STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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 Investigations: 2545560/IL194797 2543640/IL194968 An extended survey was conducted	S0000		07/28/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.1220b)3) 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.	S9999		07/28/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 1 300.690. Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 300.1210. General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 2 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.1220. Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents were supervised to prevent elopement. This failure resulted in R2 eloping from the facility on 6/15/2025, unknown as being gone and spotted 0.2 miles from the facility, alone in a parking lot by V5 (Certified Nurse Assistant) who was returning from lunch. R2 was brought back to the facility but her return condition at the time of her return remains unknown, as she received no assessment for injuries and no longer resides in the facility. This failure also resulted in R22 eloping from the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 3 facility on 7/8/25 when R22's nurse (V30) noticed him missing between 9:30 AM to 10 AM. V30 stated R22 was returned to the facility at approximately 12:40 PM. Findings Include: 1.R2's census sheet, print date of 6/18/25, documented R2 was admitted to the facility on 5/21/25. R2's medical diagnosis sheet, print date of 6/18/25, documented R2 has diagnoses including schizophrenia, depression, heart failure, cardiomyopathy, coronary atherosclerosis, hypertension, pneumonia, type 2 diabetes mellitus, and depression. R2's elopement evaluation, dated 5/21/25, documented a score value of 1 or higher indicates risk of elopement. R2's elopement evaluation score was 6. R2's community survival skills assessment, dated 6/8/25, documented R2 is not sufficiently alert, oriented, coherent nor knowledgeable to be considered for independent outside pass privileges. This form documented R2 does not know the facility address nor how to ask for/seek help in an emergent or problematic situation. This form also documented R2 does not have the ability to adhere to pass privilege policies, e.g., getting permission to leave, signing out, respecting time parameters and curfews, and informing staff upon return. This assessment conclusion documented the resident does not appear to be capable of unsupervised outside pass privileges at this time. R2's MDS (Minimum Data Set), dated 5/29/25, documented R2 is cognitively intact although on 6/18/25 at 11:51 AM V10 (Social Service Director) stated she completed R2's cognitive assessment and that R2 was able to answer the questions on the assessment but R2 was absolutely not safe to go outside on her own and that R2 would not have known to sign herself out of the building. R2's care plan, print date of 6/18/25, does not document or address R2's elopement risk. R2's hospital H&P (history and physical), dated 5/6/25,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 4 documented Pt (patient) with psychosis that appears to be new, but it appears has not been evaluated by a medical professional. She is also having an acute on chronic systolic heart failure exacerbation. Diagnosis for cause of psychosis is unclear but there is suspicion for a dementia related diagnosis given the age of onset. R2's regional hospital inpatient discharge summary, dated 5/21/25, documented principal problem pneumonia of right lower lobe due to infectious organism. Active problems: delirium. Resolved problems: no resolved hospital problems. Details of hospital stay per H&P on 5/6/25 R2 is a 74 year old F (female) w/ (with) PMH (past medical history) of dilated cardiomyopathy, CAD (coronary artery disease), HTN (hypertension), DM (diabetes mellitus), insulinoma s/p (status post) Whipple (surgical procedure of pancreas), depression who was brought to the hospital by ambulance for paranoia, found to have exacerbation of known heart failure. Per chart review, patient was BIBEMS (brought in by emergency medical services) as she came to the airport and told people there, she had been kidnapped. On arrival to the ED (emergency department) patient was combative, attempting to leave the emergency department. She was treated with Ativan, Zyprexa, and eventually IM (intramuscular) Haldol multiple times during ED stay. It continues, patient was evaluated by psych team in ED who noted unspecified schizophrenia and other psychotic disorder but given elevated BNP (B-type natriuretic peptide) concerning for HF (heart failure) exacerbation, not appropriate for psych admission at this time. Patient arrived to the floor agitated, kicking at staff, but on room air and with stable vitals. Unable to obtain medical or social history from patient. It continues, hospital course: delirium and agitation: patient brought to the ED by EMS for bizarre behavior. Initially combative and aggressive requiring multiple doses of IM Haldol and patient was placed on elopement precautions. Intermittently requiring physical restraints during the initial presentation, patient became more appropriate, with better insight as her admission progressed. This was in the context of a psychiatric consult and the initiation of scheduled PO (by mouth) Haldol for symptom management. Given acute presentation, infectious workup was completed which was negative, at which point antibiotics were discontinued. Treatment of acute heart failure exacerbation as below. Improvement in heart failure exacerbation coincided with improvement in mental status, but this is in conjunction with scheduled antipsychotic medication. Initial attempts to wean off Haldol coincided with	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 5 increased confusion and irritability, so psychiatry was reengaged and recommended a taper off of Haldol and onto Seroquel. This taper was initiated inpatient, and instructions for further tapering were provided to skilled nursing facility at time of discharge (see below). Per psych the underlying diagnosis for this is agitation in the setting of delirium and Seroquel is scheduled to stop after 2 weeks on just Seroquel, with encouragement to follow up outpatient with memory diagnostic center and geriatric clinic. It continues, Haldol to Seroquel taper (instructions below), f/u w/ memory diagnostic clinic for concerns for underlying neurocognitive disorder. On 6/26/25 at 10:26 AM V25 Transportation CNA stated she took care of R2 a few times during her stay and R2 was confused and wandered around the facility. V25 stated she started doing transports about a month ago and she did not take R2 to any appointments nor know anything about her order for a memory diagnostic center. Surveyor asked V25 how she is notified of resident appointments and V25 replied the nurses are supposed to write it down for her although they have not been doing this, so she is being trained on how to check the EMR (electronic medical record) for appointments. On 6/26/26 at 10:42 AM V25 stated she started doing resident transports on 6/2/25 and stated the facility has agency nurses and they usually do not know the process therefore she is often not notified of appointments that are needed for residents. On 6/26/26 at 10:47 PM surveyor called the Memory Diagnostic Center where R2 was referred to and V26 office employee stated there was never an appointment made for R2. On 6/26/25 at 11:16 AM V1 Administrator stated the facility never made the appointment for R2's discharge to be evaluated at the Memory Diagnostic Center. V1 stated she does not know why it was not made because the prior transport aide quit with no notice. On 6/26/25 at 12:27 PM V1 Administrator stated all resident discharge orders from hospitals including orders for follow up appointments should be added the resident's physician orders upon admission.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 6 R2's hospital progress notes/referral documents, dated 5/15/25, documented CT (computed tomography scan) head without contrast. History: 74-year-old female presenting with altered mental status. Findings: encephalomalacia in the right occipital lobe. According to the National Institutes of Health (NIH.gov) encephalomalacia is the softening or loss of brain tissue after cerebral infarction, cerebral ischemia, infection, craniocerebral trauma, or other injury. According to NIH.gov symptoms of encephalomalacia include memory loss, difficulty concentrating, difficulty with reasoning and judgment, and impaired problem solving. NIH.gov noted brain tissue damaged by encephalomalacia cannot regenerate and results in permanent brain damage. It continues, assessment/plan: AMS (altered mental status) - patient is poor historian and unwilling to participate in interview but based on collateral from friend patient with 3-5 years of worsening delusions and paranoia, has filed multiple police reports against neighbors. It continues, unclear if this is patient baseline, or gradual worsening of chronic condition vs (versus) acute presentation at this time. It continues, delirium precautions, elopement precautions. R2's hospital internal medicine daily progress notes, dated 5/12/25, documented interval history: afebrile, hemodynamically stable. Remains intermittently confused, although cooperative with staff and exam. R2's facility admission notes, dated 5/21/25 at 3:43 PM, documented resident transferred to facility via ambulance. This nurse received report from (nurse) at (regional hospital). Resident is a 74-year-old female. Alert, confusion at times, early onset dementia. Resident was found at an airport. Resident didn't remember how she got to the airport; told hospital staff she was kidnapped. Resident noted to have delusions at times. R2's facility progress note, dated 5/22/25 at 12:38 AM, documented alert with intermittent confusion. High elopement risk. Staff has to monitor very closely. Resident approached side doors several times during the shift but easily redirected. R2's progress note, dated 5/27/25 at 5:34 AM, documented resident walked around all night with no recollection of previous encounters with staff seen	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 7 within 30-minute time frame. Resident seemed angry and distressed. Resident stated that she was looking for something and stood in the dining area for one hour under supervision until moved back to room. Resident became very angry if touched all efforts redirected by letting resident move when ready. Sign has been placed on door to help resident identify living area. R2's Nurse Practitioner progress note authored by V22, dated 5/28/25, documented 74-year-old female presents to me today at NF (nursing facility) as new patient. She admitted from hospital after paranoia, AMS (altered mental status), and HF (heart failure) exacerbation. It continues, she is A&O (alert and oriented) to self. Cognitive status: confused. R2's progress note, dated 6/11/25 and authored by V22 Nurse Practitioner, documented R2 presents to me today at NF for nursing reports that R2 has been refusing medications and her sister is here and concerned about her edema. Her sister wants her to go to ER d/t (due to) the refusal of meds and her edema. She is adamant she does not wish to go. She is very agitated and paranoid this am. She will not answer ROS (review of systems) questions and only allows for limited exam. Sister wants me to give her something to be more compliant, explained that is not possible. She is also requesting (regional) hospital. Explained EMS makes that call. Also explained if she refuses when EMS arrives there is strong chance, they will not take her. She is up in chair. She is A&O (alert and oriented) to self. R2's behavior progress note, dated 6/9/25 at 3:20 AM, documented resident attempted several times to leave facility and had to be redirected multiple times. Resident states that she cannot stay here because her house is waiting for her. It continues, resident is starting to wander in the room of other residents. R2's progress note, dated 6/11/25 at 10:08 AM, documented resident out in dining room during breakfast with x2 family members present. Resident having increased behaviors, yelling, cursing, refusing medications and meal. DON (Director of Nursing), Administrator, ADON (Assistant Director of Nursing), and NP (Nurse Practitioner) present and aware. Orders received per NP to send resident to ER (emergency room) for evaluation. Resident refusing all care. Family requesting resident may need to be sent to psych	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 8 (psychiatric) eval (evaluation) for AMS (altered mental status) and increased behaviors, plus refusal of medications and care. It continues, resident currently ambulating self around facility, staff supervision/monitoring continues. R2's next progress note following the 6/11/25 progress note was on 6/14/25 at 12:57 PM and it documented resident has refused all medications, including blood glucose monitoring/insulins for this nurse today. Several attempts to offer medications during scheduled times refused and resident stated, "I don't take medicine." R2's initial psychiatric evaluation, date of service 6/13/25 and authored by V28, documented per staff patient wanders a lot and voice thoughts indicative of delusions and paranoia. Per staff patient voiced she was kidnapped and feels that she is not safe because someone wants to kill her. Patient also believes that her credit card was used to fund breakfast. Per staff patient believes she has been to jail and works at the airport. Patient appears to be exit seeking at times as she believes she needs to get to work at the airport. Per staff patient can be irritable and has been refusing to take her medication. She appears suspicious of staff and paranoid. Upon assessment today patient was not cooperative. She states, "I already have a doctor I don't need to talk to you." Denied feelings of anxiety and depression. Denies concerns with sleep or appetite. When asked about hallucinations patient states "I am done with you go on" Per documentation/chart review patient was recently discharged from the hospital for bizarre behaviors, delusions, and agitation and was started on medication management. Per staff family would like for patient to get LAI (long acting injectable). Mental status examination documented Thought Process: disorganized, Associations: loosening associations, Thought Content: paranoia and delusions elicited, Mood: irritable, Attention: impaired, Insight: poor, Judgement: poor, Orientation: person. R2's progress note, dated 6/15/25 at 10:32 AM, with a created date of 6/16/25 at 10:34 AM, and authored by V1 Administrator, documented R2 exited the facility without signing out. This writer remined R2 of the importance of signing out with the nurses and showed her where the sign out book was located. R2 has a BIMS of 13 and voiced understanding.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 9 R2's incident progress note, dated 6/15/25 at 1:16 PM, documented resident exited building and went outside. Staff with resident and assisted resident back in facility. Resident educated and reminded to sign out when going outside of building and tell staff before exiting. Resident verbally agreed. Enhanced supervision provided. R2's behavior progress note, dated 6/16/25 at 5:39 AM, documented resident A/O X 2 did not sleep well in assigned area with consistent ambulating to dining hall and sleeping on couch. Pt (patient) was redirected several times to assigned living area. Pt is pleasant but confused on why she is living here. Pt is exit seeking and sleeps no more than three to four hours late nights. It continues, resident has been placed with safety protocols. Will continue with plan of care. R2's behavior progress note, dated 6/16/25 at 6 AM, documented resident attempted exit and redirected to unit 200. Returned to hallway seeking exit 5 per staff. R2's progress note, dated 6/17/25 at 1:35 PM, documented upon return from LOA (leave of absence), residents sisters voiced that resident will be leaving facility and not returning. Family refused to wait until MD (medical doctor) notified. Family also refuses to make facility staff aware of where resident is discharging to. On 6/18/25 at 8:25 AM V7 LPN (Licensed Practical Nurse) stated R2 discharged from the facility yesterday and R2's family did not say where she was going. V7 stated she was not working when R2 left the building, but she heard R2 eloped and was by the highway. V7 stated a CNA noticed R2 on her way back from lunch and picked her up. V7 stated the times she cared for R2 in the last 2 weeks R2 was paranoid and combative. On 6/18/25 at 8:30 AM V5 CNA approached surveyor and stated, "I was working last weekend, I was returning from lunch around 11:20, and I saw (R2) down the street." V5 stated she did a u turn, stopped, and said to (R2) "I will take you home." V5 said (R2) replied "I know you from somewhere." and then got into the car with her and she brought her back to the facility. V5 stated she does not know how long (R2) was gone but she did see her at breakfast that day. V5 stated she called	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 10 and reported the incident to the DON (Director of Nursing). On 6/18/25 at 8:45 AM V9, Activity Director, stated she was not at work when R2 eloped last weekend and stated R2 was confused at times during her stay at the facility. On 6/18/25 at 8:52 AM V10, Social Service Director, stated R2 was at the facility for 2 or 3 weeks, she was very confused, combative, and non-compliant. V10 stated she completed her community assessment, and she was not safe to be out of the facility by herself. V10 stated R2 could not have signed herself out because she came to the facility after she was found at the airport claiming she was kidnapped. On 6/18/25 at 8:57 AM V1, Administrator, stated she did not report R2's elopement because she looked at her (cognitive assessment) and she was a 13. Surveyor asked V1 if she looked at R2's community/elopement assessment and V1 stated no. On 6/18/25 at 9:03 AM V11, Vice President of Clinical Services, stated based on R2's (cognitive assessment) and cognition at that time they don't think it was an elopement. On 6/18/25 at 11:43 AM V12 CNA stated she was not at work last weekend when R2 eloped. V12 stated R2 was very much confused all the time when she saw her or took care of her during her stay at the facility. On 6/18/25 at 11:51 AM V10 Social Service Director stated she completed R2's cognitive test, and R2 could answer those questions but she was absolutely not safe to go outside on her own. V10 stated she does not know what door R2 exited the facility from, but she was in room 213 which is located 2 doors down from that hall exit door. V10 stated R2 never left the facility on her own and she would not have known to sign herself out to leave the building. On 6/18/25 at 12:17 PM V1, Administrator, stated she believes R2 exited the front door when she left the facility. Surveyor asked how she reached that conclusion and V1 replied a nurse saw her by the front	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 11 door around 11 AM on 6/15/25. V1 stated she did a timeline, and she thinks R2 was only out of the facility for approximately 5 minutes. Surveyor requested a copy of the timeline and V11, Regional Director, stated we are working on it. Surveyor asked if someone deactivated the door alarm without checking to see why it went off and V1 replied she assumes so. On 6/18/25 at 12:23 PM V11, Vice President of Clinical Services, stated she knows the facility did have elopement risk binders for the residents at risk for elopement because she is the one who put them together. V11 stated she does not know if R2 had an elopement risk binder or not. V11 stated R2 was cognitively intact based on her cognition score and with resident rights she had the right to leave if she wanted to. Surveyor questioned V11 regarding the reason R2 was admitted to long term care after she was found at the airport with confusion and claiming she was kidnapped. V11 replied R2 had a hospitalization following that. Surveyor then questioned if V1 and V11 had reviewed R2's chart as it documented R2 had confusion throughout her stay at the facility and her community assessment documented she is unsafe to be out on her own. V11 replied "I am confused at times" and residents still have rights. On 6/18/25 at 12:43 PM V1, Administrator, provided R2's elopement evaluation dated 5/21/25 with a score of 6. Surveyor asked V1 if a score of 6 indicates R2 was at risk for elopement. V1 replied "let me look" and left the room. This form documented score value of 1 or higher indicates risk of elopement. On 6/18/25 at 12:46 PM V1 returned and stated it doesn't say she is high risk for elopement. Surveyor asked V1 if a score value of 1 or higher as documented on the elopement evaluation indicates R2 was at risk of elopement and V1 replied "yes" On 6/18/25 at 2:34 PM V13 LPN stated she did not write a written statement regarding R2's elopement from the facility but she did document it in her progress notes. V13 stated she was R2's nurse on 6/15/25 and she last saw her before she started her medication pass before 11 AM on 6/15/25. V13 stated she did not see R2 again until she was returned to the facility by a CNA around 11:20 AM. V13 stated she did not document an assessment of R2 upon her return to the facility. V13 stated R2 was confused on the morning of 6/15/25, was carrying	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 12 some of her belongings around in bags, and stated she was leaving. V13 stated she had previously cared for R2 on 2 other shifts at the facility and R2 was also confused during those shifts. On 6/18/25 at 2:53 PM V1 Administrator stated R2 did not have a photo taken during her admission to the facility nor did she have an elopement risk binder per the facility missing resident/elopement policy. On 6/18/25 at 3:13 PM surveyor asked V1 what enhanced precautions were put into place for R2 as documented in R2's progress notes upon her return to the facility after being found walking up the street and V1 replied "we just checked on her frequently, I don't know if it was documented or if her care plan was updated. I will check" On 6/24/25 at 10:37 AM V11 Regional Clinical Director stated if residents are at risk for elopement, then they do not have an elopement binder but if they are high risk then they do have an elopement binder. V11 stated the facility did have binders for the high-risk residents but they were misplaced when surveyor requested them, so she redid them. V11 stated she does not know why R2 did not have an elopement binder and was unaware of her history of wandering. V11 stated she would expect all staff to immediately respond to door alarms except the dining room door because there is usually a staff member outside with the residents and it is fenced in. Surveyor asked if the gate is locked as it is a fire egress and V11 stated she does not know if it is locked or not. On 6/24/25 at 10:40 AM surveyor asked V2 DON if she considered R2 high risk for elopement and V2 replied R2 wanted to go home, she went to the doors and looked out. Surveyor then asked V2 if R2's memory diagnostic appointment was completed as documented in R2's facility admission orders from the regional hospital and V2 replied she does not know if the appointment was made or not. Surveyor asked if a physical assessment of R2 was completed following R2's elopement from the facility and V2 stated she would look and see if there is one in R2's medical record. On 6/24/25 at 11:01 AM V13 LPN stated she was R2's nurse when R2 left the building on 6/15/25 without the knowledge of staff and she does not know how long she	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 13 was gone from the facility although she recalls seeing her 15 to 20 minutes prior to the CNA bringing her back in. V13 stated she did not complete nor document a skin nor any type of assessment on R2 after R2 eloped. V13 stated R2 was absolutely unsafe to go out of the facility on her own due to her psychiatric issues, periods of confusion, and poor safety awareness and stated when she cared for R2 she was fixated on wanting to leave the facility. V13 stated she does not know what door R2 left from, but she would guess door 10 as her room was just 2 doors down from that exit. V13 stated R2 didn't recall leaving and stated she didn't leave when she got back. On 6/24/25 at 2:24 PM V1, Administrator, stated R2 does not have an incident report, nursing assessment, nor skin assessment for the day she exited the building alone. On 6/25/25 at 8:59 AM V22 Nurse Practitioner stated she assessed R2 on two separate dates during her stay at the facility. V22 stated R2 was very paranoid and when she saw her on 6/11/25 she wanted to send R2 to the hospital but R2 refused. V22 stated R2 was tearing up V22's papers while she was assessing her and that R2 had been refusing medications. V22 stated R2 was confused both times she assessed her and R2 was not safe to leave the facility on her own. On 6/25/25 at 11:06 AM V5 CNA stated R2 was standing on the corner of the parking lot of the apartment building on Pawnee drive and north Illinois street when she spotted R2 as she was returning from her lunch break. V5 stated R2 seemed confused when she gave her a ride back to the facility. On 6/26/25 at 10:23 AM V24 RN (Registered Nurse) stated R2 was very confused and exit seeking every time she was R2's nurse. V24 stated she was R2's nurse multiple times. V24 stated she did not know anything about R2's order to be seen at a memory diagnostic center. On 6/26/25 at 12:31 PM V28 PMNHP (Psychiatric Mental Health Nurse Practitioner) stated she evaluated R2 on 6/13/25 and based on that evaluation and information provided by facility staff R2 was not safe to leave the facility on her own. V28 stated R2 was oriented to self only on 6/13/25, R2 did not want to speak to her, and R2 was very paranoid. V28 stated the facility staff	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 14 reported R2 had been delusional, confused, exit seeking, and non-compliant with PO (by mouth) medications. On 6/26/25 at 12:48 PM V11, Vice President of Clinical Services, stated she did not review R2's hospital records prior to R2's admission to the facility. V11 stated based on what she knows about R2 now, R2 should have had elopement risk interventions, R2's care plan should have been updated, the hospital discharge orders for R2 to follow up with specialists should have been put onto R2's physician orders, and those appointments should have been made. Surveyor asked V11 why R2 was placed in a room 2 doors down from an exit as the facility elopement policy documents room placement close to common area and away from exits. V11 replied based on what she knows now R2 should have been placed in a room closer to the nurse's station. 2.) R22's clinical census sheet, print date of 7/8/25, documented R22 was admitted to this facility on 7/1/25. R22's medical diagnosis sheet, print date of 7/8/25, documented R22 has diagnoses of paranoid schizophrenia, muscle weakness, gastro-esophageal reflux disease, primary generalized osteoarthritis, and drug induced subacute dyskinesia. R22's MDS, dated 7/8/25 at 12:53 PM, documented R22 is moderately cognitively impaired. This assessment was completed by V10 Social Service Director. R22's progress note, dated 7/8/25 at 1:02 PM and authored by V9 Activity Director, documented a second cognitive assessment with a higher score indicating R22 is cognitively intact. R22's clinical resident profile/face sheet, print date of 7/8/25, does not have R22's photo. R22's care plan, print date of 7/8/25, documented R22 is at risk for wandering/elopement with goals of the resident will not leave facility unattended and the resident's safety will be maintained. Interventions are schedule time for regular walks/appropriate activity.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 15 R22's care plan, undated, documented 7/8/25 actual elopement: placed on 1:1, will be supervised when outside, elopement risk assessment reassessed. Placed in elopement binder. Date initiated: 7/8/25. Elopement risk assessment will be completed within 72 hours of admission, readmission, and quarterly. Engage resident in purposeful activity, identify if there are triggers for wandering/eloping, provide reorientation to surroundings, and schedule time for regular walks/appropriate activity. R22's fall risk evaluation, dated 7/8/25 at 8:39 PM, documented R22 has intermittent confusion. On 7/8/25 at 10:32 AM two surveyors observed facility staff walking at a fast pace up and down the halls looking for a resident. At 10:38 AM V1 Administrator was in the conference room with the surveyors and unaware other facility staff were looking for a resident. Surveyor then alerted V1 that staff were looking for a resident. The facility does not have an overhead paging system, so surveyors did not hear any facility employees including the leadership team announce code pink per the facility policy when a resident is missing. At 10:43 AM V2 DON was observed walking at a fast pace down the 200-unit corridor, surveyor asked what resident is missing, and V2 replied (R22). At 11:00 AM surveyor checked the facility elopement binders and R22 did not have an elopement binder nor a photo in his EMR (electronic medical record). Multiple employees were observed looking around the facility for R22 in an uncoordinated manner. On 7/8/25 at 11:17 AM V2 stated the missing resident (R22) has not yet been located. On 7/8/25 at 11:41 AM exit door alarms were sounding on an ongoing basis with slow response time by staff. Facility employees were observed leaving the facility grounds to look for R22. The facility's investigation of R22's elopement on 7/8/25 documented code pink was called at 10:30 AM. This investigation contained R22's progress notes of the elopement, dated 7/8/25 at 10:30 AM and authored by V11 Vice President of Clinical Services documented (R22) was taken outside to get fresh air in the smoking area. Staff member left to bring another resident inside when staff member returned (R22) was gone and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 16 the fence gate was open. Resident description: He wanted to go to the courthouse to get his deed to his trailer. Elopement timeline documented code pink called at 10:30 AM, R22 noted missing at 10:30 AM, time resident last seen 10AM, time Administrator notified 10:30 AM. It continues, time resident is located: 12:30. This investigation contains a witness stated authored by R22's nurse V30 and it documented 7/8/25 at approx. 9:30 AM while administering scheduled medications and performing (blood glucose testing) it was brought to my attention that (R22) was not in his assigned room. I immediately notified management and appropriate staff of the situation. Facility elopement protocol has been initiated at this point. A facility wide search was underway. I was instructed to finish my med pass while staff continued to search for resident. At approx. 12:30 PM I was informed that resident had been located and returned to facility safely. This investigation documented a statement by V20 housekeeper dated 7/8/25 at 9:30 AM smoke break, I came in with (a resident) and left (R22) outside and I came back in. I did not see (R22) return. On 7/8/25 at 12:35 PM V11 Vice President of Clinical Services stated the missing resident was found as he was walking back to the facility. Surveyor asked if she knows how R22 eloped without the knowledge of staff and V11 stated he might have jumped the fence. V11 confirmed the facility did not know R22 left the facility nor where he walked to. On 7/8/25 at 12:43 PM R22 was interviewed by surveyor regarding his elopement from the facility. R22 stated he strolled around the building. R22 stated he was admitted to this facility from another facility and stated they put me in a nursing home 40 years ago. Surveyor again asked R22 where he walked to when he left the facility and R22 replied he lost all of his keys and the titles to his trailer, so he needed to go talk to someone about it. R22 then stated he went to the courthouse and then to his tax man. R22 was unable to recall where all he walked to when he left the building unattended. Surveyor asked R22 to show surveyors what door he exited the facility from and R22 started ambulating towards his room, then stopped at his room, and stated "I wrote my name here on the door." Surveyor then asked R22 do you recall where we were going and R22 did not recall the surveyor's request to show him what door he left the facility from. R22 then started talking about an accident he had years ago causing an eye injury.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 17 On 7/8/25 at 12:47 PM V11 stated R22 told her he jumped the fence when he left, walked to a gas station, to a fountain downtown, popped into some other places, was trying to get a title for his home, and to see his tax person. On 7/8/25 at 12:56 PM, V30 LPN stated she is an agency LPN who is working at this facility for the first time today. V30 stated she is very familiar with R22 as he previously resided at (another facility) previously where she frequently worked and R22 was on 1:1 supervision status there due to elopement. V30 stated that R22 has short term memory loss. V30 stated that R22 could probably navigate in the community safely but may have some periodic confusion. V30 stated that she had gone to check on R22 this morning between 9:30 AM - 10:00 AM due to her being concerned he wasn't a 1:1 status presently. V30 stated she just started looking around herself for him and when she wasn't able to find him, asked the aides and other staff who too couldn't find him, and they all started searching together. V30 stated R22 returned to the facility around 12:40 PM with staff. On 7/8/25 at 12:59 PM V4 CNA stated she has noticed a few periods of confusion when she interacted with R22. Stated he is new to the facility so she does not know much about him although if he was her family member she would not want him out of the facility on his own. On 7/8/25 at 1:35 PM V1 Administrator stated she received the referral on R22 quite a while ago and she does not recall if the facility R22 came from informed them of his history of elopement or not. On 7/8/25 1:57 PM V1 and V11 acknowledged that R22 should have had an elopement binder. On 7/8/25 at 2:06 PM V25 CNA/transports stated she noticed R22 down the street in the apartment building parking lot, he was walking back towards the facility, this was at around 12:20 PM today. R22 seemed like he knew he shouldn't leave on his own, stated he went out gate from dining room exit. R22 told her something about getting his taxes done, and walked downtown to the circle.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 18 On 7/8/25 at 2:22 PM V11 stated technically R22 should have had an elopement binder based on his elopement assessment. Stated the facility has corporate staff who handle referrals and was not aware of R22's history of elopement at his previous facility until today. On 7/8/25 at 8:41 AM V1 Administrator stated V10 Social Service Director is supposed to complete the cognitive assessments on residents. V1 stated she does not know why R22 had 2 cognitive assessments completed within a few minutes. Surveyor asked V1 if the assessment results by V10 indicating R22 is moderately confused and the cognitive assessment results by V9 Activity Director indicating R22 is cognitively intact are due to R22's fluctuations in cognition. V1 replied R22 is an odd fella, she can see there is a safety concern with R22, and she does not know why there were 2 different cognitive assessments completed a few minutes apart on 7/8/25. On 7/8/25 at 9:20 AM V10 Social Service Director stated she does not know why two cognitive assessments were completed on R22 yesterday. V10 stated R22's cognition fluctuates. V10 stated yesterday she was explaining her role at the facility to R22, and he stood there kind of lost like he did not comprehend what she was saying. Surveyor asked what the time expectation is for cognitive assessments to be completed once a new resident is admitted to the facility and V10 replied they are supposed to be done within 24 hours. Surveyor asked why R22's cognitive assessment was not completed until 7/8/25 after he eloped from the facility since he was admitted on 7/1/25. V10 replied she does not always get notified when the facility is getting new admissions, yesterday the facility admitted 2 new residents and she was unaware they were being admitted. V10 also stated she needs more help and training to get everything done. On 7/9/25 at 11:05 AM V11 stated "what we know is (R22) went outside with the smokers at 9:30 AM, (R22) is not a smoker, at 9:45 AM an employee did see R22 out there and at 10:10 AM or 10:15 AM the employee didn't see him, so she told his nurse. The van driver actually had R22 in the van at 12:20 PM, all times are estimates in the investigation." 7/9/25 11:55 AM, R22 observed in dining room with 1:1 staff at side. R22 stated he recalled speaking with me yesterday, although he could not recall the reason why.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 19 R22 stated he recalls leaving the facility yesterday to go to the "drivers license place" to get his drivers license back. R22 stated he believes a "state trooper" has is, but is unsure why. R22 stated the next time he leaves the facility, he is just going to take the bus. The facility's Missing Resident/Elopement policy, with a revision date of 6/16/25, documented Management of Missing Resident, Elopement, & Risk Reduction Strategies: Policy Guidelines: The facility strives to promote residents' safety and protect the rights and dignity of the residents. The 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. II. Definitions: 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 inside the facility aimlessly, but often without clear purpose and without regard to one's personal safety. III Procedural Components Assessment: The preadmission evaluation process includes a wandering and elopement history and whether the resident can be safely cared for at the facility. An elopement risk assessment is completed on all residents at time of admission, quarterly and with any increase in exit seeking or wandering behaviors. A facility-approved risk evaluation tool (or scoring system) is utilized. The evaluation is based on various risk factors that may precipitate an elopement event. The risk tool includes a defined parameter which, when reached, indicates an increased risk and prompts strategies, as described below. The risk evaluation and new resident observation addresses the resident's mobility and psychological, behavioral, physical, and cognitive functions. Specific risk factors include A history of wandering prior to admission or finding the resident "lost" in the facility after admission. Details of the wandering history may include when the wandering occurs, if more common during daytime or nighttime hours, the usual traffic pattern, if purposeful (e.g. need for food, toileting, exercise), if exit-seeking and other triggers such as pain, noise, and odors. Problems noted in the residents' adjustment to the facility (such as stating a desire to go home, looking for children, attempting to attend functions that are based on a past schedule). Any cognitive impairment which results in an inability of the resident(s) to appreciate safety risks and an inability	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(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
S9999	Continued from page 20 to protect himself or herself. A change in the resident's mental status, Interference with risk reduction strategies, including an expressed displeasure with a wander bracelet or an attempt to remove it. Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive. Actual wandering behavior, including Shadowing (following staff or another resident), Self- stimulatory (wandering due to boredom or lack of activity), Akathisia (motor restlessness characterized by pacing, standing, and sitting, or rocking back and forth, which may be caused by psychotropic and antidepressant medications) Exit-seeking (the resident is intent on leaving the unit or facility, looking for exits, and hovering at exits waiting for the opportunity to leave with someone, or pushing on a door). Risk Reduction Measures 1. Interventions that may be used for residents identified as high risk for elopement include a. Frequent/enhanced monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g. every 15 min. checks, 1:1 monitoring), b. Room placement close to common areas such as the nurse's station and away from exits. c. Promoting activities that are in full view of staff members. d. Alternative activities to maintain the interest level of the wanderer. e. Transfer to a more suitable or more secure unit/facility, if necessary, f. Notification by nurse to physician and family for changes in behavior, such as increasing insistence or attempts to leave. It continues, Creation of Elopement Risk Binder for each resident at risk. If an electronic surveillance system is in place, door alarms are tested weekly (at a minimum) for proper functioning and the testing is documented. The photographs are for identification purposes only. One photograph is maintained in resident record and is placed in the Elopement Risk Binder, with a description of the resident (e.g., height, weight, and eye color), which can be provided through the resident Face Sheet, and is maintained at the reception desk or facility accessible designated area. Photographs are updated as required to reflect changes in a resident's appearance and at least annually. A verification process is conducted to determine the location of each resident after a fire/elopement, drill, resident activity, outing, ect ... (B)	S9999		