

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000317		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/14/2025	
NAME OF PROVIDER OR SUPPLIER EVERCARE OF LEBANON				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NORTH ALTON , LEBANON, Illinois, 62254			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2549713/2636490 Investigation of Facility Reported Incident of September 25, 2025/2635831			S0000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. This REQUIREMENT is not met as evidenced by:			S9999			

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 Based on observation, interview and record review the Facility failed to ensure residents did not exit through an exit door and were being supervised to prevent any potential elopements for 1 of 3 residents (R2) reviewed for elopement in the sample of 6. This failure resulted in R2 pushing the exit alarm and exiting the facility around 7:45 PM with no staff intervention on 9/25/2025 from a secured memory unit and leaving the facility when it was pitch dark and he was later found at 10:00 PM (two hours and 15 minutes later) and returned to the facility. This past compliance occurred from 9/25/2025 to 9/26/2025. Findings include: On 10/7/2025 at 11:03 AM, upon entering the dementia units there are two locked memory care units, one for males (300 hall) and one for females (200 hall). All doors to enter and exit on both sides of the units are locked and a code is needed. If the code is not entered correctly the alarm sounded for both doors. R2's room is on the male side of the locked memory unit. The door to the outside on the male memory unit is not egressed and sounded immediately when the door was opened. On 10/7/2025 at 12:20 PM, R2's photo was in the elopement book at the nurse's station on both the female and male dementia units identifying R2 as an elopement risk. R2's Physician Order Sheet (POS) for October 2025 documents a diagnosis of Paranoid schizophrenia, drug induced subacute dyskinesia; insomnia; hypertension. R2's POS also document he is taking an antipsychotic medication (Haldol PRN as needed). R2's Minimum, Data Set (MDS) dated 8/14/2025 document R2 has difficulty focusing attention, for example, being easily distracted or having difficulty keeping track of what was being said and has disorganized thinking. R2 has delusions, R2 wanders and R2 receives antipsychotic medications on a routine basis PRN (as needed). R2 ambulates independently and has no impairments. R2's Care Plan with a date of 8/8/2025 document R2 has a history of leaving the facility and hiding in		S9999				

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S9999	Continued from page 2 facility dumpsters to watch staff look for him which he found humorous. R2 has a history of leaving facility and walking to the courthouse. R2 has a history of watching staff and when staff are busy with peers (R2) will exit and attempt to get to his nonexistent trailer. R2's Elopement Assessment dated 8/14/2025 document R2 was at risk for elopement. On 10/7/2025 at 11:33 AM, V1 (Administrator) stated, "We have only had one resident elope since we got our IJ (Immediate Jeopardy). (R2) eloped on 9/25/2025. He was on (Dementia Unit) and went out the door on the evening shift, it was dark, and he walks really fast. Staff responded quickly but because it was dark, and he got away. He was gone for over two hours before we found him. He left and went out the door down the hill across that creek but there is no water, just rocks, and through the wooded area. Staff found him and we alerted the police and there were helicopters, canine units, everyone was looking for him. Once staff found him, they asked him if he wanted a soda, and he said yes and he willingly got into the car, and they brought him back with no issues. He was dressed appropriately and was even carrying a water bottle with him. He said he was doing maintenance work, and he was on a mission." On 10/8/2025 at 10:33 AM, R2 stated he did leave the facility and just went out the back door as nobody was around. I wanted to go catch a bus for personal business that I need to address. It's personal. I just walked out the door and across the field to the bus stop." On 10/8/2025 at 5:30 PM, V11 (Local Chief Firefighter) stated, "We got a call saying the (Facility) had a missing resident that was on the dementia unit who was missing and confused and had gotten out of the nursing home. This was at night. The (Facility) had sent out a search group but was unsuccessful and was unable to locate (R2). We secured two canine units from neighboring police stations. We were flying drones, and we obtained a helicopter with infra-red technology and with the helicopter we were able to find him and once we found him everyone went to that location. I was with the canine units, and it let me tell you it was hectic, and I am not sure who got to him after we identified him because I was running around. It was the helicopter			S9999			

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S9999	Continued from page 3 that found (R2) and he was brought back to the facility. I cannot tell you who brought him back to the facility, only that it was the helicopter that alerted us to where to find him." On 10/9/2025 at 11:30 AM, Application for Sunrise/Sunset for (Facility town) document twilight ended at 7:17 PM and it would have been dark outside at 7:45 PM. R2's Progress Notes dated 9/25/2025 at 10:00 PM, Nurse (V19 Licensed Practical Nurse/LPN) and V20 (Certified Nursing Assistant/CNA) both heard door alarm sound. (V19) ran for the door while delegating (V20 CNA) to immediately announce a Code Pink and initiate head count. Nurse began perimeter search with (V21 CNA) and V22 CNA) while simultaneously notifying the administrator and DON. Code pink announced over intercom. Nurse noted current time as 7:45 PM. All residents on 300 hall accounted for besides resident (R2). Head count initiated on 100 hall and 200 hall and all residents accounted for. Administration arrived at facility. POA (Power of Attorney) and NP (Nurse Practitioner) notified while all areas of facility, grounds, and neighboring streets systemically searched. Administration then notified local authorities at 8:05 PM. Elopement information Form copied and shared with authorities. Staff located resident at 9:57 PM approximately two blocks from the facility near the cemetery. Resident willingly got into staff's vehicle and was smiling. Resident stated he was just taking a walk to (surrounding town) as he has a trailer there. NP (Nurse Practitioner) at facility upon return and evaluated resident. Resident denied pain. Skin clear without injury." R2's Initial Report date of incident 9/25/2025 at 7:45 PM, "(R2) is a 72-year-old male that resides at (Facility) on our male secured unit. (R2) has the diagnosis of but not limited to paranoid schizophrenia, drug induced sub-acute dyskinesia, insomnia, GERD and HTN. Alleged elopement from secured unit without injury. Final report to follow." R2's Final Report date of incident 9/25/2025 at 7:45 PM, documents, "Investigation: On 9/25/2025 at approximately 7:45 PM, staff responded to the 300-door alarm. Responding LPN (Licensed Practical Nurse) delegated to a responding CNA to announce a 'Code Pink' and initiate a head count on her way to the door per			S9999			

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S9999	Continued from page 4 our facility elopement procedure. The LPN then exited the exterior door with two additional staff and started searching the perimeter of the facility. The LPN notified the Administrator and DON (Director of Nursing) during the perimeter search. The CNA doing the head count could not account for (R2) and updated the LPN with this information. The administrator arrived at the facility approximately 7:55 PM. The administrator then delegated multiple staff to systemically search all areas of the building, grounds, and neighborhood streets and proceeded to call (R2's) POA (power of attorney). Local authorities were notified by the administrator at 8:05 PM, after staff not being able to find (R2) after a thorough systemic search, an elopement Information form on (R2) was provided to the authorities. Facility staff located (R2) at 9:57 PM at (address) which is approximately 0.19 miles away and a 4-minute walk from the exterior door of the facility. Upon staff finding him, (R2) stated to staff, 'Look it is V21, CNA and V37, CNA). (R2) was noted to be carrying a water bottle and drinking from it. The staff then asked (R2) if he wanted a (soda), to which he responded he did, and got into the staff member's vehicle. (R2) was dressed appropriately for the weather and was wearing proper footwear. Upon returning to the facility (R2) was smiling and stated upon interview 'I was taking a walk (nearby town) and I have a trailer there.' The provider for the facility was present at (R2's) return and did an examination which revealed no injuries or skin injuries. The Administrator then notified the POA with an update. Conclusion: The root cause of (R2's) exiting the facility is due to his impulsivity related to paranoid schizophrenia. Staff followed policy and procedure and located (R2)." On 10/8/2025 at 11:44 AM, verified the location where it was documented that R2 was found. It is a three-minute drive and a 24-minute walk. The area is straight from the facility to the residential area but there was no straight access unless one went through steep hills, terrain with lots of sticks, bushes, overgrowth and steep terrain. There are no bus stops in the area. R2's Police Report documents, "On 9/25/2025 at approximately 8:11 PM, I along with V8 (Local Police Officer) was dispatched to (Facility), reference an older male dementia unit walking out of the facility. I arrived in the area after (V8, Local Police Officer) and began checking the area for the patient identified as (R2). (R2) was last seen wearing a peach colored long sleeved polo shirt, grey sweatpants and brown			S9999			

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S9999	Continued from page 5 dress shoes. (V1, Administrator) told me he had left through the door at southwest corner of the building at around 7:45 PM and his direction of travel was unknown. I saw that several other individuals, consisting mostly of employees, were already searching for (R2) before (V8) and I (V7) arrived. It should be noted that (R2) had already been gone for nearly 30 minutes. I contacted (V9, Sergeant Police Officer) and advised of the situation. (V9) contacted (nearby Police) and requested a drone and contacted (Local Fire Department) for their response to help with the search. I spoke with (V10, Chief of Police) who also responded. (V11, Fire Chief) and numerous fire department personnel arrived. (V10) set up a command post at the location and had contacted other agencies for their assistance. His contacts also resulted in a helicopter from (nearby municipal) being deployed with thermal imaging. I spoke further with (V1) and other nursing home staff and learned (R2) was a dementia patient also afflicted with schizophrenia. (V1) has a history of leaving other nursing home facilities with the most recent having occurred when he was at the (Sister Facility) three months ago before he was transferred to (current facility). Prior to that he was a patient at (another facility). (V5, Officer nearby Police) arrived with his canine partner and attempted to track beginning from the door through which (R2) exited. (Another nearby Police) arrived and deployed his department drone. (Nearby Police V16) arrived with his canine partner and attempted a track beginning from the door through which (R2) exited. (Another local nearby Police V17) also arrived with his canine partner. Other police personnel who arrived to assist were (V17). At approximately 10:00 PM, all units at the scene were informed (R2) had been located by a nursing home employee at the cemetery approximately two blocks south of the nursing home. (R2) was not injured or anything, and he told me he was trying to get to his trailer (nearby city). The LEADS entry was canceled. A photo of (R2) has been attached to this report which has been submitted for information purposes." On 10/9/2025 at 8:35 AM, V17 (Officer from nearby Police) stated, "I got a call from (Local Police) and they requested assistance for a missing person from the nursing home. I responded and brought my canine (German Sheppard) to assist. They told me when I got there that the resident had been missing for over 2 hours. My dog followed the trail out the back side of the building and through the brush, it was very hilly, and we came up on a residential house. The owner approached me and told me he saw someone on his ring camera wandering around on his camera. The person had come up to the			S9999			

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S9999	Continued from page 6 back of the house and then moved to the front of the house. Then after some time someone came and picked him up in a vehicle. I then got a call that the resident was found. I did not talk with the resident and or see him. There was also a helicopter searching for him as well. I only know about the canine and my dog was picking up his scent and that area at dark was uneven terrain." On 10/9/2025 at 10:31 AM, V42 (Officer with the nearby Air Unit) stated, "We did respond to a call at (Facility) on 9/25/2025 we arrived at the scene at (Facility) at 8:45 PM with our helicopter. We were flying over the area with infra-red and were eventually able to locate a hot spot and locate the missing person. I know the canine units were also out looking for the missing person as well. We communicated via the radio and alerted the police force but there was also other ground officers involved. We found the missing person close to the cemetery in a residential area. I am unsure of you who picked up the missing person. We left the (Facility) at 10:16 PM." R2's Elopement Investigation Report dated 9/25/2025 at 7:45 PM documents, "(V19 Licensed Practical Nurse) was outside 300 interior exit doors heard 300 exit door alarm go off. I ran to the exit door and told (V20 Certified Nursing Assistant) to announce code pink and begin a head count. Delegated (V21 CNA) to call (V1 Administrator) and V2 (Director of Nursing/DON) while we searched grounds around facility." On 10/7/2025 at 5:20 PM, V19 stated, "I was working the night (R2) got out of the facility. I was on the women's unit and earlier that day the exit door on the woman's side (200 hall) was sticking which would cause the alarm to go off. That evening, I went to shut off the alarm and realized the alarm was still going on and that is when I realized it was coming from the men's (300 hall). I ran down to the other hall. You have to enter a code to go from the women's side to the male side and vice versa. I was not working the hall (V23 LPN) had a split hall that night and she was passing out medications on the 100 hall. At that time, I did not realize there was only one CNA working. I guess the other CNA was on break so there was only 1 CNA on that hall that night (R2) eloped." R2's Elopement investigation Report dated 9/25/2025 at 7:45 PM documents, "(V20 CNA) was in resident room and		S9999				

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S9999	Continued from page 7 heard exit door alarm. (V19) told me to announce code pink and start head count. (V19) and I and (V22, CNA) went straight outside to search. (V1) came in a few minutes later." On 10/8/2025 at 11:00 AM, V20 (CNA) stated, "I was working a split which is the 100 hall and the 300 men's hall. My nurse was passing out medications and the other CNA was out on lunch break. I was the only one working on that hall (men's hall) when (R2) exited the building. I was in another room with another resident getting them ready for bed. I have hearing issues, and I heard an alarm, but we had been having issues with the door from the women's side to the male's side and the door was sticking and when I heard the alarm, I thought it was just that door alarming not realizing it was the back door. Then I found out later when they did a head count that (R2) was missing. No, I did not stop when I heard the alarm and check." R2's Elopement investigation Report dated 9/25/2025 at 7:45 PM documents, "V21 (CNA) was at 200 hall nurse's station when heard exit door alarm. Went to exit door and outside with (V19) and (V22 CNA) to search. Called (V1) and (V2). Both showed up within ten minutes. Continued to search until I found (R2) at 9:57 PM at mailbox on (residential street)." R2's Elopement investigation Report dated 9/25/2025 at 7:45 PM documents, "V22 (CNA) was at nurse's station when 300 hall door alarm sounded, went straight outside and started searching perimeter." On 10/7/2025 at 3:05 PM, V22 (CNA) stated, "I was working the women's side of the 200 hall and heard the alarm. I ran out the door, it was pitch dark so I could not see anything but then (V19) came and got me and told me the alarm was not on the female side, but it was for the 200 hall men's side. I guess the alarm sounds on both sides. (V20) and I went over to the men's side and started looking for (R2) because they said he had gotten out. It was dark and everybody was looking but we could not find him, but they were able to find him a few hours later." R2's Elopement investigation Report dated 9/25/2025 at 7:45 PM documents, "V23 (LPN), "I was on the 100 hall when code pink was announced. The last time I saw (R2) was about 6:30 heading to his room after dinner."			S9999			

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S9999	Continued from page 8 On 10/8/2025 at 5:22 AM, V23 (LPN) stated she was working the night (R2) eloped from the facility, she was working the 100-hall split and men's memory care unit, when she was notified that (R2) was gone. This was over a week ago and couldn't recall the exact date or time, but it could have been after supper. We did a head count and (R2) was missing. (R2) had not made any attempts or had eloped from this facility but has eloped at other facilities prior to coming here. (R2) is alert and able to carry on a conversation, but after talking to him for a couple of minutes, he is confused and will make weird noises. On 10/8/2025 5:29 AM V31 (CNA) stated she was not here when (R2) eloped. She has known (R2) for about 20 years, and he has been in several surrounding facilities, he tried to elope all the time, and did elope several times. V31 stated after talking with (R2) you realize that he is confused. R2's Elopement investigation Report dated 9/25/2025 at 7:45 PM documents Root cause: Impulsivity related paranoid schizophrenia." On 10/8/2025 at 9:24 AM, V40 (CNA) stated I was working when (R2) got out. I was on the dementia care male side hall. At the time (R2) left the building I was on break. I worked a double shift that day. I was on my lunch break when it happened. When I came back from my break (R2) had already eloped from the building. The police were not there yet, and the nurse (V23 LPN) had me leave the facility and start looking for (R2). I started out walking on foot to see if I could find him. It was so dark I could not see a thing, so I then just got in my car and started driving around looking for him. I just started recently working there and was not familiar with (R2). I know somebody eventually found him and brought him back and the police were involved." On 10/8/2025 at 11:00 AM, V37 (CNA) stated, "I was not working that day, but I got a call from (V22 CNA) and she told me (R2) was missing and asked me to come in my truck and start driving down the streets to look for him. I live close. I came to the facility I got (V21), and I started driving to see if I could find him. We found him in a residential area standing there next to a mailbox. I got out of the truck, and he saw me, and I said 'Hey, (R2) you want a soda' and he said yes, and		S9999				

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S9999	Continued from page 9 he walked over to the truck, got in, I called (V1) to let her know we found (R2) and he was not hurt. I have no idea how he got where we found him. It was at night and dark, but he seemed fine and was smiling so I brought him back to the facility." On 10/8/2025 at 2:03 PM, V41 (Nurse Practitioner) stated, "Residents on the locked memory care unit are typically there because they have dementia, cognitive impairment, and or history of elopement. Most of these residents are confused. (R2) was on the memory unit. I feel (R2) was unique and he was alert and orientated x 3. (R2) does not understand that the reason he is in the facility is for his own protection. I do not think (R2) got very far after he eloped from the facility. I know he said he walked through some weeds and trees, and he wanted to take a shower when he came back. I believe anyone can get potentially get hurt if they are walking through weeds, trees and shrubs. When (R2) was brought back I half expected him not to be able to tell me the date and time, but he was able to. (R2) was even carrying a water bottle. When the police asked him where he wanted to go, he provided a real address. I know he said he thought he was at a bus stop, but I do not believe (town of facility) even has a bus stop." The Facility Missing Elopement Policy Guidelines policy with a revision date of 6/16/2025 documents, "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 Elopement is the ability of a cognitively impaired resident who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed who may enter into harm's way. Wandering refers to a cognitively impaired resident's ability to move about insive (sic) the facility aimlessly, but often without clear purpose and without regard to one's personal safety." The facility took the following actions to correct the noncompliance prior to the start of current survey: Facility failed to ensure residents were supervised to prevent elopement. Actions Taken: R2 was moved to a room closer to the nurse's station, placed on 1:1 with re-evaluation after 72 hours, elopement risk		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000317		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/14/2025	
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S9999	Continued from page 10 re-evaluated, and psych medication review requested. Administrator and Director of Nursing were in-serviced by the VP of Clinical Services. Administrator in-serviced the IDT (Intradisciplinary Team). Current staff were in-serviced on elopement policy and procedure. All residents that reside in the facility will have an elopement risk assessment completed. Elopement Binder was updated based on those risk assessments. Review of policy and procedure were completed to reflect current practice. All staff have been in-serviced on elopement, and procedures on steps to take if a resident is at risk. All facility staff will were in-serviced by 9/26/25 for elopement and staffing. A QA tool was implemented along with Daily audits of the 24-hour report for wandering/elopement risks. Daily audit for elopement risk assessments completed within 72 hours of admission. Audits to continue daily for 4 weeks to ensure that elopement risk is documented. Root Cause Analysis completed for elopement: Deficiency: Failed to prevent elopement. Initiated 9/25/25, Completed on 9/26/2025. "B"			S9999			