STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000317	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF LEBANON	1201 NORTH ALTON , LEBANON, Illinois, 62254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2546001/IL195593	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents did not exit	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 through an exit door and were being supervised to prevent any potential elopements for 1 of 6 residents reviewed for elopement in the sample of 15. This failure resulted in R2 pushing the exit alarm and exiting the facility around 3AM on 6/19/2025 from a secured memory unit into pitch darkness and was found wandering around by a civilian driving in his car two subdivisions over (one block east and one block north) from the facility. This past non-compliance occurred on 6/19/2025. Findings include: R2's Physician Order Sheet (POS) for June 2025 document a diagnosis of Encephalopathy, HTN (Hypertension), neurocognitive disorder with Lewy bodies, and cerebral atherosclerosis (Dementia). R2's Minimum Data Set (MDS) dated 5/2/2025 document R2 was severely impaired, and she requires specialized unit Alzheimer/dementia. R2's Care Plan does not address elopement behaviors before 6/19/2025. R2'S Care Plan documents (R2) has an ADL (activities of daily living) self-care deficit related to decreased physical functioning and severe cognitive impairment. Date initiated 2/10/2025. (R2) is High risk for falls related impulsive unaware of safety needs, poor judgment, decreased physical function, medication that can predispose to falls. R2's Elopement Evaluation dated 1/24/2025 documents, "Risk for wandering/Elopement Identified." R2's Progress Notes dated 5/3/2025 at 1:10 PM, Late Entry: Elopement Evaluation: History of elopement while at home: No. Wandering behavior a pattern or goal-directed: No. Wanders aimlessly or non-goal-directed: Yes. Wandering behavior likely to affect the safety or well-being of self/others: No. Wandering behavior likely to affect the privacy of others: No. Recently admitted or re-admitted (within past 30 days) and has not accepted the situation: No. Elopement Score: 2.0. R2's Progress Notes dated 6/19/2025 at 4:06 PM, Note Text: Writer notified (R2) (eloped from the) facility	S9999		

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S9999	Continued from page 2 around 3:45 am. Stated that Alarm sounded, staff check door and surrounding did not see anyone. Did a head count and realized that (R2) was not available. Staff notified Admin and 100 Nurse of situation. Staff got in vehicle and located (R2). (Son) was contacted and made aware of elopement. (R2) is doing fine, stated that she was just trying to go home. One to One has been put in place. Room move further away from exit door and 15 min. checks started. Care plan updated and education to be given to staff by DON (Director of Nursing). R2's Initial Report to the state surveying agency for incident date 6/19/2025 documents, at 3:35 AM, "(R2) is an 84-year-old female that residents at (Facility). (R2) has the diagnosis of but not limited to encephalopathy, HTN, neurocognitive disorder with Lewy bodies and cerebral atherosclerosis. Alleged elopement from secured memory unit without injury. Final report to follow." R2's Final Report documents, "On 6/19/2025 at 3:35 AM staff responded to the 300 North door alarm. CNA on the unit went to the door, did a visual parameter check from the doorway, no findings. Staff then followed out elopement procedure and proceeded with a head count, simultaneously (V6 Licensed Practical Nurse/LPN) was outside checking the perimeter of the facility. Staff contacted (V6) that (R2) was not accounted for. (V1) and DON (Director of Nursing) were notified. (V6) after completion of parameter check got into her vehicle to widen the search. At approximately 3:42AM, (V6) on the street parallel to the facility (R2) was noted to be sitting in a front yard with a local resident. (R2) was out of the facility for approximately 7 minutes. She stated "Honey, I am so sorry, I just wanted to go home." (R2) was dressed appropriately for the weather, she was wearing proper foot ware. Police did come out to the facility at approximately 4 AM to ensure that resident was well, since local resident had called them. No concerns were noted by the police. Conclusion: the root cause of (R2) exiting the Facility is due to her confusion related neurocognitive disorder with Lewy bodes, Staff followed procedures and located (R2) in a timely manner." On 6/30/2025 at 1:08 PM, V6 (LPN) stated, "I was working the night (R2) got out of the facility. It happened around 3 AM in the morning because it was still dark outside. (R2's) room is on the locked women's dementia unit. (R2's) room was down the hall close to the exit door. When (R2) exited through the	S9999		

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S9999	Continued from page 3 exit door, I did not see her leave, but the alarm went off. We looked outside the door but could not see anything because it was pitch black. (R2) went out the door and me and (V4), Certified Nursing Assistant (CNA), ran out the door looking for her. We did a sweep, but it was so dark outside, and we could not find her. After looking for her, I got in my car, and I finally found her in the second subdivision in someone's yard. There was a man with her at that time. I am not sure how long she was gone for. When I found her, we did an assessment after I brought her back here and she did have bruises on her legs but seemed to be okay. I am not sure what she was wearing at that time, but I think it was appropriate. I did a skin assessment on her and she did have bruising on both of her shins, and I believe her forearm." A Statement provided by V6 dated 6/19/2025 documents, "I was on the 200 hall nurses' station and heard 200 North door alarm sound. I headed towards the door and another staff member was already there looking outside. (V1) and other nurse alerted, and I went outside and got in my vehicle and started searching. Came upon bystander assisting resident. He stated she was sitting the grass in a front yard. Resident got right into my vehicle." On 6/30/2025 at 4:50 PM, V10 (Local Police) stated, "We got a call after 3:10 AM from a male citizen who said they were driving in the early hours of the morning and found a confused woman wandering in the road. The woman was one block east, and one block north of the (Facility). We found out that the confused woman was a resident at the nursing home and all the staff had lost sight of her. (R2) had eloped from the (Facility). We did not get a call from the (Facility) but from a male citizen because they were concerned for her safety. I did not do a report and staff arrived and took (R2) back to the (Facility) and I went later and checked on her at the facility." On 7/1/2025 at 1:03 PM, V4 (CNA) stated she had only been working in the facility for about two months. "I remember that night (R2) got out because I was working the floor. I was giving care to another resident that night and was in the resident's room when I heard the door alarm go off and I went running. The nurse (V6) and I were both looking but we did not see anything, but it was dark outside. I almost fell in a hole, there is a door drop pad and I almost fell. V6 went one way, and I went the other and we could not find her so we	S9999		

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S9999	Continued from page 4 both got in our cars and went opposite directions looking for (R2). I did not find (R2) but (V6) did find her and brought her back to the facility. I think she was gone for about a half an hour. (R2) said she wanted to go home. The Police came by later and was checking on her. I am not sure what she was wearing." A Statement Provided by V4 (CNA) dated 6/19/2025, documents, "I was on the 100-hall nurse station when I was notified by another staff member that there was possible elopement. I went to the 200-hall while staff was outside searching. Searched hall and completed head count." On 7/2/2025 at 1:14 PM, V17 (CNA) stated she was working the 100-hall, and a staff member came up to her to tell her a resident went out the door. I went to the back hall, and we did a head count. It was around 3 AM in the morning. Things got hectic. They were able to find the resident and return them back to the facility. I am not sure how long they were actually gone. A statement provided by V17 dated 6/19/2025 documents, "I was on the 100-hall nurse station when I was notified by another staff member that there was possible elopement. I went to the 200-hall while staff was outside searching. Searched hall and completed head count." On 7/2/2025 at 1:23 PM, V19 (LPN) stated, "I was the nurse working the 100-hall. A staff member came up to me and told me that someone had gotten out. I made sure someone was watching my hall as I went to the dementia locked unit and did a head count. (R2) was missing. The nurse on that hall (V6) and a CNA were looking for her outside. Things got hectic and I am not sure how long they were gone and/or when (R2) returned but I know (R2) was brought back to the facility. I am not sure what she was wearing but I believe it was appropriate." A statement provided by V19 dated 6/19/2025 documents, "I was the 100-hall when staff notified me of possible elopement on 200-hall. I went to the 200-hall and searched all the rooms for possible missing resident and then back to the 100-hall and completed head count." On 7/2/2025 at 1:26 PM, V18 (CNA), stated, "I was	S9999		

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S9999	Continued from page 5 working the night (R2) got out of the facility. I was working the 100-hall. All I know is a CNA came from the locked dementia unit and asked us if we had seen anyone leave the building. I told her no, and I hadn't seen anyone. I went down to the dementia unit, and we did a head count on both sides male and female sides. I then walked out of the back, and I went one way, and the other CNA went the other way and we walked the entire perimeter of the building. I almost fell because it was pitch black and bumpy and I was so worried (R2) could have fallen too and maybe she was near me, but I could not see her. I did two walk arounds. Then I went back into the facility and got my cell phone because I wanted a light. I walked the perimeter again but could not find her. I then went back to my hall (100 hall). Later (V6) returned and she had found (R2). I would say (R2) was gone maybe 20-30 minutes give or take." A Statement provided by V18 (CNA) documents, "I was on the 100-hall when I was notified of possible elopement. I immediately went outside and checked building perimeter then came inside and completed head count on Looking glass." On 7/2/2025 at 9:02 AM, R2 stated she had never tried to leave the facility. R2's skin assessment dated 6/19/2025 document she had new issues of bruising on her front left knee, left shin, right shin and right inner forearm. On 7/2/2025 at 10:02 AM, upon exiting the emergency door there is a drop off from the cement slab to the ground of about three inches. There are large amounts of vegetation, in front including bushes, weeds and fences separating the facility from a subdivision. There are several breaks in the fence to the subdivision after each house, but the vegetation is thick. Upon finding an opening and crossing over one would be in a residential yard. This street is lined with houses and crossing the street is another line of houses, and behind these houses are steep inclines and more vegetation. R2 was found in the second subdivision. The Facility Missing Elopement Policy Guidelines policy with a revision date of 6/19/2025 documents, "The facility strives to promote residents' safety and protect the rights and dignity of the residents. The	S9999		

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S9999	Continued from page 6 facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, and institute measure for resident identification at the time of admission Elopement is the ability of a cognitively impaired resident who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed who may enter into harm's way. * Wandering refers to a cognitively impaired resident's ability to move about insive (sic) the facility aimlessly, but often without clear purpose and without regard to one's personal safety." The noncompliance began on 6/19/2025 was corrected/removed on 6/19/25 after the facility took the following actions to correct the noncompliance prior to the start of current survey: R2's room was moved closer to the nurse's station. R2 was placed on 1:1 for 72 hours. R2's elopement risk was re-evaluated. R2 was placed on enhanced monitoring. All staff were in-serviced on elopement policies and procedures and verified on 6/19/2025. Daily audits were being conducted and reviewed by V1 and V2. The first daily audit was dated 6/19/25. Elopement evaluations were completed on all residents. Completion date 6/19/25 "B"	S9999		