STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Swansea	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide supervision and monitoring for 1 of 1 (R38) resident reviewed for elopement. This failure allowed a resident with fluctuating cognition impairments to sign himself out of the facility on 11/27/2025 at 3:00 PM with unknown destination, unknown return, and with staff unaware of his whereabouts. At 9:40 PM police found R38 sitting on the ground, very confused, a mile away from the facility by a busy 4 lane highway intersection. R38 was transferred to the emergency room with multiple abrasions, bruises and lethargy where he required IV fluids, a head CT, X-Ray of chest and right knee. On 12/11/2025 at 1:40 PM V2 Director of Nurses, V3 Assistant Director of Nurses, V10, V25, V26 and V27 were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on 12/12/2025 but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include: R38's Former Facility Weekly Summary, dated 11/12/2025 at 5:23 PM documents resident is alert and orientated with episodes of forgetfulness and confusion. Vision impaired. Ambulates with w/w (wheeled walker) at times forgets walker. 11/13/2025 at 3:36 PM documents resident alert to self. Ambulates with walker with supervision within facility. Incontinent of bowel and bladder. Peri care when staff he allows it. R38's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with diagnoses including Parkinson's, diabetes, Bipolar and Schizophrenia. R38's Baseline Care Plan, dated 11/18/2025, V13, LPN documented R38's vision was adequate. Functional Status: independent with eating, oral hygiene, toileting, dressing, putting on/taking off footwear, setup assistance needed for personal hygiene. Mobility: independent, walk 10 feet: not assessed/no information documented. No mobility device. Level of consciousness: alert, cognitively intact, continent of bowel and bladder. Psychotropic medications included Seroquel, Abilify and Sertraline. Self-Administer medications: no. No pain. Resident is not a diabetic and no history of falls documented. Resident is not an elopement risk documented. R38's Health Status Note, dated 11/18/2025 at 11:09 AM documents resident arrived to the facility via private vehicle. Escorted to room and orientated to call light and remote. Resident is alert and oriented x 3. No c/o (complained of) pain voiced or noted. All medication orders entered into electronic medical record. Skin assessment completed upon admission to facility. No areas of concerns noted at this time. Resident currently in bed resting with eyes closed. Respirations even and unlabored. Call light in reach and functional. R38's Electronic Medical Record dated 11/18/2025 at 11:10 AM through 11/27/2025 at 4:11 PM, no progress notes documented including no assessment of R38's cognition or behavior. R38's Nurse Practitioner (NP) New Admit Progress Note, dated 11/19/2025, documents [AGE] year-old male presents to me today at NF (nursing facility) as new admit. He has dx (diagnosis) of anxiety, bipolar disorder, HTN (high blood pressure), depression, COPD (chronic obstructive pulmonary disease), vitamin d deficiency, insomnia and diabetes. He is resting in bed. He appears stable in no acute distress. He voices no acute concerns. Nursing has no acute concerns. He is ambulatory. He is current smoker, and he does not wish to quit smoking. He is A&O (alert and oriented) to person and place. Cognitive status documented: forgetful.R38's Elopement Evaluation, dated 11/18/2025, documents he was not an elopement risk. R38's Functional Abilities and Goals - admission assessment, dated 11/18/2025 V13, LPN documented functional cognition: independent, no impairment for functional limitations range of motion, no mobility devices checked, independent with toileting. Walk 10 feet: not assessed/no information documented. Walk 50 feet with two turns: not documented. Walk 150 feet not documented. Walking 10 feet on uneven surfaces: the ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel: not documented. 1 step (curb): documented not assessed/no information. 4 steps: the ability to go up and down four steps with or without a rail: not documented. 12 steps: the ability to go up or down 12 steps with or without a rail: not documented. R38's Nurse Practitioner (NP) Progress Note, dated 11/26/2025 documents chief complaint/reason for this visit: low hemoglobin. HPI (History of Present Illness) to this visit: [AGE] year-old male is ambulatory and is A&O (Alert & Orientated) to person. Cognitive status: forgetful. R38's Health Status Note, dated 11/27/2025 at 4:12 PM, documents resident signed out LOA (leave of absence.) No documentation of where R38 was going, who he was going with, when he was expected to be back or what he was wearing when he left the facility. R38's Orders - Administration Note, dated 11/27/2025 at 6:57 PM documents LOA. No additional information was documented regarding R38 being on LOA. R38's Community Survival Skills Assessment documents the