STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145620	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evervella of Swansea	100 Rosewood Village Drive Swansea, IL 62220

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to answer call lights in a timely manner for 6 (R1, R2, R3, R4, R5, and R6) of 6 residents reviewed for timely assistance in a sample of six. Findings include:1.R1's admission record documents an admission date of 111/21/25 with diagnoses including: nondisplaced comminuted fracture of shaft of right fibula, nondisplaced [NAME] fracture of right tibia, type two diabetes mellitus, hyperlipidemia, bell's palsy, and acute kidney failure. R1's Minimum Data Set, dated [DATE] documents a brief interview of mental status of 15 indicating cognitively intact. R1's toilet transfer ability was documented as not attempted due to medical condition or safety concerns and chair to bed transfer as: partial/moderate assistance, and walk 10 feet as not attempted due to medical condition or safety concernsOn 12/12/25 at 12:48 PM R1 stated, the facility to the cushion out of her wheelchair and she had been up sitting in her chair for a while and her bottom hurt so she wanted to lay down so she would not be in pain and it took the staff over an hour before they would help her to bed. R1 stated, a few weeks ago she had to wait about three hours for a bed pan so she couldn't wait and soiled herself and had to stay like that for over an hour before someone came to assist her. R1 stated, there are other times she has waited 30 minutes to an hour before anyone would come. R1 stated, sometimes she will see the staff walk by her room when she has her call light on and they do not stop.2.R4's admission record documents an admission date of 11/26/25 with diagnoses including: chronic obstructive pulmonary disease with acute exacerbation, acute respiratory failure, peripheral vascular disease, muscle wasting and atrophy, and asthma. R4's MDS dated [DATE] documents a BIMS score of 14 indicating cognitively intact.On 12/12/25 at 12:53 PM R4 stated, sometimes she feels they do not have enough people to help. R4 stated, there are times it will take them a while to get to come assist them. R4 stated, she has put her call light on before so hopefully they would come assist R1 faster. R4 stated, the call light is on and they (the staff) just keep going on by (the room). 3. R2's admission record documents an admission date of 12/10/25 with diagnoses including: chronic diastolic heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic chronic kidney disease, persistent atrial fibrillation, obstructive sleep apnea, morbid obesity, abdominal aortic aneurysm, muscle wasting and atrophy, chronic kidney disease, and restless legs syndrome. R2 was alert to person, place and time at time of interview.R2's care plan documents a focus area of: the resident has an ADL (activities of daily living) self care performance deficit related to impaired balance and obesity with an intervention of encourage the resident to use bell to call for assistance with no date listed.On 12/12/25 at 12:56 PM R2 stated, the other night he put his call light on and he had to wait too long and had an accident and had to sit in it for a bit. R2 stated, he tried to hold it but he just could not wait any longer.4.R5's admission record documents an admission date of 07/03/25 with diagnoses including: stable burst fracture of T11-T12 vertebra, chronic kidney disease stage 4, atrial flutter, rheumatoid arthritis, obesity, cardiomegaly, diabetes mellitus, and reflex neuropathic bladder. R5's MDS dated [DATE] documents a BIMS score of 15 indicating cognitively intact. R5's functional abilities document the ability to transfer from chair to bed and to transfer to the toilet is supervision or touching assistance. R5 toileting hygiene is documented as substantial/maximal assistance is needed.On 12/12/25 at 1:04 PM R5 stated, there are times she has had to wait a while for staff to answer her call light before usually it is more at night or the weekends. R5 stated, sometimes they will walk by and not acknowledge the light, depending of the staff member.5.R6's admission record documents an admission date of 10/14/25 with diagnoses including: cerebral infarction, middle cerebral artery syndrome, chronic kidney disease, type 2 diabetes mellitus, and hemiplegia and hemiparesis following cerebral infarction. R6's MDS dated [DATE] documents a BIMS score of 15 indicating cognitively intact.R6's care plan documents a focus area of: impaired physical mobility with an undated intervention of assist resident in performing movement/tasks. This same care plan documents a focus area of: the resident had a cerebral vascular accident with an undated intervention listed as: monitor/document residents abilities for ADLs and assist resident as needed. Encourage resident to do what he/she is capable of doing for self. On 12/12/25 at 1:42 PM R6 stated, there are times in the nights he has had to wait over 30 minutes before they have come to assist him and there are other times that he has had to wait over an hour for someone to came and assist him at night.6.R3's admission record documents an admission date of 12/19/24 with diagnoses including: atherosclerotic heart disease of native coronary artery, diabetes mellitus due to underlying condition with diabetic nephropathy, atrial fibrillation, acute respiratory failure, acute and chronic