STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145897	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Lebanon	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure misappropriation of medication did not occur for 2 of 3 residents (R6 and R7) reviewed for missing medication in the sample of 8. This past non-compliance occurred from 10/8/2025 to 10/29/2025. Findings include: On 11/19/2025 at 2:52 PM, V1 (Administrator) stated, on 10/18/2025 during the day shift the DON was notified by staff nurse that she tried to reorder (R6 and R7's) medication and the pharmacy had told them they had already sent them a supply of 2 cards (sixty doses). (R6 and R7) were both missing medications. There was only one card on file and there should have been two for each of them. Staff were interviewed and all stated they were doing narcotics counts but the sheet showing there were 60 pills vs thirty was not present either, so everyone's count was off, and we did not know until we got ready to reorder the medication. We were not able to locate the medication, and we did replace but the medication was missing. On 11/19/2025 at 3:02 PM, V2 (Director of Nursing/DON) stated, I got a call on 10/18/2025 by the nurse that when she went to refill (R6 and R7's) alprazolam they learned that the pharmacy had sent 60 pills not 30 pills, so we started an investigation to look into the missing meds. On 11/21/2025 at 10:47 AM, V17 (Licensed Practical Nurse/LPN) stated I was not working the back hall I was working the front hall so when the medication was delivered from the pharmacist, I was the one who signed for it. I got a call from the DON, and she asked me if I had counted the medication when I received it and I told her yes. I also remember there were two cards rubber banded together, and I did sign for the medication and took it back to the Agency nurse (V18 LPN) on the dementia unit. I was not asked to drug test, after they found out some drugs were missing, and they said (V18) was fired because they suspected she was the one taking the drugs. On 11/21/2025 at 11:30 AM, V8 (LPN) stated, I remember (R7) was running low on his medication and I called the pharmacy to reorder. The pharmacy told me that they sent out two cards (60 pills) so he should have 30 more pills, and it was too early. I went and found (V2) she was working the floor to let her know there were issues with missing medication for R7. I guess they did a count and (R6) was missing her medication too. I am not sure if they were able to find out who took the meds. I don't know if anyone was fired. I was not drug tested. 1). On 11/20/2025 at 1:44 AM, R6 was on the locked dementia unit on the female side. R6 was confused and not able to answer questions regarding if she had ever missed any medications. R6's Physician Order Sheet for November 2025 document a diagnosis of: POTS (Postural Orthostatic Tachycardia Syndrome), schizoaffective disorder, HTN (hypertension), hypothyroidism, Afib (atrial fibrillation), anxiety, anemia insomnia, HLD (Hyperlipidemia), GERD (Gastroesophageal reflux disease), polyarthritis, dementia, schizophrenia, cognitive communication deficit, vitamin D deficiency, depression, and allergic rhinitis. R6's Minimum Data Set (MDS) dated [DATE] documents severe cognitive impairment for decision making of activities of daily living.R6's Care Plan documents she makes false accusations of mistreatment by staff/peers. 6/2/25 R6's with new onset of behaviors of sitting on floor and flailing arms, taking a blanket and laying on floor in hallway, delusions that cops are coming to take her away, she has behaviors of laying on floor and wallering. R6's Initial Report dated 10/29/2025 at 6:55 PM, Staff reported alleged misappropriation of property. MD (Medical Doctor), POA (Power of Attorney) and local police notified. Investigation (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated. Final report to follow. (R6) Resident #1 and (R7) Resident #2 neither were documented as identified offender.R6's Pharmacy Packing slip dated 10/8/2025 documents (R6) received 0.5 mg tablet alprazolam 30 cards x2, V17, Licensed Practical Nurse (LPN) signed for those meds on 10/8/2025. R6's Progress Notes does not address her missing any of her alprazolam medication. R6's Controlled Drug Receipt for October 2025 documents, alprazolam tablet 0.5 MG (milligrams) take 1 tablet twice daily. 2.) R7's POS for November 2025 documents R7 with a diagnosis of Parkinson's disease, asthma, hypotension, dementia with agitation, bipolar disorder, anxiety, insomnia and dysphagia. R7's MDS dated [DATE] document R7 was severely impaired for cognition for activities of daily living. On 11/20/2025 at 1:24 PM, R7 was on the locked dementia unit on the men's side of the building. R7 was wandering and unable to answer any questions related to if he had ever missed any of his medications. R7's Initial Report dated 10/29/2025 document, Staff reported alleged misappropriation of property. On 10/29/2025 the DON was notified by staff nurse that she was unable to re-order medications on two residents. Further review by Admin/DON revealed a discrepancy in the number of cards the facility should have on hand. All appropriate notifications were made and investigation initiated. Facility leadership noted one card of 30 alprazolam for (R6) and one card of 30 alprazolam for (R7) to not be accounted for. Both medications were replaced at the expense of the facility. All narcotics were reconciled with no further concerns noted. The Facility undated Abuse Policy documents, To ensure that facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero- tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment. Or misappropriation of resident property. This past non-compliance occurred from 10/8/2025 to 10/29/2025: Prior to the survey date of 11/21/2025, the facility had taken the following actions to correct the noncompliance. All staff and residents were interviewed. All staff was in-serviced on medication, destruction and controlled substance disposal, narcotic count verification, log for cards of narcotic medication and abuse. All residents were assessed for behaviors. Daily audit of narcotics was started by the DON. Social Service Director is doing daily audits for psychosocial on residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility was unable to account for narcotic medication (alprazolam) for 2 of 3 residents (R6 and R7) reviewed for missing narcotic medication in the sample of 8. This past non-compliance occurred from 10/8/2025 to 10/29/2025. Findings include: 1.) On 11/20/2025 at 1:44 AM, R6 was on the locked dementia unit on the female side. R6 was confused and not able to answer questions regarding if she had ever missed any medications. R6's Physician Order Sheet for November 2025 document a diagnosis of: POTS (Postural Orthostatic Tachycardia Syndrome), schizoaffective disorder, HTN (hypertension), hypothyroidism, Afib (atrial fibrillation), anxiety, anemia insomnia, HLD (Hyperlipidemia), GERD (Gastroesophageal reflux disease), polyarthritis, dementia, schizophrenia, cognitive communication deficit, vitamin D deficiency, depression, and allergic rhinitis. R6's Minimum Data Set (MDS) dated [DATE] documents severe cognitive impairment for decision making of activities of daily living.R6's Care Plan documents she makes false accusations of mistreatment by staff/peers. 6/2/25 R6 with new onset of behaviors of sitting on floor and flailing arms, taking a blanket and laying on floor in hallway, delusions that cops are coming to take her away, she has behaviors of laying on floor and wallering. R6's Initial Report dated 10/29/2025 at 6:55 PM, Staff reported alleged misappropriation of property. MD (Medical Doctor), POA (Power of Attorney) and local police notified. Investigation initiated. Final report to follow. (R6) Resident #1 and (R7) Resident #2 neither were documented as identified offender.R6's Pharmacy Packing slip dated 10/8/2025 documents (R6) received 0.5 mg tablet alprazolam 30 cards x2, V17 (Licensed Practical Nurse/LPN) signed for those meds on 10/8/2025. R6's Progress Notes does not address her missing any of her alprazolam medication. R6's Controlled Drug Receipt for October 2025 documents, alprazolam tablet 0.5 MG (milligrams) take 1 tablet twice daily. 2). R7's POS for November 2025 documents R7 with a diagnosis of Parkinson's disease, asthma, hypotension, dementia with agitation, bipolar disorder, anxiety, insomnia and dysphagia. R7's MDS dated [DATE] document R7 was severely impaired for cognition for activities of daily living. On 11/20/2025 at 1:24 PM, R7 was on the locked dementia unit on the men's side of the building. R7 was wandering and unable to answer any questions related to if he had ever missed any of his medications. R7's Initial Report dated 10/29/2025 document, Staff reported alleged misappropriation of property. On 10/29/2025 the DON was notified by staff nurse that she was unable to re-order medications on two residents. Further review by Admin/DON revealed a discrepancy in the number of cards the facility should have on hand. All appropriate notifications were made and investigation initiated. Facility leadership noted one card of 30 alprazolam for (R6) and one card of 30 alprazolam for (R7) to not be accounted for. Both medications were replaced at the expense of the facility. All narcotics were reconciled with no further concerns noted. On 11/19/2025 at 2:52 PM, V1 (Administrator) stated, on 10/18/2025 during the day shift the DON was notified by staff nurse that she tried to reorder (R6 and R7's) medication and the pharmacy had told them they had already sent them a supply of 2 cards (sixty doses). (R6 and R7) were both missing medications. There was only one card on file and there should have been two for each of them. Staff were interviewed and all stated they were doing narcotics counts but the sheet showing there were 60 pills vs thirty was not present either, so everyone's count was off, and we did not know until we got ready to reorder the medication. On 11/19/2025 at 3:02 PM, V2 (Director of Nursing) stated, I got a call on 10/18/2025 by the nurse that when she went to refill (R6 and R7's) alprazolam they learned that the pharmacy had sent 60 pills not 30 pills, so we started an investigation to look into the missing meds. On 11/21/2025 at 10:47 AM, V17 (Licensed Practical Nurse) stated I was not working the back hall I was working the front hall so when the medication was delivered from the pharmacist, I was the one who signed for it. I got a call from the DON, and she asked me if I had counted the medication when I received it and I told her yes. I (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also remember there were two cards rubber banded together, and I did sign for the medication and took it back to the Agency nurse (V18 LPN) on the dementia unit. I was not asked to drug test, after they found out some drugs were missing, and they said (V18) was fired because they suspected she was the one taking the drugs. On 11/21/2025 at 11:30 AM, V8 (LPN) stated, I remember (R7) was running low on his medication and I called the pharmacy to reorder. The pharmacy told me that they sent out two cards (60 pills) so he should have 30 more pills, and it was too early. I went and found (V2) she was working the floor to let her know there were issues with missing medication for R7. I guess they did a count and (R6) was missing her medication too. I am not sure if they were able to find out who took the meds. I don't know if anyone was fired. I was not drug tested. The Facility Narcotic Counting Policy with a revision date of 11/1/2025 documents, Always participate in the counting of the controlled substances at the beginning and ending of your shift. Never say, go ahead without me and I'll sign later. Never leave it to someone else's discretion when you are the one on duty. If you do not observe the medications that you sign as being present, you may be implicated if the medications are later missing. General Procedure for Counting Controlled Substance. Follow your facilities specific guidelines and use their specific log sheet. Obtain sign-out records/logs and keys to the controlled storage compartment. Have partner to assist in the count. Wash hands or use antiseptic foam/gel. Unlock the medication cart. Select container and read the label. State the medication's name and strength. Count the remaining doses. Observe the number of spaced for medication to ensure no medications have been punched out of sequence thus altering the count. If medications are on a card, observe the integrity of the card to make certain it has not been tampered with. Observe the appearance of the pills to identify if they are correct and ensure there has been no tampering or substitution of medications. Determine amount of liquid medication, if appropriate. Verbally state medication count to person with sign-out record. Listen while partner verifies the count. Return container to its proper location. Repeat steps 6 - 14 for each controlled substance. Sign name, time and date of completed count. Lock medication area. Return sign-out log to proper location. Return keys to appropriate person. Procedure for Responding to Errors in a Controlled Substance Count: Obtain sign-out logs and keys to the controlled substance storage compartment. Have partner to assist with the count. Wash hands or use antiseptic foam/gel. Unlock the medication cart. This past non-compliance occurred from 10/8/2025 to 10/29/2025: Prior to the survey date of 11/21/2025, the facility had taken the following actions to correct the noncompliance. All staff and residents were interviewed. All staff was in-serviced on medication, destruction and controlled substance disposal, narcotic count verification, log for cards of narcotic medication and abuse. All residents were assessed for behaviors. Daily audit of narcotics was started by the DON. Social Service Director is doing daily audits for psychosocial on residents.