STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146075	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Granite City	3500 Century Drive 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 prevent a resident-to-resident altercation for 2 of 5 (R2, R3) residents investigated for abuse. This failure resulted in R3 sustaining a minimal fracture to the left nasal bone. This past non-compliance occurred from 4/30/25 to 5/13/25. Findings include: 1.R2's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on [DATE]. R2's EMR dated 1/3/25 documents a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R2's EMR dated 5/6/25 documents a diagnosis of unspecified psychosis not due to a substance or known physiological condition. R2's MDS (Minimum Data Set) dated 4/8/25 documents a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS does not document that the resident had any verbal, physical, or other behaviors. The MDS documents that the resident was independent with roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident required supervision or touching assistance for sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. R2's Care plan dated 6/5/25 documents Resident exhibits behaviors of being verbally aggressive toward others. No care plan for abuse noted. (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	R2's Nurses Notes dated 4/30/25 at 2:20 AM documents, This writer was informed resident had a physical altercation with his roommate. Resident states that his roommate ran into the back of his wheelchair and then began hitting him on the left side of the back, left arm, and struck him in the face one time, each hit occurring with a closed fist. Resident states he then stood up out of the wheelchair and returned a blow to his roommate one time, to the forehead. Residents separated immediately. Skin assessed. No areas noted. VS obtained. 121/64 69 97.7 97%RA. ROM performed. Tolerated well. Resident c/o pain 10/10 to left arm. PRN (as needed) pain medication administered. DON (Director of Nursing)/Administrator, and physician have been notified. Resident placed on 15-minute checks. Sitting at nursing station at this time. R2's Physical Aggression Initiated dated 4/30/25 documents, At approx. 2:20am this nurse was at the nurses' station when this resident propelled his wc (wheelchair) to the station and reported that he had just had a physical altercation with his roommate. Resident states that his roommate ran into the back of his wheelchair and then began hitting him on the left side of the back, left arm, and struck him in the face one time, each hit occurring with a closed fist. Resident states he then stood up out of the wheelchair and returned a blow to the roommate one time, to the forehead. Both residents immediately kept separate and placed on q (every) 15 min checks. Nurse performed vs (vital signs) as well as a complete head to toe pain/skin/injury assessment. Neuro check, no visible injury noted to this resident. No redness or bruising, no swelling noted. Resident states that his roommate ran into the back of his wheelchair and then began hitting him on the left side of the back, left arm, and struck him in the face one time, each hit occurring with a closed fist. Resident states that he then stood up out of the wheelchair and returned a blow to his roommate one time, to the forehead. Residents separated immediately. Both placed on q 15 min checks. Head to toe pain/skin/injury assessment. No areas noted. VS obtained. 121/64 69 97.7 97% RA (room air). ROM (Range of Motion) performed Tolerated well. Neuro check. Resident c/o pain to left arm. PRN (as needed) pain medication administered. DON (Director of Nursing)/Administrator, and physician have been notified. Res alert and oriented to self and place. Needs reminders to time and situation. No visible injuries noted. c/o (complaint of) pain rated 10. Pain medication given. Effective after 45 min. Res alert and oriented to self and place. Needs reminders to time and situation. Facility received order to send res to (local hospital) geriatric psych unit for evaluation. Res admitted to (local hospital) geriatric psych unit. This resident is alert and oriented x2. He has a hx (history) of disliking his roommates. Has a hx of being verbally abusive toward roommates and threatening to harm roommates. Care plan updated. MD (Medical Director), ED (Executive Director), DON (Director of Nursing), IDPH (Illinois Department of Public Health) notified. Vs, pain/skin/injury assessment completed. ROM WNL (within normal limits). Neuro check, no visible injury noted. Res c/o pain to his left arm. PRN pain medication given. MD gave new order to send to (local hospital) geriatric psych unit for evaluation. Res family notified of new order. Res transported to (local hospital) geri psych unit. Resident admitted . Psychiatric evaluation and med review to be completed at geri psych. Resident moved to different room and to new unit, upon res return, social services will meet 2x wk. for 2 wks. to discuss safety and behaviors, behavior tracking. 2. R3's EMR undated documents that the resident was admitted to the facility on [DATE]. R3's EMR dated 8/2/24 documents a diagnosis of Cerebral Infarction, unspecified. R3's EMR dated 8/3/24 documents a diagnosis of Cognitive Social or Emotional deficit following Cerebral Infarction. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R3's EMR dated 8/5/24 documents a diagnosis of Major Depressive Disorder single episode, severe with psychotic features. R3's MDS dated [DATE] documents a BIMS score of 2 out of 15. The MDS does not document any verbal, physical, other behaviors. The MDS documents that the resident has functional limitations on both sides. The MDS documents that the resident requires supervision or touching assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident requires partial/moderate assistance for sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. R3's Care plan dated 2/20/25 documents, I have a dx of MDD/anxiety, insomnia, and benefit from the use of psychotropic medications. Resident has h/o resisting cares at time. Can become verbally and physically abusive with staff. Resident has h/o making false statements that other residents or staff are hitting him. No care plan noted for abuse. R3's Nurses Note dated 4/30/25 at 3:17 AM documents, This writer was informed resident had a physical altercation with his roommate. Resident states his roommate hit him. He states he knocked the shit out of me. When asked if he hit his roommate first, resident states he's lying. Residents separated immediately. Skin assessed. Copious amount of bright red blood noted to face, beard, hands. No visible injuries seen. Blood origin determined to be from resident's nose. VS (Vital Signs) obtained. 128/64 68 97.5 97%RA. ROM (Range of Motion) performed. Tolerated well. No c/o (complaint of) pain or discomfort voiced. Family, DON (Director of Nursing), Administrator, and physician have been notified. Resident placed on 15-minute checks. Sitting at nursing in wheelchair until EMS (Emergency Management System) arrived to (sic) transport patient to (local hospital). Transferred from wheelchair to stretcher via 2 persons assist. Tolerated well. Transported to (local hospital) for evaluation and treatment. R3's Nurses Note dated 4/30/25 at 11:55 AM documents, DON spoke with residents' wife via phone. DON explained results of ER (Emergency Room) visit showing fx (fracture) nose. DON explained the results of interviews with both (R3), and the other male involved. Res wife states she will come to the facility to discuss. R3's CAT scan report dated 4/30/25 documents, There is a minimally displaced fracture of the left nasal bone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R3's Facility's Physical Aggression Initiated dated 4/30/25 documents, At approx. 2:20am this resident's roommate informed this nurse that he had a physical altercation with this resident. Nurse immediately ensured these residents were separated. Nurse assessed res vital signs, pain/skin/injury assessment. ROM, neuro check. Res had visible bleeding from his nose. No other injury noted. Nurse attempted to stop nasal bleeding. MD (Medical Director) called. New order to send to ER for evaluation. Resident states his roommate hit him. He states, he knocked the s**t out of me. When asked if he hit his roommate first, resident states. No he's lying. Residents separated immediately. Pain/skin/injury assessment. VS obtained. 121/64 69 97.7 97%RA (room air). ROM, neuro check. Res had visible bleeding from his nose. No other injury noted. Nurse attempted to stop nasal bleeding. MD called. New order to send to ER for evaluation. Both residents involved placed on q (every) 15 min. checks. Ambulance called. Ambulance arrived at approx. 2:35am. Res transported to (local hospital) ER. Res alert and oriented to self only. BIMS of 2. Bright red blood noted from nose. PAINAD 1. Res alert and oriented to self only. BIMS of 2. Res had bright red blood noted from nose. Res sent to ER for evaluation. Res returned at 6:19am with dx (diagnosis) of nasal fx. T (temperature)-98.1, R (respirations)-18, P (pulse)-68, b/p (blood pressure) 140/70. This resident is combative. Combative with care daily. Res does swing his arms in the air daily. Care plan updated, (R3) and roommate immediately separated and placed on q 15 min checks, MD, ED (Executive Director), DON, IDPH (Illinois Department of Public Health) notified. Vs. ROM, neuro check, pain/skin/injury assessment completed. Bleeding noted from nose. 911 called. Res remained at nurses' station with nurse until ems arrived. Res transported to (local hospital) ER for evaluation. Res returned from ER at 6:19am with dx of minimal fx to left nasal bone. Pain medication to be given as ordered. Res wife made aware. Trauma screen completed. Social services to meet with res 2 x wk for 2 wks to discuss behaviors and feelings of safety, refer to psych. Will be given by (V6) psychiatrist; wife agreeable. Med review by (V5) NP and pharmacy, roommate moved to different room on different unit. On 6/5/25 at 12:13 PM, V3, RN (Registered Nurse) stated that he did not witness the incident between (R2) and (R3). He stated he documented everything that he could in his notes. On 6/5/25 at 1:37 PM, V2, DON that (R2) was verbally aggressive with everybody, staff, and residents, but never physically aggressive. Facility's policy Abuse Prevention - Illinois Only dated 1/25 documents 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. Prior to the survey date June 6, 2025, the facility took the following actions to correct the noncompliance. 1. R2 no longer resides in the facility as of 5/17/25. 2. The DON, Staffing Coordinator, Director of Rehab, Dietary Supervisor, and Housekeeping Supervisor in-serviced the staff on Abuse Prevention, Abuse Procedures, and Abuse Reporting. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Behavior Tracking audits on residents with behaviors. 4. Interviews and audits for roommate compatibility. 5. Men's group initiated with activities. 6. Trauma Screening on R2 and R3. 7. Care plans updated on residents for all known abuse residents. 8. Abuse was added to the QAPI plan and QAA agenda.