

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Evergreen Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1115 North Wenthe Effingham, IL 62401	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to provide adequate supervision for 1 of 5 (R1) residents reviewed for elopements in a sample of 5. The Findings Include; R1's face sheet documents an admission date of 1/27/2026. This same document includes the following diagnosis: unspecified dementia, mild intellectual disabilities and anxiety disorder. R1's elopement assessment was completed on 5/7/26. This assessment documents that R1 is cognitively impaired/has poor decision making skills and has pertinent diagnosis, he displays behaviors indicate of an attempt to leave (body language, etc) that an elopement is forthcoming and that an elopement care plan is initiated. R1's care plan has a problem area with an initiation date of 1/27/26 as follows: resident exhibiting wandering behaviors and is at risk for injury related to impaired safety awareness. The goal for this problem is to be free from injury by next review date of 4/27/26. The interventions for this problem area are: anticipate needs of resident as much as possible, approach resident in a calm manner, calmly redirect and cue as needed, and encourage resident to participate in activities of interest as tolerated. (All with start dates of 1/27/26). R1's most recent quarterly MDS (Minimum Data Set) dated 2/20/26 documents in Section C a BIMS (Brief Interview of Mental Status) score of 14, indicating that he is cognitively intact. In Section E 0900 it is documented that the resident has not exhibited behaviors of wandering or behavioral symptoms. On 5/31/26 at 1:15 PM, V1 (Administrator) stated that on 5/20/26 during the morning meeting with managers they were alerted by the IV (Intravenous) Drip team that R1 was missing. This was determined due to him having a scheduled drip service appointment. V1 stated that she immediately called a 'code elopement' and everyone began searching the building and outside. The code was called at around 10:30 AM and he was found at 10:37 AM by herself and V11 (Activities/CNA). V1 stated that R1 is alert and oriented and loves to go outside, but is considered an elopement risk. V1 stated that she is unsure which staff member or possibly a visitor that let R1 out to the patio at the back of the building. V1 stated that she educated the entire staff on safety and not allowing dependent residents outside on their own without someone supervising them. V1 stated that when she found R1 she asked him what happened and he walked her through it. V1 stated that R1 rolled his wheelchair to the gate of the fence and stood up to open the gate and proceeded to wheel himself on the sidewalk around the entire building. V1 stated that the sidewalk behind the building leads to the public street which then meets back up to the parking lot of the front of the facility. R1 was found on the street headed towards the parking lot. V1 stated that R1 was unharmed and immediately assessed by V12 (Registered Nurse/RN), however there is not a note put in the medical record about it. V1 stated that she educated the nurse to make sure these types of events are recorded. V1 reviewed the camera footage during this investigation and due to glitch in the video it is unable to be determined who allowed R1 outside with a code. On 5/31/26 at 12:00 PM, R1 stated that he is let outside by the facility staff all the time. R1 stated that he knows what he is doing and just likes to spend time outside getting fresh air. R1 stated that he cannot remember who let him out on 5/20/26 to the back patio, but after he sat there awhile by himself he rolled his wheel chair to the fence gate and stood up and let himself out. R1 stated that all he did was roll around the facility and get all wet due to the water on the side walk. R1 said by the time he got around the front of 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145628
		If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	building by the parking lot they were outside yelling for him. R1 stated he knows the rules of the road and would not be in any danger or get hit by a car. R1 stated that he didn't mean to get himself or anyone in trouble, he just wanted to go for a walk in his wheelchair on that nice sunny day. On 6/1/26 at 11:00 AM, V17(Licensed Clinical Social Worker) stated that he works at the facility on Mondays and Fridays. V17 stated that he did work on 5/20/26 and frequently lets R1 out on the back patio. V17 stated that it is his understanding that no one can be left out front in the gazebo or parking lot alone, but the back smoking patio they are allowed to sit out there alone. On 5/31/26 at 12:30 PM, V7 (Dietary Manager) stated that on 5/20/26 she was in the dining room around 10:15 AM when the managers came out of morning meeting and stated that R1 had eloped. V7 stated that she went outside and by the time she made it through parking lot V1 and V11 were wheeling R1 back in the parking lot. V7 stated he was coming down the road in his wheelchair when they found him. The Elopement Prevention Policy states: It is the policy of (Name of Facility) to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement. Procedure:1. A licensed nurse will complete the Elopement Risk Assessment upon admission to the facility. An interim plan of care for minimizing the risk for elopement will be initiated upon the risk determination 3. The Interdisciplinary Team will initiate a plan of care for any resident determined at risk for elopement. Facility specific measures as well as resident specific measures will be included in each at risk resident's plan of care to minimize risk factors. Individualized care plans that specify how staff should redirect each resident based on their reason for attempted elopements and the ways that are proven to help redirect them. Communication of these interventions will be made to direct care staff through exposure to the resident's plan of care and periodic review and disclosure of the contents of Elopement Binder .7. The plan of care for minimizing elopement risks will be reviewed each time the Risk Assessment is completed.		