

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000941		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/16/2025	
NAME OF PROVIDER OR SUPPLIER Evercare of Calhoun				STREET ADDRESS, CITY, STATE, ZIP CODE #1 MYRTLE LANE , HARDIN, Illinois, 62047			
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S0000	Initial Comments		S0000			10/17/2025	
	Investigation of Facility Reported Incident of October 7, 2025/2642801						
S9999	Final Observations		S9999			10/17/2025	
	Statement of Licensure Violations						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)6)						
	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						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to maintain resident safety for 1 of 4 residents (R2) reviewed for resident safety in the sample of 4. This failure resulted in R2 being left unattended, suffering a fall, and sustaining a hematoma to the left side of R2's head and severe pain to left hip. R2 required a transfer to the local hospital and found to have sustained a subcapital femoral neck fracture with at least 2.2 CM (centimeter) superior and 1.5 CM lateral displacement of the fracture. After family and medical considerations, R2 was then transferred to the Regional Hospital Trauma Service for evaluation of surgery where R2 underwent a Left Hip Hemiarthroplasty. Findings include: R2's Admission Record, dated 10/15/25, documents R2 was admitted to the facility on 11/22/20 with diagnosis of Alzheimer's disease, Dementia, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Congested			S9999			

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S9999	Continued from page 2 Heart Failure (CHF), Anxiety disorder, Major depressive disorder, Convulsions, Lymphedema, Anemia, Trigeminal Neuralgia, and Peripheral Vascular Disease. R2's Care Plan, dated 9/24/25, documents R2 is high risk for falls related to Confusion, Psychoactive drug use, and history of falls. Interventions: Anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, follow facility fall protocol, 10/14/25: Resident has short term memory issues and is not to be left in the restroom unattended for any reason, review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers Interdisciplinary Team (IDT) as to causes. It continues R2 has an Activities of Daily Living (ADL) self-care performance deficit related to Alzheimer's, Confusion, Dementia, Impaired balance, Limited Mobility, Limited Range of Motion (ROM). Interventions: Toilet Use: The resident requires (staff assistance, walker & gait belt) by (1) staff for toileting, Transfer per screen. It continues R2 has had an actual fall with (no injury) Poor Balance, Psychoactive drug use, Unsteady gait. Interventions: Alarms in place for poor safety awareness: TSA (touch sensitive alarm) to bed and wheelchair, bed placed against wall for increased safety, bilateral assist bars to bed, continue interventions on the at-risk plan, keep items frequently used within my reach and keep area free of clutter and safety hazards, anti-roll back device placed to resident's wheelchair, TSA to wheelchair, wireless TSA to bed. R2's Minimum Data Set (MDS), dated 9/30/25, documents R2 has a severe cognitive impairment and requires partial/moderate assistance for toileting and supervision/touching assistance for transfers. R2's Fall Risk Assessment, dated 9/29/25, documents R2 is a High Fall Risk. R2's Fall Risk Assessment, dated 10/8/25, documents R2 is a High Fall Risk. R2's Nurses Note, dated 10/7/25 at 10:46 PM, documents "Resident was using the toilet staff stepped away to get supplies and resident tried standing and fell. Resident assessed and noted to have a hematoma to left side of head about 2 inches above ear and complaining of severe pain to left hip. Swelling noted to front of left hip area. Resident not allowing much ROM to be		S9999				

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S9999	Continued from page 3 done. Resident assisted to bed by staff. Neuros WNL (within normal limit) at this time. VS (vital signs) -132/69, 94, 24, 97.8, pulse ox 93%. Daughter notified. Doctor on call notified." R2's Fall Investigation (Final), dated 10/7/25, documents in part "On Tuesday, October 7, 2025, around 8:30 PM, (R2) was assisted to the toilet by staff. (R2) was unattended on the toilet when staff heard (R2) fall on the bathroom floor. Resident was assessed and noted to have a hematoma to left side of head about 2 inches above the ear and was complaining of pain to left hip. Swelling was noted to front of left hip area. (R2) was assisted to bed by staff. MD (medical doctor) and POA (power of attorney) notified of incident. Orders from MD received to send (R2) to ER (emergency room) for evaluation and treatment. (R2) was transferred to (local community hospital) where x-rays were taken and revealed a subcapital femoral neck fracture. (R2) was then transferred on to (regional hospital) for further treatment including surgical repair of fracture." It continues "Upon completion of investigation, (R2) was standing up from the toilet and had lost balance and fell on the floor resulting in the fracture and injury to left side of head. At this time, (R2) has not returned to the facility. Upon readmission, facility will follow all orders regarding treatment of fracture and will be reassessed to ensure proper care is received." V2, Director of Nursing (DON's) Investigation of R2's Fall, dated 10/7/25, documents in part "Resident was placed on the toilet in room 8 due to resident's roommate being on the toilet in their room. Staff left resident to go and get supplies. Resident attempted to stand up unassisted and fell to the floor landing on her left side. Nurse was a couple of rooms up the hall. Nurse (V4, Registered Nurse/RN) stepped out in the hallway and heard a "thud". Quickly (V4) and (V3, Certified Nursing Assistant/CNA) went to the bathroom and found the resident on the floor lying on her left side." V3's handwritten statement, dated 10/7/25, documents "Resident urgently needed to use the restroom, resident requested privacy as it may take her a while. I stepped around the corner where resident could still be seen, when an alarm started to go off. I told the resident to use bathroom call light when finished as I was stepping out to answer an alarm. Resident confirmed knowing what the bathroom call light was, how to use it, and when to use it when she was finished if I wasn't back yet, answered alarm, talked with (V4, RN) regarding a resident and then heard resident fall in bathroom. All		S9999				

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S9999	Continued from page 4 of this occurred in a matter of a few minutes from my recollection of fall incident on the night of 10/7/25." R2's (local hospital) Radiology reports, dated 10/7/25, documents X-Ray Hip 2-3 views left, fall with left hip injury. Findings: Subcapital femoral neck fracture identified. There is at least 2.2 CM (centimeter) superior and 1.5 CM lateral displacement of the fracture." R2's (Local Community Hospital) Discharge Summary, dated 10/9/25, documents R2 was admitted to the floor from the ER for further management evaluation of left hip fracture. Cardiology was consulted due to R2's significant cardiac history and Thoracic Aortic Aneurysm (TAA). After family and medical considerations, R2 was transferred to (Regional Hospital) Trauma Service for evaluation of surgery. R2's (Regional Hospital) Progress Note, dated 10/14/25, documents in part 90 y.o. (year old) female with notable PMHx (past medical history) of dementia (A&O - alert and oriented x1 at baseline), legally blind, CAD (coronary artery disease) with PCI (Percutaneous coronary intervention) in 2013, on Plavix, diastolic HF (heart failure), COPD, mild to moderate aortic stenosis, TAA, Moderate Left ICA (internal carotid artery) stenosis, questionable seizures, who was found down following unwitnessed fall at skilled facility and transferred from OSH (outside hospital) with left femoral neck fracture and UTI (urinary tract infection). Surgery: 10/10/25 Left Hip Hemiarthroplasty. On 10/15/25 at 8:50 AM, V1, Administrator, stated "We had a staff member mess up and he left R2 on the toilet for about 11 minutes, which he shouldn't have done, in which time R2 fell off the toilet and fractured her hip." On 10/15/25 at 9:25 AM, V2, Director of Nursing (DON), stated "(V3, Certified Nursing Assistant (CNA)), was the one working with (R2) the night she fell. (V3) left (R2) on the toilet and (R2) got up on her own and fell with no one around her." On 10/15/25 at 4:00 PM, V3, CNA, stated "It all began when (R2) requested to use the restroom, and her roommate was already in their restroom, so I took her across the hall to use a different one. I assisted (R2) to the toilet and then heard an alarm going off in another room so I asked (R2) if she could use the call light when she is finished, and she said yes. I even asked R2 again, what do you do when you are done and	S9999					

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S9999	Continued from page 5 she said she would use the call light, so I felt like she understood so I left her to check on the other alarm. After I checked one alarm, I heard another one going off, so I checked on that one too. Both of those residents were fine, so I stopped to talk to the nurse about those residents when we heard (R2) fall on the floor. When we got there, (R2) was on the floor by the toilet, and it looked like she was trying to walk towards the restroom door and collapsed to the floor." When asked what R2's transfer status was, V3 stated "I believe she was a one-person assist with a gait belt. I was never told not to leave her alone until after the fall, now everyone is telling me that she should never be left alone. I was never taught in school when or when not to leave someone by themselves and that I didn't know (R2) well enough to know." On 10/15/25 at 11:48 AM, V5, CNA, stated "I worked all the time with (R2) and she was a feisty one, especially when trying to redirect her to call for help. I would always stay with (R2) while in the restroom and she would even get mad at me for staying with her. (R2) always had an alarm on either in her bed or wheelchair." On 10/15/25 at 3:20 PM, V6, CNA, stated "(R2) is typically an assist of one with a gait belt. Sometimes she would walk with staff using a gait belt, and sometimes she would complain of her legs hurting and refuse to walk and would have to use her wheelchair. Staff should never leave her on the toilet or anywhere else by herself because she would get up on her own. She always had an alarm on her wheelchair and on the bed and would typically hang out by the nurse's desk talking to everyone." On 10/15/25 at 3:25 PM, V7, RN, stated "(R2) was always very quick and the minute you turned your back on her, she was up. You always had to keep your eye on her and know where she is and what she is doing." On 10/15/25 at 3:45 PM, V2, DON, stated "I would expect the staff to follow resident fall precautions and interventions to keep them safe. I would expect the staff to monitor any resident who is a High Fall Risk and stay with them while using the restroom to prevent them from getting up on their own and falling." On 10/15/25 at 3:47 PM, V1, Administrator, stated "I would expect all staff to keep residents safe at all times and to monitor those residents who are a high			S9999			

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S9999	Continued from page 6 fall risk." On 10/16/25 at 9:46 AM, V1 stated "That is the only policy we have for fall precautions or Resident safety." The Facility's "Interdisciplinary Fall Reduction / Injury Prevention Protocol", dated 1/2025, documents in part "Intent: An interdisciplinary approach at reducing falls, preventing injury and increasing safety awareness ultimately resulting in improved quality of care for our residents." (A)		S9999				