

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Swansea		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 North Second Street Swansea, IL 62226	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report allegations of abuse to the administrator immediately after an allegation is made and the state agency within the 2-hour timeframe for 2 of 3 residents (R2, R3) reviewed for abuse reporting in the sample of 5.</p> <p>Findings include:</p> <p>1. R2's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including diabetes, hemiplegia/hemiparesis, anemia and anxiety.</p> <p>R2's Undated Care Plan no documentation resident was at risk for abuse.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents she was alert, uses wheelchair, requires partial assist with sit to stand and submax assist with transfer.</p> <p>On 6/10/2025 at 1:07 PM V4, Certified Nurse's Aide, CNA, stated V4 was familiar with R2 and assisted V3, CNA, to care for her on 5/11/2025. V4 stated V3 got R2 in the stand-up lift and then she left the room to get towels. V4 stated when she reentered R2's room she was very upset and stated that V3 hurt her, abused her and hurt her arm. V4 didn't report that R2 stated V3 hurt her, abused her or hurt her arm to any staff she didn't think abuse occurred because V3 isn't rough with residents to V4's knowledge. V4 stated she wrote a statement regarding the allegation R2 made and turned it into V2.</p> <p>V10's, Licensed Practical Nurse (LPN), Statement dated 5/12/2025 documented (R2) stated (V3) had hurt her while transferring her. V10 documented she did a skin assessment and didn't see any skin issues then notified V2.</p> <p>R2's Progress Note dated 5/11/2025 no documentation that R2 alleged an employee abused or hurt her.</p> <p>(continued on next page)</p>

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/2025 at 12:25 PM V2, Director of Nursing, DON stated V10, called her on 5/11/2025 between 11:00 AM - 12:00 PM and stated R2 alleged V3 was rough with R2 during a transfer. V2 stated she spoke to R2 the next day, 5/12/2025 and she started an investigation. V2 stated this allegation was not called into the State. V2 stated a soft file was documented which means there was enough concern to do an investigation but not enough to report an allegation of abuse to the state. V2 stated a soft file is documented when the facility assumes state will investigate the allegation and the facility documents the investigation and holds onto it until state enters the building to show it was investigated and everything was OK, and the allegation was unfounded. V2 stated she started an investigation on 5/12/2025 because she wanted to ensure it wasn't abuse. V2 stated when a resident alleges staff are rough that doesn't mean staff were abusive towards the resident. V2 stated V10 didn't report R2 stated an employee was abusive with her, she reported the employee was just rough.</p> <p>R2's Medical Record dated 5/2025 no documentation the facility reported the allegation of abuse to the state agency within the 2-hour timeframe.</p> <p>2. R3's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including chronic pain, cancer and a fractured pelvis.</p> <p>R3's Undated Care Plan no documentation resident was at risk for abuse.</p> <p>On 6/10/2025 at 2:31 PM R3 stated the CNA working today (name unknown) that has pink pants on intentionally dropped my legs and they were throbbing all night on 6/4/2025 into 6/5/2025. The CNA stated, I have too many patients I don't have time for this b*****. R3 stated she felt it was abusive and intentional when the CNA dropped her legs onto the bed. R3 stated she has chronic pain, a broken hip and multiple cancer. During the interview R3 was tearful and stated she doesn't want that CNA to take care of her anymore and that she was scared of her. R3 stated she reported the incident to V2 on 6/5/2025 and V2 stated she will talk to the CNA. R3 then stated after she reported the incident to V2 that the CNA came to room and stated, I can't believe you f***** reported me. R3 stated she felt intimidated by the staff at that time and was fearful of her life. R3 stated although she requested the CNA not to take care of her anymore, she was still her assigned CNA on 6/5/2025 and 6/6/2025. R3 stated she reported the incident to V1 on 6/9/2025.</p> <p>On 6/10/2025 at 3:15 PM V2 stated R3 reported to her on 6/5/2025 that V16, CNA didn't meet her needs on 6/4/2025 and it seemed to R3 that V16 had an attitude. V2 stated R3 didn't report that any staff were rough or abusive towards her at that time. V2 stated R3 just now reported that V16 dropped her legs, and she felt it was intentional and abusive and she was starting an investigation at that time. No staff including V1 reported to V2 prior to 6/10/2025 that R3 alleged rough or abusive treatment from staff prior to this day.</p> <p>On 6/10/2025 at 3:25 PM V1, Administrator stated she started working at the facility as the administrator in March 2025 and hasn't reported an allegation of abuse since she started working at the facility. V1 stated R3 reported to her that an employee was rude and rough with her at approximately 5:00 PM on 6/9/2025. V1 stated R3 didn't know the employee's name but knew from what R3 reported it was a female CNA and she was trying to find out who the employee was so she could interview them and find out what occurred. V1 stated R3 reported that the female CNA assisted her to bed and let go of her legs and R3 was really upset about how this employee treated her. V1 stated she didn't know if it was an allegation of abuse because she didn't know who the employee was yet and therefore, she didn't report the allegation to the state agency on 6/9/2025.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's Serious Injury Incident and Communicable Disease Report, dated 6/10/2015 at 2:09 PM, documents (R3) alleged abuse against (V3.) Report date: 6/2/2025.</p> <p>On 6/12/2025 at 11:10 AM V2, DON and V13, [NAME] President of Clinical Services clarified the abuse investigation regarding R3 alleging V16 was rough/abusive toward her was started on 6/10/2025 when R3 initially reported the allegation to them. Staff interviewed residents regarding the allegation of abuse on 6/10/2025, not 6/9/2025.</p> <p>R3's Medical Record dated 6/2025 no documentation the facility reported the allegation of abuse to the state agency within the 2-hour timeframe.</p> <p>On 6/11/2025 at 12:58 PM V1, Administrator stated she is the abuse coordinator and didn't know the definition of abuse. V1 left the conference room to grab the facility's abuse policy. V1 came back into the conference room and went through the facility abuse policy page by page looking for the definition of abuse. V1 stated after reviewing the facility's abuse policy the definition of abuse is knowing or willful harm to a resident.</p> <p>The Facility's Undated Abuse Prevention and Prohibition Program, the facility will report known or suspected instances of physical abuse to the proper authorities by telephone or through a confidential internet reporting tool as required by state and federal regulations. Immediately, but no longer than 2 hours after forming the suspicion - if the alleged violation involves abuse to the state survey agency, adult protective services, law enforcement and the Ombudsman.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate allegations of abuse for 2 of 3 residents (R2, R3) reviewed for abuse investigations in the sample of 5.</p> <p>Findings include:</p> <p>1.R2's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including diabetes, hemiplegia/hemiparesis, anemia and anxiety.</p> <p>R2's Undated Care Plan no documentation resident was at risk for abuse.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents she was alert, uses wheelchair, requires partial assist with sit to stand and submax assist with transfer.</p> <p>On 6/3/25 at 1:10 PM, when asked if staff treat her nicely, she shook hand to indicate so so. Surveyor asked what she meant by that, and she responded, one of the CNAs (Certified Nurse's Aides) yanked me out of the 'it and spin' and I landed on the floor. R2 stated this happened on Mother's Day (5/11/2025.) She said it was not an accident. R2 stated She told me, 'Come on, if you don't, I'll get you to move' and grabbed my left arm. My bottom was on the edge of the seat, and I just slid off and landed on the floor on my bottom. I wasn't moving fast enough, and she was tired and frustrated. We had confrontations before that. I'm not afraid here but just want to move.</p> <p>R2's Progress Note dated 5/11/2025 no documentation that (R2) alleged an employee abused her.</p> <p>Review of the Initial Abuse Investigation Report, dated 5/11/2025, documented (R2) alleged that (V3, CNA) was rough with her during a transfer and hurt her. (R2) c/o (complained of) being hurt during a transfer. She states a CNA was rough with her. (R2) and (V3) reported this situation to the nurse on duty. (V2, Director of Nursing, DON) was notified. Interviews were initiated with (V10 LPN), (V3), and (R2.) Also spoke to other residents to see if any CNAs or any other staff had abused them in anyway. At the time of interview (R2) denied any abuse and requested to be transferred to another facility closer to family. She stated if she is closer her family can visit more. Skin assessment completed and no skin issues noted.</p> <p>The Final Follow-Up Report, dated 5/13/2025, documented The physical abuse allegation against (R2) was unfounded. All persons involved were interviewed and provided witness statements. At the time it was reported (R2) stated (V3) was rough and hurt me when she was trying to transfer me.</p> <p>V10's Licensed Practical Nurse, LPN, Statement, dated 5/12/2025 documented (R2) stated (V3) had hurt her while transferring her. V10 documented she did a skin assessment and didn't see any skin issues then notified V2. No additional information was documented as to what R2 meant by stating V3 hurt her.</p> <p>V3's Written Statement, dated 5/11/2025 contained no documentation R3 alleged V3 was abusive or rough with her.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/2025 at 10:10 AM V3, CNA stated she took care of R2 often and was very familiar with her care. V3 stated R2 was a sit to stand transfer, and she transferred her on her own without additional assistance. V3 stated on 5/11/2025 R2 was being transferred with sit to stand and she let go of the sit to stand and R2's right arm flew back behind her, and she grabbed R2's arm and assisted it to the front of the sit to stand lift. V3 stated she lowered R2 to the floor and went and got V4, CNA to assist her to get R2 off the floor. V3 reported she lowered R2 to the floor to V10, LPN an agency nurse. V3 stated R2 was upset about being lowered to the floor but R3 didn't allege she was rough with her or hurt her. V3 denied abusing or being rough with R3 on 5/11/2025. V3 stated she wasn't suspended at any time during the investigation period.</p> <p>V4's, CNA, Written Statement, dated 5/11/2025, had no documentation R3 alleged V3 was abusive or rough with her.</p> <p>On 6/10/2025 at 1:07 PM V4, CNA stated was familiar with R2 and assisted V3 to care for her on 5/11/2025. V4 stated V3 got R2 in the stand-up lift and then she left the room get towels from the hallway. V4 stated when she reentered R2's room R2 was very upset at that time and stated that V3 hurt her, abused her and hurt her arm. V4 stated she didn't see what occurred because she wasn't in the room. V4 didn't report that R2 stated V3 hurt her, abused her or hurt her arm to any staff she didn't think abuse occurred because V3 isn't rough with residents to V4's knowledge. V4 stated she wrote a statement regarding the allegation R2 made and turned it into V2.</p> <p>Review of the R2's Facility's Abuse Investigation Report, dated 5/11/2025 had no interviews with other residents to whom the accused employee V3 provided care or services to were documented.</p> <p>2. R3's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including chronic pain, cancer and a fractured pelvis.</p> <p>R3's Undated Care Plan no documentation resident was at risk for abuse.</p> <p>On 6/10/2025 at 2:31 PM R3 stated The CNA working today (name unknown) that has pink pants on intentionally dropped my legs and they were throbbing all night on 6/4/2025 into 6/5/2025. The CNA stated, 'I have too many patients I don't have time for this b*****.' R3 stated she felt it was abusive and intentional when the CNA dropped her legs onto the bed. R3 stated she has chronic pain, a broken hip and multiple cancer. R3 stated she reported the incident to V2, DON on 6/5/2025 and V2 stated she will talk to the CNA. R3 then stated after she reported the incident to V2 that the CNA came to room and stated, I can't believe you f***** reported me. R3 stated she felt intimidated by the staff at that time and was fearful of her life. R3 stated although she requested the CNA not to take care of her anymore, she was still her assigned CNA on 6/5/2025 and 6/6/2025. R3 stated she reported the incident to (V1, Administrator) on 6/9/2025.</p> <p>= On 6/10/2025 at 3:15 PM V2 stated R3 reported to her on 6/5/2025 that V16, CNA, didn't meet her needs on 6/4/2025 and it seemed to R3 that V16 had an attitude. V2 stated R3 didn't report that any staff were rough or abusive towards her at that time. V2 stated R3 just now reported that V16 dropped her legs, and she felt it was intentional and abusive and she was starting an investigation at that time.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/2025 at 3:02 PM V16, CNA (was wearing pink pants) and stated she was assigned to R3 on 6/4/2025 and stated R3 was a new resident, and she didn't receive report on her, so she didn't know how to take care of her. R3 stated she needed assistance getting into bed on 6/4/2025 so V16 assisted her to bed, and she placed R3's legs on a pillow one at a time. V16 denied dropping R3's legs on the bed on 6/5/2025. V16 stated V2 spoke to her about being rough with R3 on 6/5/2025 and just told her to be careful when putting R3 to bed because R3 has chronic pain and cancer and that was it, she was not suspended, and no one asked her to write a statement regarding the allegation of her being rough with R3 at that time. V16 denied telling R3 that she has too many patients and that she didn't have time for this b***** and she also denied telling R3 that I can't believe you f***** reported me. V16 stated she did nothing wrong why would she say that to R3, and she never curses at residents.</p> <p>On 6/10/2025 at 3:25 PM V1, Administrator stated she started working at the facility as the administrator in March 2025 and hasn't reported an allegation of abuse since she started working at the facility. V1 stated R3 reported to her that an employee was rude and rough with her at approximately 5:00 PM on 6/9/2025. V1 stated R3 didn't know the employee's name but knew from what R3 reported it was a female CNA and she was trying to find out who the employee was so she could interview them and find out what occurred. V1 stated R3 reported that the female CNA assisted her to bed and let go of her legs and R3 was really upset about how this employee treated her. V1 stated she didn't know if it was an allegation of abuse because she didn't know who the employee was yet and therefore, she didn't report the allegation to the state agency that day.</p> <p>Review of R3's Serious Injury Incident and Communicable Disease Report, dated 6/10/2015 at 2:09 PM, documents, (R3) alleged abuse against (V3.) Report date: 6/2/2025.</p> <p>On 6/11/2025 at 12:58 PM V1 stated she is the abuse coordinator and didn't know the definition of abuse. V1 left the conference room to grab the facility's abuse policy. V1 came back into the conference room and went through the facility abuse policy page by page looking for the definition of abuse. V1 stated after reviewing the facility's abuse policy the definition of abuse is knowing or willful harm to a resident.</p> <p>On 6/11/2025 at 9:15 AM V13, [NAME] President of Clinical Services, stated she expects staff to interview the resident that alleged staff were rough with them or abused them to see what occurred and to ask open ended questions to see what exactly occurred and what the resident meant by alleging staff were rough/abusive. If V1 and/or V2 are not in the building the nurse assigned to the resident should go interview the resident and ask open ended questions regarding staff being rough with the resident and what exactly occurred so they can rule out abuse. If a specific employee is named as an alleged perpetrator, then she expects staff to interview other residents that the alleged perpetrator was assigned to rule out additional issues and/or concerns related to that employee.</p> <p>On 6/12/2025 at 11:10 AM V2 and V13, clarified the abuse investigation regarding R3's incident date and report date was 6/10/2025, not 6/2/2025 and staff interviewed residents that were assigned to the alleged perpetrator, V16 on 6/10/2025, not on 6/9/2025 V2 and V13 stated the abuse investigation was started on 6/10/2025 when they were aware of the allegation of abuse.</p> <p>The Facility's Undated Abuse Prevention and Prohibition Program, the documents each resident has the right to free from abuse. The facility has zero-tolerance for abuse. The facility promptly and thoroughly investigates reports of resident abuse. Interviews should include other residents to whom the accused employee provides care and services.</p>		