

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 12/17/2025
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 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. **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. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 assessment date 11/18/2025 and created dated 11/28/2025 V2 documented the resident appears to be capable of outside pass privileges at this time. On 12/9/2025 at 10:00 AM V13, LPN (Licensed Practical Nurse) stated she didn't know R38 well because he was a new resident, admitted a few weeks prior. V13 stated she admitted R38 when he was initially admitted to the facility, R38 arrived with 3 or 4 pages of paperwork from the previous facility which included his medication list and a face sheet. V13 stated she documented R38's admission paperwork from the information and how he presented upon initial observation of him. V13 stated R38 seemed to be alert and oriented to person, place and time at the time of admission. V13 stated when a resident is initially admitted to the facility the assigned nurse is responsible for documenting a clinical assessment, which is the resident's initial nurse assessment, but she couldn't find that assessment in R38's electronic medical record, V13 stated she must have forgot to do it because she is always very busy with all resident care. V13 clarified she didn't document R38's Community Survival Assessment although it's dated 11/18/2025 V13 showed it was created and documented on 11/28/2025 by V2 and she didn't understand that because R38 left the facility LOA on 11/27/2025 and he didn't return to the facility. V13 stated she works full time at the facility and recalled as the days went by after R38 was admitted , she reassessed R38 and noted he talked to himself and was very confused and was alert to person only. V13 stated she didn't document that R38 was confused in his electronic medical record, but she probably should have but she was so busy at the facility and gets overwhelmed with admissions, discharges, medications and all the things and she can't document everything. V13 stated she couldn't recall what was documented on R38's face sheet if he was his own responsible party or not upon admission but she recalled at the end of November 2025 administration was running around trying to find out if R38 had a power of attorney or not because he signed himself out of the facility and was later found by the police. V13 stated R38 ambulated without an assistive device and his gait was steady at the facility. He required assistance from staff for ADLs (Activities of Daily Living) but he often refused care and was incontinent of bladder and cursed at staff when they attempted to provide incontinence care. R38 stated V13 didn't have safety awareness and shouldn't be anywhere including out in the community by himself because he was alert to person only. V13 recalled R38 was aggressive and refused care and cursed at staff. V13 stated if R38 was his own responsible party he could sign himself out of the facility because this isn't jail, but she would want to know where he was going and when he planned to be back to the facility. V13 clarified that R38 was confused and forgetful and he shouldn't have signed himself out and left by himself because he could've got hurt. On 12/10/2025 at 10:28 AM V16, LPN stated she is an agency nurse and works at the facility a few times a month. V16 stated she (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	former facility Administration stated R38 was a resident at that facility 11/15/2025 through 11/17/2025 and then R38 was transferred to the facility. V22 stated R38 was alert to person and place and was really confused. V22 stated R38 walked with a wheeled walker, and he often forgot it in his room so staff would go get it for him. V22 stated R38 could walk approximately 25-40 feet without his wheeled walker. V22 stated R38 was a fall risk as he fatigued while ambulating easily, so he always needed his wheeled walker with him. V22 stated R38 didn't have safety awareness and although he was his own responsible party, he wouldn't allow R38 to leave without someone to drive him because he was confused and forgetful and his facility is rural, surrounded by cornfields so it wouldn't be appropriate for R38 to sign himself out and leave the facility. On 12/10/2025 at 11:42 AM V2, DON stated R38 was admitted to the facility with 3 or 4 pages of information including a face sheet, medication list and a few nurse's notes. V2 stated there was no POA paperwork, no emergency contact and no family member documented on R38's admission paperwork. V2 stated there is a corporate liaison and they sent her preadmission paperwork regarding R38 and she wasn't updated that R38 was out by himself in the past and he got lost and fell off a train platform, if she would have been given that information, she wouldn't have accepted him as a resident because he needs a locked memory unit, and the facility isn't locked. The liaison told her R38 needed a private room due to aggressive behaviors but not that he was an elopement risk. Upon admission a licensed nurse assesses the resident and documents the assessment in a resident's electronic medical record, part of the admission assessment the nurse assesses the resident's cognitive status and if the resident's cognitive status changes after admission, V2 expects the nurse to document a progress note. When a resident is a new admission, she expects the assigned nurse to document a progress note at least once a day and document how the resident is doing for the next 7 days to ensure the resident is doing well at the facility. When a resident wants to sign out and go on leave of absence, she expects the assigned nurse to look at the resident's face sheet to see if the resident is their own responsible party or if they have a POA or guardian. If the resident has a POA she expects staff to contact the POA and ask who is picking the resident up and ask where they are going and when they are expecting to returned to the facility and the assigned nurse should document that information on the 24 hour nurse report sheet to ensure the facility knows when the resident is expected to return to the facility so if they aren't back by that time staff can start calling the resident's family so the facility knows the resident is ok. No staff called her regarding R38 going out LOA, but she doesn't expect staff to call her unless something is wrong. V2 stated the night shift nurse called her the evening of 11/27/2025 approximately 7:00 PM and reported to her that the police were at the facility and reported to staff that R38 was found over a mile and a half down the street, and he was very confused, and he was at the hospital. V2 stated she spoke to the police officer and confirmed R38 was a resident at the facility, and she didn't know he was at the hospital, and he was found on the sidewalk with multiple scrapes and bruises about his body. V2 stated she had 3 or 4 interactions with R38, and she didn't know R38 good enough to say if he had safety awareness or not. V2 stated she expected staff to follow policies and procedures of the facility to ensure residents are taken care of. On 12/12/2025 at 8:30 AM V2, DON stated she didn't understand the severity of the citation regarding R38 because he signed himself out of the facility and he was his own responsible party. V2 stated the facility didn't contact IDPH to report the incident regarding R38 being found by the police and be transported to the emergency room because he signed himself out and it was her understanding when a resident sign themselves out of the facility then the facility is no longer responsible for the resident and that was the purpose of the resident signing themselves out. On 12/10/2025 at 1:31 PM V14, NP stated she initially assessed R38 on 11/19/2025 and he was alert to person and place and was forgetful and confused but he had just moved to the facility, so she didn't know if that's his baseline or not because she just met him. V14 stated she reassessed R38 on 11/26/2025 and he was alert to self only that day and he was confused and forgetful and after that assessment, V14 stated it was her professional medical assessment that R38		

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 3 residents (R26) reviewed for abuse in a sample of 32. This failure resulted in R26 obtaining a laceration to the forehead requiring medical treatment. Findings Include: R26's Undated Face Sheet documents R26 was originally admitted to the facility on [DATE] and has a Medical Diagnosis of Hypertension, Schizophrenia, Depression, Type 2 Diabetes, and Hemiplegia Affecting Left Non-Dominant Side. R26's Minimum Data Set (MDS) dated [DATE] documents R26 is cognitively intact and has had verbal behavioral symptoms directed towards others occurring 1-3 days. R26's Care Plan Date Revised 12/2/2025 documents R26 is/has potential to be physically aggressive toward peers related to anger, poor impulse control. R26's Behavior Note dated 12/2/2025 at 8:48 PM documents This nurse was notified by a Certified Nursing Assistant (CNA) that resident was bleeding from being struck in the head with an object by roommate. Resident has a laceration to left side of forehead. Resident refused vital signs (v/s) resident was in full rage resident breathing and responding well and is able to state what is going on in details. Sending resident to hospital for eval. R26's No Type Specified Note dated 12/3/2025 at 4:09 AM documents Resident returned to facility via Emergency Medical Service (EMS) two EMS workers transported resident from stretcher to bed. Resident denies pain at this moment. Residents' laceration was repaired with sutures Per hospital report the sutures should dissolve on their own. R11's Undated Face Sheet documents R11 was originally admitted to the facility on [DATE] and has a Medical Diagnosis of Hypertension, Major Depressive Disorder, Bipolar Disorder with Psychotic Features, Generalized Anxiety Disorder, and Schizophrenia. R11's MDS dated [DATE] documents R11 is cognitively intact. R11's Care Plan Last Revised 10/15/2025 documents R11 is/has potential to be physically aggressive related to anger, poor impulse control, and Bipolar. The Facility's Initial Serious Injury Incident and Communicable Disease Report dated 12/2/2025 at 8:05 PM documents Staff reported an alleged resident to resident physical altercation. The Facility's Final Serious Injury Incident and Communicable Disease Report dated 12/8/2025 documents A comprehensive investigation including resident/staff interviews and review of both residents' medical records was conducted. Medical record review reveals R11 and R26 were involved in a relationship per both of their requests. R11 was interviewed and voices that R26 pulled her hair. R11 voices she struck R26 in an attempt to have him release her hair. R26 was interviewed and voices that he grabbed R11's hair. R26 voices R11 struck him in the head. Multiple staff members were interviewed. No staff witnessed any physical contact between the two residents. Follow up Actions: R26 was transported to Local Hospital for evaluation and treatment due to minor alteration in skin integrity to scalp. R26 received 1 suture to left scalp. R11 was transferred to Local Hospital for psychiatric evaluation. Both residents returned to facility and the following actions were taken: Resident safety checks were initiated and ongoing monitoring. Both residents were separated and placed in different rooms on different halls. R11 was offered the option to transfer to another facility. R11 agreed and was transferred to another facility. Based on the results of the investigation, the facility noted staff did not observe the physical altercation. Both residents provided conflicting accounts but confirmed physical interaction and mutual aggression. Appropriate medical and psychiatric evaluations were completed, and safety interventions-including separation and eventual resident transfer-were implemented to mitigate further risk. Both residents care plans were reviewed and updated accordingly. R26's Local Hospital Medical Records Date of Service 12/2/2025 at 9:41 PM documents Chief complaint: patient presents with assault victim. Patient brought in via Emergency Medical Service (EMS) from Nursing Home Facility. Per EMS patient was involved in a dispute over peanut butter and was hit with a metal footrest of a wheelchair on the left forehead by the other individual. R26's Local Hospital Medical Records Dated 12/2/2025 at 10:22 PM documents procedure (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	laceration repair, repair type: sutures. On 12/11/2025 at 11:04 AM V13, Licensed Practical Nurse (LPN), stated R11 and R26 both have a lot of behaviors and have had multiple altercations with each other. V13 stated the last altercation with R11 and R26 was a physical altercation and both R26 and R11 were sent to the hospital for evaluation. On 12/11/2025 at 11:10 AM V9, Registered Nurse (RN), stated R11 and R26 have been verbally aggressive with staff, each other, and other residents. V9 stated R11 and R26 were in a relationship and would argue all the time. On 12/11/2025 at 11:15 AM V8, Certified Nursing Assistant (CNA), stated R11 and R26 have behaviors and have had altercations with each other. On 12/11/2025 at 11:51 AM V23, LPN, stated she was working at the facility on 12/2/2025 and was passing medications when staff came to her and stated there was an altercation between two residents. V23 stated when she went down the hall, she seen R11 holding a metal foot pedal from a wheelchair in her hand and R26 bleeding from his head. V23 stated R11 told her R26 pulled her hair and she then hit him in the head. V23 stated staff separated the residents and both were sent to local hospitals for evaluation. V23 stated R11 and R26 have had multiple verbal altercations prior to this physical altercation. On 12/11/2025 at 12:03 PM V14, Nurse Practitioner (NP), stated R11 and R26 have had altercations in the past, mostly being verbal altercations. V14 stated she was informed R11 had hit R26 in the head with an object. V14 stated R11 and R26 were sent out to Local Hospitals for evaluation. V14 stated R26 received a suture to R26's head from the altercation. V14 stated the facility should have interventions in place to keep residents safe and free from abuse. On 12/12/2025 at 8:47 AM V2, Director of Nursing (DON), stated R11 and R26 were in a relationship and would have disagreements all the time. V2 stated the facility would call R11 and R26 the facility's toxic couple. V2 stated both R11 and R26 have behaviors and the altercation that happened on 12/2/2025 was a physical altercation. V2 stated R26 stated R11 was trying to tell him to do something and R26 grabbed R11 by the hair and pulled R11 to the ground. V2 stated R11 grabbed the pedal from her wheelchair and hit R26 on the side on the head. V2 stated both R11 and R26 were sent to local hospitals and R26 obtained a suture to the laceration on R26's head. V2 stated R11 did not obtain any injuries from the altercation, that she only had some hair pulled out on the side of her head. The Facility's Abuse Prevention and Prohibition Program Policy Last Reviewed 6/1/25 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.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the Facility failed to provide residents with flavorful and properly cooked food for proper food temperatures and ensure food is held at temperatures to prevent food borne illness. This has the potential to affect all 58 residents living in the facility. Findings include: On 12/10/2025 at 7:40 AM, The Food Log for 12/10/2025 for the breakfast services was blank and did not document any food temperatures. On 12/10/2025 at 8:08 AM, during the breakfast service V24, Dietary Manger took out an industrial size pan of hash browns out of the oven. (V24) did not take the temperature of the hashbrowns and placed it in the steam table and served the residents without taking any temperatures. On 12/10/2025 at 8:59 AM, a food tray was taken after the last resident had been served and the eggs hashbrowns were not palatable and were cold with a rubbery texture and were not pleasant to eat. The hashbrowns were cold and mushy in texture. The temperatures taken with a calibrated metal thermometer were 90.4 F for the eggs and the hashbrowns were 101.0 F. On 12/10/2025 at 9:13 AM, V24, Dietary Manager stated he did not record any temperatures in the Food Logbook this morning for the breakfast menu. 1-R43's Minimum Data Set (MDS) dated [DATE] document he was cognitively intact for decision making of activities of daily living. On 12/10/2025 at 2:22 PM, R43 stated the food is not hot when it is supposed to be hot and yesterday the breakfast was cold. 2-R13's MDS dated [DATE] document she was cognitively intact for decision making of activities of daily living. On 12/10/2025 at 2:24 PM, R13 stated because of COVID they are serving everyone out of Styrofoam containers and her breakfast was cold today. The meals are cold a lot here. 3-R18's MDS dated [DATE] document she was cognitively intact for decision making of activities of daily living. On 12/10/2025 at 2:25 PM, R18 stated the food is not always hot and her breakfast this morning with state in the building was cold. 4-R15's MDS dated [DATE] document she was cognitively intact for decision making of activities of daily living. On 12/10/2025 at 2:27 PM, R15 stated her food is cold and this morning her eggs were cold, and she could not eat them. The food is usually cold here. 4-R59's MDS dated [DATE] documents he was cognitively intact for decision making of activities of daily living. On 12/10/2025 at 2:29 PM, R59 stated the food is usually cold when it comes out to the residents. Resident/Family Council Minutes dated 9/24/2025, Dietary Cold Food, Cold coffee. Resident Council Meeting Minutes dated 11/2025 document, Food has gotten better in dietary. (hotter). Dietary: No complaints food better. Resident Council Meeting dated 1/20/2025 Dietary: Running out of substitutes. Food served cold, especially the soups. On 12/12/2025 at 10:15 AM, V34, Dietician stated, I expect all food on the steam table to be held at minimum 135 degrees Fahrenheit. Anytime food temperatures drop less than 135 degrees it puts the resident at risk for food borne illness. All food should always be over 135 F while sitting on the steam table of higher.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 58 residents living in the Facility. Findings include: During the breakfast service on 12/10/2025 at 8:16 AM, V24 was serving eggs, oatmeal, and toast, and was not wearing gloves and he was touching the toast for each resident's breakfast meal without gloves. He was touching the oven, oven mitts and other things without washing his hands or disinfecting his hands. V24 handled every piece of toast without gloves. On 12/10/2025 at 8:16 AM, V32, [NAME] was on her personal cell phone, and was wearing gloves, and after the phone call had ended, she put the phone in her pocket did not change gloves or wash hands. V32 was handling butter packets and putting them in a large container. On 12/10/2025 at 8:17 AM, V32 stated she had just started working this week and has not completed any food safety training and did not know she was supposed to wash her hands after touching her phone before handling food. On 12/10/2025 at 8:19 AM, V24, Dietary Manager stated he would expect all staff to wash their hands after touching their phones and handling any food items. On 12/12/2025 at 10:20 AM, V34, Dietician stated, I would expect staff to leave all of their personal items behind including phones and drinks. If any staff would touch something like a phone, I would expect them to go to the sink in the kitchen and wash their heads because this creates cross contamination to food. I would not expect any kitchen staff to directly touch food and I would expect them to use tongs when touching toast. The Facility Dietary Staff Hand Hygiene Policy reviewed 10/1/2025 Hand washing Policy Purpose: To establish standards for employee dress, personal hygiene and hand hygiene practices. Guidelines: Employees shall adhere to the standards in the facility-wide Employee Hygiene and Hand Washing Policies/Procedures, except when a more restrictive standard is included in this policy and in the Dietary Operations Manual . Dietary employees will adhere to the facility hand hygiene policy and will perform hand hygiene as follows: Before preparing food or putting on gloves.The CMS 671 Form dated 12/9/2025 documents there were 58 residents living in the facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to wear appropriate PPE (Personal Protective Equipment) and perform hand hygiene to prevent the spread of infections. This failure has the potential to affect all 58 residents residing in the facility. Findings Include: 1. On 12/9/2025 9:54 AM R59 stated he tested positive for COVID last week and the facility staff have not worn gowns when coming into his room to provide care. There was no container or red biohazard bag observed in R59's room or bathroom to dispose of dirty Personal Protective Equipment (PPE) in. R59 stated there have been no containers with red biohazard bags to dispose dirty gown and gloves in and staff are putting their dirty gloves in his trash can. Sign of R59's door states Warning COVID-19 high risk of infection beyond this point. Please wear a face covering. No sign indicating resident is on contact/droplet isolation for COVID. R59's Undated Face Sheet documents R59 was originally admitted to the facility on [DATE] and has a Medical Diagnosis of Heart Failure, Hypertension, and Major Depressive Disorder. R59's MDS (Minimum Data Set) dated 12/5/2025 documents R59 is moderately cognitively impaired and is on isolation or quarantine for active infectious disease. R59's Care Plan Date Initiated 12/11/2025 documents R59 has infection of the Respiratory Systems. Intervention Date Initiated 12/3/2025 documents maintain universal precautions when providing resident care. R59's Physician Order dated 12/5/2025 at 8:27 PM documents strict isolation- all care to be given in room. R59's No Type Specified Note dated 12/3/2025 at 8:54 PM documents R59 returned from Local Hospital with Diagnosis (DX): of COVID. No new orders received. R59's Health Status Note dated 12/4/2025 at 1:59 PM documents Tested positive for covid 01 12-3. No distress noted. Complaints of (C/O) headache and effective treatment with Tylenol. Continues on isolation. R59's Health Status Note dated 12/10/2025 at 1:43 AM documents Resident on isolation related to (r/t) COVID 19. 2. On 12/9/2025 at 10:11 AM V7, Housekeeping, observed cleaning room [ROOM NUMBER] with a surgical mask and gloves on. Signs on room [ROOM NUMBER]'s door states Enhanced Barrier Precautions, Warning COVID-19 high risk of infection beyond this point. Please wear a face covering. V7 stated room [ROOM NUMBER] has residents that are positive for COVID-19 and she knows what Personal Protective Equipment (PPE) to wear from the sign on the room door. 3. On 12/09/25 at 12:15 PM, R1 had a sign on the outside of the door indicating COVID-19 high risk of infection beyond this point, please wear a face covering beyond this point. There is nothing indicating R1 is on contact/droplet precautions for COVID or what PPE is required to enter the room. R1 stated she tested positive for COVID after she was admitted to the facility, she has to stay in her room and sometimes the staff wear a mask when they come in her room but nothing else. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Line Listing for COVID-19 Outbreaks, document R1 tested positive for COVID on 12/4/25. 4. On 12/09/25 at 2:34 PM, R9 had a sign on the outside of the door indicating COVID-19 high risk of infection beyond this point, please wear a face covering beyond this point. There is nothing indicating R9 is on contact/droplet precautions for COVID or what PPE is required to enter the room. Face covering required beyond this point. There wasn't any trash receptacle in or immediately outside of the room to dispose of PPE or trash. The Line Listing for COVID-19 Outbreaks, document R9 tested positive for COVID on 12/6/25. 5. On 12/9/2025 at 10:31 AM V9, Registered Nurse (RN), arrived to R23's to change R23's colostomy bag. V9 put on clean gloves without washing her hands. V9 asked V5 (Certified Nursing Assistant, (CNA), if V5 could go get some hand sanitizer for her. V5 brought in bottle of hand sanitizer and place bottle on R23's bed side table. V9 removed R23's current colostomy bag and cleansed around R23's stoma. V9 disposed of gloves and put on another pair of clean gloves without performing hand hygiene and continued to cleanse R23's stoma. V9 removed gloves and donned a new pair of gloves with no hand hygiene and began cutting new colostomy bag for R23. V9 placed new colostomy bag around R23's stoma site. V9 removed gloves and began to cut adhesive tape and placed tape around R23's colostomy bag without performing hand hygiene. R23's Undated Face Sheet documents R23 was originally admitted to the facility on [DATE] and has a Medical Diagnosis of Chronic Kidney Disease Stage 3, Colostomy Status, Hypertension, Chronic Diastolic (Congestive) Heart Failure, and Need for Assistance with Personal Care. R23's MDS dated [DATE] documents R23 is cognitively intact, is dependent on staff for toileting hygiene, physical hygiene, and has a colostomy. R23's Care Plan Date Revised 11/20/2025 documents R23 will remain on Enhanced Barrier Precautions related to colostomy status. On 12/9/2025 at 10:05 AM V10, Regional Nurse Consultant, stated each resident who is on isolation for COVID-19 should have a container and a red biohazard bag in their room to dispose PPE in. On 12/12/2025 at 12:49 PM V2, Director of Nursing (DON) stated if a resident tests positive for COVID-19, the resident is to wear a mask in their room and all staff that enter the resident's room is to wear a mask. V2 stated if the resident comes out of their room, the resident is strongly encouraged to wear a mask. V2 stated staff and visitors should wear a mask and gloves when entering a resident's room who is positive for COVID-19. V2 stated staff should wear a mask, gown, and gloves if they will come into contact with a resident's bodily fluids who is COVID-19 positive. V2 stated staff and visitors are made aware of which type of personal protective equipment (PPE) to wear when entering a resident that is COVID-19 positive by the signage posted on the resident's door. V2 stated the sign posted on a resident's door will say Warning, you are required to wear a mask. On 12/12/2025 at 12:49 PM V2, Director of Nursing (DON) stated all staff are required to wash their hands every time they make contact with a resident, before assisting with food, and after touching any high contact areas. V2 stated she expects staff to wash their hands or perform hand hygiene before putting on gloves, when changing gloves, and after taking off gloves. On 12/12/2025 at 12:53 PM V26, Administrator Sister Facility B, stated a resident that is positive for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	COVID-19 should be on Contact Isolation. The CDC (Centers for Disease Control) Infection Control Guidance for SARS-CoV-2, dated 6/24/24, documents, in part, the following: Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control is recommended for individuals in healthcare settings who have suspected or confirmed SARS-CoV-2 infection. HCP (Healthcare Personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). The Infection Precaution Policy, dated 10/1/25, documents all PPE should be used once and discarded in either the trash or used linen receptacle before you leave the room. The Centers for Medicare & Medicaid Services, Form 671, dated 12/9/25, documents there are 58 residents residing in the facility.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the Facility failed to ensure Care Plans were resident centered and up to date for 1 of 5 residents (R13) reviewed for Care Plans in the sample of 32. Findings include: R13's Physician Order Sheet for December 2025 documents a diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris, adjustment disorder with anxiety, polyneuropathy, unspecified, acute posthemorrhagic anemia, unspecified sequelae of cerebral infarction, depression, mood disorder, hypertension, tachycardia, heart failure, and epilepsy. R13's POS also documents she has an order for Lidocaine External Patch 4 % (Lidocaine), Apply to left leg topically in the morning for leg pain. Lidocaine External Cream 3 % (Lidocaine). Apply to bilateral leg topically two times a day for leg pain, Date initiated 5/23/2025. R13's Hospital Physician Notes dated 10/22/2025 at 11:30 AM, 1) Knee: Bilaterally primary osteoarthritis of knee. I will provide bilateral knee braces today. Meloxicam 15 mg (milligrams), take 1 tablet every day by oral route. 2) Lumbar stenosis with neurogenic claudication. Neurological Surgeon Referral. Schedule within providers discretions. Note to Provider: Evaluate and treat. R13's Care Plan with a review date of 8/19/2025 does not address any pain in R13's knees. On 12/10/2025 at 10:02 AM, V2, Director of Nursing stated, We currently do not have a Care Plan Coordinator. We all (management) try and step in and make sure all of the Care Plans are up to date. All Care Plans should be resident centered. On 12/10/2025 at 10:24 PM, V2, Director of Nursing stated, Apparently (R13) has a lot of arthritis and she did see the specialist and they recommended therapy, but her insurance would not pay for it. She was complaining about pain, and she was supposed to get an appointment with the orthopedic specialist. I do not know anything about her having a brace. We lost our Social Service Person so I will try and make sure she gets an appointment. I did not realize (R12's) Care Plan did not address the pain in her legs. (R12's) Care Plan should have addresses her knee pain. The Care Plan Policy with a reviewed date of 9/2/2025 documents, to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.		

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 12/17/2025
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to address pain in 1 of 4 residents (R13) reviewed for pain in the sample of 32. Findings include: R13's Physician Order Sheet for December 2025 documents a diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris, adjustment disorder with anxiety, polyneuropathy, unspecified, acute posthemorrhagic anemia, unspecified sequelae of cerebral infarction, depression, mood disorder, hypertension, tachycardia, heart failure, and epilepsy. R13's POS also documents she has an order for Lidocaine External Patch 4 % (Lidocaine), Apply to left leg topically in the morning for leg pain. Lidocaine External Cream 3 % (Lidocaine). Apply to bilateral leg topically two times a day for leg pain, Date initiated 5/23/2025. R13's Care Plan with a review date of 8/19/2025 does not address any pain for R13's knee. R13's Minimum Data Set (MDS) dated [DATE] BIMS 13/15, resident is independent on most task. Does use a walker. No impairments on upper or lower extremities. On 12/10/2025 at 9:34 AM, R13 was rubbing her knees and was grimacing when she bent her legs. On 12/10/2025 at 9:39 AM, R13 stated, I am having a lot of issues, my knees, and have been in a lot of pain. My knees are killing me, and I thought they were supposed to get an appointment with the knee/bone specialist but if they have, I do not know when that appointment is, and I feel like things should be more organized. Resident was not wearing any knee braces. R13 stated her pain is a 10 out of 10 this morning. On 12/10/2025 at 10:00 AM, R13 stated she was never given a knee brace. R13 also stated they did give her pain medicine this morning, but she just took it. On 12/10/2025 at 10:03 AM, No knee braces were being stored in R13's room, under the bed and/or in the closet. On 12/10/2025 at 10:03 AM, V14, Social Service Director stated he has been here for two weeks now and was not sure about any orthopedic appointments for (R13). I will look into it. On 12/10/2025 at 10:23 AM, V14 stated, (R13) does not have any appointment scheduled for (R13) with any orthopedic specialist. R13's Hospital Physician Notes dated 10/22/2025 at 11:30 AM, 1) Knee: Bilaterally primary osteoarthritis of knee. I will provide bilateral knee braces today. Meloxicam 15 mg, take 1 tablet every day by oral route. 2) Lumbar stenosis with neurogenic claudication. Neurological Surgeon Referral. Schedule within providers' discretions. Note to Provider: Evaluate and treat. On 12/10/2025 at 10:24 PM, V2, Director of Nursing stated, Apparently (R13) has a lot of arthritis and she did see the specialist and they recommended therapy, but her insurance would not pay for it. She was complaining about pain, and she was supposed to get an appointment with the orthopedic specialist. I do not know anything about her having a brace. We lost our Social Service Person so I will try and make sure she gets an appointment. On 12/10/2025 at 12:56 AM, V2 stated I just talked with (R13) and she said she did have some braces but they were too big and so she did not wear them. I did not know this until today. The Facility Pain Policy with a reviewed date of 6/1/2025 documents, To ensure accurate assessment and management of the resident's pain.		

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 12/17/2025
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications as prescribed by the physician in 2 of 3 residents (R7, R22) reviewed for medication errors in the sample of 32. Findings Include: 1. On 12/10/25 at 8:05 AM, V12, Agency LPN (Licensed Practical Nurse), was observed administering medications to R7. V12 did not administer R7's Timolol eye drops, Anastrozole, or Omeprazole. R7's Face Sheet, undated, documents R7 has, in part, the following diagnoses: Malignant Neoplasm of the Right and Left Breast and Glaucoma. R7's MAR (Medication Administration Record), documents the following physician orders: 11/15/25 Timolol Maleate Ophthalmic Solution 0.5% instill one drop in the right eye twice daily for eye pressure; 11/15/25 Anastrozole 1mg (milligram) daily for breast cancer; 11/15/25 Omeprazole 20mg twice daily for acid indigestion. R7's MAR goes on to document that on 12/10/25, the above medications were not administered as ordered. R7's Progress Notes, dated 12/10/25, fail to document that R7's Physician was notified that those medications were not administered. 2. On 12/10/25 at 8:15 AM, V12, Agency LPN, was observed administering medications to R22. V12 did not administer R22's Omeprazole, Endurant, or OsCal. R22's Face Sheet, undated, documents R22 has, in part, a diagnosis of HIV (Human Immunodeficiency Virus). R22's MAR, documents the following physician orders: 1/14/25 Omeprazole 20mg twice daily for GERD (Gastroesophageal Reflux Disorder); 1/14/25 Edurant 25mg daily for HIV; 1/14/25 Oyster Shell 500mg twice daily. R22's Progress Notes, dated 12/10/25, fail to document that R7's Physician was notified that those medications were not administered. On 12/10/25 at 8:15 AM V12, Agency LPN, stated R7's Timolol, Anastrozole, and Omeprazole are not in the medication cart. V12 stated R22's Omeprazole, Endurant, and OsCal are not in the medication cart. V12 stated she will make a note and try to find them later. If she finds it, she will give it, but she is not going to stop because she doesn't know where the medication room is. On 12/12/25 at 1:15 PM, V2, DON (Director of Nurses), stated when a medication is not available in the medication cart, the nurse is to check the medication supply room, if it is not found, they are to contact pharmacy to see what the status is on the medication. Then the resident's physician is to be notified that the medication was not administered with a request to hold the medication until it arrives. The Medication Administration Policy, with a review date of 6/1/25, documents, in part, if a medication is not given, licensed personnel should document the medication was not given, notify the physician, and place a note in the resident's chart.		