STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Jerseyville	**410 FLETCHER ST , JERSEYVILLE, Illinois, 62052**

(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 Health Survey Facility Reported Incident of 11/8/25/2669719	S0000		12/26/2025
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A) 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. 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		12/27/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/14/2025

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. These requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 3 (R24) resident's call light in reach in a sample of 35. This failure resulted in R24 unable to call for help for over 2 hours resulting in R24 sitting in urine, feeling angry, embarrassed, unwanted, depressed and a burden. Findings include: R24's Care Plan, dated 3/25/2025, documents R24 has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke with left sided weakness. Interventions Encourage the resident to use bell to call for assistance. R24 is at risk for falls r/t Confusion, Gait/balance problems, Incontinence, Unaware of safety needs. Interventions The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach to right side of resident. R24's Minimum Data Set (MDS), dated 9/24/2025, documents R24 is cognitively impaired, always incontinent of bowel and bladder and dependent on staff for activities of daily living.	S9999		

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S9999	Continued from page 2 On 12/8/2025 at 9:36 AM R24 was transported from the dining room to her room and placed at the foot of the bed. R24 faced the bed with right side at foot of bed. R24, slumped and leaned forward and to the right side. R24 stated she had used the bathroom on herself and needed to be cleaned. R24's call light was located at the top of bed. At 9:48 AM R24 was heard calling for call light. At 9:53 AM observed reaching for call light. From 10:00AM to 11:00 AM resident observed sitting in wheelchair. Call light remained out of reach and no call light on. At 1:28 PM R24 was assisted to bed and placed on bedpan by V11, Certified Nurse's Assistant (CNA), and V20, CNA. V20 gave R24 the call light and informed R24 to use when ready. At 1:56 PM Call Light on. V19, CNA, responded to call light. V11 and V19 assisted R24 with incontinent care at time. On 12/10/2025 at 10:10 AM R24 stated yesterday she sat wet for hours. R24 stated it happens all the time. R24 stated she could not reach her call light. R24 stated she would have used it if she could reach it. R24 stated it makes her angry and embarrassed. R24 stated she feels like a burden, and no one wants to help her. R24 stated she can smell herself and the odor is bad. "How horrible is?" R24 stated she feels pain when she sits for so long wet. R24 stated she feels depressed. On 12/10/2025 at 10:13 AM V11 stated R24 is alert and able to answer questions appropriately. V11 stated R24 can use her call light. On 12/10/2025 at 12:52 PM V25, Registered Nurse (RN), stated R24 can use her call light if it is in her reach and attached to wheelchair. R24 stated R24 can use her phone with her fingers, and she has no issues with using her call light. On 12/11/2025 at 12:00 PM V35, Physician, stated R24 is alert and able to make her needs known and answer questions appropriately. V35 stated R24 can verbalize and express her feelings appropriately. V35 stated R24's call light is to be always in reach when R24 is in the room. V35 stated R24 can use call light when in reach. The Residents' Rights Long Term Care Ombudsman Program Booklet, dated 11/18, document Your facility must treat you with dignity and respect and must care for you in a manner promotes your quality of life. The facility's Call Light policy, not dated, documents Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 1. All	S9999		

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S9999	Continued from page 3 residents have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. (B) 2 of 2: 300.610a) 300.695a)3) 300.695b)3) 300.1210b) 300.1220b)3) 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. Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:	S9999		

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S9999	Continued from page 4 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; 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. 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. 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 implement its abuse and resident background check policies by failing to screen for potentially abusive residents during the admission process, failing	S9999		

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S9999	Continued from page 5 to report and track residents qualifying criminal offenses, failing to ensure a risk assessment was completed, and failing to implement protective measures to prevent abuse for 1 of 3 (R54) residents reviewed for abuse in the sample of 35. This has the potential to affect all 55 residents who reside in the facility. On 12/9/25 at 12:35 PM V1 Administrator stated the facility did not notify the IOP (Identified Offender Program) of R62's criminal convictions nor was a criminal risk assessment completed. This failure resulted in R54 being abused by R62 on 11/8/25 when R62 flashed his genitals at R54 and then R62 grabbed R54's breast. On 12/10/25 V1 Administrator stated she does not know how many identified offenders are residing in the facility. On 12/11/25 at 10:57 AM Surveyor requested R62's fingerprint criminal records and V1 Administrator stated the facility does not have a copy of those results. Surveyor asked V1 if it is facility policy to attain and keep those records on file and V1 replied, "I don't know." On 12/10/25 Surveyor requested R62's criminal background and it documented multiple criminal convictions including burglary, retail theft, criminal trespass to buildings, and violations of order of protections. V1 stated she did not notify the IOP of R62's criminal history therefore no criminal risk analysis was conducted nor does R62's care plan address his potential risks to other residents. Findings Include: R54's Medical Diagnosis sheet, print date of 12/9/25, documented R54 has diagnoses including Parkinsonism, dementia, osteoporosis, atherosclerotic heart disease, polyneuropathy, and cognitive communication deficit. R54's MDS (Minimum Data Set), dated 9/17/25, documented R54 is severely cognitively impaired and dependent on staff for ADLS (activities of daily living) and mobility. R54's care plan, undated, documented R54 has little, or no activity involvement related to immobility, physical limitations, due to Parkinson's and dementia. R54's progress note, dated 11/8/25 at 5:45 AM,	S9999		

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S9999	Continued from page 6 documented resident was up at the end of C hall in (reclining) chair sleeping when witnesses observed another resident flash his genitals to her. Staff informed aggressor that was inappropriate, and aggressor laughed. Aggressor proceeded to grab resident breast. Staff removed aggressor from resident and took aggressor to another room. Skin check of resident done, and no injuries noted. Resident went right back to sleep after incident. Resident POA (Power of Attorney) made aware, DON (Director of Nursing), Administrator and MD made aware. R62's face sheet, print date of 12/9/25, documented R62 has diagnoses including major depressive disorder, morbid obesity, hypertension, restlessness and agitation, panic disorder, psychophysiologic insomnia, and anxiety disorder. R62's MDS, dated 9/30/25, documented R62 is cognitively intact. R62's MDS, dated 10/10/25, documented R62 is supervision or touching assistance with ambulation. R62's care plan, undated, documented R62 has a criminal felony background, has been screened through the admission process and is expected to acclimate safely in this setting. It continues, my criminal history includes retail theft, battery, and aggravated battery. R62's care plan interventions include notify the resident that a representative from the ISP (Illinois State Police) will conduct an interview either in person or via a video call to ascertain the resident's risk level. R62's care plan does not document R62's risk level. R62's progress note, dated 11/8/25 at 5:15 AM, documented resident in wc (wheelchair) wheeling self-up and down hallway, grabbing onto railing and propelling self, grabbing on to locked med carts and trying to open drawers, grabbing gloves and papers sitting on med cart and throwing them, going to the phone on the wall on c hall and attempting to make calls from it, wrapping cord of phone around hand and trying to hang phone up. Once staff was able to get phone back in place resident followed nurse down the hall blocking her between med cart and wouldn't let go, unable to redirect. Refuses to leave oxygen on, refuses to cover self, and is wheeling the hallway in a gown with legs spread wide open. Will not stay in room. R62's progress note, dated 11/8/25 at 5:40 AM, documented resident getting into things and throwing things in hall. Resident exposing self to other resident and refusing to cover genitals. Staff asked resident to stop and explained that was inappropriate.	S9999		

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S9999	Continued from page 7 Resident laughed and continued to lift up gown and wheel up and down hall and by nurse's station. The facility's Serious Injury Incident and Communicable Disease Report, dated 11/8/25, documented final report, R62 perpetrator, and R54 victim. Detailed Incident Summary – Initial: It was reported at approximately 5:50 AM, that R62 and R54 were involved in an alleged altercation with inappropriate contact. Investigation initiated, POA (Power of Attorney) and MD notified. Investigation: On 11/8/25 at approximately 5:50 AM it was report by DON that V16 CNA witnessed R62 expose himself and inappropriately touched R54. V16 was interviewed by the administrator. V16 stated that she was up by the nurse's station, when R62 started lifting his gown exposing himself to R54, CNA asked R62 to stop, he did with a laugh. R62 started to go towards his room when he reached out to grab R54's right breast. V16 stated that she got R62 to let go of R54's chair, R62 proceeded to grab V16 and bite her. V17 CNA was interviewed by the administrator. V17 stated she saw R62 expose himself towards R54 and told him that it was inappropriate. V17 stated when R62 was headed towards his room, he reached out and grabbed R54's chair. V17 saw V16 remove R62 from the situation and tried to bite V16. Conclusion: Both residents at the time of the allegation showed no serious injury or harm. No redness, discoloration, or pain was noted immediately after the alleged incident. This is an isolated incident with both residents, neither resident has had an altercation with each other prior. Neither resident targeted each other. This incident is unsubstantiated as a resident-to-resident abuse allegation. The contact was not made in a threatening manner or intent to harm or hurt the other resident. This document does not note police notification. V16's written witness statement dated 11/8/25 documented R62 was sitting up by the nurse's station when he started lifting his gown up exposing his self to R54. When asked by 2 CNAS, V16 and V17, to please stop, he did with a laugh. R62 then started wheeling his self-back down his hall when he stopped by R54 and reached over grabbing her right breast. When asked by CNA V16 to please let go he laughed then grabbed her chair to mover her with him. When asked to let go, he just laughed and wound not let go of chair. Two CNAS (V16 and V17) finally got him to let go as he kept trying to then grab CNA V16 and bite her. R62 was finally taken to his room. R62 then came back out of his room and went into 2 female's room, laughing not wanting to let go and was finally taken to his room again.	S9999		

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S9999	Continued from page 8 V17's written statement dated 11/8/25 documented R62 was sitting up by the nurse's desk and exposed himself towards R54. I told him that was inappropriate and that he couldn't do that he then turned around and exposed himself again. I then saw him pulling on top part of wheelchair and when the CNA V16 tried to remove his hand he was trying to bite her. On 12/9/25 at 12:35 PM V1 Administrator stated the facility did not notify the IOP (Identified Offender Program) of R62's criminal convictions nor was a criminal risk assessment completed. On 12/9/25 at 1:04 PM V15 Regional Nurse Consultant stated she would expect the Administrator V1 to notify the IOP so a risk assessment could be completed. V15 stated no risk assessment was completed on R62. On 12/10/2025 9:09 AM Surveyor asked V1 Administrator why she did not substantiate the abuse allegation between R62 and R54. V1 replied because there was no indication of it happening, no physical indicators of abuse, no redness nor anything. Surveyor asked V1 if staff witnessed R62 grab R54's breast and V1 replied, "that is what they thought they saw." On 12/11/25 at 8:12 AM V1 Administrator stated she did not call the police when R62 grabbed R54's breast. V1 stated she does not know if it is policy to call the police or not when there is a resident-to-resident abuse incident. V1 stated the facility did not complete any type of risk assessment of R62. On 12/11/25 at 10:57 AM Surveyor requested R62's fingerprint criminal records and V1 Administrator stated the facility does not have a copy of those results. Surveyor asked V1 if it is facility policy to attain and keep those records on file and V1 replied, "I don't know." On 12/11/25 at 11:42 AM V13 LPN (Licensed Practical Nurse) stated R62 exhibited multiple behaviors while he resided at the facility. V13 stated R62 was verbally abusive and uncooperative with staff. V13 stated R62 was able to propel himself around in the wheelchair and he would stop in resident doorways and try to speak with them. V13 stated R62 was alert and oriented throughout his stay at the facility. Surveyor asked V13 if facility administration notified her of R62's criminal history and V13 replied, "no." On 12/11/25 at 11:57 AM R62's physician V35 stated	S9999		

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S9999	Continued from page 9 R62's behaviors were extreme while he was at the facility, he was driving the girls there crazy, he was drug seeking, requesting narcotics, requesting antianxiety meds, calling 911 all the time, and he went to the ER 4 or 5 times while he was at the facility and just wasting resources. V35 stated R62 abused the system by always requesting to go to the ER. Surveyor asked V35 if he was aware of R62's criminal convictions and he replied no, then asked what the convictions were for. Surveyor asked V35 if R62 had the potential to harm other residents and if he expected the facility to follow their policy and regulations to ensure other vulnerable residents were protected. V35 replied R62 was a big guy, he could have potentially harmed another resident, and he would expect the facility to follow policies and regulations with resident background checks/criminal convictions. The facility's Abuse Prevention and Prohibition Program, dated 12/2/25, documented Purpose: To ensure that the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Policy: I. 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. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment. Or misappropriation of resident property. II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being. III. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. Procedure: I. The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility. II. Screening: A. The Facility does not knowingly employ anyone who has had disciplinary action against his/her professional license, or a finding	S9999		

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S9999	Continued from page 10 entered into the state nurse aide registry related to abuse, neglect, mistreatment or misappropriation or has been convicted of abusing, neglecting, or mistreating other people. B. The facility screens for potentially abusive residents during the pre admission process. The facility's Background Checks: Employee (s) and Resident (s), dated 9/15/25, documented Purpose: To maintain a safe and secure environment for our residents and staff to comply with IDPH (Illinois Department of Public Health) regulations. Procedure: Resident checks: LTC (Long Term Care) facilities must conduct a name-based criminal history check on all new residents within 24 hours of admission. Identified Offenders: If a resident's name-based check indicates potential risks, further investigation including a fingerprint check may be required. Facilities must report any residents identified as potential risks. (B)	S9999		