

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: 146075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Granite City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement progressive interventions to reduce falls for 2 out of 9 (R12, R53) residents investigated for accidents in a sample of 34.1. R12's Electronic Medical Record (EMR) undated documents the resident was admitted to the facility on [DATE] and has a medical diagnosis of Parkinson's Disease with Dyskinesia, Dementia, and Alzheimer's Disease. R12's Minimum Data Set (MDS) dated [DATE] documents R12 is moderately cognitively impaired, has an upper and lower extremity on both sides, and needs substantial/maximal assistance with rolling left and right, sitting to lying, lying to sitting on side of bed, and chair/bed to chair transfers. R12's Care Plan Date Initiated 5/23/2025 documents R12 has an increased risk for falls related to impaired mobility, Parkinson's, Cerebrovascular Accident, Hypertension, Alzheimer's, history of falls, Osteoarthritis, incontinence, Bipolar, Anxiety, Major Depressive Disorder with use of psychotropic medication. No new progressive interventions were implemented for R12 after R12's falls on 4/21/2025, 5/17/2025, and 6/25/2025. R12's Fall Risk assessment dated [DATE] documents R12 is at a high risk for falls. R12's Fall Risk assessment dated [DATE] documents R12 is at a high risk for falls. R12's Historical Note dated 10/29/2024 at 6:01 PM documents, Resident had an unwitnessed fall in her room. This nurse was coming to give her medication when resident was found on floor mat by bed. This nurse assessed resident for any pain or head injuries and there was none noted. Once assisted back into chair, resident stated that she did not hit her head upon falling. Resident di state she had some soreness to her left arm and left side. Resident's vital signs were within normal limits. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note (Late Entry) dated 1/25/2025 at 3:00 PM documents, at approx. 3:30pm CNA (Certified Nursing Assistant) waved for this nurse to come to res room. Upon entering room resident was laying on the floor on her right side with left side of her head against dresser. Nurse completed vs (vital signs), ROM (range of motion), pain/skin/injury assessment. neuro assessment. redness and swelling to L (left) side of forehead noted. Hematoma noted to L eye. Res stated, I was trying to get my water. Nurse noted cup of water on res dresser. ROM WNL (withing normal limits). Nurse and CNA assisted res off of floor with gait belt. assisted res up to her bed. Res c/o bilateral pelvic pain by moaning and facial grimacing during assessment. MD (Medical Directory) notified. new order to send (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ER (Emergency Room) for evaluation r/t (related to) res possibly hitting head. Res noted to be barefoot. R12's Un-Witnessed Fall Report dated 1/25/2025 at 3:00 PM documents Nursing Description At approx. 3:30pm CNA waved for this nurse to come to res room. Upon entering room resident was laying on the floor on her right side with left side of her head against dresser. Nurse completed vs, ROM, pain/skin/injury assessment. neuro assessment. redness and swelling to L side of forehead noted. Hematoma noted to L eye. Res stated, I was trying to get my water. Nurse noted cup of water on res dresser. ROM WNL. Nurse and CNA assisted res off floor with gait belt. Assisted res up to her bed. Res c/o bilateral pelvic pain by moaning and facial grimacing during assessment. MD notified. New order to send to ER for evaluation r/t res possibly hitting head. Res noted to be barefoot. Resident Description: I was trying to get my water Immediate Action Taken: Resident assessed. Redness and swelling note to L side of forehead, hematoma noted to L eye. no open areas noted. 2A resident to bed with gait belt. Resident then c/o bilateral pelvic pain when assessing BLE AEB moaning and facial grimacing. EMS contacted. Neuro assessment initiated. Pupils equal but sluggish. Ice pack applied to L side of head. EMS arrived approx. 1515 and left enroute to SLU. T-98, R-18, P-67, b/p 118/70 Notes: Care place updated, MD and family notified. Son notified, vs, ROM, neuro check, pain/skin/injury assessment, Res assisted off of floor by nurse and CNA with gait belt, assisted to bed. 911 called. New order to end to ER for eval r/t hitting head. Ice pack applied to L eye. EMS arrived and transported res to ER. Res returned from ER to approx. 22:48 with no new orders. Staff will declutter res. room. staff will ensure res is wearing proper footwear when out of bed, staff will ensure res meals and fluids are within reach. will refer to therapy. Intervention 1/25/2025: staff will declutter resident room, ensure resident is wearing proper footwear when out of bed, staff will ensure resident meals and fluids are within reach, and refer to therapy. No intervention documented on R12's Care Plan for this fall. R12's Progress Note dated 3/3/2025 at 4:40 PM documents, upon hearing the screams for assistance, staff discovered the source of the screams and found the resident in her room on the floor with closet door open. Assessment done in timely manner. No injuries were noted at the time by this writer and 2 additional staff members. No s/s (signs or symptoms) of bleeding, edema or SOB (shortness of breath) thus far. Alert, talkative, and oriented. Neuro checks initiated. Resident xfer safely to w/c (wheelchair) by this writer and staff members. Resident is currently up moving around unit safely, staff readily available to assist, and care plan ongoing. NP (Nurse Practitioner) and DON (Director of Nursing) notified. Per NP, neuro checks and monitor. R12's Witnessed Fall Report dated 3/3/2025 at 4:40 PM documents: Nursing Description At approx. 4:40pm nurse yelling coming from res room. Res roommate was calling for help. She had witnessed this res fall. resident found on the floor in her room in front of her closet door. Assessment done in timely manner, wc noted behind resident. res wearing socks and shoes, room well lit. no clutter. res stated she was looking for food in her closet. Res discussed how she does not like her pureed diet. vs, ROM, pain/skin/injury assessment completed. no c/o pain. no injury noted. res assisted off of floor and up to wc by nurse with gait belt. MD notified and message left for son. Son came to facility to visit notified at that time. Res roommate stated res did not hit her head. Res roommate is alert and oriented. Resident later advised this writer that she was up looking for whole food and did not want the food she gets on her diet order. Immediate Action Taken: MD and res son aware. vs, ROM, pain/skin/injury assessment, neuro check, res xfer safety to w/c by nurse with gait belt. NP notified, will monitor for changes and notify MD as needed. T-97.7, R-20, P-77, b/p 110/70, referred to therapy (PT and ST), med review, anti-roll backs placed on res wc. Notes: Care plan updated, MD and res son (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware, vs, ROM WNL, pain/skin/injury assessment, assisted res off of floor by nurse with gait belt up to wc, refer to PT and ST, med review, res had Dysem to wc seat, res has anti tippers to wc, anti-roll backs placed on res wc. Intervention 3/3/2025: medication review, resident to have Dycem to wheelchair seat and anti-roll backs placed on wheelchair. Interventions refer to therapy was used as a previous fall intervention. No intervention documented on R12's Care Plan for this fall. R12's Progress Note dated 3/31/2025 at 9:23 PM documents: This nurse was notified by CNA that resident was on floor. Upon entering room resident was lying on the floor on her right side. Resident was alert and showed no signs of pain or distress. Resident stated that she was walking to other side of room to get her roommates walker. This nurse assessed resident for injuries, no injuries were noted. Resident was lifted to wheelchair by this nurse and CNA. POA (Power of Attorney) and DON were notified. POA and POA requested for resident to be sent to the hospital for further assessment. 911 was called and EMS (Emergency Medical Service) arrived at 8pm. EMT's (Emergency Medical Technician) assessed resident and recommended resident not be transferred to the hospital as all vitals were normal range and there were no physical signs of injury. Resident stated several times that she does not want to go to the hospital. EMT's stated that resident is A/Ox4 (Alert and Oriented) and had the right to refuse the hospital. Resident is being monitored by this nurse with neuro checks started. Resident's son, DON and NP notified of fall. R12's Un-Witnessed Fall Report dated 3/30/2025 at 7:45 PM documents: Nursing Description: This nurse was notified by CNA that resident was on floor. Upon entering room resident was lying on floor on her right side in the middle of the room. Resident was alert and showed no signs of pain or distress. Vs, ROM, neuro check completed, by CNA and nurse with gait belt. assisted to bed. Resident Description Resident stated that she was walking to other side of room to get her roommates walker. Immediate Action Taken: MD and res son called. This nurse assessed resident for injuries, no injuries were noted. vs pain/skin/injury assessment completed, ROM WNL. neuro check. Resident was lifted to wheelchair by this nurse and CNA with gait belt and placed in bed. POA and DON were notified. POA requested for resident to be sent to the hospital for further assessment. 911 was called and EMS arrived at 8 pm. EMT's assessed resident and recommended resident not be transferred to hospital as all vitals were normal range and there were no physical signs of injury. Resident stated several times that she does not want to go to the hospital. EMT's stated that resident is A/Ox4 and had the right to refuse the hospital. Resident is being monitored by this nurse with neuro checks continued. T-98.2, R-16, P-70, B/P 130/66, POA notified. POA agreeable for res to remain at facility. Notes: Care plan updated; SON POA called. MD notified. 911 called. vs, ROM, neuro check, ROM WNL, no injury noted. 911 called per POA request. Ambulance arrived. Res refused transport. Ambulance left. SON notified. SON agreeable to have res remain in facility. Removed roommates walker from room. Res roommate does not utilize walker. Roommate agreeable to removal of walker. Staff will check on re more frequently. Refer to therapy. med review. Will cont. to see psychiatry. Intervention 3/30/2025: remove roommate's walker from room, staff will check on resident more frequently, and continue to see psychiatry. Interventions of refer to therapy and medication review were used as a previous fall intervention. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/10/2025 at 2:51 PM documents: CNA informed this nurse that resident was on the floor by heater. Upon entering room resident was sitting on the floor by her wheelchair and in between the heater and her roommates bed. Resident stated she was trying to turn the heat off and slid from her chair. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's Witnessed Fall Report dated 4/10/2025 at 2:15 PM documents: Nursing Description: At approx. 2:15 pm CNA informed this nurse that resident was on the floor by heater. Upon entering room resident was sitting on the floor by her wheelchair, in between the heater and her roommates bed. Resident stated she was trying to turn the heat off and slide from her chair. vs, ROM, pain/skin/injury assessment completed. Res roommate witnessed fall. Res did not hit her head per roommate. Res assisted off of floor and up to wc by nurse and CNA with gait belt. no c/o pain. no injury noted. Resident Description: Resident stated she was trying to turn the heat of and slid from her chair to the floor. Resident stated she did not hurt anything. Res roommate stated that res did not hit her head. Immediate Action Taken: MD and res son notified. vs, ROM pain/skin/injury Assessment completed, no injuries noted at this time. Resident denies pain or discomfort. VS-165/72 bp, 72 hr., 97.8 temp, 20 resp, 96% o2. Resident placed back in wheelchair via 2 person assist. No new orders from MD. Notes: Care plan updated, MD and res son notified, Will consult with family about option of hospice care. vs, ROM, pain/skin/injury assessment, bed in low position, fall matt, canoe mattress, Dysem in wc seat, anti-roll backs on wc. res assisted off floor by nurse and CNA with gait belt. ss assisted in meeting with both residents to discuss keeping the heater at a temperature they both are agreeable to. Intervention 4/10/2025: consult with family about hospice care option, bed in low position, fall matt, canoe mattress. Interventions Dycem in wheelchair seat and anti-roll backs to wheelchair previously used as fall interventions. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/17/2025 at 2:40 PM documents: Staff was called to patient's room around 2:40pm. Patient was found on the floor on left lateral side. No bleeding, skin tears, bruising, extremities deformities, SOB or decline of LOC (loss of consciousness) noted during assessment. Patient denies pain. Currently resting in bed watching TV (television), call light in reach, and care plan ongoing. R12's Un-Witnessed Fall Report dated 4/17/2025 at 2:30 PM documents Nursing Description: Staff was called to patient's room around 2:40pm. Resident was found by staff lying on her left side on the floor between the dresser and the bed. Res was partially on the fall mat. Res stated, I tried to get up, but I failed. Resident was assessed, vs, ROM, neuro check, pain/skin/injury. no new injury noted, and resident was xferred safely from floor to bed by nurse with gait belt. MD and hospice notified. Resident Description: Resident stated I tried to get up, but I failed. Immediate Action Taken: MD and res son notified. Vitas hospice notified. VS B/P 131/78, P 76, R 18, O2 95%, T 97.3. ROM, neuro check, pain/skin/injury assessment. no injury. consult with hospice, med review by hospice, no new orders. Family does not want res sent to hospital. Fall mat in place, bed in low position, canoe mattress on bed. Notes: Care plan updated. MD and vitas hospice notified, son notified, VS B/P 131/78, P 76, R18, O2 95%, T 97.3. ROM, neuro check, pain/skin/injury assessment. no injury. consult with hospice, med review by hospice, no new orders. Family does not want res sent to hospital. fall mat in place, bed in low position, canoe mattress on bed. no new orders. ROM WNL. neuro check WNL. Intervention 4/17/2025: consult with hospice, medication review with hospice. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/21/2025 at 3:03 PM documents: Staff was called to patient's room around 3:20pm. Patient was found on the fall matt on right lateral side. Patient denies pain. No bleeding, skin tears, bruising, extremities deformities, SOB or decline of LOC noted during assessment. Xferred safely back to bed by staff. Resident stated nothing going on just was trying to sit up and watch TV on the side of the bed. Educated on using call light for staff assistance. Resident is currently lying down in bed, call light in reach, and care plan ongoing. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's Nurses Note dated 4/30/2025 at 7:09 AM documents This writer was called to resident's room. Resident was found lying on her left side beside her bed. Resident was under the bedside table, with her left leg resting on the legs of the bedside table. Resident states she doesn't know what happened and that she was probably sleepwalking. Resident denies hitting head. Skin assessed. No areas noted. No active bleeding observed. ROM performed. Tolerated well. VS obtained. 110/66 64 18 96%RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist. Tolerated well. R12's Witnessed Fall report dated 4/30/2025 at 3:17 AM documents Nursing Description: Resident was found by staff lying on her left side on the floor between the dresser and the bed. Lying on fall mat. Resident was assessed, ROM, pain/skin/injury assessment. no injuries noted, and resident was transferred with gait belt and 2 aides from floor to bed. Resident Description: Resident stated she was trying to turn the heat oof and slid from her chair to the floor. Resident stated she did no hurt anything. Res roommate stated that res dd not hit her head. Res heater is on the other side of the room. Immediate Action Taken: Skin/pain/injury assessed. No areas noted. vs, no active bleeding observed. ROM performed. Tolerated well. VS obtained. 110/66 64 18 98.4 96% RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist with gait belt. Tolerated well. Physician notified. Vitas notified. Resident's son was notified at 3:37 AM. Care plan has been updated. no new orders. res has fall mat in place, canoe mattress on bed, bed in low position. Notes: Care plan updated, MD and res son notified, vitas hospice notified. no new orders. vs, ROM, pain/skin/injury assessment. no injury, res roommate witnessed fall. res did not hit her head. Staff educated to check on res frequently and to ensure temperature in room is comfortable for both residents. Intervention 4/30/2025: ensure temperature in room is comfortable for both residents. Intervention staff to check on resident frequently was placed as an intervention for previous fall. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 5/17/2025 at 6:11 AM documents: This writer was called to resident's room. Resident was found lying on her left side beside her bed. Skin assessed. Reddened area noted to left forearm. No active bleeding observed. No open areas noted. ROM performed. Tolerated well. VS obtained. 110/66 64 18 95%RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist. Tolerated well. Resident was educated to utilize call light to ask for assistance. Resident verbalized understanding and performed a return demonstration. R12's Un-Witnessed Fall report dated 5/17/2025 at 5:10 AM documents Nursing Description: This writer was called to resident's room by CNA. Resident was found lying on her left side on fall mat beside her bed. Nurse completed vs, ROM, pain/skin/injury assessment, neuro check. res verbal. No s/s of distress. no c/o pain. small reddened circular area noted to L forearm approx. 0.5 cm x 0.5 cm. MD, resp party son called, vitas hospice notified. res assisted off floor by nurse and CNA with gait belt. assisted to bed. Res unable to explain what happened. Resident Description: Resident unable to give description. Immediate Action Taken: Skin assessed. Reddened area noted to left forearm. Approx. 0.5cm x 0.5cm. No active bleeding observed. No open areas noted. ROM performed. Tolerated well, neuro check. VS obtained. 110/66 64 18 95% RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 person assist with gait belt. Tolerated well. Physician notified. Vitas notified. The Resident's son was notified. Care plan has been updated. Consult with hospice re fall safety. Notes: Care plan updated., MD notified, res son notified, Vitas hospice notified. vs, ROM, pain/skin/injury assessment, neuro check. 0.5cm x 0.5cm circular red area to L FA. no open areas. Will observe area for s/s of infection. bed in lowest position, fall mat in place next to bed, canoe mattress on bed, consult with hospice re fall safety. medication review. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The interventions noted in this fall intervention were used for previous falls. No new interventions noted. No new interventions noted on R12's Care Plan for this fall. R12's Nurses Note dated 5/28/2025 at 1:31 PM documents resident noted on the floor in bedroom at side of the bed. resident laying on right side. resident stated that she was attempting to get up. alert and oriented x 2, able to make needs known to staff, verbal, no voiced c/o pain at time of incident. full rom noted to all extremities, weakness noted to bilateral lower extremities. no injuries or bruising noted at the time of the incident. VS: 98.0 82 18 132/67 96%-room air. R12's Un-Witnessed Fall report dated 5/28/2025 at 1:30 PM documents Nursing Description: At approx. 1:30 pm CNA found res on floor in her room and called for nurse LPN. LPN found res on the floor in her room. Lying on her left side on her fall mat next to her bed. vs, ROM, pain/skin/injury assessment completed. No injury noted. Neuro check wnl. res assisted off of floor by nurse with gait belt. Placed in bed. Bed in low position. Canoe mattress on bed. MD and hospice notified. Resident Description: Resident unable to give description. Immediate Action Taken: MD, res son notified, Vitas hospice notified. no injury noted. Res will not be sent to ER per hospice and res son. neuro check, ROM WNL, neuro check WNL, vital signs, pain/skin/injury assessment. VS: 98.0 82 18 132/67 96%-o2 sat Res will be placed Broda chair provided by hospice and placed near nurse's station when out of bed. Notes: Care plan updated. MD, res son, Vitas hospice notified. vs, ROM, ROM WNL, neuro check, neuro check WNL, pain/skin/injury assessment, no injury noted. res assisted off floor by nurse with gait belt and placed in bed. Res unable to explain what had happened. Items res uses often were within reach. canoe mattress on bed, bed in low position, fall mat in place next to bed. Consult with hospice re res safety, broad chair provided by hospice. Res will be placed in broad chair when out of bed and placed near nurse's station. Intervention 5/28/2025 documents place in Broda chair when out of bed and near nurses station. Consults with hospice and Broda chair provided by hospice previously used as a fall intervention. R12's Nurses Note dated 6/4/2025 at 6:03 PM documents CNA came to this nurse stating that resident was on the floor. This nurse went to res. room & saw her on the floor. This nurse asked res. did she hit her head & she stated no. This nurse & aides got her back in bed. Res. was assessed with no signs of injury. R12's Un-Witnessed Fall report dated 6/4/2025 at 5:45 AM documents Nursing Description: At approx. 5:45 am CNA came to this nurse stating that resident was on the floor. Nurse entered res room to find res lying on her left side, on floor mat next to her bed. Bed in low position. canoe mattress on bed. Res unable to explain what happened. vs taken, ROM, neuro check, pain/skin/injury assessment completed. no injuries. res assisted off floor by nurse and CNA with gait bed. placed in bed. Resident Description: Resident unable to give description. Immediate Action Taken: MD and res on notified, vs, pain/skin/injury assessment completed. ROM WNL, neuro check WNL. Vitas Hospice Res. Transferred by this nurse & aides & placed back in bed with gait belt. This nurse assessed res. for any signs of injuries a& there were none. V/s taken & are WNL. Consult with hospice re fall safety, fall mat in place, canoe mattress on bed, bed in lowest position. Hospice to complete a medication review. Staff to ensure res is positioned properly in bed before exiting room. T-97, R-16, P-71, b/p 120/19. Notes: MD and res son notified. Vitas hospice notified, vs, ROM, pain/skin/injury assessment completed, ROM WNL, neuro check WNL, no injury noted. hospice consulted re fall safety, fall mat in place next to bed, canoe mattress on bed, bed in lowest position., right side of bed against wall, hospice to perform medication review. Nsg. staff to ensure res is positioned properly in bed prior to leaving room. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Intervention dated 6/4/2025 on R12's Care Plan documents make sure resident positioned properly in bed. Intervention medication review by hospice used as previous fall intervention. R12's Nurses Note dated 6/25/2025 at 4:10 PM documents Unwitnessed Fall: This writer was informed that resident was on the floor around 4:12 pm. No witness was presented when resident went from the bed to the floor. Resident was observed to be sitting upright on the floor with precaution fall mat under buttock and lower extremities. Resident told this writer that she attempted to get up and walk. Resident educated on using call light for staff assistance w/ transfers. Full body assessment performed. No deformities to BUE/BLE, bruising, bleeding, wounds or skin tears present at this time. Resident xferred safely from floor to high back chair by staff x3. VS B/P 108/61, P 72, R 18, T 97.1, & O2 97% RA. Hospice notified. Per hospice no neuro checks required and monitor resident in house. R12's Un-Witnessed Fall report dated 6/25/2025 at 4:12 PM documents: Nursing Description: Unwitnessed Fall: This writer was informed that resident was on the floor around 4:12 pm. No witness was presented when resident went from the bed to the floor. Resident was observed to be sitting upright on the floor with precaution fall mat under buttock and lower extremities. Resident told this writer that she attempted to get up and walk. Full body assessment performed. No deformities to BUE/BLE, bruising, bleeding, wounds or skin tears present at this time. Resident xferred safely from floor to Broda chair by staff x3 with fait belt. VS B/P 108/61, P 72, T 97.1, & O2 97% RA. Hospice notified. Per hospice no neuro checks required and monitor resident in house. DON notified. Attempted to notify family unsuccessful. left message. Resident Description: I wanted to get up and walk. Immediate Action Taken: MD notified. message left for res son. ROM, no injury noted. VS B/P 108/61, P 72, T 97.1, & O2 97% RA. Resident xferred safely from floor to Broda chair by staff x3 with gait belt. pain/skin/injury assessment. No c/o pain. no new orders from hospice. res will remain in house. res has bed in low position, canoe mattress on bed. Fall mat on floor next to bed. Hospice to complete med review. Notes: Care Plan updated; MD notified. vs, ROM, pain/skin/injury assessment, no injury. res vitas hospice notified. consult with vitas hospice re res safety and anxiety. med review by hospice. Res has canoe mattress on bed, fall mat next to bed, bed in lowest position when res in bed. Res to be placed up in Broda chair PRN and seated near nurses station. The interventions noted in this fall intervention, resident to be placed in Broda chair and seated at nurse's station, and consult with hospice were used for previous falls. No new interventions noted on R12's Care Plan for this fall. R12's Nurses Note dated 7/2/2025 at 2:33 PM documents: Res. just had a fall. Res. stated that she didn't fall she slid out of her bed while trying to turn over. Res. states that she didn't hit her head & has no c/o pain or discomfort noted. No bruises or abrasions noted. V/S: 128/72, 18, 97.3 & O2 @97%. DON is aware & hospice is aware of the fall. New bed is being ordered for res. through hospice services. R12's Un-Witnessed Fall report dated 7/2/2025 at 2:35 PM documents: Nursing Description: Hospice social worker came in for visit & noticed res. was on the floor. This nurse went in & saw res. on the floor mat that's next to her bed. Res was lying on her right side. vs taken, ROM, neuro check, pain/skin/injury assessment completed. no injury noted. hospice nurse completed assessment as well. res assisted off the floor by nurse with gait belt. assisted back to bed and positioned comfortably. res has canoe mattress on bed. fall mat next to be		

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise care plans with progressive intervention following falls for 2 out of 9 (R12, R53) residents investigated for accidents in a sample of 34.1. R12's Electronic Medical Record (EMR) undated documents the resident was admitted to the facility on [DATE] and has a medical diagnosis of Parkinson's Disease with Dyskinesia, Dementia, and Alzheimer's Disease. R12's Minimum Data Set (MDS) dated [DATE] documents R12 is moderately cognitively impaired, has an upper and lower extremity on both sides, and needs substantial/maximal assistance with rolling left and right, sitting to lying, lying to sitting on side of bed, and chair/bed to chair transfers. R12's Care Plan Date Initiated 5/23/2025 documents R12 has an increased risk for falls related to impaired mobility, Parkinson's, Cerebrovascular Accident, Hypertension, Alzheimer's, history of falls, Osteoarthritis, incontinence, Bipolar, Anxiety, Major Depressive Disorder with use of psychotropic medication. R12's Fall Risk assessment dated [DATE] documents R12 is at a high risk for falls. R12's Fall Risk assessment dated [DATE] documents R12 is at a high risk for falls. The resident had 5 interventions for 15 falls from 10/24/2024 until 9/5/2025. R12's Historical Note dated 10/29/2024 at 6:01 PM documents, Resident had an unwitnessed fall in her room. This nurse was coming to give her medication when resident was found on floor mat by bed. This nurse assessed resident for any pain or head injuries and there was none noted. Once assisted back into chair, resident stated that she did not hit her head upon falling. Resident di state she had some soreness to her left arm and left side. Resident's vital signs were within normal limits. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note (Late Entry) dated 1/25/2025 at 3:00 PM documents, at approx. 3:30pm CNA (Certified Nursing Assistant) waved for this nurse to come to res room. Upon entering room resident was laying on the floor on her right side with left side of her head against dresser. Nurse completed vs (vital signs), ROM (range of motion), pain/skin/injury assessment. neuro assessment. redness and swelling to L (left) side of forehead noted. Hematoma noted to L eye. Res stated, I was trying to get my water. Nurse noted cup of water on res dresser. ROM WNL (withing normal limits). Nurse and CNA assisted res off of floor with gait belt. assisted res up to her bed. Res c/o bilateral pelvic pain by moaning and facial grimacing during assessment. MD (Medical Directory) notified. new order to send to ER (Emergency Room) for evaluation r/t (related to) res possibly hitting head. Res noted to be barefoot. R12's Un-Witnessed Fall Report dated 1/25/2025 at 3:00 PM documents Nursing Description At approx. 3:30pm CNA waved for this nurse to come to res room. Upon entering room resident was laying on the floor on her right side with left side of her head against dresser. Nurse completed vs, ROM, pain/skin/injury assessment. neuro assessment. redness and swelling to L side of forehead noted. Hematoma noted to L eye. Res stated, I was trying to get my water. Nurse noted cup of water (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on res dresser. ROM WNL. Nurse and CNA assisted res off floor with gait belt. Assisted res up to her bed. Res c/o bilateral pelvic pain by moaning and facial grimacing during assessment. MD notified. New order to send to ER for evaluation r/t res possibly hitting head. Res noted to be barefoot. Resident Description: I was trying to get my water Immediate Action Taken: Resident assessed. Redness and swelling note to L side of forehead, hematoma noted to L eye. no open areas noted. 2A resident to bed with gait belt. Resident then c/o bilateral pelvic pain when assessing BLE AEB moaning and facial grimacing. EMS contacted. Neuro assessment initiated. Pupils equal but sluggish. Ice pack applied to L side of head. EMS arrived approx. 1515 and left enroute to SLU. T-98, R-18, P-67, b/p 118/70 Notes: Care place updated, MD and family notified. Son notified, vs, ROM, neuro check, pain/skin/injury assessment, Res assisted off of floor by nurse and CNA with gait belt, assisted to bed. 911 called. New order to end to ER for eval r/t hitting head. Ice pack applied to L eye. EMS arrived and transported res to ER. Res returned from ER to approx. 22:48 with no new orders. Staff will declutter res. room. staff will ensure res is wearing proper footwear when out of bed, staff will ensure res meals and fluids are within reach. will refer to therapy. No intervention documented on R12's Care Plan for this fall. R12's Progress Note dated 3/3/2025 at 4:40 PM documents, upon hearing the screams for assistance, staff discovered the source of the screams and found the resident in her room on the floor with closet door open. Assessment done in timely manner. No injuries were noted at the time by this writer and 2 additional staff members. No s/s (signs or symptoms) of bleeding, edema or SOB (shortness of breath) thus far. Alert, talkative, and oriented. Neuro checks initiated. Resident xfer safely to w/c (wheelchair) by this writer and staff members. Resident is currently up moving around unit safely, staff readily available to assist, and care plan ongoing. NP (Nurse Practitioner) and DON (Director of Nursing) notified. Per NP, neuro checks and monitor. R12's Witnessed Fall Report dated 3/3/2025 at 4:40 PM documents: Nursing Description At approx. 4:40pm nurse yelling coming from res room. Res roommate was calling for help. She had witnessed this res fall. resident found on the floor in her room in front of her closet door. Assessment done in timely manner, wc noted behind resident. res wearing socks and shoes, room well lit. no clutter. res stated she was looking for food in her closet. Res discussed how she does not like her pureed diet. vs, ROM, pain/skin/injury assessment completed. no c/o pain. no injury noted. res assisted off of floor and up to wc by nurse with gait belt. MD notified and message left for son. Son came to facility to visit notified at that time. Res roommate stated res did not hit her head. Res roommate is alert and oriented. Resident later advised this writer that she was up looking for whole food and did not want the food she gets on her diet order. Immediate Action Taken: MD and res son aware. vs, ROM, pain/skin/injury assessment, neuro check, res xfer safety to w/c by nurse with gait belt. NP notified, will monitor for changes and notify MD as needed. T-97.7, R-20, P-77, b/p 110/70, referred to therapy (PT and ST), med review, anti-roll backs placed on res wc. Notes: Care plan updated, MD and res son aware, vs, ROM WNL, pain/skin/injury assessment, assisted res off of floor by nurse with gait belt up to wc, refer to PT and ST, med review, res had Dysem to wc seat, res has anti tippers to wc, anti-roll backs placed on res wc. No intervention documented on R12's Care Plan for this fall. R12's Progress Note dated 3/31/2025 at 9:23 PM documents: This nurse was notified by CNA that resident was on floor. Upon entering room resident was lying on the floor on her right side. Resident was alert and showed no signs of pain or distress. Resident stated that she was walking to other side of room to get her roommates walker. This nurse assessed resident for injuries, no injuries were (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted. Resident was lifted to wheelchair by this nurse and CNA. POA (Power of Attorney) and DON were notified. POA and POA requested for resident to be sent to the hospital for further assessment. 911 was called and EMS (Emergency Medical Service) arrived at 8pm. EMT's (Emergency Medical Technician) assessed resident and recommended resident not be transferred to the hospital as all vitals were normal range and there were no physical signs of injury. Resident stated several times that she does not want to go to the hospital. EMT's stated that resident is A/Ox4 (Alert and Oriented) and had the right to refuse the hospital. Resident is being monitored by this nurse with neuro checks started. Resident's son, DON and NP notified of fall. R12's Un-Witnessed Fall Report dated 3/30/2025 at 7:45 PM documents: Nursing Description: This nurse was notified by CNA that resident was on floor. Upon entering room resident was lying on floor on her right side in the middle of the room. Resident was alert and showed no signs of pain or distress. Vs, ROM, neuro check completed, by CNA and nurse with gait belt. assisted to bed. Resident Description Resident stated that she was walking to other side of room to get her roommates walker. Immediate Action Taken: MD and res son called. This nurse assessed resident for injuries, no injuries were noted. vs pain/skin/injury assessment completed, ROM WNL. neuro check. Resident was lifted to wheelchair by this nurse and CNA with gait belt and placed in bed. POA and DON were notified. POA requested for resident to be sent to the hospital for further assessment. 911 was called and EMS arrived at 8 pm. EMT's assessed resident and recommended resident not be transferred to hospital as all vitals were normal range and there were no physical signs of injury. Resident stated several times that she does not want to go to the hospital. EMT's stated that resident is A/Ox4 and had the right to refuse the hospital. Resident is being monitored by this nurse with neuro checks continued. T-98.2, R-16, P-70, B/P 130/66, POA notified. POA agreeable for res to remain at facility. Notes: Care plan updated; SON POA called. MD notified. 911 called. vs, ROM, neuro check, ROM WNL, no injury noted. 911 called per POA request. Ambulance arrived. Res refused transport. Ambulance left. SON notified. SON agreeable to have res remain in facility. Removed roommates walker from room. Res roommate does not utilize walker. Roommate agreeable to removal of walker. Staff will check on re more frequently. Refer to therapy. med review. Will cont. to see psychiatry. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/10/2025 at 2:51 PM documents: CNA informed this nurse that resident was on the floor by heater. Upon entering room resident was sitting on the floor by her wheelchair and in between the heater and her roommates bed. Resident stated she was trying to turn the heat off and slid from her chair. R12's Witnessed Fall Report dated 4/10/2025 at 2:15 PM documents: Nursing Description: At approx. 2:15 pm CNA informed this nurse that resident was on the floor by heater. Upon entering room resident was sitting on the floor by her wheelchair, in between the heater and her roommates bed. Resident stated she was trying to turn the heat off and slide from her chair. vs, ROM, pain/skin/injury assessment completed. Res roommate witnessed fall. Res did not hit her head per roommate. Res assisted off of floor and up to wc by nurse and CNA with gait belt. no c/o pain. no injury noted. Resident Description: Resident stated she was trying to turn the heat of and slid from her chair to the floor. Resident stated she did not hurt anything. Res roommate stated that res did not hit her head. Immediate Action Taken: MD and res son notified. vs, ROM pain/skin/injury Assessment completed, no injuries noted at this time. Resident denies pain or discomfort. VS-165/72 bp, 72 hr., 97.8 temp, 20 resp, 96% o2. Resident placed back in wheelchair via 2 person assist. No new orders from MD. Notes: Care plan updated, MD and res son notified, Will consult with family about option of hospice care. vs, ROM, pain/skin/injury assessment, bed in low position, fall matt, canoe mattress, Dysem in wc seat, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anti-roll backs on wc. res assisted off floor by nurse and CNA with gait belt. ss assisted in meeting with both residents to discuss keeping the heater at a temperature they both are agreeable to. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/17/2025 at 2:40 PM documents: Staff was called to patient's room around 2:40pm. Patient was found on the floor on left lateral side. No bleeding, skin tears, bruising, extremities deformities, SOB or decline of LOC (loss of consciousness) noted during assessment. Patient denies pain. Currently resting in bed watching TV (television), call light in reach, and care plan ongoing. R12's Un-Witnessed Fall Report dated 4/17/2025 at 2:30 PM documents Nursing Description: Staff was called to patient's room around 2:40pm. Resident was found by staff lying on her left side on the floor between the dresser and the bed. Res was partially on the fall mat. Res stated, I tried to get up, but I failed. Resident was assessed, vs, ROM, neuro check, pain/skin/injury. no new injury noted, and resident was xferred safely from floor to bed by nurse with gait belt. MD and hospice notified. Resident Description: Resident stated I tried to get up, but I failed. Immediate Action Taken: MD and res son notified. Vitas hospice notified. VS B/P 131/78, P 76, R 18, O2 95%, T 97.3. ROM, neuro check, pain/skin/injury assessment. no injury. consult with hospice, med review by hospice, no new orders. Family does not want res sent to hospital. Fall mat in place, bed in low position, canoe mattress on bed. Notes: Care plan updated. MD and vitas hospice notified, son notified, VS B/P 131/78, P 76, R18, O2 95%, T 97.3. ROM, neuro check, pain/skin/injury assessment. no injury. consult with hospice, med review by hospice, no new orders. Family does not want res sent to hospital. fall mat in place, bed in low position, canoe mattress on bed. no new orders. ROM WNL. neuro check WNL. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/21/2025 at 3:03 PM documents: Staff was called to patient's room around 3:20pm. Patient was found on the fall matt on right lateral side. Patient denies pain. No bleeding, skin tears, bruising, extremities deformities, SOB or decline of LOC noted during assessment. Xferred safely back to bed by staff. Resident stated nothing going on just was trying to sit up and watch TV on the side of the bed. Educated on using call light for staff assistance. Resident is currently lying down in bed, call light in reach, and care plan ongoing. R12's Un-Witnessed Fall Report dated 4/21/2025 at 3:20 PM documents Nursing Description: Nurse was called to res room by CNA around 3:20pm. Patient was found on the fall matt next to her bed, lying on right lateral side. vs, ROM, neuro check, pain/skin/injury assessment completed. Patient denies pain. No bleeding, skin tears, bruising, extremities deformities, SOB or decline of LOC noted during assessment. VS B/P 114/61, R 18, P 65, T 97.2, Res assisted off floor by CNA with gait belt and into bed. MD and hospice notified. Res son notified. Resident Description: Resident stated she was just sitting up watching TV on side of bed and slid off bed. Res it alert but confused. Patient denies pain. Immediate Action Taken: VS B/P 114/61, R 18, P 65, T 97.2, ROM, neuro check, pain/skin/injury assessment completed. Res assisted off floor by CNA with gait belt and into bed. MD and hospice notified. Res son notified. Res has a canoe mattress in place. Bed was in low position. fall mat next to bed. call light in place. Notes Care plan updated, MD and res son notified, Hospice notified. vs, ROM, pain/skin/injury assessment, neuro check, Res assisted off bed by CNA with gait belt. res had bed in low position, canoe mattress in place, fall mat next to bed. med review, consult with hospice. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/27/2025 at 4:56 AM documents: This writer was called to resident's room. Resident was found lying on her left side beside her bed. Resident was under the bedside table, with her left leg resting on the legs of the bedside table. Resident states that she was attempting to pull her bedside table closer and the next thing she knew she was on the floor. Resident denies hitting head. Skin assessed. Reddened area noted to left thigh. No active bleeding observed. No open areas noted. ROM performed. Tolerated well. VS obtained. 110/66 64 18 95% RA (room air). No c/o (complaint of) pain or discomfort voiced. Transferred from floor to bed via 2 persons assist. Tolerated well. Resident was educated to utilize call light to ask for assistance. Resident verbalized understanding and performed a return demonstration. Staff was educated to have personal items within reach for ease of accessibility. R12's Un-Witnessed Fall Report dated 4/27/2025 at 4:30 AM documents: Nursing Description: This writer was called to resident's room. Resident was found lying on her left side beside her bed. Res lying on fall mat. Resident was under the bedside table, with her left leg resting on the legs of the bedside table. Resident Description: Resident states that she was attempting to pull her bedside table loser and the next thing she knew she was on the floor. Immediate Action Taken: MD called. pain/skin/injury assessment. ROM, neuro check, Hospice notified. Reddened area noted to left thigh. No active bleeding observed. No open area noted. ROM performed. Tolerated well. VS obtained. 110/66 64 18 95& RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist with gait belt. Tolerated well. Staff was educated to have personal items within reach for ease of accessibility. This writer spoke with patient care coordinator, RN, a vitas nurse. RN stated a nurse would be out to assess patient later in the day. Resident's son was notified at 4:45 AM. Care plan has been updated. res has bed in low position, fall mat in place, canoe mattress on bed. Notes: Care plan updated, MD notified, vitas hospice notified, res son notified, vs, ROM, neuro check, no c/o pain. 0.2 cm x 0.2cm reddened area to l thigh. no new orders from MD. No new orders from hospice. Hospice visited res that morning. no new orders. Fall mat in place, canoe mattress on bed, bed in low position, staff will ensure res belongings are within reach of res when she is in bed. Broda chair when out of bed. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 4/30/2025 at 7:09 AM documents This writer was called to resident's room. Resident was found lying on her left side beside her bed. Resident was under the bedside table, with her left leg resting on the legs of the bedside table. Resident states she doesn't know what happened and that she was probably sleepwalking. Resident denies hitting head. Skin assessed. No areas noted. No active bleeding observed. ROM performed. Tolerated well. VS obtained. 110/66 64 18 96%RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist. Tolerated well. R12's Witnessed Fall report dated 4/30/2025 at 3:17 AM documents Nursing Description: Resident was found by staff lying on her left side on the floor between the dresser and the bed. Lying on fall mat. Resident was assessed, ROM, pain/skin/injury assessment. no injuries noted, and resident was transferred with gait belt and 2 aides from floor to bed. Resident Description: Resident stated she was trying to turn the heat oof and slid from her chair to the floor. Resident stated she did no hurt anything. Res roommate stated that res dd not hit her head. Res heater is on the other side of the room. Immediate Action Taken: Skin/pain/injury assessed. No areas noted. vs, no active bleeding observed. ROM performed. Tolerated well. VS obtained. 110/66 64 18 98.4 96% RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist with gait belt. Tolerated well. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Evercare of Granite City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician notified. Vitas notified. Resident's son was notified at 3:37 AM. Care plan has been updated. no new orders. res has fall mat in place, canoe mattress on bed, bed in low position. Notes: Care plan updated, MD and res son notified, vitas hospice notified. no new orders. vs, ROM, pain/skin/injury assessment. no injury, res roommate witnessed fall. res did not hit her head. Staff educated to check on res frequently and to ensure temperature in room is comfortable for both residents. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 5/17/2025 at 6:11 AM documents: This writer was called to resident's room. Resident was found lying on her left side beside her bed. Skin assessed. Reddened area noted to left forearm. No active bleeding observed. No open areas noted. ROM performed. Tolerated well. VS obtained. 110/66 64 18 95%RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 persons assist. Tolerated well. Resident was educated to utilize call light to ask for assistance. Resident verbalized understanding and performed a return demonstration. R12's Un-Witnessed Fall report dated 5/17/2025 at 5:10 AM documents Nursing Description: This writer was called to resident's room by CNA. Resident was found lying on her left side on fall mat beside her bed. Nurse completed vs, ROM, pain/skin/injury assessment, neuro check. res verbal. No s/s of distress. no c/o pain. small reddened circular area noted to L forearm approx. 0.5 cm x 0.5 cm. MD, resp party son called, vitas hospice notified. res assisted off floor by nurse and CNA with gait belt. assisted to bed. Res unable to explain what happened. Resident Description: Resident unable to give description. Immediate Action Taken: Skin assessed. Reddened area noted to left forearm. Approx. 0.5cm x 0.5cm. No active bleeding observed. No open areas noted. ROM performed. Tolerated well, neuro check. VS obtained. 110/66 64 18 95% RA. No c/o pain or discomfort voiced. Transferred from floor to bed via 2 person assist with gait belt. Tolerated well. Physician notified. Vitas notified. The Resident's son was notified. Care plan has been updated. Consult with hospice re fall safety. Notes: Care plan updated., MD notified, res son notified, Vitas hospice notified. vs, ROM, pain/skin/injury assessment, neuro check. 0.5cm x 0.5cm circular red area to L FA. no open areas. Will observe area for s/s of infection. bed in lowest position, fall mat in place next to bed, canoe mattress on bed, consult with hospice re fall safety. medication review. No intervention documented on R12's Care Plan for this fall. R12's Nurses Note dated 5/28/2025 at 1:31 PM documents resident noted on the floor in bedroom at side of the bed. resident laying on right side. resident stated that she was attempting to get up. alert and oriented x 2, able to make needs known to staff, verbal, no voiced c/o pain at time of incident. full rom noted to all extremities, weakness noted to bilateral lower extremities. no injuries or bruising noted at the time of the incident. VS: 98.0 82 18 132/67 96%-room air. R12's Un-Witnessed Fall report dated 5/28/2025 at 1:30 PM documents Nursing Description: At approx. 1:30 pm CNA found res on floor in her room and called for nurse LPN. LPN found res on the floor in her room. Lying on her left side on her fall mat next to her bed. vs, ROM, pain/skin/injury assessment completed. No injury noted. Neuro check wnl. res assisted off of floor by nurse with gat belt. Placed in bed. Bed in low position. Canoe mattress on bed. MD and hospice notified. Res son notified. Resident Description: Resident unable to give description. Immediate Action Taken: MD, res son notified, Vitas hospice notified. no injury noted. Res will not be sent to ER per hospice and res son. neuro check, ROM WNL, neuro check WNL, vital signs, pain/skin/injury assessment. VS: 98.0 82 18 132/67 96%-o2 sat Res will be placed Broda chair provided by hospice and placed near nurse's station when out of bed. Notes: Care plan updated. MD, res son, Vitas hospice notified. vs, ROM, ROM (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Evercare of Granite City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	WNL, neuro check, neuro check WNL, pain/skin/injury assessment, no injury noted. res assisted off floor by nurse with gait belt and placed in bed. Res unable to explain what had happened. Items res uses often were within reach. canoe mattress on bed, bed in low position, fall mat in place next to bed. Consult with hospice re res safety, broad chair provided by hospice. Res will be placed in broad chair when out of bed and placed near nurse's station. Intervention 5/28/2025 documents high back chair provided by Hospice-place in high back chair when out of bed and near nurses station. R12's Nurses Note dated 6/4/2025 at 6:03 PM documents CNA came to this nurse stating that resident was on the floor. This nurse went to res. room & saw her on the floor. This nurse asked res. did she hit her head & she stated no. This nurse & aides got her back in bed. Res. was assessed with no signs of injury. R12's Un-Witnessed Fall report dated 6/4/2025 at 5:45 AM documents Nursing Description: At approx. 5:45 am CNA came to this nurse stating that resident was on the floor. Nurse entered res room to find res lying on her left side, on floor mat next to her bed. Bed in low position. canoe mattress on bed. Res unable to explain what happened. vs taken, ROM, neuro check, pain/skin/injury assessment completed. no injuries. res assisted off floor by nurse and CNA with gait bed. placed in bed. Resident Description: Resident unable to give description. Immediate Action Taken: MD and res on notified, vs, pain/skin/injury assessment completed. ROM WNL, neuro check WNL. Vitas Hospice Res. Transferred by this nurse & aides & placed back in bed with gait belt. This nurse assessed res. for any signs of injuries a& there were none. V/s taken & are WNL. Consult with hospice re fall safety, fall mat in place, canoe mattress on bed, bed in lowest position. Hospice to complete a medication review. Staff to ensure res is positioned properly in bed before exiting room. T-97, R-16, P-71, b/p 120/19. Notes: MD and res son notified. Vitas hospice notified, vs, ROM, pain/skin/injury assessment completed, ROM WNL, neuro check WNL, no injury noted. hospice consulted re fall safety, fall mat in place next to bed, canoe mattress on bed, bed in lowest position., right side of bed against wall, hospice to perform medication review. Nsg. staff to ensure res is positioned properly in bed prior to leaving room. Intervention dated 6/4/2025 on R12's Care Plan documents Med Review-Hospice, make sure resident positioned properly in bed. R12's Nurses Note dated 6/25/2025 at 4:10 PM documents Unwitnessed Fall: This writer was informed that resident was on the floor around 4:12 pm. No witness was presented when resident went from the bed to the floor. Resident was observed to be sitting upright on the floor with precaution fall mat under buttock and lower extremities. Resident told this writer that she attempted to get up and walk. Resident educated on using call light for staff assistance w/ transfers. Full body assessment performed. No deformities to BUE/BLE, bruising, bleeding, wounds or skin tears present at this time. Resident xferred safely from floor to high back chair by staff x3. VS B/P 108/61, P 72, R 18, T 97.1, & O2 97%/ RA. Hospice notified. Per hospice no neuro checks required and monitor resident in house. R12's Un-Witnessed Fall report dated 6/25/2025 at 4:12 PM documents:Nursing Description: Unwitnessed Fall: This writer was informed that resident was on the floor around 4:12 pm. No witness was presented when resident went from the bed to the floor. Resident was observed to be sitting upright on the floor with precaution fall mat under buttock and lower extremities. Resident told this writer that she attempted to get up and walk. Full body assessment performed. No deformities to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Evercare of Granite City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BUE/BLE, bruising, bleeding, wounds or skin tears present at this time. Resident xferred safely from floor to Broda chair by staff x3 with fait belt. VS B/P 108/61, P 72, T 97.1, & O2 97% RA. Hospice notified. Per hospice no neuro checks required and monitor resident in house. DON notified. Attempted to notify family unsuccessful. left message. Resident Description: I wanted to get up and walk. Immediate Action Taken: MD notified. message left for res son. ROM, no injury noted. VS B/P 108/61, P 72, T 97.1, & O2 97% RA. Resident xferred safely from floor to Broda chair by staff x3 with gait belt. pain/skin/injury assessment. No c/o pain. no new orders from hospice. res will remain in house. res has bed in low position, canoe mattress on bed. Fall mat on floor next to bed. Hospice to complete med review. Notes: Care Plan updated; MD notified. vs, ROM, pain/skin/injury assessment, no injury. res vitas hospice notified. consult with vitas hospice re res safety and anxiety. med review by hospice. Res has canoe mattress on bed, fall mat next to bed, bed in lowest position when res in bed. Res to be placed up in Broda chair PRN and seated near nurses station. Intervention dated 6/25/2025 on R12's Care Plan documents Care plan reviewed with Hospice and Hospice consulted regarding falls, safety, and anxiety. R12's Nurses Note dated 7/2/2025 at 2:33 PM documents: Res. just had a fall. Res. stated that she didn't fall she slid out of her bed while trying to turn over. Res. states that she didn't hit her head & has no c/o pain or discomfort noted. No bruises or abrasions noted. V/S: 128/72, 18, 97.3 & O2 @97%. DON is aware & hospice is aware of the fall. New bed is being ordered for res. through hospice services. R12's Un-Witnessed Fall report dated 7/2/2025 at 2:35 PM documents: Nursing Description: Hospice social worker came in for visit & noticed res. was on the floor. This nurse went in & saw res. on the floor mat that's next to her bed. Res was lying on her right side. vs taken, ROM, neuro check, pain/skin/injury assessment completed. no injury noted. hospice nurse completed assessment as well. res assisted off the floor by nurse with gait belt. assisted back to bed and positioned comfortably. res has canoe mattress on bed. fall mat next to bed. bed noted in lowest position. Resident Description: Res. states that she didn't fall she slid out of bed while trying to turn over to her other side. Immediate Action Taken: MD notified. Hospice nurse present. This nurse got res. up from the floor with gait belt. Res. was assessed & no visible injuries noted. V/S were taken & are as follows 128/72, 18, 97.3 & O2 @97%. ROM and neuro check. DON is aware & hospice is aware of the fall. New electric hospital bed with air mattress is being ordered for res. through hospice services. Res currently has canoe mattress fall matts, bed in lowest position. Notes: MD and res son notified. Hospice nurse present. This nurse got res. up from the floor with gait belt. Res. was assessed & no visible injuries noted. V/S were taken & are as follows 128/72, 18, 97.3, O2@97%. ROM and neuro checks. DON is aware & hospice is aware of the fall. New electric hospital bed with air mattress is being ordered for res. through hospice services. fall matts, bed in lowest position. Intervention dated 7/2/2025 on R12's Care Plan documents: Hospice reevaluate and bring different mattress/bed. R12's Nurses Note dated 9/5/2025 at 9:36 AM documents: Resident continues receiving hospice services. No change in condition noted. Resident is A&Ox3 & able to make needs known to staff. Resident needs assist x1 with adls (activities of daily living) and transfers. Resident had a fall this morning while in bed eating breakfast. This nurse assessed resident & she has no visible injuries or bruising noted. This nurse & aide got resident off the floor		