STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stearns Nursing & Rehab Center	3900 Stearns Avenue Granite City, IL 62040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation and interview the facility failed maintain a clean, homelike environment for 2 of 3 (R13, R27) residents reviewed for housekeeping in the sample of 79. 1. R13's MDS, dated [DATE], documents that R13 is cognitively intact. On 4/23/2025 at 1:29 PM R13 stated that the facility is filthy. R13 stated that the odor in the building is overwhelming. R13 stated that it's so many people that live here and not enough staff to take care of the building. R13 stated that the staff won't help each other and housekeeping only mop the floor. R13 stated they don't scrub it they only light run the mop that's it. 2. R27's MDS, dated [DATE], documents that R27 is cognitively intact. 04/23/25 at 02:28 PM R27 stated that the facility smells of urine and poop all the time. R27's BIMS is 15. R27 stated that there was a leak last time it rained heavy. 04/28/25 at 10:30 AM V14, CNA stated that she would let housekeeping know if a resident's room needs cleaned or if there are any foul odors so they can clean it and take care of it. V14, CNA stated that if 2 residents are fighting, she would try and to diffuse the situation and report it to V1, Administrator. 04/28/25 at 10:35 AM, V25, CNA, stated that she lets housekeeping know if there is anything that needs cleaned up or if there are strong odors. 04/28/25 at 10:40 AM, V12, CNA stated that she carries her own air freshener if there are any odors and would let housekeeping know if a resident's room needs cleaned. On 4/21/25 at 8:15 AM, upon entrance to the facility and while walking through the dining room to get to the conference room, the dining room floor appeared dirty with food particles on the floor and was very sticky to walk on. A strong smell of urine was noticed while walking through the facility. On 4/22/25 at 7:45 AM, while walking through the facility, a strong smell of urine was noticed, residents were seen sitting in the dining room for breakfast with the floor appearing dirty and sticky to walk on. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 12:00 PM, the 100-hall had a strong smell of urine upon walking down the hall, even with the housekeeper mopping resident rooms. While walking back to the conference room, the dining room floor was dirty and sticky to walk on. 04/28/25 at 10:25AM V44, Housekeeping Supervisor, stated that residents' rooms are cleaned every day and that they use air freshener when there are odors. The facility's Job Card, not dated, documents Resident Room Cleaning (occupied) Daily Tasks: Prepare supplies & wash/sanitize hands/don gloves & applicable PPE. Check for additional signs and follow precautions as indicated. Knock/enter room /close door/ greet patient/ ask if any concerns. Survey room/remove used items /trash/ dispose of needles/ sharps. Remove infectious waste/soiled linen/personal items/loose equipment. Use EPA Registered disinfectant on room surfaces & BLUE microfiber cloth. Disinfect high touch surfaces main room using BLUE microfiber cloth -Bed rails/ controls / tray table I call box / phone/bedside table handle. Chairs/room sink/room light switch / room inner doer knob/tv remote Clean window glass. Spot clean walls/ damp wipe vertical surfaces/ counters/ledges/ sills. Disinfect high touch surfaces restroom using RED microfiber cloth - Bathroom inner doorknob & plate /bathroom light switch/handrails. Restroom sink / toilet seat I toilet flush handle I toilet bed pan cleaner / Disinfect tub and shower (10 min. dwell time) Dust mop and damp mop floor (using BLUE microfiber flat mop Damp mop restroom floor using BLUE microfiber flat mop.)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, interview, and record review the facility failed to prevent abuse for 4 of 4 (R36, R38, R88, R90) residents reviewed for abuse in the sample of 79. This failure resulted in R36 suffering psychosocial harm and feeling scared, unsafe, unable to protect himself and less of a man. This failure also resulted in R90 suffering harm and being hit in the face, stomach and leg by another resident and R88 having a scratch to upper lip. 1. R36's Care Plan, not dated, does not document R36's risk for or interventions to prevent abuse. R36's Minimum Data Set (MDS), dated [DATE], moderately cognitively impaired. On 4/21/2025 at 9:27 AM observed R36 and R38 striking each other with closed fist. R38 yelled out and struck R36 repeatedly, with closed fist on the arm, hand and shoulder. R36 then grabbed R38's arm and swung closed fist at R38, making contact with R38's chest. R38 continued to yell out and push the door into R36's wheelchair and R36's arm. V29, Safety Aide, intervened and attempted to calm the residents. V29 instructed the residents to stop then removed R38's hand from R36's arm. R38 was then taken from room. On 4/21/2025 at 3:50 PM reviewed R36's medical record. No documentation of the resident to resident altercation. On 4/22/2025 at 11:30 AM R36's medical record reviewed. No documentation of the resident to resident altercation. The facility's Midnight Census report dated 4/24/2025 at 9:54 AM documents that R38 and R36 remain roommates. On 4/23/2025 at 1:30 PM the facility provided documentation of resident to resident abuse reported to IDPH. On 4/22/2025 at 1:10 PM R36 stated that his roommate is still in the room. R36 stated that his roommate is mean. R36 stated that R38 has been mean and hitting him since moving to the room. R36 stated that he is scared and does not feel safe in the room. R36 stated that he feels that he can't protect himself. R36 stated that he feels less of a man because he can't really defend himself. R36 stated that he has notified V31, Social Services Director (SSD), about he and his roommate not getting along and feeling scared. On 4/22/2025 at 1:14 PM V4, Registered Nurse (RN), stated that she was not aware of a resident to resident altercation that occurred between R36 and R38. V4 stated that R38 does have aggressive and combative behaviors. V4 stated that R38 is usually the aggressor. V4 stated that R36 is quiet and doesn't bother anyone. V4 stated that R36 has not had any behaviors of aggression towards staff and or resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/23/2025 at 11:45 AM V4, RN, stated that she notified V2, DON, of the resident to resident altercation that was reported to her yesterday. On 4/23/2025 at approximately at 12:30 PM V1, Administrator, stated that she was not aware of a resident to resident altercation that occurred between R36 and R38 until today. V1 stated that when the state surveyor reported it; V1 that is the time it was reported to the state. V1 stated that she was not notified by the staff that were present. V1 stated that V29 is not a CNA. V1 stated that V29 is a safety aide and here to help monitor the residents to keep them safe. V1 stated that V29 did not report the abuse. On 4/28/2025 at 11:00 AM V4 stated that R36 is alert and oriented and able to voice needs. V4 stated that he can answer questions appropriately. R38's Care Plan, dated 12/30/2024, documents that R38 BEHAVIOR: (R38) has a hx (history) of physical aggression towards peers. i.e. (for example) on 12/1/24 (R38) grabbed another resident's arm causing him to bleed. 50908 2. R88's face sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, osteoarthritis, degenerative disease of nervous system, and psychosis not due to a substance or known physiological condition. R88's MDS, dated [DATE], documented he is severely cognitively impaired. R88's Care Plan does not include him to be at risk for abuse. R90's face sheeting documented he was admitted on [DATE] with diagnosis of, in part, osteoarthritis, dementia with moderate agitation, and psychosis. R90's MDS, dated [DATE], documented he is severely cognitively impaired. R90's Care Plan dated 12/12/24 documented he is at risk for abuse and/or neglect related to impaired cognitive skills, diagnosis of Alzheimer's and Dementia. The facility's Initial Event Reporting dated 2/7/25, documented, Please find this as the initial reporting related to an allegation of a resident to resident physical altercation. R90 and R88, two cognitively impaired male residents of the facility locked dementia care unit, were reported to have had an altercation resulting in a small scratch to R88's upper lip. Staff intervened to ensure safety with assessments and notifications completed. R90 was transferred for evaluation related to his behaviors and remains at the ER (emergency room) at this time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's final report regarding the allegation of resident-resident physical altercation occurring on 2/7/25 documented, On 2/7/25 at approx. (approximately) 1830 (6:30 PM), memory unit staff heard a commotion from the room of R88. Staff responded to the room urgently. As they were approaching R88 was exiting his room reporting R90 had entered his room and became agitated when he was asked to leave. R88 states that R90 had entered his room and became agitated when he was asked to leave. R88 states that R90 hit him three time(sic). R88 reports that R90 hit his face, stomach, and leg. Staff separated resident's immediately. The facility's interview statement with V42, CNA, dated 2/8/25 documented, R88 was wandering said looking for his wife last I saw by shower room. We heard some yelling, rushed to them. R90 said he hit him. We got R88 away and watched him until he went out. He thought they were sleeping with his wife or something. V42 documented that R90 was last seen wandering. The facility's interview statement with V43, LPN, dated 2/8/25, documented, R90 was wandering looking for his wife. When we heard the commotion and got to the room they were just yelling. R88 said R90 hit him. We got them away, did assessments and notified and sent R90 out. R88 was okay. He said he thinks he was looking for his wife and he didn't have her. V43 documented R88 was last seen wondering. The facility's interview statement with R90 dated 2/8/25, documented he had no recollection of the event.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on interview and record review the facility failed to report allegations of abuse for 4 of 4 (R36, R38, R49, R358) residents reviewed for Abuse in the sample of 79. 1. R36's Care Plan, not dated, does not document R36's risk for or interventions to prevent abuse. R36's Minimum Data Set (MDS), dated [DATE], documents moderately cognitively impaired. On [DATE] at 9:27 AM observed R36 and R38 striking each other with closed fist. R38 yelled out and struck R36 repeatedly, with closed fist on the arm, hand and shoulder. R36 then grabbed R38's arm and swung closed fist at R38, making contact with R38's chest. R38 continued to yell out and push the door into R36's wheelchair and R36's arm. V29, Safety Aide, intervened and attempted to calm the residents. V29 instructed the residents to stop then removed R38's hand from R36's arm. R38 was then taken from room. On [DATE] at 3:50 PM reviewed R36's medical record. No documentation of the resident to resident altercation. On [DATE] at 11:30 AM R36's medical record reviewed. No documentation of the resident to resident altercation. The facility's Midnight Census report dated [DATE] at 9:54 AM documents that R38 and R36 remain roommates. On [DATE] at 1:30 PM the facility provided No documentation of resident to resident altercation reported to IDPH. On [DATE] at 1:14 PM V4, Registered Nurse (RN), stated that she was not aware of a resident to resident altercation that occurred between R36 and R38. V4 stated that R38 does have aggressive and combative behaviors. V4 stated that R38 is usually the aggressor. V4 stated that R36 is quiet and doesn't bother anyone. V4 stated that R36 has not had any behaviors of aggression towards staff and or resident. On [DATE] at 11:45 AM V4, RN, stated that she notified V2, DON, of the resident to resident altercation that was reported to her yesterday. On [DATE] at approximately at 12:30 PM V1, Administrator, stated that she was not aware of a resident to resident altercation that occurred between R36 and R38 until today. V1 stated that when the state surveyor reported it, at that time it was reported to the state. V1 stated that she was not notified by the staff that was present. V1 stated that V29 is not a CNA. V1 stated that V29 is a safety aide and here to help monitor the residents to keep them safe. V1 stated that V29 did not report the abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:05 PM V29, Safety Aide, stated that (R36) and (R38) were not hitting each other but they were cussing at each other and that he let a CNA know. 2. R38's Care Plan, dated [DATE], documents that R38's BEHAVIOR: (R38) has a hx (history) of physical aggression towards peers. i.e. (for example) on [DATE] (R38) grabbed another resident's arm causing him to bleed. [DATE] [NAME] had aggressive behaviors including attempting to pull his roommate from his bed. R38's MDS, dated [DATE], documents that R38's daily decision making skills are moderately impaired, has verbal and physical behaviors affecting others. R38's Progress Note, dated [DATE] at 4:45 PM, documents Resident has been agitated this shift. Has been yelling and cursing at other Residents and staff. He pushed on the back of another Resident's w/c. He was re-directed and explained his behavior is not appropriate. Re-directed him back to his room to lay down in bed. R38's Progress Note, [DATE] at 5:05 PM, documents that Resident has been angry and agitated this shift. He has been yelling and cursing at other Residents and staff. Re-directed him and explained that his behavior is not appropriate. Resident finally calmed down and allowed staff to help him with his ADL's. Will continue to monitor. On [DATE] at 1:15 PM V4, RN, stated that there was an incident that happened last week when R38 was cursing at other residents. V4 stated that she notified the Director of Nursing. On [DATE] at 12:25 PM V2, Director of Nursing, stated that incidents on [DATE] and [DATE] were reported to IDPH on [DATE]. V2 stated that they were made aware of the incidents at that time. V2 stated that the incidents had not been previously reported or investigated. V2 stated that the nurse documented the progress notes as late entry on [DATE]. V2 stated that she would expect the staff to report abuse immediately. 44967 3. R49's Admission Record, dated [DATE], documents R49 was originally admitted to the facility on [DATE] with diagnosis of Huntington's Disease, Major Depressive Disorder, and Anxiety Disorder. R49's Care Plan, dated [DATE], documents R49 has potential for psychosocial well-being problem related to history of physical and sexual abuse. Interventions: Consult with: Social services, Psych services, increase communication between (R49)/family/caregivers about care and living environment: Explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, options, provide opportunities for the resident and family to participate in care. It continues R49 has an alteration in neurological status related to diagnosis of Huntington's Disease. Interventions: Assess for effects of psychotropic meds; dystonia, akathisia, akinesia, rigidity, tremors, etc., cueing, reorientation as needed, educate R49 to use scanning (move eyes across affected side) to prevent neglect/injury to affected side, give medications as ordered, monitor/document for side effects and effectiveness. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R49's Minimum Data Set (MDS), dated [DATE], documents R49 has a moderate cognitive impairment and requires supervision/touching assistance for eating, setup/cleanup for toileting, partial/moderate assistance for bathing, and is independent on transfers. R49's Nurse Practitioner (NP) Note, dated [DATE], documents in part [NAME] female nursing home resident since [DATE]. Pt (patient) up in wheelchair, reports doing ok, random jerking and tremors present from neurological issue Huntington's disease psychosis. Staff observed roommate (R358) standing by her bed with pillow, pt woke up and began yelling, no physical contact made, peer has memory issues. Care conference with staff, behavioral tracking active, staff reports no concerns. Continue to use nonpharmacological interventions for behavioral management. 4. R358's Admission Record, dated [DATE], documents R358 was admitted to the facility on [DATE] and was discharged /deceased on [DATE]. R358's diagnosis include: Depression, Anxiety Disorder, Disorientation, Cerebral Aneurysm-non-ruptured. R358's Baseline Care Plan, dated [DATE], documents Cognition: Confused, Communication: Verbal, Vision: Adequate, Bowel and Bladder: Incontinence care, Safety: History of Falls, Smoking. R358's MDS, dated [DATE], documents R358 had a severe cognitive impairment and was independent for all transfers and ambulation. R358's Nurses Note, dated [DATE] at 1:38 AM, documents Resident remains on Hospice Care. She is resting comfortably in bed with no signs of acute distress or pain. Lorazepam given as ordered and Fentanyl patch confirmed to be in place to left side of chest. CNA remains at bedside for monitoring. Plan of care ongoing including monitoring for changes in condition, needs, and safety. Care coordination with the Hospice team is ongoing. R358's NP Note, dated [DATE], documents in part [NAME] female nursing home resident since [DATE]. Pt. (patient) is being followed by Hospice, pt up in wheelchair, on one-to-one staff supervision, was standing by roommate's (R49) bed last night holding a pillow, no ill intent or physical contact between patients, peer was yelling out for staff scared, today patient does not remember event reporting she went home last night. Care conference with staff, behavior tracking active, electronic record from last month reviewed, continue to use nonpharmacological interventions for behavior management. V1, Administrator's Investigation includes the following: The Facility's Supervisor Investigation Summary Form, dated [DATE], documents How and when was event discovered: CNA (Certified Nursing Assistant) passing room reported to nurse a concern of (R358) attempts to do something with (R49) pillow and was concerned. Briefly describe event: Notified, DNS (Director of Nursing Supervisor) spoke to CNAs on phone. CNA states (R358) was standing by (R49) bed holding the pillow. (R358) did not touch her. Follow-Up Actions: Psych NP (Nurse Practitioner) evaluates to ensure safety without concerns. Contacted VP (Vice President) to review at time reported. Based on statement of concern no evidence of concern. (R358) was assisting (R49) with pillow positioning per (R49) reports/statements. Conclusion: No alleged issue - CNA observation concerned her. No Reportable per interviews immediate on eve of [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V2, Director of Nursing (DON), Interview/Investigation Record, dated [DATE], documents V27, CNA, stated per phone call I saw her (R358) standing by (R49) bed with her pillow in her hands. That's all. She didn't touch her. V2, DON, Interview/Investigation Record, dated [DATE], documents When asked did anything happen last night? (R358) stated I wasn't here. I just got here this morning with my husband. V2, DON, Interview/Investigation Record, dated [DATE], documents Asked did something happen with your roommate last night? (R49) stated No No Did your roommate try to hurt you? (R49) stated No No Help Help Happy Happy she good. On [DATE] at 2:05 PM, V1, Administrator, stated In our eyes it did not happen, therefore it was not reportable. There was no separation of residents pending investigation, and nothing reported to Illinois Department of Public Health (IDPH). The Facility's Abuse Prevention - Illinois Only, dated ,d+[DATE], documents in part a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident. d) Physical Abuse: This includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. e) Mental Abuse: The use of verbal or non-verbal conduct which cause or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation including staff taking or using photograph or records in any manner that wound demean or humiliate a resident. Reporting: Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24-hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency, APS, and local law enforcement as required). Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42108 Based on interview and record review the facility failed to investigate allegations of abuse for 1 of 4 (R38) residents reviewed for allegations of abuse in the sample of 79. Findings include: 1. R38's Progress Note, dated 4/18/2025 at 5:05 PM, documents that Resident has been angry and agitated this shift. He has been yelling and cursing at other Residents and staff. Re-directed him and explained that his behavior is not appropriate. Resident finally calmed down and allowed staff to help him with his ADL's. Will continue to monitor. On 4/22/2025 at 10:00 AM request abuse investigations. As of 4/28/2025 at 2:00 PM the facility had not provided an investigation for verbal altercations occurring on 4/15/2025 and 4/18/2025. On 4/22/2025 at 1:15 PM V4, RN, stated that there was an incident that happened last week when R38 was cursing at other residents. V4 stated that she notified the Director of Nursing. On 4/28/2025 at 12:25 PM V2, Director of Nursing, stated that incidents on 4/15/2025 and 4/18/2025 were reported to IDPH on 4/22/2025. V2 stated that they were made aware of the incidents at that time. V2 stated that the incidents have not been investigated. V2 stated that the nurse documented the progress notes as late entry on 4/22/2025. V2 stated that she would expect the staff to report abuse immediately. The facility's Abuse Prevention policy dated 1/2025 documented, the facility is committed to protecting the residents form abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteer and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. It also documents Invesyigation: The facility will initiate at the time of any finding of abuse or neglect and injuries of unknown origin an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on Interview, Observation, and Record Review, the facility failed to identify and treat a resident's wounds for 1 of 4 residents (R18) reviewed for wound care in the sample of 79. This resulted in R18 experiencing severe excoriation, including skin breakdown and pain. The Findings Include: R18's Admission Record, dated 4/22/25, documents R18 was admitted to the facility on [DATE] with diagnosis of Cerebral Infarction, Dysphagia, Dementia, Major Depressive Disorder, Anxiety Disorder, Trigeminal Neuralgia, and Morbid Obesity. R18's Care Plan, dated 11/6/24, documents R18 has an ADL (Activities of Daily Living) self-care performance deficit related to Limited Mobility. Interventions: Toilet Use: R18 is not toileted, she is frequently incontinent, unable to transfer to toilet, use of bedpan encouraged, incontinent care per staff. It continues (4/7/25) R18 has potential for impairment to skin integrity related to impaired mobility, current medications, incontinence of B&B (bowel and bladder). Interventions: Complete pressure ulcer risk assessment quarterly and PRN (as needed), observe skin daily with care, notify MD (medical doctor)/NP (nurse practitioner) of any abnormal findings, pressure redistribution mattress to bed, provide diet as ordered, RD (registered dietitian) to follow related to wound care and nutrition, refer to Specialized Wound Management, staff to assist with turning and repositioning as tolerated, staff to provide incontinent care after each incontinent episode, weekly skin assessment. R18's Minimum Data Set (MDS), dated [DATE], documents R18 has a severe cognitive impairment and is dependent on staff for toileting and bathing. R18 is always incontinent of both bowel and bladder. R18's Physician Order, dated 2/10/25, documents Skin assessment weekly every Tuesday day shift. Every day shift every Tuesday for weekly skin check. Please complete skin checks in (computer system). R18's Physician Order, dated 4/22/25, documents Cleanse bilateral buttocks with NS (normal saline) or WC (wound cleaner), apply barrier cream daily and PRN (as needed). Every Day shift for incontinence dermatitis. R18's Physician Order, dated 7/19/24, documents Cleanse peri area with mild soap and water or facility wipes, pat dry, apply Calazinc cream to buttocks, peri area, and inner thighs PRN. R18's Weekly Skin Assessment, dated 4/15/25, documents Incontinence Dermatitis to left buttock, right thigh, and left thigh. R18's Weekly Wound Assessment, dated 3/11/25, documents R18 had a Pressure Ulcer to left buttock that was healed. There is no further wound notes completed. R18's (Wound Management Specialist) Note, dated 3/18/25, documents in part Visit Date: 3/18/25, DC (discontinue) (Wound Management Specialist) services, Nursing to continue to monitor and notify me of changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stearns Nursing & Rehab Center	3900 Stearns Avenue Granite City, IL 62040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/22/25 at 10:00 AM, V12, Certified Nursing Assistant (CNA), in to do peri-care on R18, and during incontinent care, R18 was rolled to her right side, and her buttocks appeared very reddened with open sores that appear like skin tears with slight bleeding from areas. V12 continued to wipe R18, causing even more bleeding. A clean brief was applied with no moisture barrier cream applied to R18 and no drying seen done. On 4/22/25 at 10:18 AM, V12, CNA, stated (R18) did not have these sores on her bottom the last time I was working here. It looks like it is from sitting in wetness, especially when sitting her in her wheelchair. On 4/23/25 at 9:10 AM, V19, Wound Nurse, stated (R18) did have sores on her buttock before and the (Wound Management Specialist) was working with her, but that was all healed. The CNAs are supposed to be putting moisture barrier on her with each incontinence care. When told that R18's buttocks were excoriated and bleeding, V19 stated No one has told me about that, I was not aware of it. I will check her out this morning and probably have (Wound Management Specialist) look at her again. On 4/23/25 at 9:48 AM, V15, CNA, stated If I'm doing incontinent care and the resident has redness or open sores, I would use a barrier cream and will tell the nurse about it. On 4/23/25 10:50 AM, V19 gathered supplies to assess R18's wounds with V22, CNA, assisting. V19 opened R18's legs to expose her inner thighs and perineum area which were very bright red and excoriated. V22 turned R18 to her right side exposing her buttocks which showed three open wounds to her back side with the entire buttocks, anal area, gluteal creases all red and excoriated. V19 stated I was not aware of any of these wounds. R18 has been red for quite a while, and we were supposed to be using moisture barrier cream for it because she is a heavy wetter and is always saturated. I will have to call the physician now and get some orders for wound treatment. This looks very painful, and she should be in pain the way it looks. V19 measured R18's wounds which was the right buttock 2 CM (centimeters) X 5 CM X 1.0 CM, the left inner thigh 1.0 CM X 4.3 CM, and the right gluteal fold 0.4 CM X 3.7 CM. On 4/23/25 at 10:55 AM, V22 stated I just did peri-care on (R18), and she was yelling that it hurt every time I would wipe her. She was definitely in pain. On 4/28/25 at 11:00 AM, V2, Director of Nursing (DON), stated I would expect the CNAs to report any resident's change in skin condition to the nurse and I would expect the nurses to perform skin and wound assessments and provide appropriate treatments as ordered by the physician. On 4/23/25 at 11:30 AM, V19 stated I just spoke with the physician and (R18) will be followed up with (Wound Management Specialist) again and he gave me orders to take care of her wounds. On 4/23/25 at 11:35 AM, V19 gathered her supplies for wound care. V19 sprayed 4X4 gauze with wound cleaner and right buttock wound wiped, then Collagen and Calcium Alginate and foam dressing applied. R19 started to have a loose bowel movement so the wound care paused for peri-care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 11:53 AM, V19 continued wound care on R18. Previous dressing was replaced due to feces on it. Wound cleanser sprayed on 4X4, wound wiped, then patted dry. Cavalon wiped on left inner thigh and right gluteal fold wounds, allowed to dry, then V19 wiped barrier cream all over R18's buttock/anal area. The previous dressing on R18's right buttock was falling off, V19 removed the old dressing, recleaned site, applied Collagen and Calcium Alginate and foam dressing again. While R18 was turned to her right, a small thin open slit was noticed on R18's gluteal cleft, V19 made aware and wiped barrier cream on it. R18 rolled back to her back side and covered up. There was no cleaning, or wound care provided to R18's front inner thighs or peri-area. R18's New Physician Order, dated 4/23/25, documents Cleanse bilateral buttocks with NS or WC, apply barrier cream Q shift and PRN. Every shift for incontinence dermatitis/excoriation/ MASD (moisture associated skin dermatitis). R18's New Physician Order, dated 4/23/25, documents Cleanse wound to right buttock NS or WC, apply Collagen, Calcium Alginate, and cover with a foam dressing daily and PRN. Every Day shift for open area to right buttock. R18's New Physician Order, dated 4/23/25, documents Cleanse anterior inner things with NS or WC and apply barrier cream Q shift and PRN. Every shift for excoriation/MASD to BIL (bilateral) inner thighs. R18's New Physician Order, dated 4/23/25, documents Cleanse BIL posterior inner thighs with NS or WC and apply barrier cream Q shift and PRN. Every shift for excoriation/MASD to inner thighs. R18's New Physician Order, dated 4/23/25, documents Cleanse BIL posterior inner thighs/gluteal folds with NS or WC, pat dry, and apply Cavilon once weekly and PRN. Every day shift every Wed (Wednesday) for excoriation/MASD to BIL thighs. The Facility's Guide for Wound Evaluation, undated, documents in part Procedure: 1. Upon identification of a pressure ulcer/injury (arterial, venous, or neuropathic), regardless if developed in-house or upon admission, the area is to be documented on the Wound Evaluation Form or in the electronic format. 2. Non-Ulcers are to be documented weekly on a Skin Condition Form or in electronic format. 3. Contact physician, interdisciplinary team, family members, and significant others as indicated. 4. Initiate appropriate treatment per treatment protocol and physician order. 5. Evaluate further interventions that may be indicated to promote healing and prevent infection. 6. Documentation of wound status will occur at least once a week. This weekly evaluation will be documented electronically or on the Wound Evaluation Form / Skin Condition Form as appropriate. 7. The physician is to be notified if there is no improvement in area, signs and symptoms of infection or signs of deterioration. 10. The Director of Nursing Services and/or designated Licensed Nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be addressed. Resident lack of progress will be evaluated. Directives may be given for further interventions and changes in plan of care. The Facility's Wound Care Treatment Protocol, dated 11/2012, documents in part Evaluate the wound daily for signs and symptoms of infection and for signs of healing. Document / Report findings. Provide treatment as per physician's order.