Illinois State Department of Health

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 **12/17/2025**

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 Annual Licensure & Certification Complaint Investigations: 25411892/IL2686045 25412146/IL2691082	S0000		12/24/2025
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.3210t) 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.	S9999		12/24/2025

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 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 3 residents (R26) reviewed for abuse in a sample of 32. This failure resulted in R26 obtaining a laceration to the forehead requiring medical treatment. Findings Include: R26's Undated Face Sheet documents R26 was originally admitted to the facility on 4/29/2025 and has a Medical Diagnosis of Hypertension, Schizophrenia, Depression, Type 2 Diabetes, and Hemiplegia Affecting Left Non-Dominant Side. R26's Minimum Data Set (MDS) dated 10/27/2025 documents R26 is cognitively intact and has had verbal behavioral symptoms directed towards others occurring 1-3 days. R26's Care Plan Date Revised 12/2/2025 documents R26 is/has potential to be physically aggressive toward peers related to anger, poor impulse control. R26's Behavior Note dated 12/2/2025 at 8:48 PM documents "This nurse was notified by a Certified Nursing Assistant (CNA) that resident was bleeding from being struck in the head with an object by roommate. Resident has a laceration to left side of forehead. Resident refused vital signs (v/s) resident was in full rage resident breathing and responding well and is able to state what is going on in details. Sending resident to hospital for eval." R26's No Type Specified Note dated 12/3/2025 at 4:09 AM documents "Resident returned to facility via Emergency Medical Service (EMS) two EMS workers transported resident from stretcher to bed. Resident denies pain at this moment. Residents' laceration was repaired with sutures Per hospital report the sutures should dissolve on their own." R11's Undated Face Sheet documents R11 was originally admitted to the facility on 3/7/2025 and has a Medical Diagnosis of Hypertension, Major Depressive Disorder, Bipolar Disorder with Psychotic Features, Generalized Anxiety Disorder, and Schizophrenia.	S9999		

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S9999	Continued from page 2 R11's MDS dated 12/1/2025 documents R11 is cognitively intact. R11's Care Plan Last Revised 10/15/2025 documents R11 is/has potential to be physically aggressive related to anger, poor impulse control, and Bipolar. The Facility's Initial Serious Injury Incident and Communicable Disease Report dated 12/2/2025 at 8:05 PM documents "Staff reported an alleged resident to resident physical altercation." The Facility's Final Serious Injury Incident and Communicable Disease Report dated 12/8/2025 documents "A comprehensive investigation including resident/staff interviews and review of both residents' medical records was conducted. Medical record review reveals R11 and R26 were involved in a relationship per both of their requests. R11 was interviewed and voices that R26 pulled her hair. R11 voices she struck R26 in an attempt to have him release her hair. R26 was interviewed and voices that he grabbed R11's hair. R26 voices R11 struck him in the head. Multiple staff members were interviewed. No staff witnessed any physical contact between the two residents. Follow up Actions: R26 was transported to Local Hospital for evaluation and treatment due to minor alteration in skin integrity to scalp. R26 received 1 suture to left scalp. R11 was transferred to Local Hospital for psychiatric evaluation. Both residents returned to facility and the following actions were taken: Resident safety checks were initiated and ongoing monitoring. Both residents were separated and placed in different rooms on different halls. R11 was offered the option to transfer to another facility. R11 agreed and was transferred to another facility. Based on the results of the investigation, the facility noted staff did not observe the physical altercation. Both residents provided conflicting accounts but confirmed physical interaction and mutual aggression. Appropriate medical and psychiatric evaluations were completed, and safety interventions-including separation and eventual resident transfer-were implemented to mitigate further risk. Both residents care plans were reviewed and updated accordingly." R26's Local Hospital Medical Records Date of Service 12/2/2025 at 9:41 PM documents "Chief complaint: patient presents with assault victim. Patient brought in via Emergency Medical Service (EMS) from Nursing Home Facility. Per EMS patient was involved in a dispute over peanut butter and was hit with a metal footrest of a wheelchair on the left forehead by the	S9999		

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S9999	Continued from page 3 other individual." R26's Local Hospital Medical Records Dated 12/2/2025 at 10:22 PM documents "procedure laceration repair, repair type: sutures." On 12/11/2025 at 11:04 AM V13, Licensed Practical Nurse (LPN), stated R11 and R26 both have a lot of behaviors and have had multiple altercations with each other. V13 stated the last altercation with R11 and R26 was a physical altercation and both R26 and R11 were sent to the hospital for evaluation. On 12/11/2025 at 11:10 AM V9, Registered Nurse (RN), stated R11 and R26 have been verbally aggressive with staff, each other, and other residents. V9 stated R11 and R26 were in a relationship and would argue all the time. On 12/11/2025 at 11:15 AM V8, Certified Nursing Assistant (CNA), stated R11 and R26 have behaviors and have had altercations with each other. On 12/11/2025 at 11:51 AM V23, LPN, stated she was working at the facility on 12/2/2025 and was passing medications when staff came to her and stated there was an altercation between two residents. V23 stated when she went down the hall, she seen R11 holding a metal foot pedal from a wheelchair in her hand and R26 bleeding from his head. V23 stated R11 told her R26 pulled her hair and she then hit him in the head. V23 stated staff separated the residents and both were sent to local hospitals for evaluation. V23 stated R11 and R26 have had multiple verbal altercations prior to this physical altercation. On 12/11/2025 at 12:03 PM V14, Nurse Practitioner (NP), stated R11 and R26 have had altercations in the past, mostly being verbal altercations. V14 stated she was informed R11 had hit R26 in the head with an object. V14 stated R11 and R26 were sent out to Local Hospitals for evaluation. V14 stated R26 received a suture to R26's head from the altercation. V14 stated the facility should have interventions in place to keep residents safe and free from abuse. On 12/12/2025 at 8:47 AM V2, Director of Nursing (DON), stated R11 and R26 were in a relationship and would have disagreements all the time. V2 stated the facility would call R11 and R26 the facility's "toxic couple." V2 stated both R11 and R26 have behaviors and the altercation that happened on 12/2/2025 was a physical altercation. V2 stated R26 stated R11 was trying to tell him to do something and R26 grabbed R11 by the	S9999		

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S9999	Continued from page 4 hair and pulled R11 to the ground. V2 stated R11 grabbed the pedal from her wheelchair and hit R26 on the side on the head. V2 stated both R11 and R26 were sent to local hospitals and R26 obtained a suture to the laceration on R26's head. V2 stated R11 did not obtain any injuries from the altercation, that she only had some hair pulled out on the side of her head. The Facility's Abuse Prevention and Prohibition Program Policy Last Reviewed 6/1/25 documents "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property." (B) 2 of 2 300.610a) 300.1210b) 300.1210c) 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. c) Each direct care-giving staff shall review and be	S9999		

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S9999	Continued from page 5 knowledgeable about his or her residents' respective resident care plan. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide supervision and monitoring for 1 of 1 (R38) resident reviewed for elopement. This failure allowed a resident with fluctuating cognition impairments to sign himself out of the facility on 11/27/2025 at 3:00 PM with unknown destination, unknown return, and with staff unaware of his whereabouts. At 9:40 PM police found R38 sitting on the ground, very confused, a mile away from the facility by a busy 4 lane highway intersection. R38 was transferred to the emergency room with multiple abrasions, bruises and lethargy where he required IV fluids, a head CT, X-Ray of chest and right knee. Findings include: R38's Former Facility Weekly Summary, dated 11/12/2025 at 5:23 PM documents resident is alert and orientated with episodes of forgetfulness and confusion. Vision impaired. Ambulates with w/w (wheeled walker) at times forgets walker. 11/13/2025 at 3:36 PM documents resident alert to self. Ambulates with walker with supervision within facility. Incontinent of bowel and bladder. Peri care when staff he allows it. R38's Undated Face Sheet, documents he was initially admitted to the facility on 11/18/2025 with diagnoses including Parkinson's, diabetes, Bipolar and Schizophrenia. R38's Baseline Care Plan, dated 11/18/2025, V13, LPN documented R38's vision was adequate. Functional Status: independent with eating, oral hygiene, toileting, dressing, putting on/taking off footwear, setup assistance needed for personal hygiene. Mobility: independent, walk 10 feet: not assessed/no information documented. No mobility device. Level of consciousness: alert, cognitively intact, continent of bowel and bladder. Psychotropic medications included Seroquel, Abilify and Sertraline. Self-Administer medications: no. No pain. Resident is not a diabetic and no history of falls documented. Resident is not an elopement risk documented. R38's Health Status Note, dated 11/18/2025 at 11:09 AM documents resident arrived to the facility via private vehicle. Escorted to room and orientated to call light and remote. Resident is alert and oriented x 3. No c/o (complained of) pain voiced or noted. All medication	S9999		

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S9999	Continued from page 6 orders entered into electronic medical record. Skin assessment completed upon admission to facility. No areas of concerns noted at this time. Resident currently in bed resting with eyes closed. Respirations even and unlabored. Call light in reach and functional. R38's Electronic Medical Record dated 11/18/2025 at 11:10 AM through 11/27/2025 at 4:11 PM, no progress notes documented including no assessment of R38's cognition or behavior. R38's Nurse Practitioner (NP) New Admit Progress Note, dated 11/19/2025, documents 75-year-old male presents to me today at NF (nursing facility) as new admit. He has dx (diagnosis) of anxiety, bipolar disorder, HTN (high blood pressure), depression, COPD (chronic obstructive pulmonary disease), vitamin d deficiency, insomnia and diabetes. He is resting in bed. He appears stable in no acute distress. He voices no acute concerns. Nursing has no acute concerns. He is ambulatory. He is current smoker, and he does not wish to quit smoking. He is A&O (alert and oriented) to person and place. Cognitive status documented: forgetful. R38's Elopement Evaluation, dated 11/18/2025, documents he was not an elopement risk. R38's Functional Abilities and Goals – Admission assessment, dated 11/18/2025 V13, LPN documented functional cognition: independent, no impairment for functional limitations range of motion, no mobility devices checked, independent with toileting. Walk 10 feet: not assessed/no information documented. Walk 50 feet with two turns: not documented. Walk 150 feet not documented. Walking 10 feet on uneven surfaces: the ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel: not documented. 1 step (curb): documented not assessed/no information. 4 steps: the ability to go up and down four steps with or without a rail: not documented. 12 steps: the ability to go up or down 12 steps with or without a rail: not documented. R38's Nurse Practitioner (NP) Progress Note, dated 11/26/2025 documents chief complaint/reason for this visit: low hemoglobin. HPI (History of Present Illness) to this visit: 75-year-old male is ambulatory and is A&O (Alert & Orientated) to person. Cognitive status: forgetful. R38's Health Status Note, dated 11/27/2025 at 4:12 PM, documents resident signed out LOA (leave of absence.) No documentation of where R38 was going, who he was	S9999		

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S9999	Continued from page 7 going with, when he was expected to be back or what he was wearing when he left the facility. R38's Orders – Administration Note, dated 11/27/2025 at 6:57 PM documents LOA. No additional information was documented regarding R38 being on LOA. R38's Community Survival Skills Assessment documents the assessment date 11/18/2025 and created dated 11/28/2025 V2 documented the resident appears to be capable of outside pass privileges at this time. On 12/9/2025 at 10:00 AM V13, LPN (Licensed Practical Nurse) stated she didn't know R38 well because he was a new resident, admitted a few weeks prior. V13 stated she admitted R38 when he was initially admitted to the facility, R38 arrived with 3 or 4 pages of paperwork from the previous facility which included his medication list and a face sheet. V13 stated she documented R38's admission paperwork from the information and how he presented upon initial observation of him. V13 stated R38 seemed to be alert and oriented to person, place and time at the time of admission. V13 stated when a resident is initially admitted to the facility the assigned nurse is responsible for documenting a clinical assessment, which is the resident's initial nurse assessment, but she couldn't find that assessment in R38's electronic medical record, V13 stated she must have forgot to do it because she is always very busy with all resident care. V13 clarified she didn't document R38's Community Survival Assessment although it's dated 11/18/2025 V13 showed it was created and documented on 11/28/2025 by V2 and she didn't understand that because R38 left the facility LOA on 11/27/2025 and he didn't return to the facility. V13 stated she works full time at the facility and recalled as the days went by after R38 was admitted, she reassessed R38 and noted he talked to himself and was very confused and was alert to person only. V13 stated she didn't document that R38 was confused in his electronic medical record, but she probably should have but she was so busy at the facility and gets overwhelmed with admissions, discharges, medications and all the things and she can't document everything. V13 stated she couldn't recall what was documented on R38's face sheet if he was his own responsible party or not upon admission but she recalled at the end of November 2025 administration was running around trying to find out if R38 had a power of attorney or not because he signed himself out of the facility and was later found by the police. V13 stated R38 ambulated without an assistive device and his gait was steady at the facility. He required assistance from staff for ADLs (Activities of Daily	S9999		

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S9999	Continued from page 8 Living) but he often refused care and was incontinent of bladder and cursed at staff when they attempted to provide incontinence care. R38 stated V13 didn't have safety awareness and shouldn't be anywhere including out in the community by himself because he was alert to person only. V13 recalled R38 was aggressive and refused care and cursed at staff. V13 stated if R38 was his own responsible party he could sign himself out of the facility because this isn't jail, but she would want to know where he was going and when he planned to be back to the facility. V13 clarified that R38 was confused and forgetful and he shouldn't have signed himself out and left by himself because he could've got hurt. On 12/10/2025 at 10:28 AM V16, LPN stated she is an agency nurse and works at the facility a few times a month. V16 stated she arrived at the facility on 11/27/2025 at approximately 7:00 AM and was assigned to the 100 hall and was assigned to R38. V16 stated she never met R38 before and she didn't get report from night shift nurse (name unknown) because the night shift nurse had left the facility prior to her arrival. V16 stated she recalled R38 took his medications without issue that morning, but she didn't know him at all and didn't know if he was alert or what his diagnoses were. V16 recalled R38 ambulated without an assistive device but she couldn't recall if his gait was steady or not. V16 recalled at approximately 3:00 PM R38 stated he was leaving the facility, so she asked the 200-hall nurse (V9) how to sign R38 out and she told her to have R38 sign out in the resident sign out book and to document R38 was leaving in his electronic medical record. V16 stated she didn't know if R38 had a power of attorney or if he was his own responsible party the time he requested to leave the facility but this isn't a prison so she thought he could leave. V16 stated she didn't look to see if R38 had medications due and didn't send any medications when he signed out. V16 stated she didn't ask R38 where he was going or when he'd be back to the facility, but it was Thanksgiving and she assumed he was going to have Thanksgiving dinner with his family. V16 stated there was a lot of residents coming and going that day and she didn't have time to look at all the resident's medical records to check on their face sheet status. V16 stated she left the facility for lunch for 30 minutes at 3:00 PM so she didn't let R38 out of the facility and she didn't see R38 leave the facility. R16 stated when she got back to the facility after coming back from lunch R38 was on LOA. V16 stated she didn't observe R38 walking around outside and if she did, she would have addressed him and asked what he was doing because he definitely shouldn't be walking around	S9999		

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S9999	Continued from page 9 outside by himself because it was really cold that day and she would want to ensure he was safe. V16 stated she didn't know what the big deal was that R38 signed himself out because this isn't prison and he has the right to leave. R38's POS, dated 11/27/2025 documents R38 had medications prescribed at 5:00 PM for treatment of Parkinson's disease: Carbidopa Levodopa 25/100 milligrams (mg), medication to treat heart disease: Entresto 49/51 mg, medication to treat diabetes: Metformin 500 mg and medication to treat blood pressure: Metoprolol 25 mg. R38's Medication Administration Record (MAR), dated 11/27/2025 staff documented "1" in the space for R38's 5:00 PM medications "absent from home without medications." On 12/10/2025 at 9:52 AM V9, Registered Nurse (RN) stated she worked 11/27/2025 day shift from 6:00 AM to 6:00 PM and was assigned to the 200 hall. V9 stated she didn't know R38 and didn't meet him. V9 didn't know who the 100 hall nurse was that worked that day but she recalled it was an agency nurse. R9 recalled at some point that day the 100 hall nurse asked her how to document when a resident wants to leave the facility and she showed the 100 hall nurse to document the resident was leaving and to document he was on LOA in his electronic medical record as well. When a resident wants to leave the facility V9 stated she first checks the resident's face sheet to ensure the resident is their own responsible party and doesn't have a power of attorney because if the resident has a power of attorney she would call the resident's POA to ensure they are picking the resident up and ask what time the resident's approximate time of return so she knew where the resident was going and to ensure the resident was safe. On 12/10/2025 at 12:30 PM V9 stated she didn't let R38 out of the facility on 11/27/2025 and she didn't see R38 leave the facility. On 12/10/2025 at 8:15 AM V20, CNA stated she worked day shift from 6:00 AM to 2:00 PM on 11/27/2025 and was assigned the split assignment, which consists of residents on both 100 and 200 halls. V20 stated R38 was independent with ADLs and residents on the 200 halls were dependent so she spent 99% of the shift on the 200 hall. V20 stated she didn't know R38's cognitive status and didn't know R38 well at all because he was a new resident. On 12/10/2025 at 12:33 PM, V20 stated she didn't assist R38 with any ADLs that shift, and she left the facility at 2:00 PM so she didn't walk him out of the facility and she didn't see R38 leave the	S9999		

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S9999	Continued from page 10 facility. On 12/9/2025 at 9:00 AM V8, CNA stated she worked on 11/27/2025 and was assigned to 200 hall. V8 stated she arrived to the facility at 6:00 AM and left the facility around 6:00 PM that day. V8 stated she recalled R38 and stated he ambulated without any devices at the facility and his gait was steady. V8 stated R38 knew his name and talked to himself often. V8 stated R38 didn't have safety awareness and he was exit seeking all day long and often set exit door alarms off. R38 threatened staff he was going to sign himself out and leave the facility but V8 didn't think he should do that because he could get lost outside if he leaves by himself. V8 stated she didn't have a lot of hands on care interactions with R38 because she wasn't assigned to him but she could tell he was confused because he talked to himself often and he didn't know his name at times. 12/11/2025 at 2:16 PM V8, CNA spoke with me regarding R38 going LOA a few days ago and stated she worked day shift on 11/27/2025 and was assigned to 200 hall so she wasn't assigned to R38. V8 stated she assisted residents to the dining room from the 100 hall and observed R38 pacing back and forth at the 100 hall nurse's station at approximately 11:45 AM and he was saying he wasn't going to eat this s*** food and he was leaving. V8 stated it was a really busy day at the facility that day and that residents were going in and out of the facility. V8 stated she didn't let R38 out of the facility and didn't see R38 leave the facility. On 12/12/2025 at 8:30 AM V28, CNA stated she was assigned to 200 hall on 11/27/2025 and worked from 2:00 PM to 10:00 PM. V28 stated when she got to the facility that day there were no CNAs on the 100 hall and the day shift CNAs had already left the facility. V28 stated she did her best to take care of residents on both 100 and 200 hall but the 200 hall residents are more dependent on staff care so she stayed on the 200 hall most of the shift. V28 stated no CNAs were on the 100 hall until V30 got to the facility and that was between 4:00 PM and 4:30 PM that shift. V28 stated she didn't know R38 at all, she hadn't met him. V28 stated she didn't let any residents out of the facility that day and she didn't observe any residents leaving the facility (including R38.) V28 stated it was a very crazy day at the facility because residents were going in and out of the facility all day long. On 12/9/2025 at 1:15 PM V19, LPN stated she worked night shift on 11/27/2025. V19 stated she got to the facility at 6:00 PM and worked until 11/28/2025 at 6:00	S9999		

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S9999	Continued from page 11 AM. V19 stated she was assigned to the 100 hall, and she didn't receive nurse report from the day shift nurse (V16) because she already left the facility before she got there. V19 stated there were a lot of residents on LOA because they were with their families for Thanksgiving. V19 stated R38 was a new resident, he was admitted a few weeks ago and she worked night shift so she administered his medications a few times but that was all interactions she had with him, and he seemed to be alert. V19 stated she didn't know if R38 had safety awareness because she only had interactions of administering him medications at night. V19 stated R38 ambulated without an assistive device and his gait was steady. V19 didn't know R38 was on LOA that day until the police came to the facility at approximately 10:00 PM and told her R38 was found outside sitting on the side of the road and was transported to the emergency room. V19 stated she knew R38 was his own responsible party because when the police came to the facility, she printed his face sheet and there was no POA, or family contacts documented on R38's face sheet at that time. V19 stated after the police left the facility, she immediately called V2, DON and reported to her that R38 was found by the police and was at the emergency room. R38's Sign Out/Acceptance of Responsibility for Leave of Absence Form, documents he signed out at 3:00 PM on 11/27/2025. The responsible person signature is illegible. No additional documentation on this form. R38's Electronic Medical Record, dated 11/27/2025 no documentation of resident being found by the police in the community. A Police Report dated 11/27/2025 documents on 11/27/2025 at 9:40 PM police officer was dispatched to the area of Illinois 161 and Boul Avenue in reference to a pedestrian in the roadway. Dispatch advised the caller was an elderly black male and appeared intoxicated. Arrived in the area and located the caller, who pointed out the subject sitting on the ground on the north side of Illinois 161 across from 1721 Boul Avenue. I advised dispatch of the location and activated my emergency lights, which activated body cameras. Approached the subject, later identified as (R38.) I asked R38 what was going on. R38 attempted to stand and appeared very unsteady on his feet. I noted R38 appeared very lethargic and had a hard time keeping his eyes open. R38 had very slurred and garbled speech, but no other indications of intoxication. R38 was difficult to understand. However, I was able to gather that he lived at a nursing home, went for a walk and had got lost. R38 stated he lost his wallet and did not	S9999		

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S9999	Continued from page 12 have a cell phone. R38 stated he was from Peoria, Illinois and he just wanted assistance getting home. Due to his state, I requested EMS respond to the scene. While waiting for the ambulance R38 was assisted by 2 police officers to a patrol car so he could sit inside and warm up. While waiting on the ambulance, I tried to gather more information from R38. Originally, he told me a wrong name (resident very confused and didn't know his name at that time) and that his birthday was sometime in June. I asked dispatch to run that name, but no records were located. R38 continued to state that he was from Peoria, Illinois. R38 stated that he did have Thanksgiving dinner somewhere nearby, but that I was unable to determine where. R38 only stated that he took a nap, went for a walk, and then ended up in an unfamiliar neighborhood. I asked R38 some medical questions and he confirmed that he was diabetic, I provided this information to the dispatch as well. When EMS arrived, I explained my findings to them and agreed R38 should be transported for advised that they had contacted all the local nursing homes and none of them have a patient missing from their facility. I search Omnigo and in house records, there was no record in either database for the resident's name. Upon arriving at the ambulance bay, the EMT advised R3's hands were too cold to extract to sample for a blood sugar test. When I arrived to the emergency room, I provided staff with the information I had. I continued speaking with R38 while the doctor performed an assessment. R38 had several bleeding lacerations and abrasions to his knees and shins. R38 also had a wound on his left foot. R38 both hands appeared black, which the doctor indicated was a sign of frostbite. I continued to ask questions and R38 advised that last name could be (R38 gave a different name), which I believed may be his mother's name. I asked dispatch to run that name combination, with no success. EMS personnel advised R38 kept stating he lived in Peoria at a facility that was named "Ever-something." With this I decided to go to the facility in person to verify no patients were missing from the facility. When I arrived at the facility, I spoke with V19, who advised R38 was a resident of the facility but that he had been checked out earlier in the day. V19 showed me the resident sign out sheet, which showed someone checked R38 out at 3:00 PM. The place where the "responsible party" was to sign, was illegible, and no other information was completed on the sheet. I obtained an information sheet from the nurse, which showed no emergency contact information. I advised V19 I would have a report on file and that R38 was currently unwell at the local hospital. I returned to the emergency room and provided the doctor with R38's information sheet and medication list. She advised that R38 had abnormal labs and would be	S9999		

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S9999	Continued from page 13 admitted for the night. The doctor stated when R38 is cleared, they will ensure he returns to the facility safely. Per the police report R38 gave the police officers over 3 different names. ON 12/10/2025 at 6:10 PM, V21 Police Officer stated a passerby called 911 and reported there was a pedestrian was in the middle of the road and they were afraid they were going to get hit by a car. V21 stated R38 was very confused and gave her at least 3 different names he was so confused he didn't even know his name. She had dispatch call around to local nursing homes to see if they were missing residents and the local nursing homes denied missing any residents. V21 stated her and another police officer had to assist R38 to sit in her police car until the ambulance arrived so he could warm up. V21 stated R38's gait was terrible, and he was stumbling around, V21 stated her and the other police officer were holding him up to walk him to her vehicle. V21 noted R38 had multiple bruises and scrapes on him so she called an ambulance to transport him to the emergency room. V21 stated she was very concerned for him because he was so confused and didn't know what was going on and he could have really got hurt outside in the cold and being by himself. R38 finally told her he lived at "Ever something" and so she went to the facility and staff told her R38 wasn't missing because he had signed himself out. V21 stated she spoke to V19 at the facility and she showed her that R38 signed himself out of the facility and stated she wasn't working at that time because R38 signed himself out at 3:00 PM and she arrived to work at the facility at 6:00 PM that day. V19 told her she didn't know R38's cognitive status and didn't know if he had safety awareness and didn't know if R38 was cognitively able to be out in the community by himself. V21 stated she updated V19 that R38 is currently at the emergency room getting assessed and that he was unwell. R38's Hospital Paperwork, dated 11/18/2025 documents history and physical illness: 75-year-old male with history of significant high blood pressure, COPD, heart failure, bipolar and dementia brought in by EMS from side of the road. Per EMS report patient has been out in the cold for a while found by PD called EMS patient reportedly alert orientated x 1 at the time of contacts. Unable to give much history according to PD, patient found on the found at highway. They believe that he may be from nursing home. Emergency department (ED) physical assessment: Constitutional appearance: ill- appearing. Vital signs temperature 97.8 degrees, pulse 116, respirations 23, blood pressure 106/70 and oxygenation saturation 100%. Skin: abrasion right knee and on the palm of the right hand, great toe on the	S9999		

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S9999	Continued from page 14 left looks like that has some trauma to the toenail with blood underneath and bruising present. Neurological: unable to give name, date or location, oriented times zero at this time and weakness present. R38 had IV fluids to treat dehydration, blood work drawn, CT head without contrast and X-Ray of chest and right knee. ED triage notes: EMS reports patient had been out in the cold for a while by police department called EMS patient A&Ox1, unable to give accurate answers telling different year for the birthday and places. EMS reports patient possibly fell and complaint of knee pain, small laceration on right hand. An ER RN documented on 11/28/2025 at 2:48 AM, attempted to contact facility via phone to give an update regarding patient's admission status, no answer at this time. R38's Communication with Family (Next of Kin)/POA (Power of Attorney) dated 11/28/2025 at 5:18 PM, documents spoke with V6, R38's family. She states he is doing better today but states he could've frozen to death, and he has had to have a blood transfusion. She states we allowed him to be outside long. She states he shouldn't have been outside by himself. I explained he signed out and he had a coat on and was dressed appropriately. He told staff he was going out for Thanksgiving dinner. She is asking the facility what kind of compensation the facility will be giving him, and she wants to know by Mon (Monday) or she will be forced to call the state. I contacted our Admin (Administrator) to follow-up with her. On 12/9/2025 at 11:22 AM V6, R38's Family stated R38 has limited sight due to having cataracts and glaucoma and only see blurry images. V6 stated R38 was initially admitted to the facility a few weeks ago and no one at the facility contacted her to get information regarding R38's health or safety status. V6 stated she called and attempted to give the facility information regarding R38's care and lack of safety awareness but she wasn't transferred to a nurse, and no one called her back. V6 stated R38 has dementia, Parkinson's and psychotic disorders including Schizophrenia and Bipolar. V6 stated R38 knows his name and that's it, he is very confused and doesn't have safety awareness, R38 needs staff to assist him to change his clothes and he is incontinent of bowel and bladder, and he won't change his diaper if staff don't assist him. V6 stated the facility didn't notify her that R38 signed himself out of the facility or that the police were at the facility regarding his whereabouts or that he was in the hospital on 11/27/2025. At approximately 10:00 PM on 11/27/2025 the hospital called her and requested consent to treat R38, but she didn't know why he was at the hospital and didn't know he left the facility by	S9999		

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S9999	Continued from page 15 himself until 11/28/2025 and she was very upset because she is R38's family and he shouldn't have been able to sign himself out because he is very confused and forgetful and isn't cognitive enough to be out by himself. V6 stated R38 was admitted to the facility because she could no longer take care of him because he needs managed care 24/7 and they let him leave the facility by himself and he could have died on the street by himself. On 12/10/2025 at 8:35 AM V6 stated in 2024 R38 left a hospital in St. Louis, Missouri and he ended up taking a train and to Illinois and he fell off the train platform and had to have extensive tests done and had a huge goose egg on his back from the fall. V6 stated when R38 was transferred to the facility from a sister facility the nurses, social worker and the transport staff told her that R38's paperwork including the POA paperwork was sent with him and given to staff at the facility upon admission on 11/18/2025. V6 stated she visited R38 in the evening on 12/9/2025 and he was a lot more alert and knew who the president is now and told her he was outside by himself a few days ago and he was scared to death because he couldn't see all he could see was bright lights and he felt he was going to get hit by a truck. R38 also told her that he was crawling around trying to get shelter because he was freezing and afraid he was going to freeze to death. On 12/10/2025 at 4:40 V22 former facility Administration stated R38 was a resident at that facility 11/15/2025 through 11/17/2025 and then R38 was transferred to the facility. V22 stated R38 was alert to person and place and was really confused. V22 stated R38 walked with a wheeled walker, and he often forgot it in his room so staff would go get it for him. V22 stated R38 could walk approximately 25-40 feet without his wheeled walker. V22 stated R38 was a fall risk as he fatigued while ambulating easily, so he always needed his wheeled walker with him. V22 stated R38 didn't have safety awareness and although he was his own responsible party, he wouldn't allow R38 to leave without someone to drive him because he was confused and forgetful and his facility is rural, surrounded by cornfields so it wouldn't be appropriate for R38 to sign himself out and leave the facility. On 12/10/2025 at 11:42 AM V2, DON stated R38 was admitted to the facility with 3 or 4 pages of information including a face sheet, medication list and a few nurse's notes. V2 stated there was no POA paperwork, no emergency contact and no family member documented on R38's admission paperwork. V2 stated there is a corporate liaison and they sent her preadmission paperwork regarding R38 and she wasn't	S9999		

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S9999	Continued from page 16 updated that R38 was out by himself in the past and he got lost and fell off a train platform, if she would have been given that information, she wouldn't have accepted him as a resident because he needs a locked memory unit, and the facility isn't locked. The liaison told her R38 needed a private room due to aggressive behaviors but not that he was an elopement risk. Upon admission a licensed nurse assesses the resident and documents the assessment in a resident's electronic medical record, part of the admission assessment the nurse assesses the resident's cognitive status and if the resident's cognitive status changes after admission, V2 expects the nurse to document a progress note. When a resident is a new admission, she expects the assigned nurse to document a progress note at least once a day and document how the resident is doing for the next 7 days to ensure the resident is doing well at the facility. When a resident wants to sign out and go on leave of absence, she expects the assigned nurse to look at the resident's face sheet to see if the resident is their own responsible party or if they have a POA or guardian. If the resident has a POA she expects staff to contact the POA and ask who is picking the resident up and ask where they are going and when they are expecting to returned to the facility and the assigned nurse should document that information on the 24 hour nurse report sheet to ensure the facility knows when the resident is expected to return to the facility so if they aren't back by that time staff can start calling the resident's family so the facility knows the resident is ok. No staff called her regarding R38 going out LOA, but she doesn't expect staff to call her unless something is wrong. V2 stated the night shift nurse called her the evening of 11/27/2025 approximately 7:00 PM and reported to her that the police were at the facility and reported to staff that R38 was found over a mile and a half down the street, and he was very confused, and he was at the hospital. V2 stated she spoke to the police officer and confirmed R38 was a resident at the facility, and she didn't know he was at the hospital, and he was found on the sidewalk with multiple scrapes and bruises about his body. V2 stated she had 3 or 4 interactions with R38, and she didn't know R38 good enough to say if he had safety awareness or not. V2 stated she expected staff to follow policies and procedures of the facility to ensure residents are taken care of. On 12/12/2025 at 8:30 AM V2, DON stated she didn't understand the severity of the citation regarding R38 because he signed himself out of the facility and he was his own responsible party. V2 stated the facility didn't contact IDPH to report the incident regarding R38 being found by the police and be transported to the	S9999		

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S9999	Continued from page 17 emergency room because he signed himself out and it was her understanding when a resident sign themselves out of the facility then the facility is no longer responsible for the resident and that was the purpose of the resident signing themselves out. On 12/10/2025 at 1:31 PM V14, NP stated she initially assessed R38 on 11/19/2025 and he was alert to person and place and was forgetful and confused but he had just moved to the facility, so she didn't know if that's his baseline or not because she just met him. V14 stated she reassessed R38 on 11/26/2025 and he was alert to self only that day and he was confused and forgetful and after that assessment, V14 stated it was her professional medical assessment that R38 didn't have safety awareness and should not be out in the community by himself due the cognitive status because he could fall or get hit by a car if he attempted to cross the street and could die. V14 stated she expected a licensed nurse to assess the resident upon admission and to document the assessment, so staff know the resident's baseline cognitive status and if a licensed nurse assessed the resident was more confused after admission, she expects the nurse to document a progress note clarifying the resident's cognition status. V14 stated she expected facility staff to follow all policies and procedures at the facility to ensure the residents are safe and taken care of. On 12/10/2025 at 2:30 PM V14, NP stated anything could have happened to R38 while he was out in the community by himself, considering he was only alert to self and confused/forgetful, if he attempts to cross the street he could have got hit by a car or fall which could result in death. Facility Admission Assessment Policy reviewed 9/2/2025 documents purpose: to ensure that resident's needs and life history are identified and a plan of care is developed accordingly. Policy: licensed nursing staff will complete an admission assessment for residents upon admission to the facility. Procedure: Upon admission, a licensed nurse will conduct an admission assessment of the resident using the form available on the electronic health record platform. A comprehensive assessment will consider factors pertaining the medical, behavior and social needs of the resident. The assessment process must include direct and indirect observation and communication with the resident, as well as communicated with licensed and non-licensed direct care staff members on all shifts. The assessment may include separate paper or electronic forms (i.e. pain assessment, skin risk assessment, fall risk assessment, ect.) Assessment findings may necessitate	S9999		

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S9999	Continued from page 18 communication with attending physician for treatment or care orders. The assessment will be documented and will be communicated with licensed and non-licensed direct care staff members on all shifts. The admission assessment will be included in the resident's medical record and will be used to create an initial baseline care plan for the resident. Facility Missing Resident/Elopement Policy, revised 6/16/2025, documents 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 of elopement, implement risk reduction strategies for those identified as an elopement risk and institute measure for resident identification at the time of admission. Definitions: elopement is the ability of a cognitively impaired resident who is not capable of protecting himself 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. 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 (i.e. need for food, toileting, exercise) if exit seeking and and other triggers such as pain, noise and odors. Problems noted in the resident's 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 inability of the resident to appreciate safety risks and an inability to protect himself. A change in the resident's mental status. Interference with risk reduction strategies, including	S9999		

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S9999	Continued from page 19 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 is agitated or aggressive. Actual wandering behavior, including shadowing (following staff or another resident), self-stimulatory (wandering due to boredom or lack of activity) and exit seeking (the resident is intent on leaving the unit or facility, looking for exits, and hoovering at exits for the opportunity to leave with someone, or pushing on a door.) A sign in/sign out system is implemented, which requires responsible parties to sign the resident out when leaving and noting an expected return time. Facility Leave of Absence Policy reviewed 9/15/2025 guidelines: residents may go on the therapeutic leave of absences as deemed appropriate. Each resident leaving the premises (excluding transfer/discharges) should be signed out in leave of absence. Unless otherwise prohibited by law, medications that should be administered while the resident is out should be given to the resident/person signing the resident out with instructions on when and how to administer the medication(s). Resident should be signed back in return from leave of absence when they return. (A)	S9999		