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	01/16/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from resident-to-resident abuse for 3 of 3 residents (R2, R7, and R9) in a sample of 24. This failure resulted in R3 physically assaulting R7 and R7 being sent out to the hospital and receiving staples for a head laceration, R9 being slapped on the right side of his face and a red area appearing, and R2 being struck in the face with a cane and sustaining a laceration to her right jawline. Findings Include: R3's Local Hospital Referral, admission date of 09/30/25, documented the following: History of Present Illness (HPI)/Subjective.Patient (Pt) is a [AGE] year-old African American male with past medical history of dementia and Traumatic brain injury. Patient currently lives with wife at home. Per wife patient gets more confused as the day goes on. He does become physically aggressive at night often leaving bruises on her. Patient also tries to escape the residence. Patient is alert to self only. It also documented on 9/29/25: last night had aggressive behavior to the nurse. It further documented Present Illness and Reason for admission: [AGE] year-old black male admitted [DATE] for wellness check per wife's request, who reports R3 becomes more confused, aggressive and wanders at night. History (Hx) of agitation, aggression, code green 09/28/25 at which time a Registered Nurse (RN) was knocked to the ground. Pt lives with wife at home. Per documentation from wife, pt becomes violent and more confused as the day progresses, sundowners. By the evening pt. will hit and attempt to leave/elope from the home. Wife currently is unable to safely care for pt and wants placement. R3's Face Sheet, admission date of 10/10/25, documented he has diagnoses (dx) of but not limited to unspecified dementia, unspecified severity, with other behavioral disturbance, Type II Diabetes Mellitus with hyperglycemia, Essential (Primary) Hypertension, and Atrial Fibrillation. R3's Minimum Data Set (MDS), dated [DATE], documented R3 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 00 out of 15, had Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred 1 to 3 days, put R3 at significant risk for physical illness or injury, and did not put others at significant risk of physical injury. R3's Care Plan, admission date of 10/10/25, documented on 10/10/25 R3 had a history (hx) of physical aggression towards staff related to (r/t) diagnosis (dx) of dementia. Goal: R3 will have no physical aggression through next review. Interventions include but are not limited to approach R3 calmly and respectfully, behavior tracking in place, provide choices, when possible, to give R3 a sense of control, provide positive reinforcement for calm or cooperative behaviors, report allegations of abuse neglect to Administrator immediately (initiated on 11/25/25), utilize clear, simple communication giving directions or explanations. Avoid arguing or reasoning when R3 is upset. R3 is at risk for abuse/neglect related to impaired cognitive skills, needs assistance with activities of daily living (ADLs), impaired cognitive skill, dx of dementia. Goal: R3 will have no psych decline through next review. R3's Progress Note, dated 10/26/25 at 8:16 PM, documented R3 was observed in (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	another resident's room (R7) assaulting the other resident with his (R3) walker at 6:03 PM by the certified nursing assistant (CNA). 1. R7's Face Sheet, admission date of 01/18/21, documented R7 has diagnoses of but not limited to Alzheimer's disease with late onset, unspecified dementia, moderate with agitation, and dementia, with behavioral disturbance. R7's MDS, dated [DATE], documented R7 is severely cognitively impaired, was resistive to care at times, and was dependent on staff for most of his ADLs. R7's Care Plan, admission date of 01/18/21, documented R7 is at risk for abuse/neglect r/t needs assistance with ADLs, impaired cognitive skills, dx of dementia, interventions include but not limited to report allegations of abuse/neglect immediately. R7's Progress Notes, dated 10/26/2025 at 8:08 PM, documented resident was observed at 8:03 PM by the nurse in room with a head injury. The CNA stated she heard a resident screaming for help and she observed another resident hitting R7 with a walker. 911 was called and R7 was transported to the Emergency Department (ED) by EMS (Emergency Medical Services). R7's ED report, dated 10/26/25, documented History of Present Illness (HPI) this is a [AGE] year-old male with history of dementia who presents to the ED for physical assault and head laceration. Per EMS patient apparently got into an altercation with a fellow resident and was hit in the head with a cane and sustained a laceration. Patient is otherwise not able to participate in history taking due to his dementia. It further documented, he had a 2-centimeter (cm) laceration to the scalp and was repaired with staples. 2. R9's Face Sheet, print date of 01/08/26, documented R9 has diagnoses of but not limited to Dementia without behavioral disturbances, anxiety disorder, and psychosis not due to a substance or known physiological condition. R9's MDS, dated [DATE], documented R9 is severely cognitively impaired, and he requires assistance with his ADLs. R9's Care Plan, admission date of 08/08/25, and documented R9 is at risk for abuse/neglect r/t needs assistances with ADLs, impaired cognitive skills, dx of dementia. Interventions include but not limited to monitor R9 closely for any signs of abuse, neglect, or peer to peer altercations; report and document all incidents per facility policy and report allegations of abuse/neglect to administrator immediately. R9's Progress Notes, dated 11/11/25 at 8:23 AM, documented Resident was in his bedroom room in bed resting when R3 entered the restroom belonging to R9 and another resident. When R3 was done in the restroom he exited and entered R9's room. R9 stated that he approached R3 and told him that he was in the wrong room when R3 then stood from his chair and struck R9 across the face. R9 let out a scream that was heard by CNAs who were in the dining area preparing the residents for breakfast. Once R9 approached the nurse's station I could see that R9 had redness to the right side of his face around his eye. R9 stated that R3 had struck him with an open hand, a smack to the face. R9's IDPH Final Report, dated 11/11/25, documented the following: R9 is a [AGE] year-old male that includes a Dx of: Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, and Anxiety. R9 has a Brief Interview for Mental Status (BIMS) score of 0. R9 uses a wheelchair for locomotion. R3 is a [AGE] year-old male with a DX that includes Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance and Dementia in other Diseases. R3 has a BIMS score of 0 and uses a wheelchair at times for locomotion. Both residents reside on the memory unit. Staff overheard R9 yelling in his room. Upon entering R9's room he stated that R3 smacked him in the face stating, you are in the wrong room. R3 had already exited the room. Staff continued to keep them separated. A skin assessment was performed on R9 that revealed a small red area to the right eye. All pertinent parties were notified. IDPH was notified. Care plans of both residents were assessed. Both residents were separated for 48- hour observation. In conclusion the physical altercation between R9 and R3 did occur. Trauma assessments were completed on both residents and both residents stated that they felt safe in the facility. R3 took a wrong turn when exiting the bathroom and thought that R9 was in his room, which he was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	not. R3 was moved to the top of the hall into a private room with a bathroom to aide in his room confusion. 3. R2's Face Sheet, dated 1/15/25, documented R2 has diagnoses of but not limited to Restlessness and agitation, anxiety disorder, paroxysmal atrial fibrillation, and dementia, moderate, with agitation. R2's MDS, dated [DATE], documented R2 was severely cognitively impaired, had no behaviors documented, and required assistance with her ADLs. R2's Care Plan, admission date of 07/01/24, documented R2 is at increased risk for abuse and neglect r/t dementia with other behavioral disturbances and interventions include but not limited to Keep R2 safe at all times and report suspects abuse/neglect immediately to the facility administrator. R2's Progress Notes, dated 11/25/2025 at 1:54 PM, documented Resident was in her room sleeping when another resident who was in the wrong room stood over her and struck her in the face with a cane causing a laceration to the right side of her jawline. Resident is now in her room a little frantic but resting quietly. Resident stated that she is in pain at a rate of 8 on a scale of 1 to 10. Resident was given two 500mg (milligram) Tylenol tabs tablets (tabs). R2's IDPH Final Report, Incident date of 11/25/25 at 12:51 PM, documented R2 is a [AGE] year-old female resident with a diagnosis of but not limited to Restlessness and agitation, anxiety disorder, paroxysmal atrial fibrillation. BIMS of 0. R3 is a [AGE] year-old male with diagnosis of but not limited to Unspecified Dementia, unspecified severity, with other behavioral disturbance. Hyperlipidemia and Hypertension. BIMS of 0. On 11/25/25, the facility ED was notified that R2 was asleep in her bed located in the memory unit when the LPN heard yelling. She ran to the sound and saw R3 standing over R2 holding a cane. She immediately removed the cane and removed R3 from the room. Upon assisting with getting R2 to a sitting position, she noticed blood coming from R2's jawline. A skin assessment was completed at this time. 1.) Residents were immediately separated.2.) R3 was sent to the local hospital. R3 was admitted with the DX of MDD (Major Depressive Disorder) with psychotic features.3.) Interview with residents and staff were completed.4.) Notified family and MD (Medical Doctor).5.) Care plans updated for R2 and R3. The son and his wife were contacted on 11/25/25 to speak about future living arrangements for R3. They were going to discuss him possibly moving in with them in [NAME] Wisconsin. Follow up calls were made to the family with no further contact. Therefore, an immediate discharge was issued. Trauma assessments were completed on R2 with no further issues noted. On 12/03/25, V36, Family Nurse Practitioner (FNP) wrote a letter regarding R3 and it documented the following: To whom it may concern, R3, DOB (date of birth) 11-28-46, poses an imminent risk of harm to the patients and staff at the facility. He has been trialed on multiple medications, but unfortunately aggressive episodes are unprovoked and unpredictable making the facility unable to meet his needs at this time due to harming others. Thank you for your time, V36, FNP. On 01/05/26 at 11:35 AM, V5, Resident Aide (RA) said R3 could get agitated quick, and he didn't really like to be redirected. She said you would never know when he was going to become aggressive. On 01/05/26 at 11:40 AM, V6, Licensed Practical Nurse (LPN) said she was at the nurse's station and heard a scream, she ran down the hall to where she heard the scream and seen R3 standing over R2 getting ready to hit R2 again with a cane. V6 said she grabbed the cane before R3 could strike R2 again. V6 said R3 thought R2 was in his room and R3 becomes aggressive when he thinks people are in his room/personal space. On 01/06/26 at 11:10 AM, V15, Social Service Director (SSD) said she wasn't aware R3 was aggressive when they accepted him into the facility. She said with R3 the hospital would have faxed over a referral and then the clinical team would have reviewed it. The clinical team consist of the nurse managers (V2, Director of Nursing) as one of them. She said she doesn't believe she was in on R3's referral and she normally isn't involved. On 01/13/26 at 1:15 PM, V2, Director of Nursing (DON) said, when it comes to admitting R3 to the facility she and V15, SSD both went to the hospital and seen R3 for (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	themselves. She said he was calm and cooperative when they went up to see him. She said she talked with R3's sitter and the nurse who was working and asked them if he was having any behaviors and they both told her he had been nothing but cooperative and the only incident he had was the one when he first came into the emergency room (ER). On 01/13/26 at 1:05 PM, V1, Administrator said on the day of R3's incident with R2 the nurse who was working on the memory care unit came running down to her office frantic with a cane in her hand and stated R3 hit someone with a cane. V1 said the nurse explained to her (V1) R3 went into R2's room and struck R2 with a cane. V1 said V6 stated to her she heard all the commotion, so she ran down to R2's room and when she got there R3 had a cane in his hand, and it was raised to strike R2. V1 said they assisted R2 in sitting up and that's when they saw R2 had blood on her jawline, and they realized she had been hit with the cane. V1 said the staff escorted R3 out of R2's room. V1 said they tried everything regarding R3. She said they thought he was getting confused because of the jack/[NAME] bathrooms so they moved him to a room that had a private bathroom but that didn't work. She said R3 was very protective of what he thought was his bed and if he seen someone sitting on it or lying down on it, he would have an issue with them. V1 said they never knew when R3 was going to go off and she said all the residents were at risk with him here. On 01/14/26 at 10:45 AM, V2, DON said they implemented a lot of different things to try and rectify the situation with R3. They got him psych visits; they did multiple room changes. The last move they did was to put him in a room with a private bathroom thinking he was getting confused and entering the wrong room when coming out of the bathroom. She said that was working well. On the day of the incident between R2 and R3, R3 was in the dining room eating and when he was finished, he got up and was going to his room. He passed up his room and went into R2's room by accident and he thought she was in his bed. V2 said there wasn't anything specific that would trigger R3. The Facility's Abuse Prevention and Prohibition Program, Review date of 12/02/25, 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. It further documents Procedure II. Screening B. The facility screens for potentially abusive residents during the pre-admission process. It also documented IV. Prevention E. The facility maintains adequate staffing on al shifts to ensure that the needs of each resident are met. It also documented G. The facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse.