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	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Stearns	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 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. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure sexual abuse did not occur for 1 of 4 residents (R3) reviewed for abuse and neglect of a sexual nature in the sample of 6. This failure resulted in R2 touching R3 inappropriately when R3 could not deny the advances or give her approval or consent. R3 was incapable of declining to participate in the sexual act and lacks the ability to understand the nature of the sexual act. Findings include: 1-R2's Physician Order Sheet for December 2025 documents a diagnosis of dementia, COPD (Chronic Obstructive Pulmonary Disease), major depression disorder, and muscle weakness, abnormalities of gait and mobility. R2's Minimum Data Set (MDS) dated [DATE] document R2 was moderately impaired for cognition for activities of daily living. Resident does not use a wheelchair or scooter. Sit to stand supervision or touching assistance and walk 10 feet and 50 feet with two turns. R2's Care Plan with a focus date of 11/22/2025 (R2) has had sexual behavior noted related to confusion. Date initiated 11/22/2025. Goal: Resident will not have sexual behaviors and act appropriately with other residents. Date initiated 11/22/2025. Intervention dated 11/22/2025, Place on 1:1 monitoring, behavior monitoring for increased sexual desires will be monitored. R2's Care Plan date initiated of 10/27/2025 also documents (R2) engages in self-stimulation related to dementia, occasionally performing the behaviors in her room without closing the door. On 12/5/2025 at 8:35 AM, V1, Administrator stated we did have an incident with (R2) and (R3), but (R3) could not tell you anything. When we interviewed (R2) she was confused, and she said she just thought she was helping (R3) because she used to be a CNA (Certified Nursing Assistant) and her roommate's (adult diapers) were full of BM (bowel movement) and it was just a big misunderstanding. On 12/5/2025 at 8:49 AM, V2, Director of Nursing stated they did an internal investigation and felt like (V4) jumped the gun because (R2) had her pants down but they were able to determine nothing occurred. On 12/5/2025 at 12:58 AM R2 stated she use to be a CNA (Certified Nursing Assistant) and has never tried to provide care to any other residents including roommate. She states the AC was on and when she went over to turn it down her roommate grabbed her and her pants fell down and then the nurse walked in on her but she was not touching her roommate. They were in bed together. They separated them after that. She also says her roommate was not wet and/or needing changed and/or had poop. R2's Nurse's Notes dated 11/22/2025 at 7:00 PM, SSD (Social Service Director) met with (R2) who is resting in bed. Trauma assessment complete. (R2) denies trauma. SSD asked (R2) if she feels safe here. She responded yes. (R2) asked SSD why she was asking this question. SSD stated to ensure she feels safe. SSD asked why she was on her roommate's side of the room. (R2) responded that she was just trying to help her. SSD asked why (R2) pants were down. (R2) responded that they always slide down and was attempting to pull them up. R2's Progress notes dated 11/24/2025 at 9:21 PM, Resident continues to have a 1:1 related to resident to residents. Resident currently in bed resting with call light in reach. No s/s (signs or symptoms) of acute distress noted at present moment. R2's Initial Report 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Investigation of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. R2's Final Report date of 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Education of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. Investigation: (V4, LPN) entered (R2) and (R3) to observe (R2) on her knees next to the bed with her pants down. (R2) hand was on the bed with her back to (R2) laying on her side. (V4) noted that the room was very cold and that (R2) had BM (bowel movement) on her hand and (R3) had BM on her bed. (V4) did not see (R2) acting inappropriately with (R3), nor did she have history of being inappropriate with resident. (R2) was a long time CNA (certified nursing assistant) of (Facility) prior to coming to live at the facility. (R2) was interviewed, she was noted to have some confusion during questioning but was able to answer some questions sensical. She stated that she was cold and went to turn off the air. The air was noted to be on when (V4) was in the room. When asked why her pants were down she stated, they had fallen down, they were not fastened. (R2) was noted to have BM on her hand. She did not know where that had come from however her hand was located on (R3's) bed that did have BM on it. She was using the bed to help her get off her knees. When asked if she had

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to operationalize their abuse policy and procedures for 2 of 4 reviewed (R2 and R3) for policies in the sample of 6. On 12/5/2025 at 8:35 AM, V1, Administrator stated we did have an incident with (R2) and (R3), but (R3) could not tell you anything. When we interviewed (R2) she was confused, and she said she just thought she was helping (R3) because she used to be a CNA (Certified Nursing Assistant) and her roommate's (adult diapers) were full of BM (bowel movement) and it was just a big misunderstanding. On 12/5/2025 at 8:45 AM, V1 stated the Facility was requesting past noncompliant (PNC) for F600 abuse even though through their investigation they had no findings. V1 stated they did not believe the abuse occurred because (R2) use to be a certified nursing assistant, at this building. They did a PNC ready just in case. On 12/5/2025 at 8:49 AM, V2, Director of Nursing stated they did an internal investigation and felt like (V4) jumped the gun because (R2) had her pants down but they were able to determine nothing occurred. R2's Initial Report 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Investigation of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. R2's Final Report date of 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Education of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. Investigation: (V4, LPN) entered (R2) and (R3) to observe (R2) on her knees next to the bed with her pants down. (R2) hand was on the bed with her back to (R3) laying on her side. (V4) noted that the room was very cold and that (R2) had BM (bowel movement) on her hand and (R3) had BM on her bed. (V4) did not see (R2) acting inappropriately with (R3), nor did she have history of being inappropriate with resident. (R2) was a long time CNA (certified nursing assistant) of (Facility) prior to coming to live at the facility. (R2) was interviewed, she was noted to have some confusion during questioning but was able to answer some questions sensical. She stated that she was cold and went to turn off the air. The air was noted to be on when (V4) was in the room. When asked why her pants were down, she stated, they had fallen down, they were not fastened. (R2) was noted to have BM on her hand. She did not know where that had come from however her hand was located on (R3's) bed that did have BM on it. She was using the bed to help her get off her knees. When asked if she had touched (R3) she said no. I am just trying to help her. (R3) was unable to be interviewed. She was noted to be sleeping at the time of concern. (R3's) skin assessment was completed WNL (within normal limits). Pain assessment completed; no pain noted. (R3) did not have an increase or behavioral changes after time of concern. Other residents were interviewed, when asked if another resident ever touched them inappropriately, all answered no. When asked if they felt safe in the facility, all stated they did. When asked of residents know who to report concerns to, they stated they did, if they did not residents were education. Conclusion: Our investigation concluded that (R2) did not have any inappropriate contact with (R3). (R2) was trying to turn off the air conditioning and got tangled up in her pants that had fallen down. She went to use (R3's) bed to get up where she had placed her hand on (R3's) soiled bedding. When our nurse entered the room, we do not believe that anything inappropriate occurred, the police were called and agreed that there was no cause for concern. V5, Psyche Nurse Practitioner conducted a [NAME] health visit with both residents to ensure residents were behaving at baseline. (V5) stated she had known (R2) for a long time and has not had any behaviors involving other residents. Final Interventions: (R1) room moved. (R1) placed on 15-minute checks to monitor for increased/changes in behaviors. Skin, pain, trauma assessment completed on (R3). (R2) was interviewed. (R2) was placed on 1:1: monitoring for a change in behaviors. (R2) clothing noted to fit well, Reviewed ability to fasten her clothing properly. Psych MP completed [NAME] health visits on both, the same night as the concern was noted. SSD (Social Service Director) to follow up. Care Plans updated. (This report does not mention R2 touched R3's private parts or address R2's Police report and or any statement by the eyewitness (V4). R3's Nurses Notes do not document anything related to the incident with her roommate (R2) on 11/22/2025. On 12/5/2025 at 8:45 AM, V1 stated the Facility was requesting past noncompliant for F600 abuse even though through their investigation they had no findings. (R2) and (R3), but (R3) could not tell you anything. When we interviewed

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure all alleged violations are thoroughly investigated for 2 of 4 residents (R2 and R3) reviewed for abuse investigations in the sample of 6. Findings include: On 12/5/2025 at 8:35 AM, V1, Administrator stated we did have an incident with (R2) and (R3), but (R3) could not tell you anything. When we interviewed (R2) she was confused, and she said she just thought she was helping (R3) because she used to be a CNA (Certified Nursing Assistant) and her roommate's (adult diapers) were full of BM (bowel movement) and it was just a big misunderstanding. On 12/5/2025 at 8:45 AM, V1 stated the Facility was requesting past noncompliant (PNC) for F600 abuse even though through their investigation V1 stated she had no findings. V1 stated they did not believe the abuse occurred because (R2) use to be a certified nursing assistant, at this building. They did a PNC ready just in case. On 12/5/2025 at 8:49 AM, V2, Director of Nursing stated they did an internal investigation and felt like (V4) jumped the gun because (R2) had her pants down but they were able to determine nothing occurred. R2's Initial Report 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Investigation of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. R2's Final Report date of 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. 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