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	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Nursing & Rehabilitation	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 interviews and record reviews the facility failed to prevent abuse for 6 out of 8 residents, (R1, R2, R3, R5, R6, R7) reviewed for abuse in a sample of 8. This failure resulted in R2 being hit in the face resulting in a bruised chin, feeling uncomfortable and R5 feeling unsafe in the facility. Findings include: 1. R1's Minimum Data Set (MDS) dated [DATE] documented R1 was cognitively intact, that he has delusions, verbal behavioral symptoms directed towards others occurring daily, rejection of care occurred daily, and wandering occurred daily. R1's MDS continued to document that R1's current behavior status has worsened. R1's Care Plan dated 4/9/25 documented R1 has potential to be physically aggressive related to anger and poor impulse control with interventions placed on 4/9/25 to administer medications as ordered, monitor/document for side effects and effectiveness, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff member when agitated. On 4/9/25 R1 was care planned for having the potential to be verbally aggressive related to poor impulse control with interventions placed on 2/3/25 to give the R1 as many choices as possible about care and activities, when the R1 becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. R2's face sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, idiopathic peripheral autonomic neuropathy, major depressive disorder, and atrial fibrillation. R2's MDS dated [DATE] documented he is cognitively intact with no behavioral concerns. R2's Care Plan dated 4/10/25 documented no plan for risk of abuse. R1's face sheet documented he was admitted to the facility on [DATE] with diagnoses of, in part, severe protein calorie malnutrition, schizophrenia and cataract. On 6/23/25 at 10:50 AM, a bruise approximately 3 centimeters in diameter was noted on R2's left lower chin. (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	On 6/23/25 at 11:25 AM, V1, Administrator, and V2, Director of nursing (DON) played a recording of the hallway where the incident on 6/21/25 took place with R2 present. In the video, R2 walked up to the men's restroom door but it was in use, so he walked away, then R1 wheeled up to the restroom and tried to get in. R2 saw R1 at the restroom and walked up to him, bent down with his hands in his pockets, told R1 something and then R1 hit R2's face with a small light colored object grasped in R1's hand approximately the size of his hand, and then again seconds after with a cup of water, the cup making contact with R2's face. The material of the cup could not be identified due to the video quality. After R1 hit R2 twice in the face, V6 (LPN) watched the incident then walked up to the residents and they backed away from each other. On 6/23/25 at 12:30 PM, video footage showed R1 throwing a chair down while R4 was nearby in the room on 6/21/25. The facility's initial report for the abuse investigation dated 6/21/25 documented at approximately 5:00 PM, R1 was in the west unit restroom. When he exited the restroom, he threw a cup with water in it at R2. Residents immediately separated. R1 placed on 1:1. Residents do not reside on the same unit. R2 was noted to have an abrasion to his mouth. MD (medical doctor) notified. ED (executive director) and DON (director of nursing) notified. Residents will remain separated. A full investigation to follow. On 6/23/25 at 10:50 AM, R2 stated he has to use the community men's restroom because he doesn't have one in his room. On Saturday evening, R2 went to use it but someone was in there, so he had to wait. R2 stated he saw R1 try to go in the restroom while the other resident was still in there, so he went up to him and told him not to go in because it was being used and that he had a restroom in his own room if he needed to go. R2 stated R1 then struck him in the face with a metal water bottle and water spilled everywhere. R2 stated he called the local police department and made a report about it. R2 stated he is the resident council president and has gotten many complaints on R1 over the past year. R2 stated the staff assessed him after the incident and offered to send him to the hospital but he said there was no need. R2 stated he has to avoid R1 anywhere he goes in the facility and feels uncomfortable with him here. R2 stated R1 has made verbal threats to him in the past but could not remember details. R2 stated he reported everything to the social worker. On 6/25/25 at 10:36 AM, R2 stated R1 injured his chin, how else would I have this as he pointed to a bruise on his left lower chin. R2 stated R1 threatened him by hitting him in the face. R2 stated, This should be a safe place, I shouldn't have gotten hit. On 6/23/25 at 1:36 PM, R1 stated he has never had any issues with any of the other residents and he gets along with everyone. R1 stated he has never gotten in an argument with anyone here. On 6/23/25 at 2:42 PM, V6 (LPN) stated she was working at the time of the incident with R1 and R2 on 6/21/25. V6 stated she was in the middle of medication pass she thinks and didn't hear anything but turned around and saw R1 hit R2. V6 stated she was on orientation, and it was just her third shift. V6 didn't have the other nurse next to her at the time and was shocked. V6 stated she told R1 not to hit R2 and tried to separate them. V6 stated R1 hit R2 with a Styrofoam cup and the cup broke. V6 stated R1 was put on 1:1 when she first started and was newly off it when the incident occurred. V6 stated at first R1 didn't seem to have a lot of behaviors but she's only worked three days and doesn't know if he was provoked by R2, she couldn't hear anything that was being said. V6 stated it looked like R1 and R2 were waiting for the restroom when it happened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/23/25 at 3:26 PM, V5 (LPN) stated she was in another room when the incident happened with R1 and R2 on 6/21/25. V5 stated R2 told the police that he bent down and told R1 he wasn't supposed to use that restroom. V5 stated there was a red spot on R2's left lower chin he claimed was from R1 hitting him. V5 stated R1 doesn't always start stuff, some residents provoke him, and she doesn't think R1 has the capability of restraining himself in response. 2. R3's face sheet he was admitted to the facility on [DATE] with diagnosis of, in part, spinal stenosis, idiopathic peripheral autonomic neuropathy, and major depressive disorder. R3's MDS dated [DATE] documented he is cognitively intact, with verbal behavioral symptoms occurring 4 to 6 days. R3's Care Plan dated 3/26/25 documented diagnosis of insomnia, MDD (major depressive disorder) with use of psychotropic medication. R3 has a history of becoming verbally abusive to staff and other residents. Becomes irritated easily with interventions to evaluate effectiveness and side effects of psychotropic drugs for possible decrease in dosage/elimination of drug, administer medications as ordered, observe for change in mood/behaviors, refer to psychiatry as needed, observe for changes in cognitive status, notify MD as needed, educate regarding appropriate behavior within the facility, encourage resident to talk about his emotions to avoid any verbal/physical aggression toward others dated 1/11/2025. The facility's abuse investigation involving R1 and R3 dated 2/1/25 documented R3 propelled his wheelchair up to R1 and told him to move out of the way. R1 did not move and R3 began yelling, screaming, and cursing at R1 stating you better f*****g move. R3 screamed and put his face within inches of R1's face. R1 responded by tossing a cup of ice at R3. R3 grabbed R1's arm and raised his hand and made a fist putting it in front of R1's face. The nurse jumped in and separated R1 and R3. R1 was propelling himself to another unit and R3 went after him and stated, I'm going to get you. Staff intervened and redirected R3. The conclusion of the facility's investigation documented on 2/1/25 there was a resident-to-resident altercation between R3 and R1 with no injuries. The residents were separated with no other incidents occurring. Both residents state they feel safe in the facility. On 6/23/25 at 9:55 AM, R3 stated R1 has hit him in the forehead before and he has thrown water and cold coffee at him too. 3. R5's face sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease, and heart failure. R5's MDS dated [DATE] documented he is severely cognitively impaired and has no behavioral concerns. R5 answers questions appropriately. R5's Care Plan dated 4/18/25 does not document any risk for abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's abuse investigation involving R1 and R5 dated 4/28/25 documented at approximately 3:30 AM, R1 was being very disruptive in the common area and hallway on the East Unit. As witnessed by a nurse, R1 was repeatedly going to the fire extinguisher on the wall and opening the door to it. Staff repeatedly attempted to redirect R1 unsuccessfully. R1 began to yell and curse loudly to himself and staff. R1 propelled his wheelchair down the hallway and began to open resident's doors while yell and cursing. Staff attempts at redirection were unsuccessful. R1 went to his room and after a few minutes R1's roommate R5 came out to the nurse's station. R5 stated, I got up out of bed and he threw cold coffee on me and my bed sheets. I think he was mad because I wouldn't talked to him. Nurse separated R1 and R5. The facility's investigation conclusion documented R1 was physically aggressive toward R5 as evidenced by R1 throwing cold coffee on R5. No injury occurred. On 6/24/25 at 12:33 PM, R5 stated R1 used to be his roommate and it was horrible. R5 stated R1 is a ticking time bomb. R5 stated he remembers R1 throwing cold coffee on him while he was sleeping in the middle of the night, and he would take my things all the time and call me offensive names. R5 stated he doesn't trust R1 and thinks R1 is capable of hurting other residents at the facility. R5 stated he didn't feel safe in the same room with R1 ever. R5 stated R1 would creep the halls every night yelling. 4. R6's MDS dated [DATE] documented he is cognitively intact with no behavioral concerns. R6's Care Plan dated 5/12/25 does not document him to be at risk for abuse. R7's face sheet documented she was admitted to the facility on [DATE] and discharged on 5/21/25 with diagnosis of, in part, idiopathic peripheral autonomic neuropathy, type two diabetes mellitus, and generalized anxiety disorder. R7's MDS date 4/28/25 documented she was cognitively intact with no behavioral concerns. R7's Care Plan documented an onset of problem with history of yelling/shouting at other when frustrated with interventions for behavior tracking as needed, refer to psychiatry as needed and group therapy, social services to provide 1:1 with R7 when behaviors are inappropriate last reviewed May 2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's abuse investigation involving R1, R6 and R7 dated 3/24/25 documented that at approximately 6:00 PM there were two residents (male and female) having a verbal altercation in the dining room. R6 inserted himself into the conversation and stated he was sticking up for the lady. R6 told R1 to quit yelling at the lady. R1 began using racial slurs toward R6. The verbal altercation escalated between R1 and R6 and both were threatening to kick the others a**. Staff immediately separated the two and R6 went to the common area. R1 went to his room and then wheeled himself back up the hall with a butter knife in his hand waving it in the air. This was witnessed by a visitor who told V5 licensed practical nurse (LPN) who followed R1 to the activity room where she saw R1 place the butter knife under the popcorn machine. V5 retrieved the knife. R6 had no other contact with R1. R6 stated, I just heard him (R1) being loud with her, so I said something to him. I told him to get out of here and to quit yelling at her. Then R1 just started yelling at me and calling me a n****r. Then I said I'll kick you're a**. He said the same to me. Then V5 came and took him away. I went to the lobby. I didn't talk to him anymore after that. The interview with R7 documented, I backed into him. I apologized. It was my fault. I wanted to back up and he wouldn't move, so I backed up. He yelled at me, so I called him a mother f****r. The interview with R1 documented, she (R7) backed into me. Then she called me a mother f****r. I called her a b***h. Then R6 came over and we argued. I called him a n***r. We both threatened to kick each other's a****s. I went and got a knife. I wasn't going to do anything with it. It was a butter knife. The facility's investigation conclusion documented there was a verbal altercation between R7 and R1. There was a verbal altercation between R6 and R1. R1 was seen with a butter knife. It is not known what his intentions were. R1 did not attempt to harm anyone with the knife, and it was immediately retrieved. Since that time, they have had no further incidents. R1 and R6 are getting along with no issues. All residents involved stated they are comfortable and safe living in the facility. On 6/25/25 at 9:58 AM, V1 stated she expects all residents to be free from abuse and that the facility is responsible to keep the residents free from abuse. The facility's Abuse policy dated 1/25 documented 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 agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. The policy documented it is the responsibility of all staff to provide a safe environment for the residents. The facility's Resident Rights policy review 1/15 documented facility residents shall have the right to be free from mental and physical abuse.