

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/14/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Jerseyville		STREET ADDRESS, CITY, STATE, ZIP CODE 410 Fletcher St Jerseyville, IL 62052	
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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse and resident background check policies by failing to screen for potentially abusive residents during the admission process, failing to report and track residents qualifying criminal offenses, failing to ensure a risk assessment was completed, and failing to implement protective measures to prevent abuse for 1 of 3 (R54) residents reviewed for abuse in the sample of 35. This failure resulted an Immediate Jeopardy when R62 was admitted to the facility on [DATE] without appropriate screening, referrals and interventions for criminal convictions and proceeded to sexually abuse R54. This has the potential to affect all 55 residents who reside in the facility. The Immediate Jeopardy began on 9/26/25 when R62 was admitted to the facility. R62's Criminal History record, dated 9/29/25, documented R62 has a history of criminal convictions including retail theft, obstructing justice, deceptive practice, battery, and aggravated battery with great bodily harm. R62's care plan, undated, documented I/my representative deny any history of abuse, neglect, or mistreatment, and there is no indication that I have been a recipient or a perpetrator of mistreatment. R62's care plan documented R62 is an identified offender, his CHIRP (Criminal History Information Response Process) indicates that R62 has a criminal felony background. R62 has been screened through the admission process and is expected to acclimate safely in this setting. R62's criminal history includes retail theft, battery, and aggravated battery. Notify the resident that a representative from the ISP (Illinois State Police) will conduct an interview either in person or via a video call to ascertain the resident's risk level. On 12/9/25 at 12:35 PM V1 Administrator stated the facility did not notify the IOP (Identified Offender Program) of R62's criminal convictions nor was a criminal risk assessment completed. This failure resulted in R54 being abused by R62 on 11/8/25 when R62 flashed his genitals at R54 and then R62 grabbed R54's breast. On 12/10/25 V1 Administrator stated she does not know how many identified offenders are residing in the facility. On 12/11/25 at 10:57 AM Surveyor requested R62's fingerprint criminal records and V1 Administrator stated the facility does not have a copy of those results. Surveyor asked V1 if it is facility policy to attain and keep those records on file and V1 replied, I don't know. On 12/10/25 Surveyor requested R62's criminal background and it documented multiple criminal convictions including burglary, retail theft, criminal trespass to buildings, and violations of order of protections. V1 stated she did not notify the IOP of R62's criminal history therefore no criminal risk analysis was conducted nor does R62's care plan address his potential risks to other residents. V1 Administrator and V3 ADON (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 12/11/25 at 1:05 PM. The immediacy was removed on 12/12/25 but the facility remains out of compliance at a Level II due to additional time needed to evaluate implementation and effectiveness of training. Findings Include: R54's Medical Diagnosis sheet, print date of 12/9/25, documented R54 has diagnoses including Parkinsonism, dementia, osteoporosis, atherosclerotic heart disease, polyneuropathy, and cognitive communication deficit. R54's MDS (Minimum Data Set), dated 9/17/25, documented R54 is severely cognitively impaired and dependent on staff for ADLS (activities of daily living) and mobility. R54's care plan, undated, documented R54 has little, or no activity involvement related to immobility, physical limitations, due to Parkinson's and dementia. R54's progress note, (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	dated 11/8/25 at 5:45 AM, documented resident was up at the end of C hall in (reclining) chair sleeping when witnesses observed another resident flash his genitals to her. Staff informed aggressor that was inappropriate, and aggressor laughed. Aggressor proceeded to grab resident breast. Staff removed aggressor from resident and took aggressor to another room. Skin check of resident done, and no injuries noted. Resident went right back to sleep after incident. Resident POA (Power of Attorney) made aware, DON (Director of Nursing), Administrator and MD made aware. R62's face sheet, print date of 12/9/25, documented R62 has diagnoses including major depressive disorder, morbid obesity, hypertension, restlessness and agitation, panic disorder, psychophysiological insomnia, and anxiety disorder. R62's MDS, dated [DATE], documented R62 is cognitively intact. R62's MDS, dated [DATE], documented R62 is supervision or touching assistance with ambulation. R62's care plan, undated, documented R62 has a criminal felony background, has been screened through the admission process and is expected to acclimate safely in this setting. It continues, my criminal history includes retail theft, battery, and aggravated battery. R62's care plan interventions include notify the resident that a representative from the ISP (Illinois State Police) will conduct an interview either in person or via a video call to ascertain the resident's risk level. R62's care plan does not document R62's risk level. R62's progress note, dated 11/8/25 at 5:15 AM, documented resident in wc (wheelchair) wheeling self-up and down hallway, grabbing onto railing and propelling self, grabbing on to locked med carts and trying to open drawers, grabbing gloves and papers sitting on med cart and throwing them, going to the phone on the wall on c hall and attempting to make calls from it, wrapping cord of phone around hand and trying to hang phone up. Once staff was able to get phone back in place resident followed nurse down the hall blocking her between med cart and wouldn't let go, unable to redirect. Refuses to leave oxygen on, refuses to cover self, and is wheeling the hallway in a gown with legs spread wide open. Will not stay in room. R62's progress note, dated 11/8/25 at 5:40 AM, documented resident getting into things and throwing things in hall. Resident exposing self to other resident and refusing to cover genitals. Staff asked resident to stop and explained that was inappropriate. Resident laughed and continued to lift up gown and wheel up and down hall and by nurse's station. The facility's Serious Injury Incident and Communicable Disease Report, dated 11/8/25, documented final report, R62 perpetrator, and R54 victim. Detailed Incident Summary - Initial: It was reported at approximately 5:50 AM, that R62 and R54 were involved in an alleged altercation with inappropriate contact. Investigation initiated, POA (Power of Attorney) and MD notified. Investigation: On 11/8/25 at approximately 5:50 AM it was report by DON that V16 CNA witnessed R62 expose himself and inappropriately touched R54. V16 was interviewed by the administrator. V16 stated that she was up by the nurse's station, when R62 started lifting his gown exposing himself to R54, CNA asked R62 to stop, he did with a laugh. R62 started to go towards his room when he reached out to grab R54's right breast. V16 stated that she got R62 to let go of R54's chair, R62 proceeded to grab V16 and bite her. V17 CNA was interviewed by the administrator. V17 stated she saw R62 expose himself towards R54 and told him that it was inappropriate. V17 stated when R62 was headed towards his room, he reached out and grabbed R54's chair. V17 saw V16 remove R62 from the situation and tried to bite V16. Conclusion: Both residents at the time of the allegation showed no serious injury or harm. No redness, discoloration, or pain was noted immediately after the alleged incident. This is an isolated incident with both residents, neither resident has had an altercation with each other prior. Neither resident targeted each other. This incident is unsubstantiated as a resident-to-resident abuse allegation. The contact was not made in a threatening manner or intent to harm or hurt the other resident. This document does not note police notification. V16's written witness statement dated 11/8/25 documented R62 was sitting up by the nurse's station when he started lifting his gown up exposing his self to R54. When asked by 2 CNAs, V16 and V17, to please stop, he did with a laugh. R62 then started wheeling his self-back down his hall when he stopped by R54 and reached over grabbing her right breast. When asked by CNA V16 to please let go he laughed then grabbed her chair to mover her with him. When asked to let go, he just (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	laughed and wound not let go of chair. Two CNAS (V16 and V17) finally got him to let go as he kept trying to then grab CNA V16 and bite her. R62 was finally taken to his room. R62 then came back out of his room and went into 2 female's room, laughing not wanting to let go and was finally taken to his room again. V17's written statement dated 11/8/25 documented R62 was sitting up by the nurse's desk and exposed himself towards R54. I told him that was inappropriate and that he couldn't do that he then turned around and exposed himself again. I then saw him pulling on top part of wheelchair and when the CNA V16 tried to remove his hand he was trying to bite her. On 12/9/25 at 12:35 PM V1 Administrator stated the facility did not notify the IOP (Identified Offender Program) of R62's criminal convictions nor was a criminal risk assessment completed. On 12/9/25 at 1:04 PM V15 Regional Nurse Consultant stated she would expect the Administrator V1 to notify the IOP so a risk assessment could be completed. V15 stated no risk assessment was completed on R62. On 12/10/2025 9:09 AM Surveyor asked V1 Administrator why she did not substantiate the abuse allegation between R62 and R54. V1 replied because there was no indication of it happening, no physical indicators of abuse, no redness nor anything. Surveyor asked V1 if staff witnessed R62 grab R54's breast and V1 replied, that is what they thought they saw. On 12/11/25 at 8:12 AM V1 Administrator stated she did not call the police when R62 grabbed R54's breast. V1 stated she does not know if it is policy to call the police or not when there is a resident-to-resident abuse incident. V1 stated the facility did not complete any type of risk assessment of R62. On 12/11/25 at 10:57 AM Surveyor requested R62's fingerprint criminal records and V1 Administrator stated the facility does not have a copy of those results. Surveyor asked V1 if it is facility policy to attain and keep those records on file and V1 replied, I don't know. On 12/11/25 at 11:42 AM V13 LPN (Licensed Practical Nurse) stated R62 exhibited multiple behaviors while he resided at the facility. V13 stated R62 was verbally abusive and uncooperative with staff. V13 stated R62 was able to propel himself around in the wheelchair and he would stop in resident doorways and try to speak with them. V13 stated R62 was alert and oriented throughout his stay at the facility. Surveyor asked V13 if facility administration notified her of R62's criminal history and V13 replied, no. On 12/11/25 at 11:57 AM R62's physician V35 stated R62's behaviors were extreme while he was at the facility, he was driving the girls there crazy, he was drug seeking, requesting narcotics, requesting antianxiety meds, calling 911 all the time, and he went to the ER 4 or 5 times while he was at the facility and just wasting resources. V35 stated R62 abused the system by always requesting to go to the ER. Surveyor asked V35 if he was aware of R62's criminal convictions and he replied no, then asked what the convictions were for. Surveyor asked V35 if R62 had the potential to harm other residents and if he expected the facility to follow their policy and regulations to ensure other vulnerable residents were protected. V35 replied R62 was a big guy, he could have potentially harmed another resident, and he would expect the facility to follow policies and regulations with resident background checks/criminal convictions. The facility's Abuse Prevention and Prohibition Program, dated 12/2/25, documented Purpose: 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. Policy: I. 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. II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	well-being. III. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. Procedure: I. The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility. II. Screening: A. The Facility does not knowingly employ anyone who has had disciplinary action against his/her professional license, or a finding entered into the state nurse aide registry related to abuse, neglect, mistreatment or misappropriation or has been convicted of abusing, neglecting, or mistreating other people. B. The facility screens for potentially abusive residents during the pre-admission process. The facility's Background Checks: Employee (s) and Resident (s), dated 9/15/25, documented Purpose: To maintain a safe and secure environment for our residents and staff to comply with IDPH (Illinois Department of Public Health) regulations. Procedure: Resident checks: LTC (Long Term Care) facilities must conduct a name-based criminal history check on all new residents within 24 hours of admission. Identified Offenders: If a resident's name-based check indicates potential risks, further investigation including a fingerprint check may be required. Facilities must report any residents identified as potential risks. The Immediate Jeopardy that began on 9/26/25 was removed on 12/12/25, when the facility took the following actions to remove the immediacy. A. R62 no longer resides in the facility. B. R54 remains in the facility. Will remain free from sexual abuse. No incident has occurred since allegation. C. Administrator and DON will be in-serviced on the abuse policy, the admission process, how to track and report qualifying criminal offenses, ensure that risk assessments are completed, and failing to implement protective measures to prevent abuse. (Completed by RNC on 12/11/25). D. Administrator will in-service IDT team on abuse and neglect, the admissions process, and implement protective measures to prevent abuse. (Completed by the Administrator on 12/11/25). E. IDT team will in-service staff on abuse and neglect policy, the admission process, and implementing protective measures. F. The DON will in-service nursing staff on the abuse policy, the admission process, ensure that risk assessments are completed, and to implement protective measures to prevent abuse. (Completed by DON/Designee on all current working staff completed on 12/11/25). G. Staff will not work until in-serviced on the abuse policy, the admission process, ensure that risk assessments are completed, and implement protective measures to prevent abuse. (Completed by DON/Designee this will be on-going.)H. 24-hour report reviewed for the 14 days to ensure that there were not allegations of abuse or neglect. (Completed by VP of Clinical Services on 12/11/25). I. Facility will interview residents to ensure that no abuse allegation have not gone unreported. (Started by Administrator on 12/11/25, completed by 12/12/25.)J. Administrator will review all residents to ensure that their background checks are completed, and the process of reporting and tracking is initiated. K. A quality assurance tool was implemented: 1. On-going audit: The Administrator/Designee will review the 24-hour report 5x/week x 4 weeks to ensure that there are no reports of abuse or neglect. If abuse was reported was interventions put in place. (Start date 12/11/25 by the Administrator/designee will be ongoing.) 2. On-going Audit: The Administrator/designee will audit 5x/week x 4 weeks all new admissions to ensure that their background check was completed and report if needed. (Start date 12/11/25 by the Administrator/designee will be ongoing). 3. On-going Audit: The DON/designee will audit all new/re-admissions 5x/week x 4 weeks to ensure that their risk assessment has been completed. (Start date 12/11/25 by the DON/designee will be on-going).L. Root cause analysis completed for abuse and neglect. (Completed by VP of Clinical on 12/11/25.)		

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F 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure 1 of 3 (R24) resident's call light in reach in a sample of 35. This failure resulted in R24 unable to call for help for over 2 hours. This also resulted in R24 sitting in urine, feeling angry, embarrassed, unwanted, depressed and a burden. Findings include: R24's Care Plan, dated 3/25/2025, documents R24 has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke with left sided weakness. Interventions Encourage the resident to use bell to call for assistance. R24 is at risk for falls r/t Confusion, Gait/balance problems, Incontinence, Unaware of safety needs. Interventions The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach to right side of resident. R24's Minimum Data Set (MDS), dated [DATE], documents R24 is cognitively impaired, always incontinent of bowel and bladder and dependent on staff for activities of daily living. On 12/8/2025 at 9:36 AM R24 was transported from the dining room to her room and placed at the foot of the bed. R24 faced the bed with right side at foot of bed. R24, slumped and leaned forward and to the right side. R24 stated she had used the bathroom on herself and needed to be cleaned. R24's call light was located at the top of bed. At 9:48 AM R24 was heard calling for call light. At 9:53 AM observed reaching for call light. From 10:00AM to 11:00 AM resident observed sitting in wheelchair. Call light remained out of reach and no call light on. At 1:28 PM R24 was assisted to bed and placed on bedpan by V11, Certified Nurse's Assistant (CNA), and V20, CNA. V20 gave R24 the call light and informed R24 to use when ready. At 1:56 PM Call Light on. V19, CNA, responded to call light. V11 and V19 assisted R24 with incontinent care at time. On 12/10/2025 at 10:10 AM R24 stated yesterday she sat wet for hours. R24 stated it happens all the time. R24 stated she could not reach her call light. R24 stated she would have used it if she could reach it. R24 stated it makes her angry and embarrassed. R24 stated she feels like a burden, and no one wants to help her. R24 stated she can smell herself and the odor is bad. How horrible is? R24 stated she feels pain when she sits for so long wet. R24 stated she feels depressed. On 12/10/2025 at 10:13 AM V11 stated R24 is alert and able to answer questions appropriately. V11 stated R24 can use her call light. On 12/10/2025 at 12:52 PM V25, Registered Nurse (RN), stated R24 can use her call light if it is in her reach and attached to wheelchair. R24 stated R24 can use her phone with her fingers, and she has no issues with using her call light. On 12/11/2025 at 12:00 PM V35, Physician, stated R24 is alert and able to make her needs known and answer questions appropriately. V35 stated R24 can verbalize and express her feelings appropriately. V35 stated R24's call light is to be always in reach when R24 is in the room. V35 stated R24 can use call light when in reach. The Residents' Rights Long Term Care Ombudsman Program Booklet, dated 11/18, document Your facility must treat you with dignity and respect and must care for you in a manner promotes your quality of life. The facility's Call Light policy, not dated, documents Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 1. All residents have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location.		

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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 physical abuse of a resident from another resident with a known criminal history for 1 of 4 residents (R54) reviewed for abuse in the sample of 35. This failure resulted in R62 exposing his genitals to R54 and R62 then grabbed R54's breast. A reasonable person would expect to be safe in their home and would experience fear/anxiety, humiliation, and anger if physically and sexually abused. Findings Include: R54's Medical Diagnosis sheet, print date of 12/9/25, documented R54 has diagnoses including Parkinsonism, dementia, osteoporosis, atherosclerotic heart disease, polyneuropathy, and cognitive communication deficit. R54's MDS (Minimum Data Set), dated 9/17/25, documented R54 is severely cognitively impaired and dependent on staff for ADLS (activities of daily living) and mobility. R54's care plan, undated, documented R54 has little, or no activity involvement related to immobility, physical limitations, due to Parkinson's and dementia. R54's progress note, dated 11/8/25 at 5:45 AM, documented resident was up at the end of C hall in (reclining) chair sleeping when witnesses observed another resident flash his genitals to her. Staff informed aggressor that was inappropriate, and aggressor laughed. Then aggressor proceeded to grab resident breast. Staff removed aggressor from resident and took aggressor to another room. Skin check of resident done, and no injuries noted. Resident went right back to sleep after incident. Resident POA (Power of Attorney) made aware, DON (Director of Nursing), Administrator and MD made aware. R62's face sheet, print date of 12/9/25, documented R62 has diagnoses including major depressive disorder, morbid obesity, hypertension, restlessness and agitation, panic disorder, psychophysiologic insomnia, and anxiety disorder. R62's MDS, dated [DATE], documented R62 is cognitively intact. R62's MDS, dated [DATE], documented R62 is supervision or touching assistance with ambulation. R62's care plan, undated, documented R62 has a criminal felony background, has been screened through the admission process and is expected to acclimate safely in this setting. It continues, my criminal history includes retail theft, battery, and aggravated battery. R62's care plan interventions include notify the resident that a representative from the ISP (Illinois State Police) will conduct an interview either in person or via a video call to ascertain the resident's risk level. R62's care plan does not document R62's risk level. R62's progress note, dated 11/8/25 at 5:40 AM, documented resident getting into things and throwing things in hall. Resident exposing self to other resident and refusing to cover genitals. Staff asked resident to stop and explained that was inappropriate. Resident laughed and continued to lift up gown and wheel up and down hall and by nurse's station. The facility's Serious Injury Incident and Communicable Disease Report, dated 11/8/25, documented final report, R62 perpetrator, and R54 victim. Detailed Incident Summary - Initial: It was reported at approximately 5:50 AM, that R62 and R54 were involved in an alleged altercation with inappropriate contact. Investigation initiated, POA (Power of Attorney) and MD notified. It continues, Investigation: On 11/8/25 at approximately 5:50 AM it was report by DON that V16 CNA (Certified Nurse Assistant) witnessed R62 expose himself and inappropriately touched R54. It continues, V16 was interviewed by the administrator. V16 stated that she was up by the nurse's station, when R62 started lifting his gown exposing himself to R54, CNA asked R62 to stop, he did with a laugh. R62 started to go towards his room when he reached out to grab R54's right breast. V16 stated that she got R62 to let go of R54's chair, R62 proceeded to grab V16 and bite her. V17 CNA was interviewed by the administrator. V17 stated that she saw R62 expose himself towards R54 and told him that it was inappropriate. V17 stated that when R62 was headed towards his room, he reached out and grabbed R54's chair. V17 saw V16 remove R62 from the situation and tried to bite V16. Conclusion: Both residents at the time of the allegation showed no serious injury or harm. No redness, discoloration, or pain was noted immediately after the alleged incident. This is an isolated incident with both residents, neither resident has had an altercation with each other prior. Neither (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident targeted each other. This incident is unsubstantiated as a resident-to-resident abuse allegation. The contact was not made in a threatening manner or intent to harm or hurt the other resident. V16's written witness statement dated 11/8/25 documented R62 was sitting up by the nurse's station when he started lifting his gown up exposing his self to R54. When asked by 2 CNAS, V16 and V17, to please stop, he did with a laugh. R62 then started wheeling his self-back down his hall when he stopped by R54 and reached over grabbing her right breast. When asked by CNA V16 to please let go he laughed then grabbed her chair to mover her with him. When asked to let go, he just laughed and wound not let go of chair. Two CNAS (V16 and V17) finally got him to let go as he kept trying to then grab CNA V16 and bite her. R62 was finally taken to his room. R62 then came back out of his room and went into 2 female's room, laughing not wanting to let go and was finally taken to his room again. V17's written statement dated 11/8/25 documented R62 was sitting up by the nurse's desk and exposed himself towards R54. I told him that was inappropriate and that he couldn't do that he then turned around and exposed himself again. I then saw him pulling on top part of wheelchair and when the CNA V16 tried to remove his hand he was trying to bite her. On 12/9/25 at 12:35 PM V1 Administrator stated the facility did not notify the IOP (Identified Offender Program) of R62's criminal convictions nor was a criminal risk assessment completed. On 12/9/25 at 1:04 PM V15 Regional Nurse Consultant stated she would expect the Administrator V1 to notify the IOP so a risk assessment could be completed. V15 stated no risk assessment was completed on R62. On 12/10/2025 9:09 AM Surveyor asked V1 Administrator why she did not substantiate the abuse allegation between R62 and R54. V1 replied because there was no indication of it happening, no physical indicators of abuse, no redness nor anything. Surveyor asked V1 if staff witnessed R62 grab R54's breast and V1 replied, that is what they thought they saw. On 12/11/25 at 8:12 AM V1 Administrator stated she did not call the police when R62 grabbed R54's breast. V1 stated she does not know if it is policy to call the police or not when there is a resident-to-resident abuse incident. V1 stated the facility did not complete any type of risk assessment of R62. The facility's Abuse Prevention and Prohibition Program, dated 12/2/25, documented Purpose: 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. Policy: I. 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. II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being. III. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. Procedure: I. The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility. II. Screening: A. The Facility does not knowingly employ anyone who has had disciplinary action against his/her professional license, or a finding entered into the state nurse aide registry related to abuse, neglect, mistreatment or misappropriation or has been convicted of abusing, neglecting, or mistreating other people. B. The facility screens for potentially abusive residents during the pre-admission process.		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely and complete incontinent care for 4 of 4 (R7, R8, R22, R24,) residents in a sample of 35. This failure resulted in R24 feeling angry, embarrassed, unwanted, depressed and a burden. Findings include:1. R24's Care Plan, dated 3/25/2025, documents that the resident has bladder incontinence r/t (related to) Confusion, Dementia, Impaired Mobility, Poor toileting habits total assist with transfers per Hoyer lift. It also documents interventions: Brief Use: The resident uses disposable briefs. Change every 2 hours and prn (as needed). Clean peri-area with each incontinence episode. Incontinent: Check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes. R24's Minimum Data Set (MDS), dated [DATE], documents that resident is rarely/never understood, always incontinent of bowel and bladder and dependent on staff for activities of daily living. R24's Neurologic Focused Evaluation, dated 11/28/2025, documented that Alert & Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. On 12/8/2025 from 9:36 AM to 1:28 PM R24's sat in urine without the benefit of toileting and or incontinent care. At 9:36 AM R24 was transported from the dining room to her room and placed at the foot of the bed. R24, slumped and leaning forward and to the right side, stated that she had used the bathroom on herself and needed to be cleaned. At 9:48 AM R24 was heard calling for call light. At 9:53 observed reaching for call light. From 10:00 AM to 11:00 AM no staff entered room. 11:36 AM R24 was repositioned not toileted. 11:36 AM transported to dining room. 12:40 PM waiting to smoke. 1:00 PM Outside smoking. 1:16 PM sitting at nurses' station I need to go to the bathroom. 1:28 PM V11, Certified Nursing Assistant (CNA), and V12, CNA, performed incontinent care. R7 was incontinent of urine and stool. V11 and V20, CNA, transferred R24 into the bed. V11 and V20 then removed R24's urine soiled pants and heavily soiled incontinent brief. V11 and V20 then turned R24 onto her right side and placed bedpan beneath. V11 and V20 applied R24's blanket and left room. At 1:56 PM V11 and V19 CNA, turned R24 onto her right side and removed the bedpan from beneath R24. The bedpan was empty, but the large amount of formed stool was on buttocks. V11 then using a wet washcloth wiped R24's left buttock. An incontinent brief was placed beneath R24. R24 was then rolled on her back. V11 then with a wet washcloth cleansed R24's right and left groin and inner labia. V11 did not cleanse R24's left buttock, inner thighs, supra pubic area. On 12/8/2025 from 9:36 Am to 1:56 PM R24 was observed as being alert and oriented x3, appropriately answering questions and corresponding. On 12/10/2025 at 10:10 AM R24 stated that yesterday she sat wet for hours. R24 stated it happens all the time. R24 stated t makes her angry and embarrassed. R24 stated she feels like a burden and that no one wants to help her. R24 stated she can smell herself and the odor is bad. How horrible is that? R24 stated she feels pain when she sits for so long wet. R24 stated she feels depressed. On 12/10/2025 at 10:13 AM V11 stated R24 is alert and able to answer questions appropriately. On 12/10/2025 at 12:52 PM V25, Registered Nurse (RN), stated R24 can use her call light if it is in her reach and attached to wheelchair. R24 stated R24 can use her phone with her fingers, and she has no (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	issues with using her call light. On 12/11/2025 at 12:00 PM V35, Physician, stated R24 is alert and able to make her needs known and answer questions appropriately. V35 stated R24 can verbalize and express her feelings appropriately. V35 stated R24's call light is to be always in reach when R24 is in the room. V35 stated R24 can use call light when in reach. 2. R7's Care Plan, dated 4/9/2025, documents the resident has bladder incontinence r/t Confusion, Dementia, Impaired Mobility, Inability to communicate needs, Physical limitations, Poor toileting habits. Interventions: The resident uses disposable briefs. Change every 2 hours and prn. Clean peri-area with each incontinence episode. Check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. R7's MDS, dated [DATE], documents R7 is cognitively impaired, frequently incontinent of stool and always incontinent of urine and dependent on staff for toileting. On 12/8/2025 at 10:40 AM V11, CNA, and V12, CNA, assisted R7 with incontinent care. R7 was incontinent of urine and stool. R7's incontinent brief and using a wet washcloth V11 wiped R7's right and left groin area and inner labia. V11 and V12 then turned R7 onto her right side and cleansed R7's left buttock. V11 and V12 then turned R7 onto her left side and partially cleansed R7's right buttock. V11 did not cleanse R7's inner thighs, supra pubic, outer labia, and entire right buttock. 3. On 12/20/2025 at 12:41 PM during incontinent care. V21, CNA used wet washcloths then sprayed no rinse cleanser on washcloth. V21, CNA cleansed R8's right groin, then left groin, scrotum and then penis. V21, CNA did not pull foreskin back to cleanse. V21, CNA then turned R8 to his right side facing the wall. R8 incontinent of stool. V21 cleansed rectal area. V21 did not cleanse inner thighs or buttocks. V21 did not dry R8 prior to putting on clean adult diaper. R8's care plan dated 7/31/2025 documents R8 has an Activity of Daily Living (ADL) self-care performance deficit related to hemiplegia, impaired balance, limited mobility, limited Range of Motion (ROM), stroke. R8's care plan documents R8 requires assistance by one staff for toileting. R8's care plan documents R8 has bowel incontinence related to immobility. R8 care plan documents intervention to provide peri care after each incontinent episode. R8's MDS dated [DATE] documents R8 is always incontinent of bowel and bladder. 4. R22's Medical Diagnosis sheet, print date of 12/9/25, documented R22 has diagnoses including bilateral primary osteoarthritis of knee, COPD (chronic obstructive pulmonary disease), depression, hypertension, hyperlipidemia, obesity, chronic pain syndrome, and muscle weakness. R22's MDS, dated [DATE], documented R22 is cognitively intact, is always incontinent, and is dependent on staff for toileting hygiene. R22's care plan, undated, does not address R22's incontinence needs. On 12/8/25 at 1:50 PM V10 CNA placed damp wash cloths on R22's footboard of bed. V10 then removed R22's urine saturated adult diaper and cleansed on each side of R22's labia without the benefit of cleansing R22's inner labia. V10 then rolled R22 on her left side and cleansed R22's buttock without the benefit of changing gloves. V10 also did not cleanse R22's outer hip region. V10 stated he (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	used body wash to cleanse R22. V10 did not rinse the body wash after cleansing R22 nor did V10 dry R22 after cleansing her with the wet washcloths. On 12/10/2025 1:47 PM V3 ADON (Assistant Director of Nursing) stated she would expect the CNAs to cleanse inner labia and buttocks during peri-care. V3 stated the facility body wash is not a no-rinse wash so the CNA should have rinsed and dried R22. The facility's Incontinence Care policy, dated 6/17/25, documented Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. Procedure: 1. Explain procedure to resident and bring equipment to bedside. Provide privacy. 2. Perform hand hygiene and put on non-sterile gloves. 3. Assist the resident to lie on back and expose the perineal area. 4. Soap one cloth at a time to was genitalia using clean part of the cloth for each swipe. In the female, separate labia with strokes from top downward, each side separately with a clean cloth or clean area of the cloth. Keep labia separated with one hand. In the male resident, wash the penis first, turn the resident to the side, then wash perineal area. A. Wash the labia first then groin area. B. Rinse with remaining cloth using clean surfaces for all 3 surface areas (female). Do not place soiled soapy cloths back in clean basin water until procedure completed. May drape soiled cloths over the side of the wash basin, or place directly in soiled linen plastic bag. C. Clean/rinse inner/upper thigh areas to remove urine moistures. 5. Observed for redness, irritation, and discharge. 6. Gently pat area dry with towel from anterior to posterior. 7. Assist resident to turn to side away from you. Remove/wipe any fecal material first with toilet tissue as necessary. 8. Using the final rinse cloth, from front washing, wash and rinse the peri-anal area. Pat dry. 9. Change gloves and perform hand hygiene. 10. Apply clean incontinence brief or incontinence pad. 11. Empty basin, clean, and dry. Place soiled cloths in linen plastic bag. Put soiled toilet tissue or incontinence wipes and soiled incontinence brief in plastic trash bag. 12. Assist resident to a comfortable position and place call light in reach. Do not touch any clean surfaces while wearing soiled gloves. 13. Assist resident to a comfortable position and place call light in reach.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and observation, the facility failed to post the facility staffing data daily, reviewed for staffing in the sample of 35. This failure has the potential to affect all 55 residents residing in the facility. The findings include: On 12/8/25 at 8:00 AM and upon entrance to the facility, there was no posting of daily staffing seen on the boards or walls in the front lobby or in the halls. On 12/9/25 at 4:30 PM, there was still no posting of the facility daily staffing seen. On 12/10/25 at 8:00 AM, there was still no posting of the facility daily staffing seen. On 12/10/25 at 8:30 AM, V3, Assistant Director of Nursing (ADON), stated, I am the one who posts the daily staffing, and I have not done it this week. I usually post it either by the front door or by the Director of Nursing's (DON's) office. On 12/10/25 at 3:45 PM, V1, Administrator, stated, I don't think we have a policy on posting of staffing. I would expect the staff to be posting the staffing daily. On 12/10/25 at 3:47 PM, V28, Regional Director of Operations, stated, We would follow the State and Federal guidelines for the posting of daily staffing. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 10/8/25, documents there are 55 residents residing in the facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medication, label and discard expired medication. This has the potential to affect all 55 residents residing in the facility. Findings include: On 12/8/2025 at 8:59 AM the facility medication room was inspected. In the refrigerator located in inside the medication room observed: 3 boxes of Influenza with expiration date 6/2025. 1 box of open and partially used multidose vial of Aplisol with handwritten date of 11/1/25. The Tuberculin (Aplisol) Purified Protein Derivative (Mantoux) Tubersol package insert, dated April 2016, documents, A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. On 12/9/2025 at 3:24 PM V29, Licensed Practical Nurse, stated the facility did administer influenza. V29 stated the influenza vaccine is stored in the refrigerator in the medication room. V29 verified the influenza vaccine was expired. V29 stated the medication should not be in the refrigerator and should have been destroyed. V29 verified the Aplisol multidose vial 11/1/25 date was the open date, and the vial should be destroyed. V29 stated the influenza vaccine and Aplisol are stock meds and used for everyone as long as they have an order and no allergy. 3. On 12/9/25 at 9:40 AM, Med Cart on the C-Hall was observed with V13, Licensed Practical Nurse (LPN), with the following noted: Aspirin 325 MG (milligram) - expiration date 10/2025, had an open date of 8/12/24. CoQ10 100 MG - expiration date 10/2025, did not have an open date. 4. The following medications were in the cart and did not have an open date written on the open bottle: Tylenol 500 MG (almost empty), Vitamin C 500 MG, Tylenol 325 MG (almost empty), Vitamin B12 (1 pill left), Arthritis Pain/Tylenol 650 MG, Vitamin B Complex Magnesium Oxide 400 MG X2, MVI with Iron, Ibuprofen 200 MG, Tums, Mucous Relief 600 MG, Calcium 500 MG Iron Tabs, Geri-Kot 8.6 MG, Iron 27 MG, Melatonin 3 MG, Loratadine 10 MG, and Docusate 100 MG. On 12/11/25 at 8:45 AM, V2, Director of Nursing (DON), stated, The nurses are supposed to date when they open a bottle of medication. I would expect the nurses to be dating all medications they open and to discard of expired medications. On 12/11/25 at 8:47 AM, V3, Assistant Director of Nursing (ADON), stated, I would expect the nurses to be dating all medications they open as well as discarding any expired medications. On 12/11/25 at 10:40 AM, V25, Registered Nurse (RN), stated, The nurses should be discarding any medication that is expired. Anytime we open a medication bottle, we should be dating the bottle. On 12/11/25 at 12:55 PM, V1, Administrator, stated, I would expect expired medications to be discarded, and all open medications should be dated when opened. The Facility's Medication Storage policy, dated 8/1/25, documents in part 3. General Storage Procedures: 4. Facility should ensure that medications and biologicals that: (1) have an expired date (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. 15. Facility should ensure that medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed or returned to the provider. 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 10/8/2025, documents 55 total residents in facility.		

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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 interview, observation, and record review, the facility failed to dispose of expired food items, to wear proper hair nets when required, and to practice proper infection control including using clean utensils and performing hand hygiene, reviewed for the storage, preparation, and sanitary serving of food in the sample of 35. These failures have the potential to affect all 55 residents in the facility. The findings include: On 12/08/25 at 8:40 AM, Initial Kitchen Observation completed with V4, Dietary Manager, who has a valid food service certificate. Upon entrance to the kitchen, V4 was seen in the kitchen without a hair net on with short hair, a mustache and a beard. On 12/8/25 at 8:42 AM, V6, Dietary Aide, was seen working in kitchen with a hair net on and large amounts of hair coming out from the front, sides, and back of her hair net. On 12/8/25 at 8:44 AM, V7, Cook, seen in kitchen working with the food, serving the food to residents at the warming station, with a hair net on and large amounts of hair coming out of front, sides, and back of the hair net. The Refrigerator located in the main kitchen: There was a gallon jug of Aloe Gel with approximately 1/4 left, the writing on top of the lid documents Do Not Eat, and on the product label, it documents Not for Internal Use. On 12/8/25 at 8:55 AM, there was a bag of dried Au gratin potatoes slices with a date of 10/28/24 on the package. When asked about these, V4 stated We don't even use those, they must be left over from the previous company. On 12/8/25 at 11:20 AM, during lunch observation, V4 was seen walking around kitchen without a hair net or beard net on. V6 and V7 seen serving food with gloves on and no hand hygiene prior to donning gloves. On 12/8/25 at 11:22 AM, V6, Dietary Aide, was seen working in kitchen and assisting with food and making sandwiches with a hair net on and large amounts of hair coming out from the front, sides, and back of her hair net. On 12/8/25 at 11:34 AM, While checking the food temperatures, V7 used no gloves, handled each utensil to mix the food item in the food pans. The scoop utensil used in the pureed stew fell into the food, V7 used her bare hands and pulled it out, wiped it off, and left inside the pan of food, then used it to serve the residents. Once temperature checks were completed, V7 donned gloves with no hand hygiene and began serving the food onto plates. V7 kept the same pair of gloves on the entire time serving, including reaching for lids, utensils, dishes, and getting a tray of deserts from a cart. V7 was serving the cornbread with her hands and same pair of gloves on and no tongs. On 12/8/25 at 11:35 AM, V7 was seen in kitchen plating the food with a hair net on and large amounts of hair coming out of front, sides, and back of the hair net. There were multiple staff were seen lined up outside the kitchen serving line, taking a lunch tray to residents in the dining room with no hand hygiene seen done. On 12/8/25 at 11:47 AM, V6, Dietary Aide, was asked to make a ham and cheese sandwich. V6 donned gloves, went into the walk-in fridge and got packages of cheese, ham slices, and then a loaf of bread. With the same gloves on, V6 opened each package and put together a sandwich, then delivered it to the window for staff to deliver to a resident. V6 doffed her gloves and without any hand hygiene, donned new gloves and assisted again with assembling lunch trays. On 12/8/25 at 11:55 AM, V8, Dietary Aide, was seen assisting in the kitchen with hair net on and large amounts of hair coming out from the front, sides, and back of her hair net. On 12/8/25, V7 was asked about several food items that are in the storage room in a plastic container sitting on a shelf. V7 stated, Those items are resident food items from when a family brings it in, we store it for them and will give to the resident when asked. When asked who checks the expiration dates, V7 stated, I'll be honest, I don't check the expirations on any food that resident family brings in. Found in the container was a packet of soup mix that had an expiration date of 9/19/25, an opened 6-ounce bag of French Dried Onions that had an expiration date of 12/2/25. There were 16 pouches of ranch dressing mix, that had an old appearance, one being opened and undated, with an unknown date of expiration or Best if Used By on the packet. The only numbers seen on the packet was 0430930 20A 14:25. There was no date written on the packets, either expiration or best used by. On 12/9/25 at 10:50 AM, V4 was seen in the kitchen with no hair net covering his head, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	beard, or mustache. After interviewing V4, he was noted to get a hair net and put it on his head only. On 12/11/25 at 10:50 AM, V8, Dietary Aide, stated, I do hand hygiene anytime I come out of the kitchen to help in the dining room and any time I am messing with the food. I wear a hair net all day long. When asked if her hair is supposed to be tucked inside her hair net, which is currently sticking out on front, sides, and back, V8 stated, Yes, my hair is supposed to be tucked under the hair net at all times, I thought it was. On 12/11/25 at 12:55 PM, V1, Administrator, stated, I would expect the dietary staff to always have their hair up inside the hairnet while in the kitchen. I would expect them to perform hand hygiene and all infection control practices while serving food to the residents. The Facility's Dietary Staff Hygiene/Hair Nets Policy, undated, documents, 1. 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. 2. d) Hairnets or coverings shall be worn at all times in the Dietary Department and applied appropriately to keep hair from contacting exposed food, clean utensils and single service/use items, if unwrapped. e) Beards are to be trimmed and covered with face mask or snood (beard net). 4. Dietary employee will adhere to the facility hand hygiene policy and will perform hand hygiene as follows: a) Before preparing food or putting on gloves. g) After engaging in any activities that might contaminate the hands, such as taking out garbage, handling soiled utensils or equipment, or handling cleaning chemicals. h) Directly before touching ready-to-eat food or food-contact surfaces. The Facility's Hand Hygiene Policy, undated, documents Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing): Before glove placement, After glove removal. The Facility's Food and Supply Storage Policy, dated 8/1/25, documents in part 6. All foods will be covered, labeled, and dated. If there is no expiration date on the package or container, a use-by date must be written on the product. The Facility's Food from Family, Visitors, Community Policy, undated, documents in part Residents may choose to accept food from family, friends, or other guests and may choose to participate in meals provided by community groups. In order to prevent foodborne illness outbreaks, the facility staff will ensure proper handling, serving, and storage of any food item brought into the facility. 5. Food stored for residents should be labeled and dated appropriately and discarded per safe food storage guidelines. A facility may choose to utilize a specific refrigerator or area of cooler for resident food. The Facility's Staff Hygiene/Hair Nets Policy, undated, documents in part 1. 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 an in the Dietary Operations Manual. d. Hairnets or coverings shall be worn at all times in the Dietary Department and applied appropriately to keep hair from contacting exposed food, clean utensils and single? service/use items, if unwrapped. e. Beards are to be trimmed and covered with face mask or snood (beard net). 4. Dietary employee will adhere to the facility hand hygiene policy and will perform hand hygiene as follows: g. After engaging in any activities that might contaminate the hands, such as taking out garbage, handling soiled utensils or equipment or handling cleaning chemicals. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 10/8/25, documents there are 55 residents residing 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. Based on interview, observation, and record review, the facility failed to perform hand hygiene and to don appropriate Personal Protective Equipment (PPE) for 4 of 24 residents (R7, R8, R27, R54), and the laundry staff failed to don PPE while laundering isolation linen, all was reviewed for infection control in the sample of 35. These failures have the potential to affect all 55 residents residing in the facility. The findings include: 1. On 12/9/25 at 8:09 AM, V14, Certified Nursing Assistant (CNA), was seen feeding two residents while sitting between them, no hand hygiene seen as she would turn and feed R54 on her right side, then with no hand hygiene, would turn and feed R27 on her left side. V14 was seen assisting other residents across the table with their drinks while feeding R54 and R27 with no hand hygiene seen done before, during, or after assistance given. On 12/11/25 at 10:55 AM, V2, Director of Nursing (DON), stated, I would expect the staff to do hand hygiene when assisting the residents in feeding and should not be feeding one resident after another without doing hand hygiene between. 2. On 12/10/25 at 12:55 PM, V23, Housekeeping/Laundry Supervisor, stated, If there is a resident on isolation, the staff will put all linen and trash into red bags, the laundry is then placed into a yellow barrel with a lid, transported to the laundry room where it is placed inside a washer. After completed, that washer is decontaminated by using the Isolation/#6 button on the washer. Then the yellow barrel is decontaminated by a spray and wipes. The staff doing this in the laundry room should be wearing appropriate PPE, including gown and gloves. On 12/10/25 at 1:00 PM, when asked what she wears when doing isolation laundry and transferring the contaminated items from yellow barrel to the washer, V24, Laundry Aide, stated, I wear what I have on. We do not have any gowns or anything else to wear in the laundry room. On 12/10/25 at 1:10 PM, V23 stated, I have only been here a couple of weeks, and I was not aware the staff in the laundry room did not have PPE available. I will make sure they have it immediately and will discuss with them in tomorrow's meeting. This can potentially contaminate all resident linen being done by V24 as she was not wearing appropriate PPE while washing contaminated linen, then would continue to wash and fold the normal linen afterwards. On 12/11/25 at 12:55 PM, V1, Administrator, stated, I would expect them to perform hand hygiene and all infection control practices while serving food to the residents. I would expect all staff to perform hand hygiene when caring for a resident, when providing feeding assistance to a resident, and to don PPE for a resident on isolation. 3. On 12/10/2025 at 12:41 PM, V21, CNA, pushed R8 in wheelchair in his room to provide care. V21 did not don gown or gloves prior to entering R8's room. V21, CNA then transferred R8 from wheelchair to bed. V21 then pulled R8's pants down to provide care. Sign posted on the wall outside R8's room documents the facility Enhanced barrier precautions, undated posted outside R8's room documents, Stop, everyone must cleanse their hands, including before entering and leaving room. Providers and staff must also: wear gloves and gowns for the following high contact (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8's electronic medical record documents R8 has a pressure sore to Right hip. On 12/10/2025 at 12:48PM V21, CNA stated to V25, Registered Nurse (RN), I did not do that, I thought it was for (R8's) roommate, while observing V25 donning gloves and gown prior to entering R8's room to change R8's dressing. 4. On 12/8/2025 at 8:45 AM observed R7 lying in bed. Overbed table was soiled with food, liquid and brown sticky substance over the top of the table. V9, CNA, and V10, CNA, performed incontinent care. R7 was incontinent of bowel and bladder. V10 placed wash cloths in the sink and wet them with water. V10 then placed wet towels on the soiled over bed table. V10 then removed the wipes sprayed with peri wash and placed them back on the dirty table. V10 then used the towels from the soiled overbed table to cleanse R7's peri area. The Facility's Hand Hygiene policy, undated, documents in part Examples of When to Perform Hand Hygiene (Either Alcohol Based Hand Sanitizer or Handwashing): Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed), After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient, before glove placement, and after glove removal. The Facility's Linen Handling-Laundry Department Policy, dated 10/25/25, documents in part Purpose: To ensure the proper handling, storage, processing, and transport of all linens and laundry in accordance with accepted national standards in order to produce hygienically clean laundry and prevent the spread of infection to the extent possible. 1.The Laundry Department shall be designed so that there is a flow of functions that prevents contamination of clean linen. 2.Chemical barrels and other supplies are stored on skids to aid floor care. Work surfaces shall be cleaned daily, including sinks, lint traps and washer and dryer surfaces by laundry personnel. 3. Every effort will be made to ensure that soiled articles do not come into contact with the floor, uniforms, furniture, or other areas deemed clean. 6.Laundry personnel shall wear aprons and utility or non-sterile gloves when handling linens soiled with blood or body fluids. 9.Aprons and gloves shall be removed, and hand hygiene performed prior to handling clean linens and personal laundry. 16. Hands shall be washed immediately in the event of accidental contamination of blood and body fluids and handling soiled linens and laundry. The Facility's EBP Policy, undated, documents in part Enhanced Barrier Precautions (EBP): recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug- resistant organism status. EBP may be considered and implemented for: Wounds and/or indwelling medical devices (central line, feeding tube, tracheostomy, drains, etc), infection or colonization with a novel or targeted MDRO when contact isolation does not apply (see CDC listed MDRO list), at discretion of the Infection preventionist. Standard Precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: Dressing, Bathing/Showering, Providing Hygiene, Changing Linens, Incontinence Care, Medical Device Care, Wound care. Points to Remember: Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment. Alcohol-based hand rub may be used if hands are not visibly soiled. Sign will be posted to door to notify that on EBP to notify family and visitors. The Facility's Infection Prevention Policy, undated, documents in part It is the policy of this facility (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions. The 2007 Centers for Disease Control and Prevention (CDC) Guidelines for Isolation Precautions will be utilized in this facility with some modifications. Transmission-Based Precautions will be employed for known or suspected infections for which the route of transmission/prevention is known. The transmission-based categories are the following: Airborne, Droplet, and Contact. Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment. Alcohol-based hand rub may be used if hands are not visibly soiled. Gather all equipment and supplies needed before going into the room. Only take needed supplies into the room. When possible, dedicate the use of noncritical resident-care equipment to a single resident or cohort of residents infected or colonized with the pathogen requiring precautions. When use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another resident. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 10/8/25, documents there are 55 residents residing in the facility.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview, and record review, the facility failed to ensure the continuing competence of Certified Nursing Assistants (CNAs), by providing 12 hours of education and/or training per year, including dementia management training and resident abuse prevention training, reviewed for required training for CNAs in the sample of 35. This failure has the potential to affect all 55 residents residing in the facility. The findings include: On 12/10/25 at 8:35 AM, V3, Assistant Director of Nursing (ADON), stated, When we hire a new CNA, they always have a license already. They will go through orientation with V18, Medical Records/CNA. Then they will have at least 3 days of floor training with a peer. If that person needs more training, we will give them more days. We do monthly in-services that are scheduled, and each employee must do that in-service before their next day of work. We also do competencies yearly for each staff member and then PRN (as needed) if someone is lacking in a certain task. When asked to see any CNAs 12-hour training, V3 stated, (V1, Administrator) has that binder. On 12/10/25 at 8:45 AM, When V1 was asked to see the training binder, V1 opened the binder, and a list of staff was seen with no training hours listed. V1 stated to V3, This is how they were keeping track of the training? On 12/10/25 at 8:50 AM, When asked to show each CNA's 12-hours of annual training, V1 stated, I will have to look and go through each in-service and add up their hours. On 12/11/25 at 10:45 AM, V27, CNA, stated she has been working at facility since July 2025 and her initial training consisted of 3 days on the floor and no other computer or paper training done. V27 stated they have monthly in-services and talk about different things. V27 stated she does not remember having any training for abuse or dementia. On 12/11/25 at 10:55 AM, V2, Director of Nursing (DON), stated, Staff training is done by either me, or (V3, ADON), including the CNA annual training for abuse and dementia. I have not heard of any staffing problems since I've been here and if we have call-ins, we try to get it filled or someone from the offices will go out and help. On 12/11/25 at 11:03 AM, V21, CNA, stated, I have been here since September 2024 and my training was three days of orientation on the floor and no other training. We do have monthly in-services, and I did the abuse and dementia training. On 12/11/25 at 11:10 AM, V34, CNA, stated, I've been here since November 2024, and I had on the floor training only. We do have in-services monthly and I remember doing the abuse and dementia training. A random pick of CNAs with a review of their annual education, shows that none of the CNAs have had a total of 12-hours of annual training with only three of the nine having abuse training, and four of the nine having dementia training. V9, CNA's, CNA In-Service Record, dated from 6/25/24 through 10/14/25, documents V9 was hired on 5/13/24 and has only 10.5 hours of training and is missing the required dementia training. V10, CNA's, CNA In-Service Record, dated from 1/14/25 through 9/9/25, documents V10 was transferred to this facility on 11/1/24 and has only 3.0 hours of training and is missing both the required abuse prevention training and the dementia training. V16, CNA's, CNA In-Service Record, dated from 6/25/24 through 8/12/25, documents V16 was hired on 5/24/24 and has only 8.5 hours of training and is missing both the required abuse prevention training and the dementia training. V17, CNA's, CNA In-Service Record, dated from 7/25/24 through 5/14/25, documents V17 was hired on 6/27/24 and has only 5.0 hours of training. V21, CNA's, CNA In-Service Record, dated from 5/14/25 through 11/13/25, documents V21 was hired on 9/4/24 and has only 3.0 hours of training and is missing the required abuse prevention training. V30, CNA's, CNA In-Service Record, dated from 9/9/25 through 11/13/25, documents V30 was hired on 9/2/25 and has only 3.0 hours of training and is missing the required abuse prevention training. V31, CNA's, CNA In-Service Record, dated from 8/12/25 through 9/9/25, documents V31 was hired on 7/6/25 and has only 3.5 hours of training and is missing both the required abuse prevention training and the dementia training. V32, CNA's, CNA In-Service Record, dated from 8/19/25, documents V32 was hired on 7/17/25 and has only 0.5 hours of training and is missing both the required abuse prevention training and the dementia training. V33's CNA In-Service Record, undated, documents V33 was hired on (continued on next page)		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7/25/25 and has only 0.0 hours of training and is missing both the required abuse prevention training and the dementia training.The facility's CNA Training Policy, dated 11/1/25, documents in part Education: CNAs are responsible for obtaining and maintaining current certification. CNAs are required to obtain 12-hours of continuing education provided by the facility during in? services and 1:1 interaction to ensure they are up to date with CMS compliance.The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 10/8/2025, documents 55 total residents in facility.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to answer call lights timely for 4 of 24 residents (R2, R6, R12 and R30) reviewed for call lights in the sample of 35. Findings include:1. On 12/9/2025 at 10:30AM during resident group meeting. R2, R6, R12 and R30 all stated call lights are not answered timely.R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact. R6's MDS dated [DATE] documents R6 is cognitively intact.R12's MDS dated [DATE] documents R12 is cognitively intact.R30's MDS dated [DATE] documents R30 is cognitively intact.Resident council minutes dated 12/2/2025 documents residents feel that call lights are not being answered in a timely manner.Resident council minutes dated 10/6/2025 documents call lights are not being answered in a timely manner.Resident council minutes dated 8/4/2025 documents call lights are taking too long to be answered.Resident council minutes dated 6/2/2025 documents call lights are taken too long to be answered.On 12/10/2025 at 9:25AM V21 Certified Nursing Assistant (CNA) stated some days there is not enough staff. V21 stated call lights are to be answered when can get to it. V21 stated if there is a delay in answering call light it is because providing care to someone else. The facility policy Call light, undated, documents the purpose is to respond to resident requests and needs in a timely and courteous manner. The policy documents resident call lights will be answered in a timely manner. The policy documents all staff should assist in answering call light. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility failed to implement fall interventions as identified in resident care plans for 4 of 9 residents (R1, R9, R33 and R53) reviewed for accidents in the sample of 35. Findings include: 1. On 2/8/2025 at 8:50 AM recliner in R53's room does not have mat in the seat. On 2/10/2025 3:15PM R53's recliner in room does not have mat in the seat as identified as intervention in care plan. R53's care plan dated 10/29/2025, documents R53 is at risk for fall, refuses wheelchair handles on wheelchair, related to stroke with right sided weakness, confusion, gait/balance problems and incontinence poor communication/comprehension, Unaware of safety needs. R53's care plan documents the following intervention for fall: 9/25/2025 place Dycem in recliner chair, follow facility fall protocol. R53's care plan documents that R53 has had 5 falls since 7/24/2025. R53's Minimum Data Set (MDS) dated [DATE] document R53 has severe cognitive impairment. R53's MDS documents R53 requires substantial/maximal assistance for transfer from chair to bed 2. R9's face sheet dated 12/10/2025 documents in part a diagnosis of flaccid hemiplegia affecting right dominant side. On 12/9/2025 during the noon meal and on 12/10/2025 at 12:13PM R9 eating lunch in dining room. R9 in his wheelchair. R9's Minimum Data Set (MDS) dated [DATE] documents R9 has severe cognitive impairment. R9's MDS documents R9 is dependent on staff for eating. R9's MDS documents R9 requires substantial/ maximal assistance for chair to bed transfer. R9's progress notes 11/24/25 at 10:06AM documents clinical meeting for fall 11/22/2025 root cause resident wheeled self to room after he finished eating and attempted to transfer self to bed. Intervention resident will be placed in regular chair at meal, until staff is able to put him to bed. R9's care plan dated 9/2/2025, documents R9 is at risk for falls related to gait/balance problems, poor communication/comprehension, psychoactive drug use, unaware of safety needs, CVA (cerebrovascular Accident) and hemiplegia. R9's care plan documents the following intervention: Intervention for fall 11/22/2025 resident to be placed in a regular chair at meals. On 12/10/25 at 1:04PM V25, Registered Nurse (RN) stated the facility puts interventions in place after falls. V25 stated R9 is to be placed in a regular chair at meals. V25, RN stated R9 should have been in a regular chair at lunch, and not his wheelchair. The facility Fall evaluation and prevention policy, dated reviewed 6/1/2025 documents the purpose is to ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The policy (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents the facility will evaluate residents for their fall risk and develop interventions for prevention. 3. R33's Medical Diagnosis sheet, print date of 12/9/25, documented R33 has diagnoses including pulmonary fibrosis, anxiety disorder, dementia, aphasia, dysphagia, osteoarthritis, bipolar disorder, major depressive disorder, and unspecified protein-calorie malnutrition. R33's Minimum Data Set (MDS), dated [DATE], documented R33 is severely cognitively impaired and requires partial/moderate assistance with transfers. R33's fall risk assessment, dated 11/17/25, documented R33 is at high risk for falls. R33's progress notes and incident reports documented R33 sustained falls on 7/19/25, and 11/5/25. R33's care plan, print date of 12/9/25, documented a fall intervention of a bolster mattress was implemented on 2/17/25. On 12/9/25 at 8:50 AM surveyor asked V13 LPN (Licensed Practical Nurse) if R33 has a bolster mattress on her bed as documented on her care plan. Surveyor observed V13 pull back R33's sheets on her mattress, V13 stated there are no bolsters on R33's mattress. On 12/9/25 at 9:04 AM Surveyor asked V3 ADON (Assistant Director of Nursing) if R33's current care plan documents R33 is supposed to have bolsters on her mattress to reduce her risk of falls. V3 agreed R33's current care plan documents a bolster mattress and V3 agreed R33's bed does not have bolsters on the mattress. On 12/11/25 at 9:36 AM V3 ADON stated R33 is considered high risk for falls based on her fall risk assessments. 4. R1's Medical Diagnosis sheet, print date of 12/12/25, documented R1 has diagnoses including Epilepsy, Dementia, Moderate Intellectual Disabilities, Glaucoma, and Anxiety. R1's MDS, dated [DATE], documented that R1's is severely cognitively impaired and requires partial/moderate assistance with transfers. R1's Fall Risk Assessments, dated 6/19/25, 7/5/25, 8/22/25, 8/31/25, 9/12/25, 9/16/25, 11/6/25, documented R1 is at high risk for falls. R1's progress notes and incident reports documented R1 sustained falls on 7/5/25, 8/22/25, 8/31/25, 9/12/25, 9/22/25, 11/6/25, R1's Care Plan, dated 2/14/2025, documents the resident is at risk for falls r/t (related to) Confusion, Gait/balance problems, Unaware of safety needs. Interventions: Intervention for fall 11/6/2025-green sign next to bathroom door to ask for assistance to toilet. Intervention for fall 5/14/2025 lower cloths rod in closet. Intervention for fall 5/9/2025 place wheelchair in hall when resident in bed. Intervention for fall 6/18/2025 Bolster mattress. Intervention for fall 6/18/2025 ensure resident is placed in center of bed. Intervention for fall 7/5/2025 green sign to ask for help. Intervention for fall 8/22/2025 drop wheelchair seat, anti-tippers. Intervention for fall 8/31/2025 resident not to be left unattended in room. Intervention for fall 9/12/2025 floor bed. Intervention for fall 9/22/2025, sign in room to alert (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNAS that if resident is in room to lay resident down. On 12/8/2025 at 8:37 AM no floor bed or bolster mattress in place to bed. No sign in room to lay resident down when in room. On 12/9/2025 at approximately 1:00 PM R1 observed in room in wheelchair. No staff present. 1:30 PM R1 lying in bed on the edge. R1's bed not on floor. On 12/12/2025 at 1:46 PM Observed R1 lying in bed. No bolster mattress in place and bed not in low position. V3 verified that R1 did not have a bolster mattress in place and the bed was not in the lowest position. V3 then proceeded to lower the bed to the floor. On 12/12/2025 at 1:47 PM V3, Assistant Director of Nursing, stated that R1 is high risk for falls. V3 stated that R1 is alert and confused. V3 stated that R1 has memory problems. V3 stated that R1 is not aware of safety problems. V3 stated that R1 has fallen because she tries to take herself to the bathroom and bed. V3 stated that R1 would not read the sign, remember it or follow due to her confusion and impaired cognition. V3 stated that the interventions on the care plan are to be in place. V3 stated that at this time she is not sure why they are not but would find out. The facility's Fall Prevention policy, dated 6/1/2025, documents that Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and monitor the use of a lap tray for 2 of 2 (R27, R54) residents reviewed for restraints in a sample of 35. Findings include: 1. R27's admission Record, print date 12/9/2025, document R27 has diagnosis including Vascular Dementia, Anxiety, and Depression. R27's Care Plan does not address R27's lap tray and restraint. R27's Minimum Data Set, dated [DATE], documents that R27 is cognitively impaired, dependent on staff for care and does not use restraints. R27's Physician Orders do not document an order for a lap tray or a restraint. On 12/8/2025 at 9:41 AM observed R27 sitting in room facing television. R27 sitting in reclining wheelchair with lap tray attached and secured across R27's lap. R27 was not able to remove lap tray upon request. 12/9/2025 at 10:00 AM observed R27 sitting in reclining wheelchair with lap tray attached and secured across R27's lap. On 12/10/2025 at 8:24 AM observed R27 sitting in reclining wheelchair with lap tray attached and secured across R27's lap. On 12/10/2025 at 8:25 AM V27, Certified Nurse's Assistant (CNA), stated that R27 is not able to remove the lap tray. 2. R54's Medical Diagnosis sheet, print date of 12/9/25, documented R54 has diagnoses including Parkinsonism, dementia, osteoporosis, atherosclerotic heart disease, polyneuropathy, and cognitive communication deficit. R54's MDS (Minimum Data Set), dated 9/17/25, documented R54 is severely cognitively impaired and dependent on staff for ADLS (activities of daily living) and mobility. R54's MDS documented no restraint in use and does not document R54's lap tray restraint. R54's care plan, undated, documented R54 has little, or no activity involvement related to immobility, physical limitations, due to Parkinson's and dementia. This care plan also documented R54 has impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions. R54's care plan documented R54 is at risk for falls related to her confusion. R54's care plan does not address her lap tray restraint. R54's physician orders, dated 12/10/25, do not document an order for a lap tray restraint. On 12/8/25 at 1:0 PM R54 was observed sitting in her reclining wheelchair in her room with a lap tray attached to her chair. R54 was lethargic and confused. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/8/25 at 1:43 PM V10 CNA stated R54 has a lap tray on when up except while she is eating. V10 stated R54's daughter insists R54 has it on because she slides out of the chair. V10 stated the lap tray is provided by hospice. On 12/9/25 at 8:53 AM R54 was observed sitting in a reclining wheelchair in her room with a lap tray on. Surveyor asked R54's nurse V13 LPN if R54 can remove the lap tray on command. V13 stated someday she can remove it and other days she is not able to. R54 was lethargic and did not respond to questions during this observation. R54 was not able to release the lap tray when requested by the nurse. On 12/9/25 at 11:52 AM V3 ADON (Assistant Director of Nursing) stated the facility did not complete a restraint assessment on R54's lap tray, did not care plan the lap tray, nor has the facility been documenting on the use of the lap tray. On 12/10/2025 2:39 PM V15 Regional Nurse Consultant stated she expects the facility staff to follow the facility Restraint Policy when residents utilize lap trays. The facility's Restraints Policy, dated 8/29/25, documented Purpose: Residents shall be provided an environment that is restraint- free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measures shall be used. Policy: 1. Definitions: Physical Restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. This may include bed tails, beds against walls, restrictive clothing, etc. Medical Symptom is defined as an indication or characteristic of a physical or psychological condition. Chemical Restraint is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms. Treatment Restraint is a restraint used for the protection of the resident during treatment and diagnostic procedures. Postural Support means any method other than orthopedic braces used to assist patients to achieve proper body position and balance. Postural support may include devices such as soft ties, seat belts, lap trays, lap buddies. Lateral supports or cloth vests. 2. The facility honors the resident's right to be free from any restraints that are imposed for reasons other than treatment of the resident's medical symptoms. The facility will ensure that restraints will not be imposed for purposes of discipline or convenience. 3. Medical symptoms will be evaluated to determine if underlying causes may be eliminated. 4. If underlying causes of medical symptoms cannot be eliminated, alternative measures must be tried before a restraint is used. 5. If alternative measures are unsuccessful, the least restrictive form of a restraint will be used. 6. Unless otherwise specified by the Attending Physician's order, alternative methods of behavioral control must be attempted and documented in the resident's medical record before a physical restraint is used. 7. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. Treat the medical symptom; b. Protect the resident's safety; and c. Help the resident attain the highest level of his/her physical or psychological well-being. 8. The facility will not use restraints on a PRN or as necessary basis. 9. Every attempt will be made to avoid a decline in the resident's physical functioning. 10. Except in emergency situations, a physical restraint shall be used only after the Interdisciplinary Team (IDT) has performed an assessment, attempted to determine, and alleviate precipitating factors, determined the need for restraint and identified the least restrictive device. a. Emergency use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment, and no other less- restrictive interventions are feasible. b. The attending physician must be notified of such use and the reason for the order. c. Orders for emergency (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restraints may be received by telephone. d. The emergency use of restraints must not extend beyond the immediate episode. 11. Treatment restraints: a. Informed consent will be obtained from the resident or responsible party if a restraint will be used during treatment or diagnostic procedures. b. Treatment restraints shall be applied for no longer than the time required to complete the treatment. It continues, 13. Postural Support: a. Postural support will only be used to improve a resident's mobility and independent functioning, or for positioning, rather than to restrict movement. The use of postural support and the method of application will be specified I the resident's Care Plan. b. Postural supports will be applied: i. Pursuant to an Attending Physician's order. ii. Under the supervision of a Licensed Nurse; and iii. In accordance with principles of good body alignment and with concern for circulation and allow for change of position. c. Use of postural support for these purposes is not considered a physical restraint. Procedure: I. An assessment will be completed by a licensed nurse prior to the application of any device that restricts movement or access to one's body. The assessment will be repeated quarterly thereafter. If a resident is admitted with a restraint, the assessment will be completed upon admission. It continues, V1. Physician Order &ndash; There must be a physician's order for the use of the restraint which includes A. Medical symptoms for use. B. Frequency of use. C. Type of restraint. D. Release protocols; and E. Plan for reduction, when applicable. VII. Informed Consent: A. Before any type of restraint is used, the Licensed Nurse will verify that informed consent has been obtained from the resident/ responsible party and that the resident/ responsible party was educated regarding the risks and benefits of restraint use. B. If the resident or their representative refuses to consent, the IDT will meet with the Administrator, Ombudsman, Attending Physician, and the resident and/or surrogate decision-maker to determine if the resident's physical or behavioral issues jeopardize the facility's ability to provide for the safety of the resident and/or others. C. If immediate action is necessary to prevent serious bodily harm or to protect others, the Licensed Nurse is not required to document that the resident and/or his or her representative has consented to the restraints. In this emergency situation when it is impractical to obtain the required consent, the restraint use must be the customary proactive of Attending Physicians and Licensed Nurses in good standing. VIII. Application of Physical Restraints: A. Nursing staff will remove any potentially harmful objects (e.g. neckties, shoestrings, belts, necklaces, sharp rings) before applying restraints. B. Nursing staff will apply the restraint so that the circulation is not impaired in any way. It continues, IX. Safety Guidelines: A. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. B. Acceptable forms of physical restraints are cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. C. Physical restraints shall be applied in such a manner that they can be easily removed in case of fire or other emergency. D. A resident placed in a restraint will be observed at least every 30 minutes by Nursing staff. E. The opportunity for motion and exercise will be provided for a period of not less than ten (10) minutes during each 2 hours in which restraints are employed. F. Nursing staff will ensure that the resident is restrained only in an area that is under supervision of staff and is afforded protection from other residents who may be in the area. G. Seclusion, which is defined as the placement of a resident alone in a room, shall not be employed. H. If the unsafe behaviors continue to escalate while the resident is receiving a physical or chemical restraint, the facility will implement a plan to keep the resident and others safe until the unsafe behaviors cease. It continues, II. Care Planning - Care plans for residents with restraints will reflect: A. The type of restraint to be used. B. The medical symptoms requiring the use of restraints. C. The treatment team's goals in using the restraint. D. Interventions that address the immediate medical symptom(s) and the underlying problems that may be causing the symptom(s). E. Systematic and gradual approaches for minimizing or eliminating the concerning behavior and restraint use. F. Frequent observation and release every 2 hours for toileting and /or repositioning and checking the condition of skin and impaired circulation if indicated. G. The use of postural support and the method of application will be specified in the resident's care plan. II. Medical Record Documentation: A. Documentation for residents with restraints (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall include the following: i. A comprehensive assessment. ii. The least restrictive alternatives attempted. iii. A specific medical symptom. iv. The rationale for physical restraint use. v. Restraint information (type and period of time). vi. A signed consent form. vii. A written physician's order for restraint use. viii. A plan for gradually reducing or eliminating restraint. ix. The resident's response to restraint application, reduction, or elimination. x. Observation, range of motion and repositioning. B. The licensed nurse may use the restraint log to document residents with restraints. i. Postural support devices do not need to be documented on the restraint log. IV. Ongoing Review: A. Restrained residents will be reviewed regularly (at a minimum of quarterly) by the IDT to determine the continued need for restraints. The IDT will consider the elimination of restraints, less frequent use of restraints, or a less restrictive device whenever possible. It continues, C. The IDT will monitor the resident for any adverse effects of the use of restraints including but not limited to i. Declines in the resident's physical functioning and muscle condition. ii. Contractures. iii. Increased incidence of infections and pneumonia. iv. Impaired skin integrity, bruising, or abrasions. v. Withdrawal from social activities. vi. Mood changes such as agitation, depression, or delirium. vii. Sensory deprivation. viii. Decreased appetite. ix. Sleeping pattern disturbances. x. Incontinence or constipation. D. The IDT will document the effectiveness of the use of restraints in the resident's medical record.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide eating assistance for 1 of 24 residents (R9) reviewed for assistance with eating in the sample of 35. On 12/09/2025 at 8:00AM R9 observed sitting in wheelchair in dining room eating cooked cereal out of bowl. Glass of orange juice, and glass of water sitting in front of R9. Plate with scrambled eggs and biscuit with jelly also in table. At 8:47AM R9 observed eating scrambled eggs with his hands. R9 ate 100% of cooked cereal and drank glass of water. At 8:55AM R9 drank 100% of orange juice. At 8:58AM R9 turned plate clockwise with biscuit and jelly and scrambled eggs., touched eggs with hands. At 9:03AM V34, Certified Nursing Assistant (CNA) approached table and ask R9 if would like more to drink, and requests coffee. V34 did not provide R9 touch assistance or encouragement to eat his scrambled eggs or biscuit. R9 had 50% of his scrambled eggs and 1/2 of biscuit remaining on his plate. R9's dietary note dated 11/11/2025 at 13:45 documents Registered Dietitian (RD) for weight variance. Note documents R9 receives a regular diet as ordered with intake noted to be 51-100% of meals. R9's dietary note documents R9's weight on 11/6/2025 151 pounds. R9's note documents review of weights shows loss over 30days of 5% (8#). Note document's goal is for intake of meals to remain greater than 50% with no significant weight change.R9's Physician Order (PO) dated 8/29/2025 documents regular diet, regular texture, regular thin consistency.R9's care plan dated 9/2/2025 documents R9 has unplanned/unexpected weight loss related to poor food intake.R9's Minimum Data Set (MDS) dated [DATE] documents eating, supervision or touch assistance.R9's weight summary documents weight of 169.6 pounds on 8/29/2025, and most current weight of 152 pounds on 12/5/2025. On 12/20/2025 at 12:30PM V1, Administrator stated R9's weight was 169 pounds on admission to facility from the hospital.On 12/11/2025 at 2:50PM V3, Assistant Director of Nursing (ADON) stated she would expect staff to provide assistance and cueing if needed during meals. The facility policy Activities of Daily Living (ADL), Supportive dated, revised 7/15/2025 documents residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The policy documents residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy documents appropriate care and service will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks) The policy documents interventions to improve or minimize a resident's assessed needs, preferences, stated goals and recognized standards of practice.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide feeding assistance for a resident with weight loss for 1 of 24 residents (R9) reviewed for nutritional status in the sample of 35. On 12/09/2025 at 8:00AM R9 observed sitting in wheelchair in dining room eating cooked cereal out of bowl. Glass of orange juice, and glass of water sitting in front of R9. Plate with scrambled eggs and biscuit with jelly also in table. 8:47AM R9 observed eating scrambled eggs with his hands. R9 ate 100% of cooked cereal and drank glass of water. At 8:55AM R9 drank 100% of orange juice. At 8:58AM R9 turned plate clockwise with biscuit and jelly and scrambled eggs., touched eggs with hands. At 9:03AM V34, Certified Nursing Assistant (CNA) approached table and ask R9 if would like more to drink, and requests coffee. V34 did not provide R9 touch assistance or encouragement to eat his scrambled eggs or biscuit. R9 had 50% of his scrambled eggs and 1/2 of biscuit remaining on his plate. R9's dietary note dated 11/11/2025 at 13:45 documents Registered Dietitian (RD) for weight variance. Note documents R9 receives a regular diet as ordered with intake noted to be 51-100% of meals. R9's dietary note documents R9's weight on 11/6/2025 151 pounds. R9's note documents review of weights shows loss over 30days of 5% (8#). Note document's goal is for intake of meals to remain greater than 50% with no significant weight change. R9's Physician Order (PO) dated 8/29/2025 documents regular diet, regular texture, regular thin consistency. R9's care plan dated 9/2/2025 documents R9 has unplanned/unexpected weight loss related to poor food intake. R9's Minimum Data Set (MDS) dated [DATE] documents eating, supervision or touch assistance. R9's weight summary documents weight of 169.6 pounds on 8/29/2025, and most current weight of 152 pounds on 12/5/2025. On 12/20/2025 at 12:30PM V1, Administrator stated R9's weight was 169 pounds on admission to facility from the hospital. On 12/11/2025 at 2:50PM V3, Assistant Director of Nursing (ADON) stated she would expect staff to provide assistance and cueing if needed during meals. The facility policy Activities of Daily Living (ADL), Supportive dated, revised 7/15/2025 documents residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The policy documents residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy documents appropriate care and service will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks) The policy documents interventions to improve or minimize a resident's assessed needs, preferences, stated goals and recognized standards of practice.		