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 07/24/2025

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

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S0000	Initial Comments Complaint Investigations: 2546140/IL196020 2546689/IL2566383	S0000		07/31/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1035a)2) 300.1035d) 300.1220b)3) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only	S9999		07/31/2025

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

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S9999	Continued from page 1 prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record. Section 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 interview and record review, the facility failed to follow advanced directives for 1 of 3 (R5) residents reviewed for advanced directives in a sample of 16. This failure resulted in staff performing unnecessary chest compressions, respiratory ventilation for 20 plus minutes, and intubation on R5 against his advanced directive status. Findings include: R5's Physician Order Sheet (POS), dated 7/2025, documented diagnoses of Chronic Obstructive Pulmonary Disorder, Chronic Diastolic Congestive Heart Failure, and Morbid (severe) Obesity with Alveolar Hypoventilation. It also documented an order dated on 6/2/2025 "DNR (Do Not Resuscitate)." R5's Post Acute Care Transfer Report from the local hospital, dated 6/5/2025, documented, "Code Status Information: Limited: No CPR (cardiopulmonary resuscitation) Modified Resuscitation Specifics: Provide aggressive: No intubation…"	S9999		

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S9999	Continued from page 2 R5's Care Plan did not document R5's code status. On 7/16/2025 at 9:56 AM, V7, Licensed Practical Nurse, (LPN), stated that at around 5:20 AM on 7/4/2025, she was passing medications, and she stopped at R5's room, and took his medications in to him. She stated that she set them down on the table, called his name and he didn't respond, so she shook him, and he felt cold, and his color was pale. He did not respond, so she rubbed his chest and checked his neck for a pulse and did not feel anything. She stated she yelled for help, she checked her computer, that was right outside of R5's room, and there was not a code status in the computer. V7 was asked where she would find a code status on a resident in the computer, V7 stated that on the MAR (Medication Administration Record) by the resident's picture is their code status. V7 stated that the other nurse called 911, and she started Cardiopulmonary Resuscitation (CPR), had the bed flat. V7 stated that Emergency Management Services (EMS) arrived 15-20 minutes later and took over CPR. V7 stated that since she could not find the code status, she treated it as a Full Code. She also stated that while EMS was performing CPR, she went to the nurse's station and checked the "BIG" computer and there still wasn't a code status that could be found. She continued to state that she entered R5's room and EMS had stopped CPR at around 5:47- 5:50 AM and the MD (medical doctor) from the hospital called it (time of death). V7 stated that when the day shift nurse came in, she showed her where R5's code status was in miscellaneous in R5's electronic medical records. V7 stated that prior to her going into R5's room to give him medication at 5:20 AM, the last time she checked on R5 was around 12:30-12:45 AM. V7 stated that code status for all residents is on the home page and the Medication Administration Record (MAR), both located in the electronic medical record (EMR). On 7/16/2025 at 2:00 PM, V8, Certified Nurse Assistant, (CNA) stated that she was not R5's CNA the night he passed away, but she was working so she went down to his room while CPR was in progress and before EMS came, and V7 had her perform CPR, because the nurse was getting tired. V8 stated that she couldn't answer where she would find a resident's code status. On 7/16/2025 at 9:30 PM, V14, LPN, who was the day shift nurse on 7/4/2025 that came in at 6:00 AM for her shift and assisted V7 with finding the code status, stated that when she came in, R5 was being coded by EMS, and that he was intubated. V14 stated that the DNR was in the miscellaneous section of his chart and that	S9999		

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S9999	Continued from page 3 it was not on the computer screen where V7 could find it. V14 stated that she knew he was a DNR because she admitted him from the hospital on 6/5/2025. V14 also stated that there is a list of residents who are DNR at the nurse's station by the computer, but his name wasn't on it. V14 stated that EMS did intubate R5 and used the Ambu bag and that the doctor at the hospital told EMS to stop CPR. V14 was asked when a resident returns from the hospital, like R5 did, who gets the order from the doctor for the new code status? V14 stated that it is usually the admitting nurse, but she continued to state that she didn't think she got the order for R5's DNR nor did she put it in the computer and that was why it did not show up when V7 was looking for it. V14 stated that when she was helping V7 look for it, it was not on R5's home page in the electronic medical record and that was why V7 couldn't find it. On 7/17/2025 at 11:55 AM, V17, Social Services Director, stated that she was not aware of R5's code status change when he returned from the hospital on 6/5/25. V17 stated that no one notified her of the change of code status from full code to DNR, so a new POLST (Physician Orders for Life-Sustaining Treatment) was not made in June. V17 stated that when R5 returned from the hospital she went down to see him, and he gave her his will and the healthcare power of attorney, and she continued to state that in that paperwork there was no DNR, nor did it document a code status change. V17 then stated that you can't be a DNR and be comfort care and that she did not think this was a DNR, but she also did not approach R5 with a new POLST since she was not aware of his decision. On 7/17/2025 at 12:25 PM, V2, Director of Nurses, stated that R5's code status was changed when he came back from the hospital on 6/5/25 and she did not know why an order was never written on that date. She continued to state that the social worker was given his living will, but she doesn't remember who the nurse was or what had happened to the hospital paperwork, but the DNR never was put into their computer system on 6/5/25. V2 stated that the nurse started CPR on 7/4/25 on R5 because she couldn't find in the system where R5 was a DNR, so their protocol was to start CPR. V2, stated that 2 things happened during that code, 1. the paper was found that he was a DNR and 2. the daughter told them to stop CPR. V2 stated that the issue was that the nurse working did not see where the code status was. V2 stated that someone, could not recall which nurse, communicated with her that R5 was a DNR on 6/5/25, it's possible that that nurse is no longer employed at the facility, it is the responsibility of that nurse to write the order for the DNR and to make sure social	S9999		

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S9999	Continued from page 4 services knows and then we follow up on it to make sure it was done. No one followed up on his DNR and that was why the order was written on 7/4/25 and back dated for 6/2/25. V2 stated that R5 should not have been Coded on 7/4/2025 but the agency nurse did not see he DNR and our protocol is to start CPR. V2 stated that agency nurses have access to the medical records system where it has code status and there was a list at the desk of who are do not resuscitate (DNR). On 7/17/2025 at 2:00 PM, V1, Administrator, stated that what she is learning at this time was that at the hospital he decided to make that change and that paperwork, with the DNR and it was not given to social services. V1 stated that the nurse who admitted him on 6/5/2025, should have put the DNR orders in when he was re admitted and then let social services know so a new POLST could have been done. V1 stated that she would expect the staff to know where to find a resident's DNR on the dashboard and in point click care (electronic medical records). V1 stated that R5 should have been reassessed upon readmission and the breakdown in communication was that social service was not being made aware by nursing of the change in code status and that the physicians order should have been written by the nurse. On 7/16/2027 at 3:03 PM. V12, R5's daughter and Healthcare Power of Attorney (HCPOA), stated that her father did not want to be intubated but when they called her that morning and was told they were doing CPR, she stated that she told them to stop CPR because he was a DNR. V12 continued to state that the last time her father was in the ICU, which was the end of May and early June, they, her, her sister (V13) and the doctor had a serious talk about code status and that her dad wanted CPR but did not want to be intubated and that the doctor told him one could not be done without the other. V12 stated that they all had a concern that if her father was to be intubated, then he may never get off a ventilator and he did not want that, so he decided that he would be a DNR. V12 stated that early June is when the paperwork was done, and it went back to the nursing home with him that he would be a DNR. On 7/21/2025 at 10:35 AM, V18, R5's Nurse Practitioner, stated that code statuses are updated in the files and when she looked this morning, in his file, he was a DNR. She continued to state that they, do not have a specific procedure with DNR, if it was signed at the hospital and that it was signed by a physician there. V18, stated that she would expect the facility to honor the residents wishes with their code status.	S9999		

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S9999	Continued from page 5 R5's Progress Note, dated 7/4/25, at 6:35 AM, written by V7 documented, “This nurse started CPR until (Local) police arrived with paramedics and this nurse was instructed to stop CPR. This nurse left out of the room and continued to find polst form for code status. Another nurse came in and went into computer and located DNR paperwork and this nurse went and took paperwork to medical staff assisting with the code. This nurse called POA, and she stated that the resident just signed DNR forms and to stop CPR. The physician that called time of death is (Hospital Doctor) with (local) hospital. Time of death called at 6:07 am. Daughter is in route to facility. DON called and informed of resident expiring awaiting daughter to arrive. This nurse spoke with coroner (County Coroner). Oncoming nurse aware that she will need to call coroner with name of funeral home once next of kin arrives.” The Facility's policy, Advance Directives, undated, documented, "1. At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law. 2. The Social Service and/or Admissions Director will be responsible for providing copies of state statutes, regulations, and information regarding Advanced Directive(s), to resident, legal representatives upon admission, and also to families who wish to receive such information and assistance regarding Advanced Directive(s) and decisions regarding life sustaining measures and in no event shall give legal advice on the need for medical care directives. 3. The resident, the legal representative, or the individual who has been authorized as the resident's health care representative will be asked if an Advanced Directive, as recognized under the state law, has been executed. Documentation concerning this inquiry, and the individual response shall include the date the entry was made and the individual making this inquiry. This information shall then be included in the resident's medical record." It continues, "6. Copies of the resident's Advanced Directive shall be made and maintained in the resident's clinical record and financial folder." (B)	S9999		