

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: 145897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate pressure relief to prevent new pressure ulcers from developing and prevent declines in existing pressure ulcers in 1 of 1 resident (R8), reviewed for Treatment/Services to Prevent/Heal Pressure Ulcers in the sample of 37. These failures led to R8 developing a new pressure ulcer and a decline in current pressure ulcers. Findings Include: R8's Face Sheet, undated, documents R8 has the following diagnoses, in part: Cerebrovascular Disease, Traumatic Brain Injury, Vascular Dementia, Epilepsy, Hypertension, Hypothyroidism, Hyperlipidemia, Stage 3 Pressure Ulcer to the Sacrum (Coccyx), and Stage 2 Pressure Ulcer to the Left Hip. R8's Minimum Data Set, dated [DATE], documents R8 has severe cognitive impairment, is dependent on staff for all activities of daily living has three stage 2 pressure ulcers that were not present upon admission, and three stage 3 pressure ulcers, one was present upon admission. R8's Care Plan, dated 5/14/25, documents R8 has current skin breakdown with the potential for further breakdown related to decreased mobility, spends most of her time in her bed or chair, and is incontinent of bowel and bladder. R8 has interventions in place to float her heels, and she is dependent on staff to turn/reposition her at least every two hours and more often if needed or requested. R8's Pressure Ulcer Risk Assessment, dated 1/20/26, documents R8 is at high risk for pressure ulcer development. R8's Pressure Ulcer Risk Assessment, dated 4/22/26, documents R8 is at very high risk for pressure ulcer development. R8's Wound Care Note, dated 4/1/26, documents R8 had a newly acquired pressure ulcer to the left hip and a decline in the coccyx and right medial foot wounds. R8's Wound Care Note, dated 4/8/26, documents a decline in the left hip, coccyx and right medial foot wounds. R8's Wound Care Notes, dated 4/15/26 and 4/22/26, document the left hip wound is the same, and a decline in the coccyx and right medial foot wounds. All above notes have comments to offload pressure per facility policy. On 4/29/26 at 2:00 PM, R8 was observed severely emaciated, positioned on her right side. There weren't any pillows or pressure relieving devices between her knees or ankles and her feet were touching the bed and were not floating. Wound care was observed on R8 with V4 (Assistant Director of Nurses (ADON)/Wound Care Nurse), and V12 (Wound Care Physician's Assistant) to all pressure ulcers. R8's sacral wound was approximately 6 cm (centimeters) by 6 cm, covered in wet necrotic tissue (slough), with a foul odor. R8's left hip wound was approximately 5 cm by 5 cm and was covered in dried necrotic tissue. R8's right medial foot wound was approximately 2 cm by 2 cm and was draining clear fluid. On 4/29/26 at 3:17 PM, R8 was observed positioned on her left side, with no pressure relieving devices in place between her knees or ankles, her left foot was touching the bed, and her feet were touching each other. On 4/30/26 at 8:00 AM, R8 was observed in her reclining wheelchair in the dining room. On 4/30/26 at 9:00 AM, R8 was observed in her reclining wheelchair chair in the TV (Television) area. On 4/30/26 at 9:35 AM, 10:00 AM, and 10:27 AM, R8 was observed in her reclining wheelchair in dining room in an activity. On 4/30/26 at 11:16 AM and 11:30 AM, R8 was observed in her reclining wheelchair in the TV area. On 4/30/26 at 11:50 AM, R8 was observed in her reclining wheelchair in the dining room. On 4/30/26 at 10:37 AM, V14 (Certified Nursing Assistant/CNA), stated R8 was just repositioned by her and V15 (Activity Director) about 5 minutes ago. V14 stated she and V15 repositioned R8 in her chair by (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: 145897
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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 0686 Level of Harm - Actual harm Residents Affected - Few	moving her up in her chair. On 4/30/26 at 10:40 AM, V15 (Activity Director) stated about 15 minutes ago she and V14 repositioned R8 in her chair by moving her up and over in her chair. On 4/30/26 10:55 AM V12 (Wound Care Physician's Assistant) stated ideally R8, would have something between her ankles and knees for pressure relief. V12 stated effective repositioning with R8 would be to get her out of her chair, lay her down/reposition her and get her up again later, not moving her up in the chair. V12 stated R8's deterioration in the right foot and coccyx wounds could have been caused by the lack of effective pressure redistribution. On 4/30/26 at 12:30 PM, V4 (ADON/Wound Care Nurse) stated R8 should be turned and repositioned every two hours. V4 stated when R8 is in bed, she usually has a pillow or something between her knees and ankles. V4 stated when R8 is up in her chair, they reposition her by moving her up in the chair, repositioning her side to side and then lying the back of the wheelchair down. V4 stated she has a special pillow that they usually put between her legs and boots when she is up in the wheelchair, but she forgot to put her boots on this morning. The Wound Management Policy, with a review date of 9/5/25, documents, in part, a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. A pressure ulcer is any lesion that is caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. The Repositioning Policy, with a review date of 7/1/25, documents, in part, the purpose of the policy is to focus on regularly changing a resident's body position to prevent pressure injuries and provide comfort and well-being. The frequency and specific positioning techniques should be tailored to each resident's individual needs, considering factors such as their mobility, skin condition, medical status, and comfort. The primary goal is to relieve pressure on bony prominences where pressure injuries are most likely to develop. Certain situations, existing pressure injuries, those in specific positions, or those using pressure relieving devices, require specific adjustments to the turning and repositioning plan.		