

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 07/24/2025
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)		
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578</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 interview and record review, the facility failed to follow advanced directives for 1 of 3 (R5) residents reviewed for advanced directives in a sample of 16. This failure resulted in an Immediate Jeopardy on [DATE] when staff performed unnecessary chest compressions, respiratory ventilation for 20 plus minutes, and intubation on R5 against his advanced directive status. On [DATE] at 9:22 AM V1, Administrator was notified of the Immediate Jeopardy. The Surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on [DATE], after abatement reviews dated [DATE] at 7:35 AM and [DATE] at 3:07 PM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-servicing training and policies and procedures. Findings include: R5's Physician Order Sheet (POS), dated 7/2025, documented diagnoses of Chronic Obstructive Pulmonary Disorder, Chronic Diastolic Congestive Heart Failure, and Morbid (severe) Obesity with Alveolar Hypoventilation. It also documented an order dated on [DATE] DNR (Do Not Resuscitate). R5's Post Acute Care Transfer Report from the local hospital, dated [DATE], documented, Code Status Information: Limited: No CPR (cardiopulmonary resuscitation) Modified Resuscitation Specifics: Provide aggressive: No intubation. R5's Care Plan did not document R5's code status. On [DATE] at 9:56 AM, V7, Licensed Practical Nurse, (LPN), stated that at around 5:20 AM on [DATE], she was passing medications, and she stopped at R5's room, and took his medications in to him. She stated that she set them down on the table, called his name and he didn't respond, so she shook him, and he felt cold, and his color was pale. He did not respond, so she rubbed his chest and checked his neck for a pulse and did not feel anything. She stated she yelled for help, she checked her computer, that was right outside of R5's room, and there was not a code status in the computer. V7 was asked where she would find a code status on a resident in the computer, V7 stated that on the MAR (Medication Administration Record) by the resident's picture is their code status. V7 stated that the other nurse called 911, and she started Cardiopulmonary Resuscitation (CPR), had the bed flat. V7 stated that Emergency Management Services (EMS) arrived 15-20 minutes later and took over CPR. V7 stated that since she could not find the code status, she treated it as a Full Code. She also stated that while EMS was performing CPR, she went to the nurse's station and checked the BIG computer and there still wasn't a code status that could be found. She continued to state that she entered R5's room and EMS had stopped CPR at around 5:47- 5:50 AM and the MD (medical doctor) from the hospital called it (time of death). V7 stated that when the day shift nurse came in, she showed her where R5's code status was in miscellaneous in R5's electronic medical records. V7 stated that prior to her going into R5's room to give him medication at 5:20 AM, the last time she checked on R5 was around 12:30-12:45 AM. V7 stated that code status for all residents is on the home page and the Medication Administration Record (MAR), both located in the electronic medical record (EMR). On [DATE] at 2:00 PM, V8, Certified Nurse Assistant, (CNA) stated that she was not R5's CNA the night he passed away, but she was working so she went down to his room while CPR was in progress and before EMS came, and V7 had her perform CPR, because the nurse was getting tired. V8 stated that she couldn't answer where she would find a resident's code status. On [DATE] at 9:30 PM, V14, LPN, who was the day shift nurse on [DATE] that came in at 6:00 AM for her shift and assisted V7 with finding the code status, stated that when she came in, R5 was being coded by EMS, and that he was intubated. V14 stated that the DNR was in the miscellaneous section of his chart and that it was not on the computer screen where V7 could find it. V14 stated that she knew he was a DNR because she admitted him from the hospital on [DATE]. V14 also stated that there is a list of residents who are DNR at the nurse's station by the computer, but his name wasn't on it. V14 stated that EMS did intubate R5 and used the Ambu bag and that the doctor at the hospital told EMS to stop CPR. V14 was asked when a resident returns from the hospital, like R5 did, who gets the order from the doctor for the new code status? V14 stated that it is usually the admitting nurse, but she continued to state that she didn't think she got the order for R5's DNR nor did she put it in the computer and that was why it did not show up when V7 was looking for it. V14 stated that when she was helping V7 look for it, it was not on R5's home page in the electronic medical record and that was why V7 couldn't find it. On [DATE] at 11:55 AM, V17, Social Services Director, stated that she was not aware of R5's code status change when he returned from the hospital on [DATE]. V17 stated that no one notified her of the change of code status from full code to DNR, so a new POLST (Physician Orders for Life-Sustaining Treatment) was not made in June. V17 stated that when R5 returned from the hospital she</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to ensure residents were free from misappropriation of property for 1 of 6 residents (R10) reviewed for abuse in the sample of 17.1.R10's Face Sheet documents R10 was admitted to the facility on [DATE] with diagnoses including alcohol dependence with alcohol-induced dementia and need for assistance with personal care.R10's Minimum Data Set (MDS) dated [DATE] documented R10 was moderately cognitively impaired with inattention and disorganized thinking and ambulated with walker.R10's Care Plan does not address risk of abuse and neglect.The Facility's Initial Report sent to the Illinois Department of Public Health (IDPH) on 2/18/25 documents R10 notified V17, Social Services Director, of allegation of misappropriation of money, and an investigation was initiated.The Facility's Abuse Investigation Report by V46, Former Administrator, documents, On 2/18/25 (V17) made a phone call when (R10) was in her office to (V36, R10's Family) regarding (R10)'s debit card due to it not working. (V36) has (R10)'s bank statement and informed (V17) and (R10) that the debit card had been used in (four various cities). (V36) named multiple places it was used, including (Real Estate Company). (V36) included the phone number for the real estate group. He stated (R10) had no money because of this. The Facility's Summary of Investigators Findings documents, (V17) discovered (R10)'s debit card was used on multiple dates in January (2025). Per real estate group, debit card was used on 1/17/25 to pay rent in the amount of (\$)209.99 for (V25, Certified Nursing Assistant, CNA). On 7/18/25, V25 and V46 were no longer working in the Facility.The Facility's 2/20/25 interview with V47, CNA, documents R10 asks people all the time to go to the store for him.The Facility's 2/20/25 interview by V48, CNA, documents R10 is always giving out his (debit) card.The Facility's 2/21/25 interview by V40, Housekeeper, documents R10 asks anyone and everyone to go to the store for him.On 7/22/25 at 12:50 PM, V33, CNA/Transportation, stated R10 has asked her to buy him things with his debit card.V17's Written Statement documents V36 reported all R10's money was gone and stated it looked like it was spent in four different towns, beginning on 1/16/25. V36 stated there was a \$209.00 payment made to a phone number on 1/17/25 for which a reverse search listed a (Real Estate Group). R10 stated he did not remember who he gave his card to, when he gave it to them, or what they looked like.On 7/18/25 at 1:50 PM, V17 stated it was reported several months ago that V25 took money from R10. The allegation was reported and investigated, and V25 was terminated. V17 stated (R10) has alcoholic dementia, and he always wants to give his debit card to people. We try to remind him to only give his card to me to purchase items for him, but he forgets. The Facility's 2/21/25 Abuse Allegation Interview with V25 documents R10 is always asking people to go to the store for him. V25 was asked whether she had ever purchased anything for herself with resident money, and she stated, No, my hands have not been on his debit card. V25 was informed that a transaction was made on the debit card in her name for rent. She stated, I didn't touch his debit card, but I can give it back. I can bring it to you.On 7/18/25 at 2:07 PM, V25 was not available for interview by phone.On 7/22/25 at 2:45 PM, V33, CNA/Activities, stated V25 used R10's debit card, then ended up getting fired. The Facility's Final Report sent to IDPH on 2/24/25 documents during the investigation, it was noted that R10's debit card was compromised and had been used in the (Local) area. R10 is known to give money or debit card to anyone, including other residents and visitors if he feels they will purchase items for him at the store. There was one possible purchase that could be linked to a facility member in January 2025. On 7/23/25 at 11:55 AM, V1, Administrator, stated she was not the administrator at the time of R10's investigation, but stated it looked like it happened, and the detective said who came out to the Facility to follow up on the case stated V25 used R10's debit card to pay rent. She stated she would expect the Facility to follow its abuse policy.The Facility's Undated Abuse Prevention and Prohibition Program Policy documents 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.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review the facility failed to implement its written policy by not ensuring that required background checks were completed prior to allowing direct care staff to work with residents. This failure had the potential to place all 52 residents living in the facility. Findings include: V37's, Certified Nursing Assistant, CNA, personnel file documented R37 was employed by facility beginning on 3/3/2025 through 5/15/2025. There was no Criminal Background Check completed by the facility; however, the facility did have a background check from previous employer dated 11/27/2024. V1, Administrator, stated Ideally this facility should've done a background check. V1 stated (V37) came from a sister facility and just kind of showed up one day. V2, Director of Nursing, DON, stated Typically when a staff member requests a transfer from a sister facility, we would call that facility and let them know the staff is requesting a transfer. There are new procedures put in place now that onboarding and background checks are to be done. Facility's undated abuse policy states To ensure that the 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. Facility's resident roster dated 7/14/2025 documents 52 residents residing in the facility.</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to report allegations of exploitation immediately to the Executive Director for 1 of 3 residents (R5) reviewed for reporting of abuse in the sample of 17. Findings include: R5's incident note dated 7/17/2025 at 2:30PM documents R5 was a resident at this facility with a BIMS of 15 and diagnosed with the following but not limited to: Major Depressive Disorder, recurrent moderate Chronic Obstructive Pulmonary Disease, Unspecified Type 2 Diabetes with Hyperglycemia, and essential primary hypertension, Chronic Congestive Heart Failure. At approximately 2:30PM on 7/17/2025, an Illinois Department of Public Health surveyor reported to V1, Administrator, that there was an allegation of an inappropriate relationship between R5 and former staff members V37, V35, Certified Nurse's Aides, CNAs, and an unknown staff member. On 7/22/2025 at 11:35AM V32, CNA, stated There were 2 staff that would make R5 food, and he would pay their bills, give them gifts, give them the keys to his house, put money in their cash app. The staff were V35 and V37. R5 paid V37's insurance premium. I told the administration before the facility was bought out. On 7/22/2025 at 3:30PM V37, CNA, stated (R5) and I were just really good friends. He sent me money to my cash app a couple of times for coffee and donuts but that was it. On 7/23/2025 at 12:00PM V1, Administrator, stated I found out about the abuse of R5 when the surveyors told me. V37 had already been terminated for tardiness. I was not the Administrator yet, but I would've expected the outgoing Administrator to have passed that information along to me. Facility's undated abuse policy states To ensure that the 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.</p>