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	04/16/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 2 of 4 residents (R3 and R5) were protected from resident-to-resident abuse. This failure resulted in R3, who was nonverbal under end-of-life care, being the victim of sexual abuse by another resident (R2) with known inappropriate sexual behaviors. A reasonable person would likely suffer serious psychosocial harm, such as emotional distress or trauma and fear for safety as a result of sexual abuse. Findings Include:1. R3's Face Sheet, admission date of 03/13/16, documents R3 has diagnoses of but not limited to unspecified dementia, malignant neoplasm of upper-outer quadrant of unspecified female breast, major depressive disorder, recurrent, in partial remission, and hypertension (HTN). R3's Minimum Data Set (MDS), dated [DATE], documents R3 is severely cognitively impaired, and she was dependent on staff for all her activities of daily living (ADLs) R3's Care Plan documents R3 has a terminal prognosis related to (r/t) cerebral atherosclerosis and receives hospice care with an initiated date of 6/20/25. R3's Physician's Orders, dated 01/10/25 at 11:09 AM, documents Hospice to evaluate and treat as indicated. R3's Nurse Practitioners (NP) Progress Note, dated 02/10/26, documents R3 is nonverbal. R3's Progress Notes, dated 03/27/26 at 1:14 PM, documents R3 passed away at the facility at 11:40 AM. R2's Pre-admission Progress Notes, dated 07/16/25 at 12:54 PM, documents R2 was going back to his room after a smoke break and was heard by a nurse if he could play with a resident's breast. Social Service confronted him, and he denied it. When Social Service told him a nurse heard him, he had nothing to say. Social Service reminded him that it is highly inappropriate. R2's Pre-admission Progress Notes, dated 07/16/25 at 10:50 AM, documents Resident exhibiting impulsive behaviors wanting to touch other residents inappropriately. Nurse Practitioner (NP) notified and new orders were given to transfer R2 to a local hospital for evaluation and treatment. R2's Face Sheet, admission date of 08/08/25, documents R2 has diagnoses of but not limited to bipolar disorder, schizoaffective disorder, bipolar type, cerebral infarction, and dysphagia following cerebral infarction. R2's MDS, dated [DATE], documents he is cognitively intact with a Brief Interview of Mental Status (BIMS) of 14 out of 15. R2's Care Plan, admission date of 08/08/25, has no documentation (problem, goal, or interventions) R2 has sexually inappropriate behaviors. It does document R2 has potential to be physically aggressive related to (r/t) physical aggression to peer on 02/04/26. Interventions include but are not limited to send out to the hospital for evaluation and room move to (XXX) hallway from the dementia unit. R2's Psychiatry Note, dated 08/18/25, documents the chief complaint: Review of patient's behaviors, and symptoms related to his mental health. History of present Illness: R2 is a male patient with a history of Schizoaffective bipolar type, Generalized Anxiety Disorder (GAD), attention deficit hyperactivity disorder (ADHD), psychoactive substance abuse, tobacco use and insomnia. At the last visit, Divalproex was initiated to target impulsivity and inappropriate sexual behaviors. R2's Progress Notes, dated 03/30/26, Chief complaint: Per staff patient has recently exhibited hypersexual behavior while in the front of the building, which resulted in his transfer back to the memory care unit. It also documents ongoing behavioral dysregulation with inappropriate sexual behaviors, poor impulse control, and boundary violations evidenced by hypersexual actions (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	inappropriate touching of staff, and need for increased supervision. R2's and R3's Final report to the state surveying agency, incident date of 03/28/26 at 5:30 PM, documents: Investigation: An allegation was made that R2 allegedly was in R3's room and touched R3 inappropriately after it being reported that he was just in her room. When asked if there were any eyewitnesses, it was reported that they did not know that this was just a rumor they heard. R2 was interviewed and stated that he doesn't know what we were talking about and that he didn't know who R3 was. He knows that he was placed on the secure unit because he was wandering into rooms but that he didn't touch anyone. R2 was on frequent monitoring due to his increased confusion and wandering during the time of this allegation/hearsay rumors. R3 is not interviewable and has since passed away under hospice care. On the date of the allegation R3 was observed several times not under any distress even when R2 was observed in her room. This allegation was alleged after her passing by an anonymous person. Staff were interviewed and stated that they were not aware of any issues with R2 and R3. They were aware of his wandering and that he was placed on the secure unit due to that and his confused behaviors. When asked if R2 uses vulgar and inappropriate language staff did confirm that it is his normal vocabulary. When asked who the abuse coordinator all answered the administrator and they are aware of what should be reported to the administrator. Other residents were interviewed and asked if they have an issue with R2 being inappropriate with them or making lewd gestures. All residents interviewed stated no. They asked if they felt safe in the facility. All reported they do. When asked who they can report abuse or neglect to they reported to the administrator or their nurse. Conclusion: The facility was unable to determine if the allegations that were alleged were true. The rumors that were noted were asked to staff members if they had witnessed any of the allegations. All staff members reported no. When asked if he was in her room there were witnesses that stated he was in her room but not more than 10-15 minutes due to frequent checks on him and on her for different reasons. In an abundance of precautions and due to excessive wandering R2 was placed on the secure unit and due to prior behaviors, he was placed 1:1 for observation. Final Interventions: 1) In an abundance of precautions: a facility improvement plan was set in place.2) Staff in-serviced3) Investigation completed4) Resident interviewed5) Staff interviewed6) Initial audit that staff and residents know who to report abuse to.7) Ongoing audits set in place to ensure that allegations of abuse and increased behaviors get reported and interventions implemented timely. On 04/02/26 at 8:55 AM, V7 (Certified Nursing Assistant/CNA) said the incident happened last Tuesday (03/24/26) with R2 and R3 and then R3 passed away a few days later. V7 said she was assisting R3 with her breakfast and she wasn't eating very well so after she was finished, she laid R3 back down in bed and put a new brief on her and made sure it was secured tightly (she said R3 was not able to remove/loosen the brief up herself due to her decline in health). V7 said she then left the room to take care of other residents and about 15 minutes later she was walking by R3's room and looked in. When she looked in, V7 said she seen R2 up against R3's bed rail and so she yelled and told R2 he wasn't supposed to be in that room. She said when R2 started to step away from R3 she noticed his hand was in R2's brief and then he moved his hand away. V7 said she went in and got R2 from the room and she noticed R3's brief was now loose. V7 said V8 (MDS Coordinator) must have heard her yell because she came and got R2 and took him to his room. On 04/02/26 at 10:55 AM, Follow up interview with V7 (CNA). V7 said R3 was positioned on her back after she put her into bed. R2 was standing up close to R3 and when she yelled for him to back away from R3 she saw R2 remove his hand from the front of R3's brief. She said she didn't tell anyone because V8 came and got R2 and took him to his room and then V1 (Administrator) came and got R2 took him to the lobby and told him they were going to move him to a different room, so she thought they all knew. She said it's her fault that it wasn't reported. V7 said no one asked her any questions about the incident between R2 and R3. On 04/02/26 at 11:25 AM, R2 was questioned about the incident regarding R3 and he stated I f****d her in the a**. He said he did touch her inappropriately, that was the first time he had done it, he hasn't done it to anyone else, and that was the reason he was moved to the locked unit.On 04/09/26 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	at 11:49 AM, V26 (Psychiatry Nurse Practitioner/NP) said he started seeing R2 when R2 came to this facility. He said R2 had been displaying sexually intermittent sexually inappropriate behaviors. He said he has been doing medication modification since November to keep residents safe. He said to keep resident safe in his opinion there should be medication management, redirection attempts, reinforcement of appropriate behaviors. He said safety is his number one priority and good medication management. On 04/10/26 at 11:06 AM, V32 (NP) said when it comes to psychological impact of sexual abuse on a person it depends on a lot of things. She said it is distressing situation for anyone. She said it will differ from person to person also. It can cause emotional damage, anxiety, depression, post-traumatic stress disorder (PTSD), and yes there is always a risk for sexually transmitted disease (STD). 2. R5's Face Sheet, admission date of 08/25/25, documents R5 has diagnoses of but not limited to dementia, major depressive disorder, and schizophrenia. R5's MDS, dated [DATE], R5 is severely cognitively impaired, and he is dependent on staff for most of his ADLs. R5's Care Plan, with admission date of 08/25/25, documents safety concerns recipient of physical aggression by peer with bruise to right (R) face/eye. R2's and R5's state surveying agency Investigation documents the following: Initial Investigation: Incident date of 02/04/26 at 7:00 PMIncident Category: Resident to Resident Altercation. Resident #1 Involved in Incident/Reportable Event: R2 is a male, interviewable, informed decisions, alert and oriented times two. Resident #2 Involved in Incident/Reportable Event: R5 is a male, he is not interviewable, can't make informed decisions, alert and oriented times 1. Police were notified.Detailed Incident Summary:R2 BIMS of 14, is a [AGE] year-old male who resides on our secured male unit here at Evercare of Lebanon. He has a past medical history of Cerebral infraction, dysphasia, COPD, Bipolar disorder, schizoaffective disorder, anxiety disorder, ADHD, unspecified dementia, and depression. R5 BIMS 99 is a [AGE] year-old male who resides on our secured male unit here at Evercare of Lebanon. He has a past medical history of obstructive and reflex uropathy, major depressive disorder, schizophrenia and generalized anxiety disorder. Initial Report:Staff reported an alleged Resident to Resident physical altercationInitial Interventions:1. Residents immediately separated2. Residents assessed.3. MD (Medical Doctor) & Responsible parties notified4. Increased monitoring initiated on both residents5. Investigation initiated6. Final to follow in 5 working days. Final Report:A comprehensive investigation including resident/staff interviews and review of both residents' medical records was conducted. Facility staff were interviewed and voiced that R5 was visualized coming out of R2's room. R5, BIMS of 99 was interviewed and could not express to staff any events that just occurred. R2 BIMS of 14 was interviewed and voiced that R5 wandered into his room when he was sleeping and was going through his belongings. R5 expressed feeling startled by R5. When asked if residents feel safe in the facility, R5 stated yup, yup. When asked if R2 feels safe in the facility, he stated yes. Facility staff were interviewed and expressed no concerns related to abuse. Other residents were interviewed and expressed no concerns related to abuse. Based on the results of the investigation, the facility has found no evidence to support abuse. The IDT determined the alleged interaction was related to wandering behavior and cognitive impairments. Final Interventions:1. Increased monitoring for both residents2. R5 sent to hospital for evaluation3. R2 sent to (name of facility) for psych evaluation and returned 2/94. R5 returned same day 2/4 on 15min checks for 72 hours5. R2 room move with resident/family approval and 15min checks for 72 hours6. Psych consultation requested for R27. Assessments completed on both residents: BIMS, Trauma Informed Care, Skin Checks, Pain and vials8. Abuse Policy In-Service completed On 04/02/26 at 8:50 AM, R2 said he did have a fight with someone back here (the unit). He said someone was lying in his bed. When asked what happened he stated, I fought him. R2 was asked if he was hurt during the altercation and he stated, no and when asked if the other resident was hurt R2 said yeah, he was. The facility's Abuse Prevention and Prohibition Program, reviewed date of 12/2/25, documents Purpose: To ensure that the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designated to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Policy:I. 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.II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being.III. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems.It further documents: M. Resident-to-Resident altercations must be reported if the altercation is caused by a willful action that results in physical injury, mental anguish or pain.The presence of a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate non-accidental behavior.Assessing psychosocial outcome of the victim of abuse may be difficult to determine or incongruent with what would be expected. In these situations, the investigatoriii. should consider how a reasonable person in the resident's circumstances would be impacted by the incident.N. The Administrator will provide initial and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies as outlined in Section IX below.i. If the investigation substantiates the allegation, corrective action will be documented as part of the investigation and implemented to prevent recurrence. It also documents VII. Protection D. If the allegation is regarding a resident-resident altercation, the residents will be separated immediately, pending the investigation. Resident-Resident altercations will only be investigated as an incident of abuse if the incident meets the criteria of the definition of abuse.It further documents IX. Reporting/Response A. Facility Staff are Mandatory Reporters. The facility Resident Listing report, dated 04/02/26, documents there are 73 residents residing at the facility.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure sexual abuse allegations were reported for 1 of 4 residents (R3) reviewed for abuse. This failure occurred when R2, who had known sexually inappropriate behaviors, went into R3's room and was observed with his hands in R3's briefs and staff did not report the incident. A reasonable person would likely suffer serious psychosocial harm, such as emotional distress or trauma and fear for safety as a result of sexual abuse. Findings include: Immediate Jeopardy began on 03/24/26 in the A.M., when R2, with known sexually inappropriate behavior, was seen in R3's room with his hand in R2's brief and staff did not report the incident.V1 (Administrator), V12 (Regional Nurse Consultant) and V21 (Regional Director of Operations) were notified of the Immediate Jeopardy on 04/10/26 at 12:57 PM. Abatement plan number one was not accepted. Abatement plan number two was accepted. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 4/14/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. R3's Face Sheet, admission date of 03/13/16, documents R3 has diagnoses of but not limited to unspecified dementia, malignant neoplasm of upper-outer quadrant of unspecified female breast, major depressive disorder, recurrent, in partial remission, and hypertension (HTN).R3's Minimum Data Set (MDS), dated [DATE], documents R3 is severely cognitively impaired, and she was dependent on staff for all her activities of daily living (ADLs)R3's Care Plan documents R3 has a terminal prognosis related to (r/t) cerebral atherosclerosis and receives hospice care with an initiated date of 6/20/25. R3's Physician's Orders, dated 01/10/25 at 11:09 AM, documents Hospice to evaluate and treat as indicated.R3's Nurse Practitioners (NP) Progress Note, dated 02/10/26, documents R3 is nonverbal.R3's Progress Notes, dated 03/27/26 at 1:14 PM, documents R3 passed away at the facility at 11:40 AM.R2's Face Sheet, admission date of 08/08/25, documents R2 has diagnoses of but not limited to bipolar disorder, schizoaffective disorder, bipolar type, cerebral infarction, and dysphagia following cerebral infarction. R2's MDS, dated [DATE], documents he is cognitively intact with a Brief Interview of Mental Status (BIMS) of 14 out of 15.R2's Care Plan, with admission date of 08/08/25, has no documentation (problem, goal, or interventions) R2 has sexually inappropriate behaviors.R2's Psychiatry Note, dated 08/18/25, documents he was seen by V26 (Psychiatry Nurse Practitioner/NP) and was seen for follow up for target impulsivity and inappropriate sexual behaviors.R2's Progress Notes, dated 03/30/26, Chief complaint: Per staff patient has recently exhibited hypersexual behavior while in the front of the building, which resulted in his transfer back to the memory care unit. It also documents ongoing behavioral dysregulation with inappropriate sexual behaviors, poor impulse control, and boundary violations evidenced by hypersexual actions inappropriate touching of staff, and need for increased supervision.On 04/02/26 at 11:25 AM, R2 was questioned about the incident regarding R3 and he stated I f****d her in the a**. He said he did touch her inappropriately, that was the first time he had done it, he hadn't done it to anyone else, and that was the reason he was moved to the locked unit.R3's Initial and Final state surveying agency reports were reviewed, and the final report documents the following: Date of Incident: 03/28/26 at 17:30 (5:30 PM).R2 is interviewable and makes informed decisions and alter and oriented times three. He is also capable of communication.R3 is not interviewable, can't make informed decisions, alert and oriented times one and she isn't able to communicate.Detailed Incident Summary documents: R2 is a [AGE] year-old male who resides at the facility. He has a past medical history of bipolar disorders, schizoaffective disorder, anxiety disorder, attention deficit hyperactivity disorder (ADHD), unspecified dementia and depression.R3 is a [AGE] year-old female who resides at the facility. She has a past medical history of unspecified dementia, major depressive disorders and mixed anxiety disorder.Initial Report: Staff reported an alleged (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	resident to resident physical incident. Investigation initiated. Final to follow.Initial Interventions:1. Residents immediately separated2. Residents assessed3. MD & Responsible parties notified4. Increased monitoring5. Investigation initiated6.Final to follow in 5 working days7. Abuse and Neglect In-service startedInvestigation: An allegation was made that R2 allegedly was in R3's room and touched R3 inappropriately after it being reported that he was just in her room. When asked if there were any eyewitnesses, it was reported that they did not know that this was just a rumor they heard.R2 was interviewed and stated that he doesn't know what we were talking about and that he didn't know who R3 was. He knows that he was placed on the secure unit because he was wandering into rooms but that he didn't touch anyone. R2 was on frequent monitoring due to his increased confusion and wandering during the time of this allegation/hearsay rumors. R3 is not interviewable and has since passed away under hospice care. On the date of the allegation R3 was observed several times not under any distress even when R2 was observed in her room. This allegation was alleged after her passing by an anonymous person. Staff were interviewed and stated that they were not aware of any issues with R2 and R3. They were aware of his wandering and that he was placed on the secure unit due to that and his confused behaviors. When asked if R2 uses vulgar and inappropriate language staff did confirm that it is his normal vocabulary. When asked who the abuse coordinator all answered the administrator and they are aware of what should be reported to the administrator.Other residents were interviewed and asked if they have an issue with R2 being inappropriate with them or making lewd gestures. All residents interviewed stated no. They asked if they felt safe in the facility. All reported they do. When asked who they can report abuse or neglect to they reported to the administrator or their nurse.Conclusion: The facility was unable to determine if the allegations that were alleged were true. The rumors that were noted were asked to staff members if they had witnessed any of the allegations. All staff members reported no. When asked if he was in her room there were witnesses that stated he was in her room but not more than 10-15 minutes due to frequent checks on him and on her for different reasons. In an abundance of precautions and due to excessive wandering R2 was placed on the secure unit and due to prior behaviors, he was placed 1:1 for observation.Final Interventions:1) In an abundance of precautions: a facility improvement plan was set in place.2) Staff in-serviced3) Investigation completed4) Resident interviewed5) Staff interviewed6) Initial audit that staff and residents know who to report abuse to.7) Ongoing audits set in place to ensure that allegations of abuse and increased behaviors get reported and interventions implemented timely. On 04/02/26 at 8:55 AM, V7 (Certified Nursing Assistant/CNA) said the incident happened last Tuesday (03/24/26) with R2 and R3 and then R3 passed away a few days later. V7 said she was assisting R3 with her breakfast and she wasn't eating very well so after she was finished, she laid R3 back down in bed and put a new brief on her and made sure it was secured tightly (she said R3 was not able to remove/loosen the brief up herself due to her decline in health). V7 said she then left the room to take care of other residents and about 15 minutes later she was walking by R3's room and looked in. When she looked in, V7 said she seen R2 up against R3's bed rail and so she yelled and told R2 he wasn't supposed to be in that room. She said when R2 started to step away from R3 she noticed his hand was in R2's brief and then he moved his hand away. V7 said she went in and got R2 from the room and she noticed R3's brief was now loose. V7 said V8 (MDS Coordinator) must have heard her yell because she came and got R2 and took him to his room. On 04/02/26 at 10:55 AM, Follow up interview with V7 (CNA). V7 said R3 was positioned on her back after she put her into bed. R2 was standing up close to R3 and when she yelled for him to back away from R3 she saw R2 remove his hand from the front of R3's brief. She said she didn't tell anyone because V8 came and got R2 and took him to his room and then V1 (Administrator) came and got R2 took him to the lobby and told him they were going to move him to a different room, so she thought they all knew. She said it's her fault that it wasn't reported. V7 said no one asked her any questions about the incident between R2 and R3.On 04/02/26 at 12:05 PM, V10 (Business Office Manager/BOM), said R2 had been hanging/lurking around R3's room so they moved R2 to keep him (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	from doing anything.On 04/02/26 at 1:30 PM, V11 (Vice President of Clinical Services) said R2 originally started out on the locked unit but he was having some behaviors with some of the other residents back there. She said he has a vulgar vocabulary and some of the dementia residents couldn't handle it well, so they made the decision to move him off the unit and make him a 1:1 for a while to see how he does. V11 said it was last Tuesday (03/24/26) and R2 was out in the hall and was wandering. She said he pulled his pants down in the middle of the hallway but his shirt was long enough and covered him so you couldn't see anything. V11 said later he wandered across the hall into R3's room and a CNA went back to get R3 up for lunch and found R2 in her room. She said V8 (MDS Coordinator) heard the CNA yell you can't be in here so she went to see what was going on and she then took R2 back to his room and then they notified V1 (Administrator) who in turn called her (V11) and they made the decision to move R2 back to the locked unit and make him a 1:1 so he would be monitored. V11 said nothing was said or reported to them that justified them doing a reportable and turning into the state surveying agency. On 04/07/26 at 11:20 AM, V8 (MDS Coordinator said she was sitting in her office (was the room next door to R3's room) and she heard a CNA who was in R3's room say hey, you're not supposed to be in here. She said she immediately went to the room and when she walked in R2 was sitting in his wheelchair and the CNA was pulling up R3's blanket. V8 said she removed R2 from the room and took him to his room and questioned R2 on what he was doing in that room. She said R2 told her he didn't know. V8 said she immediately went to V1 (Administrator) and reported to her what she saw. V8 said that is when they immediately started making plans to move R2. V8 said she wasn't involved or a part of R2's referral that would have been the old administrator (V16). She said R2 is physically and verbally aggressive, but he hasn't had any inappropriate sexual behavior that she is aware of. On 04/07/26 at 3:30 PM, V24 (CNA) and V25 (CNA) both stated later that same day they seen R2 in R3's room again and had to get him out. They didn't see anything inappropriate going on. They said R2 hadn't been moved back over to the locked unit, but they were in the process of trying to get him moved and they found R2 in R3's room and had to get him out of it.On 04/09/26 at 11:46 AM, V1 (Administrator) said V8 (MDS Coordinator) came into her office (Tues) and told her R2 was in R3's room. She said V8 told her she got him out of the room and took him to his room. V1 said she got up and went down there to check and when she got down there R2 was sitting in his room. Nothing else was reported to her. On 04/09/26 at 11:49 AM, V26 (Psychiatry Nurse Practitioner/NP) said he started seeing R2 when R2 came to this facility. He said R2 had been displaying sexually intermittent sexually inappropriate behaviors. He said he has been doing medication modification since November to keep residents safe. He said to keep resident safe in his opinion there should be medication management, redirection attempts, reinforcement of appropriate behaviors. He said safety is his number one priority and good medication management. On 04/09/26 at 2:47 PM, V6 (CNA) said she wasn't there the day it happened, so she didn't do anything after she heard about R2, there was nothing for her to do. She said it was after the fact, and they had already moved R2 back to the unit. She said if she had been here the of the incident she would have reported it immediately/as soon as possible (ASAP). On 04/10/26 at 11:06 AM, V32 (NP) said when it comes to psychological impact of sexual abuse on a person it depends on a lot of things. She said it is distressing situation for anyone. She said it will differ from person to person also. It can cause emotional damage, anxiety, depression, post-traumatic stress disorder (PTSD), and yes there is always a risk for sexually transmitted disease (STD). On 04/10/26 at 1:10 PM, This surveyor and supervisor went in to inform V1 and other administration (V12 and V21) of the IJ at 12:57 PM. After reading through the IJ information V1 stated they said they did an IDPH reportable investigation and turned it in. This surveyor asked why the investigation wasn't in with the other reported investigations that I had asked for upon entering. V1 said because it hadn't been 5 days, and she hadn't completed the investigation at that time. The facility's Abuse Prevention and Prohibition Program, reviewed date of 12/2/25, documents Purpose: To ensure that the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designated to screen and (continued on next page)

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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Lebanon	1201 North Alton Lebanon, IL 62254

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 stat requirements. Policy:I. 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.II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being.III. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems.It further documents: VI. InvestigationThe facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts.The Facility has protocols for investigation of theft/misappropriation of resident property abuse.If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of an unknown source or crime, the Administrator or designee, may appoint a member of the facility's management team (the Investigator) to investigate the alleged incident.If the investigation is delegated, the Administrator provides the Investigator with any supporting documents related to the alleged incident.The facility ensures protection of residents during abuse investigations.The investigator may take some or all of the following steps:Reviews all relevant documentation;Reviews the resident's medical record to determine events preceding the alleged incident;Interviews the person(s) making the incident report;Interviews any witnesses to the alleged incident;Interviews the resident (as medically appropriate);Interviews the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition;Interviews Facility Staff members who have had contact with the resident during the period of the alleged incident;Interviews the resident's roommate, family members, and visitors;Interviews other residents to whom the accused employee provides care or services;Reviews all events leading up to the alleged incident;Exercise caution when handling materials that may be used for evidence of a criminal investigation. The Investigator will ensure the facility does not impede on any criminal investigation (i.e., wash lines or clothing, destroy documentation, and bathing or cleaning the resident before the resident has been examined).Communicates with the Administrator on a daily basis regarding the progress of the investigation; andPrepares an investigation report documenting findings of the investigation.It also documents G. Witness reports must be given in writing and signed and dated.It further documents M. Resident-to-Resident altercations must be reported if the altercation is caused by a willful action that results in physical injury, mental anguish or pain.The presence of a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate non-accidental behavior.Assessing psychosocial outcome of the victim of abuse may be difficult to determine or incongruent with what would be expected. In these situations, the investigatorshould consider how a reasonable person in the resident's circumstances would be impacted by the incident.N. The Administrator will provide initial and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies as outlined in Section IX below.If the investigation substantiates the allegation, corrective action will be documented as part of the investigation and implemented to prevent recurrence.It also documents VII. Protection D. If the allegation is regarding a resident-resident altercation, the residents will be separated immediately, pending the investigation. Resident-Resident altercations will only be investigated as an incident of abuse if the incident meets the criteria of the definition of abuse.It further documents IX. Reporting/Response A. Facility Staff are Mandatory Reporters.It also (continued on next page)

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The Facility will report known or suspected instances of physical abuse, including sexual abuse, and criminal acts to the proper authorities by telephone or through a confidential internet reporting tool as required by state and federal regulations.Immediately, but no later than 2 hours after forming the suspicion -if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the ombudsman.No later that 24 hours after forming the suspicion- if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman.Reporting requirements are based on real (clock) time, not business hours.The administrator will provide the state survey agency, law enforcement and the Ombudsman with a copy of the investigative report within 5 days of the incident. It also documents: Failure to file a report within the required time frames may result in disciplinary action, up to and including termination. X. Special Consideration for Reporting Suspected Incidents of Criminal Sexual AbuseAnyone who suspects that criminal sexual abuse has been committed against a resident must immediately report this information Administrator and to the Director of Nursing Services.The facility will treat allegations as criminal sexual abuse wherein the Facility determines that the resident does not have the decision-making capacity to consent to the sexual act.The Director of Nursing Services or designee will immediately report this information to the Attending Physician.The Administrator then acts to ensure the following steps are taken:The proper authorities and individuals are notified immediately or within 2 hours, including but not limited to law enforcement, the Attending Physician, the resident's representative, the state survey agency, and adult protective services.A Licensed Nurse assesses the resident (alleged victim) for possible injuries.The resident is provided with medical treatment and emotional support necessary to prevent further deterioration of his/her health and wellbeing.The area where the alleged incident occurred is not disturbed or accessed by anyone before law enforcement arrives.The resident's clothing is not changed to avoid disturbing or destroying evidence.The resident is not bathed or, of female, douched, to avoid compromising potential evidence.The resident is transported to the hospital or other destination as instructed by law enforcement.The administrator will follow the reporting requirements outlined in Section IX above. The facility Resident Listing report, dated 04/02/26, documents there are 73 residents residing at the facility. The Immediate Jeopardy that began on 03/24/26. The immediacy was removed on 04/14/26 when the facility took the following actions: All residents that reside in the facility could be affected by deficient practice.A) R3 no longer resides in the facility. B) R2 was placed on the secured unit with 1:1 supervision. No behaviors exhibited since 3/24/26. currently out to the hospital. C)Administrator & Director of Nurses will be in-serviced on the abuse policy & procedure, how to conduct a complete investigation, including interviewing, reporting, and implementation. D) IDT team in-serviced by Administrator on abuse and neglect policy and procedure, reporting timely, and encouraging staff to report abuse & neglect. E) IDT team in-serviced staff on abuse and neglect, reporting timely, and ensuring accurate information was provided when reporting, and reporting of any behaviors. F) Staff will not work until in-serviced on abuse policy, reporting timely, and reporting behaviors to the appropriate staff. G) 24- hour report reviewed for the last 7 days to ensure that no reports of abuse of neglect were not reported timely or needing investigated. H) Facility will interview staff to ensure that no abuse allegations have gone unreported. I) Facility will interview residents to ensure that no abuse allegations have gone unreported. J) Facility will ensure residents who have a history of sexual inappropriate behaviors care plan will be reviewed to ensure interventions are appropriated.1) On-going Audit: The administrator/Designee will review the 24- hour report 5x/wk x 4 weeks to ensure that there were no reports of abuse or neglect. If abuse was noted and not reported 1:1 in-servicing will be completed.2) On-going Audit: The RDO/RNC/Designee will audit any abuse allegation to ensure that investigation was completed, timely and completely per facility policy. If an investigation was not completed 1:1 education will be provided.3) On-going Audit: The Administrator/Designee will review the 24-hour report 5x/wk x 4wks (continued on next page)

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