

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Evercare at Stearns		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the misappropriation of a resident's narcotic pain medication for 1 of 3 (R3) residents reviewed for liquid narcotic medication in a sample of 6. Findings include: R3's Care Plan, dated [DATE], documents that (R3) has potential for acute pain r/t (related to) dx (diagnosis) Dementia, Chronic Kidney Disease, GERD. The facility's initial letter, dated [DATE], documents that the facility's medication tampering suspected by hospice nurse. Please find this as the initial reporting of Suspected medication tampering by hospice nurse during care provided to mutual resident of the facility. It appears that the nurse changed the label and repurposed a bottle of liquid medications from a deceased resident to a current resident. No harm occurred and the hospice company was notified, and an investigation initiated. A full report will follow upon completion of all investigation steps. R3's Physician Order, dated [DATE], documents Morphine Sulfate Oral Solution 20 MG/5ML (milligram/milliliter) Give 0.25 ml by mouth every 4 hours as needed for pain. R3's Controlled Drug Record documents 30ml bottle of Morphine Sulfate 100mg/5ml. It also documents on 9/16 at 9:20 0.25 ml given and at 5:45 0.25 ml given. A handwritten line is drawn across the Controlled Drug Record. It continues starting 29.50ml in bottle and V5's initials. It then documents 0.5ml doses administered 9/20 at 8pm, 9/21 at 10 AM, 9/21 2PM, 9/21 4 PM, 9/21 8PM, 9/22 2AM. It documents R3's name with a hand drawn line thru it and R5's name handwritten above. It also documents that on [DATE] 26.5 ml of morphine sulfate was disposed of V2's initials and V8's signature. The facility's final letter, dated [DATE], documents Re: Medication tampering suspected by hospice RN. On [DATE] during narcotic destruction it was noted that a medication label had been altered by the Vitas Hospice nurse at the time of admitting a new patient onto their services. All notifications were made, and initial reporting completed. Vitas hospice conducted an investigation into the nurse responsible for the label alteration from the original resident (also a Vitas Hospice patient) to the newly admitted Vitas patient. The nurse in question admitted changing the label so as not to delay getting the medication started for the patient who was in active decline. Despite her feeling she was doing what was best for the resident at the time, the nurse was educated and ultimately terminated from her position due to her actions. The facility DNS has educated all hospice providers on the incident and outcome to ensure no future instance occur. No medication dose discrepancies were noted as all medication was provided to residents under the care of Vitas Hospice. V6's written statement, dated [DATE] at 1000 AM, documents that the hospice nurse could not get the new man's meds, so she used the other guy's stuff. I questioned it but she said she okayed with her boss, and it was meds for a patient of theirs that died. R5's Physician Orders, dated [DATE], documents Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) Give 0.5 ml by mouth every 1 hours as needed for Pain. On [DATE] at 1:32 PM V2, Director of Nursing, stated that she has a strict policy as the floor nurses are not to destroy narcotics. V2 stated that the medication is counted on the floor and given to her for destruction. V2 stated that because of using agency staff and past experiences she put this in place to prevent diversion. V2 stated that R3 passed away on a Wednesday or Thursday. V2 stated that when she went to destroy the medication, she noted that the Controlled Drug Record was altered with R3's name marked out and R5's name handwritten on the record. V2 stated that she checked the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication and noted that the medication and noted that the original box was altered in the same way. V2 stated that she then checked with her staff and was informed by V6, LPN , that when R5 was admitted he was experiencing pain. It was noted that the morphine was in the cart and V5, Hospice RN, changed the name on the record and the box. V2 stated that she notified hospice of what she was made aware. V2 stated that her staff did administer R3's medication to R5. V2 stated that this is medication tampering and is not allowed in her facility. On [DATE] at 3:07 PM V5 stated that she came to the facility because R5 was being admitted to hospice. V5 stated that R5 was in a lot of pain and family was requesting pain relief. V5 stated that she was informed by V6 that R3's Morphine was in the cart. V5 stated that she initialed that R3 had 29.5 mls of Morphine. V5 stated that she did not alter the record or the container and did not administer the medication. V5 stated that V6 altered the document and the bottle. V5 stated that she did place orders for R5's medication but did not order the morphine because she was informed by V6 that that the facility would use R3's medication. On [DATE] at 10:22 AM V9, LPN, stated that she administered R5's 0.5ml from the morphine bottle labeled in the cart and documented on the Controlled Drug Record labeled with R5's name. V9 stated that the signature on R3's Controlled Medication Record dated 9/21 at 10 am, 2pm and 4pm were her signature. V9 stated that the medication was administered to R5. V9 stated that she did not pay attention to the marked-out name she only looked at R5's name. V9 stated that they don't use other residents' medication and if she would have noticed it, she would have said something. The facility's Abuse Prevention policy, dated 1/25, documents POLICY: The facility is committed to protecting the residents from 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. Definitions g) Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document an appropriate reason for discharge from the facility, the specific needs of the resident that could not be met at the facility, the services available at the receiving facility and issue a notice for 1 of 3 (R2) resident's reviewed for Admission, Transfer & Discharge Requirements. Findings include: R2's admission Record, R2's Care Plan, dated 06/03/2025, documents I do not need to be asked about discharge on each assessment due to plans to remain in this facility long term. admission Record, print date 9/17/2025, documents that R2 was admitted to the facility 5/30/2025 with Unspecified Dementia, moderate with agitation and Schizophrenia listed as diagnosis. R2's Minimum Data Set, dated [DATE], cognitively intact with behaviors of delusions. R2's Progress Note, dated 7/30/2025, documents R2 was very angry, unable to redirect threats of self-harm and harm to others. Violent towards V2. 911 called. Resident aggressive with EMTs and police. Physical restraints applied. Transferred to local hospital. R2's Progress Note, dated 8/13/2025, documents official discharge from facility. Facility provided a list of locations for placement. On 11/13/2025 at 10:51 AM V11, Social Worker at Local Hospital, stated that R2 admitted to the hospital from the facility on 7/30/2025. V11 stated that the hospital contacted the facility and they agreed to take R2 back. V11 stated that the facility was later notified that R2 would be possibly discharged to their facility. V11 stated that she then received a call from V1 and informed her that they would not be taking R2 back. V11 stated that she informed V1 that they had already agreed to R2 returning. V11 stated that she was informed at that time R2 will not be accepted. V11 stated that she was informed that the facility had not given a notice or involuntary discharge paperwork. V11 stated that V1 informed V11 that she would bring one if she had to and had not brought it to the hospital. V11 stated that R2 stayed at the hospital and was discharged on 10/1/2025 to another facility. On 11/17/2025 at 9:15 AM V1, Administrator, stated that she is familiar with R2's behaviors in the facility and discharge. V2 stated that R2 had behaviors that the facility couldn't control. V2 stated that on the last day at facility R2 believed she was God, yelling screaming and dressed inappropriately. V1 stated that there were multiple attempts to redirect without success. V1 stated that the ambulance was called and R2 was uncontrollable and began attempting to stab the EMTs. V1 stated that she called and notified the hospital that they were not taking R2 back. V1 stated that they did not give an involuntary discharge notice. On 11/17/2025 at 12:50 PM V2, Director of Nursing, stated that R2 was admitted to facility from (Regional Hospital). Stated that she did go and see the patient prior to admission and did not see any behaviors at that time. R2 was admitted to the facility and immediately started refusing medication and started to have increased behaviors of her being God, verbally and physically abusive to staff. Unable to redirect her. R2 had a behavior of being God, yelling and swinging at staff she was trying to hurt herself and others. Ambulance was called and police arrived as well. R2 attempted to stab the EMTs with pens and pencils. Stated that she required restrained. V2 stated that they were not aware of these behaviors and are not equipped to handle behaviors of this level. V2 stated that they worked with the hospital, and they agreed that the resident was not appropriate for the facility. V2 stated that they did not give a notice of discharge because they were working with the hospital to find placement. On 11/17/2025 at 3:25 PM V12, Psych [NAME] President, stated that R2 was admitted to the hospital on [DATE] and discharged [DATE]. V12 stated that the facility had agreed to take R2 back after treatment and then refused. V12 stated that V1 notified the hospital that they would not take R2 back. V12 stated that V1 did not issue a notice to the resident. The facility's Discharge and Transfer policy, dated 4/25, documents that POLICY: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. The facility must permit each (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident to remain in the facility and not transfer or discharge the resident from the facility unless specific criteria, as outlined below, are met. It continues Procedure: 2. Documentation will be entered into the resident's medical record regarding the transfer/discharge reason(s) and the appropriate transfer/discharge information will be communicated to the receiving healthcare center, provider, resident and/or Resident Representative. a. Documentation includes: 1. The basis for the transfers/discharges for reasons listed (a) through (g) above. 2. The specific need(s) that cannot be met, the attempts to meet the needs, and the service available at the receiving facility to meet the need(s) for (a) above. 3. The resident's physician will provide documentation for a transfer due to (a) and (b) above. 4. A physician will provide documentation for a transfer/discharge due to (c) and (d). 8. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and the resident representative or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding bed-hold policies. 13. Involuntary discharge will be effected after the minimum notice requirements prescribed by applicable state law and regulation, or thirty (30) days notice if no state law or regulation is applicable (unless the health or safety of others in the facility is jeopardized), subject to any legal rights of appeal or challenge prescribed by law.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to label medication per current standards of practice. This has the potential to affect all 99 residents residing in the facility. Findings include: R3's admission Record, dated [DATE], documents admission date [DATE] with Dementia, Chronic kidney Disease, hypertension, and Anxiety listed as diagnosis. R3's Care Plan, dated [DATE], documents that (R3) has potential for acute pain r/t (related to) dx (diagnosis) Dementia, Chronic Kidney Disease, GERD. R3's Physician Order, dated [DATE], documents Morphine Sulfate Oral Solution 20 MG/5ML (milligram/milliliter) Give 0.25 ml by mouth every 4 hours as needed for pain. R3's Controlled Drug Record documents 30ml bottle of Morphine Sulfate 100mg/5ml. It documents R3's name with a hand drawn line thru it and R5's name handwritten above it. It also documents on 9/16 at 9:20 0.25 ml given and at 5:45 0.25 ml given. A handwritten line is drawn across the Controlled Drug Record. It continues starting 29.50ml in bottle and V5's initials. It then documents 0.5ml doses administered 9/20 at 8pm, 9/21 at 10 AM, 9/21 2PM, 9/21 4 PM, 9/21 8PM, 9/22 2AM. The facility's initial letter, dated [DATE], documents that the facility's medication tampering suspected by hospice nurse. Please find this as the initial reporting of Suspected medication tampering by hospice nurse during care provided to mutual resident of the facility. It appears that the nurse changed the label and repurposed a bottle of liquid medications from a deceased resident to a current resident. No harm occurred and the hospice company was notified, and an investigation initiated. A full report will follow upon completion of all investigation steps. The facility's final letter, dated [DATE], documents Re: Medication tampering suspected by hospice RN. On [DATE] during narcotic destruction it was noted that a medication label had been altered by the Vitas Hospice nurse at the time of admitting a new patient onto their services. All notifications were made, and initial reporting completed. Vitas hospice conducted an investigation into the nurse responsible for the label alteration from the original resident (also a Vitas Hospice patient) to the newly admitted Vitas patient. The nurse in question admitted changing the label so as not to delay getting the medication started for the patient who was in active decline. Despite her feeling she was doing what was best for the resident at the time, the nurse was educated and ultimately terminated from her position due to her actions. The facility DNS has educated all hospice providers on the incident and outcome to ensure no future instance occur. No medication dose discrepancies were noted as all medication was provided to residents under the care of Vitas Hospice. On [DATE] at 1:32 PM V2, Director of Nursing, stated that she has a strict policy as the floor nurses are not to destroy narcotics. V2 stated that the medication is counted on the floor and given to her for destruction. V2 stated that because of using agency staff and past experiences she put this in place to prevent diversion. V2 stated that R3 passed away on a Wednesday or Thursday. V2 stated that when she went to destroy the medication, she noted that the Controlled Drug Record was altered with R3's name marked out and R5's name handwritten on the record. V2 stated that she checked the medication and noted that the medication and noted that the original box was altered in the same way. V2 stated that she then checked with her staff and was informed by V6, ???, that when R5 was admitted he was experiencing pain. It was noted that the morphine was in the cart and V5, Hospice RN, changed the name on the record and the box. V2 stated that she notified hospice of what she was made aware. V2 stated that her staff did administer R3's medication to R5. V2 stated this is not the normal practice of the facility and she expects her staff to use medication that is prescribed for the resident and not change the label and use for another resident. On [DATE] at 3:07 PM V5 stated that she came to the facility because R5 was being admitted to hospice. V5 stated that R5 was in a lot of pain and family was requesting pain relief. V5 stated that she was informed by V6 that R3's Morphine was in the cart. V5 stated that she initialed that R3 had 29.5 mls of Morphine. V5 stated that she did (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not alter the record or the container and did not administer the medication. V5 stated that V6 altered the document and the bottle. V5 stated that she did place orders for R5's medication but did not order the morphine because she was informed that that they would use R3's medication. On [DATE] at Approximately 10:00 AM V2 provided Midnight Census report, dated [DATE], that documents 99 occupied resident beds in the facility. On [DATE] at 2:12 PM V10, Pharmacist, stated that the medications are labeled, with a specific resident's name and sent from the pharmacy with that label. V10 stated that once the medication leaves the pharmacy the label remains the same and is not to be changed in the facility. If the medication is expired or the person dies the medication is to be destroyed. V10 stated that each medication is specific to a particular resident and not to be shared or used for another. The facility's Medication Storage policy, dated 1/15, documents that POLICY: All drugs, treatments, and biologicals must be stored securely and following the manufacturer's labeled recommendations, or per facility policy. The facility's Medication Administration General Guidelines, dated 1/15, documents that POLICY: Medications are administered as prescribed, in accordance with good nursing principles and practices. Procedure; 18. Prior to administration, the medication and dosage schedule on the resident's MAR I TAR is compared with the medication label. Information on the medication should be checked against the MAR / TAR at least three times during the med preparation and administration process. If the label and MAR I TAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule prior to administering. If the medication is discontinued, outdated, or unusable, remove the medication for proper disposal.		