

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Lebanon		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 North Alton Lebanon, IL 62254	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to ensure residents did not exit through an exit door and were being supervised to prevent any potential elopements for 1 of 3 residents (R2) reviewed for elopement in the sample of 6. This failure resulted in R2 pushing the exit alarm and exiting the facility around 7:45 PM with no staff intervention on 9/25/2025 from a secured memory unit and leaving the facility when it was pitch dark and he was later found at 10:00 PM (two hours and 15 minutes later) and returned to the facility. This past compliance occurred from 9/25/2025 to 9/26/2025. Findings include: The Immediate Jeopardy began on 9/25/2025 when R2 eloped from the facility and there was no staff available to redirect R2. R2 was found at 10:00 PM (two hours and 15 minutes later) and returned to the facility. The area R2 was found is straight from the facility to the residential area but there was no straight access unless one went through steep hills, terrain with lots of sticks, bushes, overgrowth, and steep terrain. V1 (Administrator) and V42 (VP of Clinical Operations) were notified of the Immediate Jeopardy on 10/10/25 at 3:22 PM. The surveyor confirmed by observation, interview, and record review that the immediacy was removed, and the deficient practice was corrected on 9/26/25. On 10/7/2025 at 11:03 AM, upon entering the dementia units there are two locked memory care units, one for males (300 hall) and one for females (200 hall). All doors to enter and exit on both sides of the units are locked and a code is needed. If the code is not entered correctly the alarm sounded for both doors. R2's room is on the male side of the locked memory unit. The door to the outside on the male memory unit is not egressed and sounded immediately when the door was opened. On 10/7/2025 at 12:20 PM, R2's photo was in the elopement book at the nurse's station on both the female and male dementia units identifying R2 as an elopement risk. R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Paranoid schizophrenia, drug induced subacute dyskinesia; insomnia; hypertension. R2's POS also document he is taking an antipsychotic medication (Haldol PRN as needed). R2's Minimum, Data Set (MDS) dated [DATE] document R2 has difficulty focusing attention, for example, being easily distracted or having difficulty keeping track of what was being said and has disorganized thinking. R2 has delusions, R2 wanders and R2 receives antipsychotic medications on a routine basis PRN (as needed). R2 ambulates independently and has no impairments. R2's Care Plan with a date of 8/8/2025 document R2 has a history of leaving the facility and hiding in facility dumpsters to watch staff look for him which he found humorous. R2 has a history of leaving facility and walking to the courthouse. R2 has a history of watching staff and when staff are busy with peers (R2) will exit and attempt to get to his nonexistent trailer. R2's Elopement assessment dated [DATE] document R2 was at risk for elopement. On 10/7/2025 at 11:33 AM, V1 (Administrator) stated, We have only had one resident elope since we got our IJ (Immediate Jeopardy). (R2) eloped on 9/25/2025. He was on (Dementia Unit) and went out the door on the evening shift, it was dark, and he walks really fast. Staff responded quickly but because it was dark, and he got away. He was gone for over two hours before we found him. He left and went out the door down the hill across that creek but there is no water, just rocks, and through the wooded area. Staff found him and we alerted the police and there were helicopters, canine units, everyone was looking for him. Once staff found him, they asked him if he wanted a soda, and he said yes and he willingly got into the car, and they brought him back with no issues. He was dressed appropriately and was even carrying a water bottle with him. He said he was doing maintenance work, and he was on a mission. On 10/8/2025 at 10:33 AM, R2 stated he did leave the facility and just went out the back door as nobody was around. I wanted to go catch a bus for personal business that I need to address. It's personal. I just walked out the door and across the field to the bus stop. On 10/8/2025 at 11:44 AM, verified the location where it was documented that R2 was found. It is a three-minute drive and a 24-minute walk. The area is straight from the facility to the residential area but there was no straight access unless one went through steep hills, terrain with lots of sticks, bushes, overgrowth and steep terrain. There are no bus stops in the area. On 10/8/2025 at 5:30 PM, V11 (Local Chief Firefighter) stated, We got a call saying the (Facility) had a missing resident that was on the dementia unit who was missing and confused and had gotten out of the nursing home. This was at night. The (Facility) had sent out a search group but was unsuccessful and was unable to locate (R2). We secured two canine units from neighboring police stations. We were flying [NAME], and we obtained a helicopter with infra-red technology and with the helicopter we were able to find him and once we found him everyone went to that location. I was with the canine units, and it let me tell you it was hectic, and I am not sure who got to him after we identified</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, interview, and record review, the facility failed to have an adequate number of staff available to care for the residents when reviewed for staffing. This failure has the potential to affect all 76 residents residing in the building. Findings Include: The facility's Final Report to the state surveying agency, dated 10/3/25, documents R2 eloped from the facility on 9/25/25 at 7:45 PM from the male locked memory care unit, on which he resided. On 10/7/25 at 5:05 AM, there were two CNAs (Certified Nursing Assistant), one on the male locked memory care unit, one on the female locked memory care unit, and one nurse that was working both the male and female locked memory care units. V28 (Licensed Practical Nurse/LPN), was observed in the beauty shop with the lights off, leaned back in a chair, sleeping. V28 was working on the 100 hallway with two CNAs. On 10/7/2025 at 5:20 PM, V19 (LPN) stated, I was working the night (R2) got out of the facility. I was on the women's unit and earlier that day the exit door on the woman's side (200 hall) was sticking which would cause the alarm to go off. That evening, I went to shut off the alarm and realized the alarm was still going on and that is when I realized it was coming from the men's (300 hall). I ran down to the other hall. You have to enter a code to go from the women's side to the male side and vice versa. I was not working the hall (V23 LPN) had a split hall that night and she was passing out medications on the 100 hall. At that time, I did not realize there was only one CNA working. I guess the other CNA was on break so there was only 1 CNA on that hall that night (R2) eloped. On 10/8/25 at 5:22 AM, V23 (LPN) stated she was working the night R2 eloped from the facility, she was working the 100-hall split (1/2 of the 100 hallway and the male memory care unit), when she was notified that R2 was gone. V23 stated this was over a week ago and couldn't recall the exact date or time but it could have been after supper. V23 stated they did a head count and R2 was missing. On 10/8/25 at 5:39 AM, V28 (LPN) stated he has worked the midnight shift for over 20 years and had never had trouble with it until he was in a car accident recently. V28 stated sometimes he just needs to sit back, relax, and waits for his name to be called when he is needed. On 10/8/25 at 6:37 AM, V1 (Administrator) stated she has not had any recent concerns brought to her attention regarding staff sleeping on the job. V1 stated she will often come into the facility between 2:00 AM and 5:00 AM, to talk with the night shift staff and hasn't observed anyone sleeping. On 10/8/2025 at 11:00 AM, V20 (CNA) stated, I was working a split 100 hall and men's hall. My nurse was passing out medications, and the other CNA was out on lunch break. I was the only one working on that hall when (R2) exited the building. I was in another room with another resident getting them ready for bed. I have hearing issues, and I heard an alarm, but we had been having issues with the door from the women's side to the male's side and the door was sticking and when I heard the alarm, I thought it was just that door not realizing it was the back door. Then I found out later when they did a head count that (R2) was missing. No, I did not stop when I heard the alarm and check. The Staffing Policy, undated, documents it is the policy of the facility to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the (state surveying agency). The Resident Census, dated 10/7/25, documents there are 76 residents residing in the facility.</p>		