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	01/15/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure working call lights for 2 of 2 residents (R1, R3) reviewed for call lights in the sample of 6. Findings include:R1's admission Record documented an admission Date of 11/20/25 and listed Diagnoses including Hypertension, Prediabetes, and Postpolio Syndrome. R1's Minimum Data Set, dated [DATE] documented that R1 has no deficits in cognition and requires substantial/maximal assistance for toileting. R1's Care Plan dated 11/20/25 documented a problem area, Resident has an ADL (Activities of Daily Living) self-care performance deficit related to Musculoskeletal impairment /Postpolio Syndrome.On 1/14/26 at 12:15pm, R1 was alert and oriented to person, place, time, and purpose. R1 stated he was discharged home from the facility on12/30/25. R1 stated the care he received at the facility was 'terrible.' R1 stated twice during his stay, he was incontinent and left to sit in feces and was told by staff they were too busy serving supper, and he would have to wait, which took over two hours on both occasions. R1 stated he found it humiliating to be a grown man sitting in his own feces. R1 stated he had been left on bedpan more than an hour on more than one occasion. R1 stated call lights were very slow, up to an hour, and then if you needed the nurse, it might be another hour before she got there. R1 stated more than once staff would come in turn off the call light and never come back.R3's admission Record documented an admission Date of 11/21/25 and listed Diagnoses including Diabetes Type 2 and Fractures of the Left Tibia and Fibula. R3's Minimum Data Set, dated [DATE] documented that R3 has no deficits in cognition and requires partial to moderate assistance for toileting. R3's Care Plan dated 12/12/25 documented that R3 has an activity of daily living self-care performance deficit related to leg fractures.On 1/14/26 at 10:20am, R3 was alert and oriented to person, place, time, and purpose. R3 stated her call light has not been working for 3-4 days now. R3 pushed the button and the light did not come on outside the door. R3 stated staff are supposed to be checking on her more frequently because of this. R3 stated day shift is good about checking on her frequently but night shift doesn't, and she has had to yell for help during the night shift. R3 stated a couple nights ago nobody came to check on her and she hollered for help for about 30 minutes until somebody came. R3 stated she could hear staff talking nearby so she knows they could hear her. R3's call light was pressed and it was observed to not come on. R3 stated she has been left in her own urine for an extended period of time in an undignified manner. On 1/14/26 at10:30am, V3, Licensed Practical Nurse, stated today they will be moving R3 to a different room because the call light isn't working. V3 stated she is not sure how long the call light has been out, but V3 worked 1/13/26 and it wasn't working, so staff were checking on R3 at least every hour.On 1/14/26 at 2:40pm, V2, Director of Nurses, stated she was made aware that morning that R3's call light was not working, and it was her understanding it stopped working today. When asked about the above interviews in which residents complained of long call wait times, V2 stated she does not believe this is accurate and represents inaccurate resident perception. V2 stated it (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is her expectation that staff answer call lights within a 10-minute time frame. On 1/14/26 at 1:45pm, V7, Corporate Maintenance Supervisor, stated the facility is currently looking to hire a full time Maintenance Supervisor. V7 stated he was aware R3's call light wasn't working and that he is not sure how long it has been out, but he did replace a battery in part of the unit on 1/12/26. On 1/14/26 at 3:15pm, V6, Activity Director, stated she is the staff member responsible for scheduling Resident Council meetings. V6 stated in the past 90 days residents have complained about call lights taking up to an hour.A Call Light Policy documented, Purpose: To respond to residents requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in a timely manner. 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. 3. Bathroom lights should be viewed as emergencies and immediate attention will be given.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain a working call light system for one resident (R3) of 5 residents reviewed for call lights in the sample of 6. Findings include:R3's admission Record documented an admission Date of 11/21/25 and listed Diagnoses including Diabetes Type 2 and Fractures of the Left Tibia and Fibula. R3's Minimum Data Set, dated [DATE] documented that R3 has no deficits in cognition and requires partial to moderate assistance for toileting. R Care Plan dated 12/12/25 documented that R3 has an activities of daily living self-care performance deficit related to right leg fractures.On 1/14/26 at 10:20am, R3 was alert and oriented to person, place, time, and purpose. R3 stated her call light has not been working for 3-4 days now. R3 pushed the button and the light did not come on outside the door. R3 stated it is her understanding that the facility does not currently have a Maintenance Supervisor. R3 stated staff are supposed to be checking on her more frequently because of this. R3 stated day shift is good about checking on her frequently but night shift doesn't, and she has had to yell for help during the night shift.On 1/14/26 at10:30am, V3, Licensed Practical Nurse, stated today they will be moving R3 to a different room because the call light isn't working. V3 stated she is not sure how long the call light has been out, but V3 worked 1/13/26 and it wasn't working, so staff were checking on R3 at least every hour.On 1/14/26 at 2:40pm, V2, Director of Nurses, stated she was made aware that morning that R3's call light was not working and it was her understanding it stopped working today.On 1/14/26 at 1:45pm, V7, Corporate Maintenance Supervisor, stated the facility is currently looking to hire a full time Maintenance Supervisor. V7 stated he was aware R3's call light wasn't working and that he is not sure how long it has been out but he did replace a battery in part of the unit on 1/12/26. V7 stated he is not sure what the issue is but the contracted security company responsible for the system will be working on it today. V7 stated there had been issues last week with call lights in other areas of the building not working, and knows there are some in empty rooms currently not working. An undated Call Light Policy documented, 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 5. Hand bells will be provided for alert dependent residents when positioned out of reach of permanent call light when needed. 6. Call bell system defects will be reported promptly to the Maintenance Department for servicing. A. Room checks will occur hourly until system is repaired.