R72, R76, R84, R89, R92, R95, R98, R99) reviewed for resident living space in the sample of 62 . Based on observation, interview, and record review, the facility failed to provide 80 square feet of floor space per resident in eight, 3-bed resident rooms for 19 of 19 residents (R3, R22, R24, R25, R27, R34, R36, R45, R51, R66, R71, R72, R76, R84, R89, R92, R95, R98, R99) reviewed for resident living space in the sample of 62 . Findings include: On 08/28/25 at 11:55 AM, the 8 three-bed resident rooms, (Rooms 51-58). Each room has three beds in it. Each room was licensed and available for three residents per room. According to historical measurement data, these eight rooms only provide 77 square feet per resident bed. The following residents reside in these rooms: R3, R22, R24, R25, R27, R34, R36, R45, R51, R66, R71, R72, R76, R84, R89, R92, R95, R98, and R99. On 8/28/2024 at 11:48 AM V1, Administrator, stated We evaluate the compatibility and any behaviors a resident may be having, prior to putting them in a 3-person room. All eight of these three-bed resident rooms are Medicare / Medicaid certified.		