STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000616	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERVELLA OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE , SWANSEA, Illinois, 62220

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S0000	Initial Comments Complaint Investigation: 25411136/IL2668042 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1630b) 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or	S0000		12/05/2025

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

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S0000	Continued from page 1 other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to continue intravenous antibiotics to 1 resident (R1) of 1 resident reviewed for antibiotic use in the sample of 5. This failure resulted in R2 being re-diagnosed with osteomyelitis and having a peripherally inserted central catheter (PICC) reinserted. During the onsite survey, past noncompliance was cited after the facility implemented actions to correct the noncompliance which included in services and quality assurance checks. The deficient practice occurred on 10/10/2025 and was corrected on 11/11/2025 prior to the start of this survey and was therefore Past Noncompliance. The facility was able to demonstrate monitoring of the corrective action and sustained compliance. Findings include: R2's face sheet documents an admission date of 7/5/2018. Diagnosis include Osteomyelitis, Chronic Kidney Disease, Cerebral Infarction, Peripheral Vascular Disease, Dementia. R2's Minimum Data Set, MDS, dated 10/8/2025 documents R2 is severely cognitively impaired, is dependent for all activities of daily living, and requires substantial/maximum assist with turning and transfers. R2's care plan dated 5/6/2025 documents Potential for Impaired Skin Integrity as evidenced by Braden Scale for Predicting Pressure Ulcer Risk. Interventions include educate Resident / Representative about proper skin care to prevent skin breakdown. Educate Resident / Representative about the proper usage of pressure reducing devices. Educate Resident / Representative on importance of keeping skin clean and moisturized. Evaluate skin integrity. R2's progress notes dated 9/30/2025 at 1:56PM documents R2 arrived back to the facility by way of ambulance at 1:30PM and was readmitted to room. R2 is alert and mood is stable, dependent on staff for all care needs. R2	S0000		

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S0000	Continued from page 2 has a diagnosis of osteomyelitis and per report from hospital nurse, R2 has a midline to left upper arm and will continue intravenous, IV, antibiotic until 10/10/25. No complaints of pain or discomfort upon arrival. R2 was assessed. R2 has midline to left upper arm, dressing is intact. scattered bruising to left lower and upper arm. scratch noted to face on right cheek. Callus noted to right side of right foot. Tip and nail to 2nd toe on right foot is detached from toe and rest of toe is dark in color. R2 needs assist of 2 with mechanical lift for transfers. R2 is currently lying in bed with call light in reach. R2's discharge paperwork dated 9/30/2025 at 12:24PM documents Ceftriaxone 2 gram in sodium chloride 0.9. 1/o Solution 70 milliliters, ml, start taking on October 1, 2025, inject 2 grams into the vein daily. End of treatment, EOT, 11/10/2025. R2's medication administration sheets (MARS) document Ceftriaxone Sodium Solution Reconstituted 2 gram intravenously every 24 hours for infection until10/10/2025. Start Date-10/01/2025 at 11:00AM. R2's progress notes document PICC line discontinued 10/17/2025 at 3:25PM. R2's progress notes dated 11/10/2025 at 2:25PM document During the telehealth visit with Infectious Disease, ID, today. Nurse discovered that the intravenous, IV, antibiotic order entered upon R2's return from hospital on 9/30/25 was entered incorrectly. The stop date was supposed to be 11/10/25, but the stop date was entered as 10/10/25. IV antibiotics ended on 10/10/25. Infectious Disease states that her labs have looked ok and that it would be up to the family if they wanted to restart the IV antibiotics. Nurse was instructed to call back to ID and tell them that they need to decide the next plan of action and fax orders to the facility. Nurse called ID who stated their recommendation is to send R2 to the hospital for culture/x-rays and new orders on if antibiotics were still necessary. ID called and notified power of attorney, POA, of such so R2 is being sent to hospital for evaluation. Consultation with ID doctor and R2 sent to hospital per their recommendation. R2's progress notes dated 11/10/2025 at 4:09PM document Received order from Physician to send R2 to hospital for evaluation and treatment related to osteomyelitis to right foot. Family made aware. R2 will be sent to hospital, awaiting emergency medical services, EMS, for transporting. R2 is alert and mood is stable, no complaints of pain or discomfort at this time.	S0000		

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S0000	Continued from page 3 R2's progress notes dated 11/12/2025 at 1:16PM documents R2 arrived at the facility at 11:40AM by way of EMS accompanied by two emergency medical attendants, EMT, attendants. R2 was readmitted and was reorientated to room. R2 is alert with confusion; mood is stable and dependent on staff for all care needs. Per hospital nurse R2's diagnosis is osteomyelitis and R2 will be on IV and by mouth antibiotics until 12/24/25. R2 had no complaints of pain or discomfort upon return. R2 has a peripherally inserted central catheter (PICC) reinserted. PICC line to left upper arm which is intact. Hardened knot near left elbow. No open areas to buttocks, old scar tissue in between left and right buttocks. Old scar tissue under left buttocks. Heels are intact, toenail to 2nd toe on right foot is hanging and toe has a scab. Appetite was good during lunch. R2 is currently lying in bed with call light in reach. R2's hospital discharge paperwork dated 11/12/2025 documents R2 had external catheter placed on 11/12/2025 at 9:00AM. On 11/20/2025 at 12:00PM R2 was resting in bed with eyes open. V3, Assistant Director of Nursing, ADON, and V4, wound nurse performed skin check on R2. R2's second great toe appears calloused and darkened. On 11/19/2025 at 3:05PM V2 stated R2 came back from the hospital on 9/30/2025. The nurse that took the orders transcribed the discontinue date of her antibiotics as 10/10/2025 and it was supposed to be 11/10/2025. We realized the error when R2 was in a telehealth meeting with the infectious disease specialist and the nurse that had incorrectly transcribed the orders was in the meeting with R2. R2's labs had been normal, and her white blood cell count had returned to normal. The Dr even said it was up to the family if they wanted to restart the antibiotic. We didn't feel it was fair to put that decision on the family, so we sent R2 out to the hospital and there she was restarted on the antibiotic. We did some education, training, and quality assurance on all residents on an antibiotic and the stop dates. On 11/21/2025 at 8:50AM V11, Pharmacist, stated "Discontinuing the antibiotic early for osteomyelitis is a big deal. That would be a significant medication error. That could lead to all sorts of problems." On 11/21/2025 at 9:35AM V12, Nurse Practitioner, NP, stated "The incorrect transcription of the antibiotic for (R2)'s osteomyelitis definitely contributed to her being re-diagnosed with osteomyelitis and needing	S0000		

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S0000	Continued from page 4 further antibiotics. I would expect the orders to be transcribed correctly." Facility's medication administration policy dated 6/1/2025 states "To provide practice standards for safe administration of education for residents in the facility. Medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner or as a consistent state law. The licensed nurse must know the following information about any medications they are administering the drug's name, route of administration, action, indication for use and desired outcome, usual dosage and side effects." (A)	S0000		