

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000936		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/16/2025	
NAME OF PROVIDER OR SUPPLIER Evercare at Stearns				STREET ADDRESS, CITY, STATE, ZIP CODE 3900 STEARNS AVENUE , GRANITE CITY, Illinois, 62040			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			12/31/2025	
	Complaint 25411751/2683522						
S9999	Final Observations		S9999			12/31/2025	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.3210t)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident..						
	Section 300.3210 General						
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interview and record review the Facility failed to ensure sexual abuse did not occur for 1 of 4 residents (R3) reviewed for abuse and neglect of a sexual nature in the sample of 6. This failure resulted in R2 touching R3 inappropriately when R3 could not deny the advances or give her approval or consent. R3 was incapable of declining to participate in the sexual act and lacks the ability to understand the nature of the sexual act. Findings include: 1-R2's Physician Order Sheet for December 2025 documents a diagnosis of dementia, COPD (Chronic Obstructive Pulmonary Disease), major depression disorder, and muscle weakness, abnormalities of gait and mobility. R2's Minimum Data Set (MDS) dated 11/21/2025 document R2 was moderately impaired for cognition for activities of daily living. Resident does not use a wheelchair or scooter. Sit to stand supervision or touching assistance and walk 10 feet and 50 feet with two turns. R2's Care Plan with a focus date of 11/22/2025 (R2) has had sexual behavior noted related to confusion. Date initiated 11/22/2025. Goal: Resident will not have sexual behaviors and act appropriately with other residents. Date initiated 11/22/2025. Intervention dated 11/22/2025, Place on 1:1 monitoring, behavior monitoring for increased sexual desires will be monitored. R2's Care Plan date initiated of 10/27/2025 also documents (R2) engages in self-stimulation related to dementia, occasionally performing the behaviors in her room without closing the door. On 12/5/2025 at 8:35 AM, V1, Administrator stated we did have an incident with (R2) and (R3), but (R3) could not tell you anything. When we interviewed (R2) she was confused, and she said she just thought she was helping (R3) because she used to be a CNA (Certified Nursing Assistant) and her roommate's (adult diapers) were full		S9999				

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S9999	Continued from page 2 of BM (bowel movement) and it was just a big misunderstanding." On 12/5/2025 at 8:49 AM, V2, Director of Nursing stated they did an internal investigation and felt like (V4) jumped the gun because (R2) had her pants down but they were able to determine nothing occurred. On 12/5/2025 at 12:58 AM R2 stated she use to be a CNA (Certified Nursing Assistant) and has never tried to provide care to any other residents including roommate. She states the AC was on and when she went over to turn it down her roommate grabbed her and her pants fell down and then the nurse walked in on her but she was not touching her roommate. They were in bed together. They separated them after that. She also says her roommate was not wet and/or needing changed and/or had poop." R2's Nurse's Notes dated 11/22/2025 at 7:00 PM, "SSD (Social Service Director) met with (R2) who is resting in bed. Trauma assessment complete. (R2) denies trauma. SSD asked (R2) if she feels safe here. She responded yes. (R2) asked SSD why she was asking this question. SSD stated to ensure she feels safe. SSD asked why she was on her roommate's side of the room. (R2) responded that she was just trying to help her. SSD asked why (R2) pants were down. (R2) responded that they always slide down and was attempting to pull them up. R2's Progress notes dated 11/24/2025 at 9:21 PM, Resident continues to have a 1:1 related to resident to residents. Resident currently in bed resting with call light in reach. No s/s (signs or symptoms) of acute distress noted at present moment." R2's Initial Report 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated. Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Investigation of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent." R2's Final Report date of 11/22/2025, Initial Allegations: At approximately 3:30 PM, a nurse reported an allegation of abuse. Investigation initiated.		S9999				

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S9999	Continued from page 3 Initial interventions: 1) Residents separated and placed on 1:1 monitoring. 2) Interviews with residents and staff initiated. 3) Education of abuse and neglect initiated. 4) Notified: Police, Family and MD. 5) Assessment initiated. 6) IDPH initial report sent. Investigation: (V4, LPN) entered (R2) and (R3) to observe (R2) on her knees next to the bed with her pants down. (R2) hand was on the bed with her back to (R2) laying on her side. (V4) noted that the room was very cold and that (R2) had BM (bowel movement) on her hand and (R3) had BM on her bed. (V4) did not see (R2) acting inappropriately with (R3), nor did she have history of being inappropriate with resident. (R2) was a long time CNA (certified nursing assistant) of (Facility) prior to coming to live at the facility. (R2) was interviewed, she was noted to have some confusion during questioning but was able to answer some questions sensical. She stated that she was cold and went to turn off the air. The air was noted to be on when (V4) was in the room. When asked why her pants were down she stated, they had fallen down, they were not fastened. (R2) was noted to have BM on her hand. She did not know where that had come from however her hand was located on (R3's) bed that did have BM on it. She was using the bed to help her get off her knees. When asked if she had touched (R3) she said no. I am just trying to help her. (R3) was unable to be interviewed. She was noted to be sleeping at the time of concern. (R3's) skin assessment was completed WNL (within normal limits). Pain assessment completed; no pain noted. (R3) did not have an increase or behavioral changes after time of concern. Other residents were interviewed, when asked if another resident ever touched them inappropriately, all answered no. When asked if they felt safe in the facility, all stated they did. When asked if residents know who to report concerns to, they stated they did, if they did not residents were educated. Conclusion: Our investigation concluded that (R2) did not have any inappropriate contact with (R3). (R2) was trying to turn off the air conditioning and got tangled up in her pants that had fallen down. She went to use (R3's) bed to get up where she had placed her hand on (R3's) soiled bedding. When our nurse entered the room, we do not believe that anything inappropriate occurred, the police were called and agreed that there was no cause for concern. V5, Psyche Nurse Practitioner conducted a tela health visit with both residents to ensure residents were behaving at baseline. (V5) stated she had known (R2) for a long time and has not had any behaviors involving other residents. Final Interventions: (R2) room moved. (R2) placed on 15-minute checks to monitor for increased/changes in behaviors. Skin, pain, trauma assessment completed on (R3). (R2) was interviewed.			S9999			

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S9999	Continued from page 4 (R2) was placed on 1:1: monitoring for a change in behaviors. (R2) clothing noted to fit well, Reviewed ability to fasten her clothing properly. Psych MP completed tela health visits on both, the same night as the concern was noted. SSD (Social Service Director) to follow up. Care Plans updated." (This report does not mention R2 touched R3's private parts). 2-R3's POS for December 2025 documents a diagnosis of Alzheimer disease with late onset, Dementia in other diseases classified elsewhere moderate with other behavioral disturbances, Delirium Due to known physiological condition, Patient's noncompliant with medical treatment and regimen. R3's MDS dated 9/7/2025 document R3 was severely impaired for cognition for activities of daily living. She has no impairments on the upper and or lower extremities and uses a wheelchair and is dependent on staff, helper does all of the effort. Resident does none of the effort to complete the activity. R3's Care Plan: (R3) is at risk for abuse and/or neglect r/t impaired cognitive skills, needs assistance with ADL's (activities of daily living) and dx (diagnosis of) of dementia. Date Initiated: 11/01/2024 R3's Nurses Notes does not document anything related to the incident with her roommate (R2) on 11/22/2025. R3's Social Service Notes dated 11/22/2025 at 5:56 PM, documents F/U (follow up) SSD (Social Service Director) met with (R3) who is in dining room for dinner. SSD asked (R3) how she is feeling, (R3) stated ok. SSD attempted to complete trauma assessment. (R3) was unable to participate meaningfully in the assessment related to dx of dementia, Conversation was characterized by rambling speech and an illogical flow of thoughts, preventing completion of evaluation. Will continue to monitor for change in mood, behavior." Statement from V4, Licensed Practical Nurse (LPN) documents, "I went to see if either resident was in their room because I needed to stick their fingers for blood sugars. When I entered the room. (R2) was on her knees next to (R3's) bed on the floor mat resting her knees. (R3) was in bed, lying on her left side face towards the wall. (R2) had her left hand in (R3's)		S9999				

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S9999	Continued from page 5 buttocks region and was lifting her buttocks at which point she placed her middle finger near (R3's) rectum and I asked her to stop immediately at which time (R2) stopped and stood up, fixing her pants from their lowered position and sent over to her bed. I remained in the room, completed body assessment and called for CNA assistance, as staff remained with (R2) and other staff assisted (R3) to the bathroom and provided care then assisted her to the nurse's station area to remain 1:1 then assisted to the dining room to prepare for dinner. Staff remained 1:1 with (R2) in her room and I notified management. Body assessment with no injuries were done. (R3) cannot say what happened since she is non-sensible. (R2) just said she was trying to "help her". I spoke to the doctor, the families and then the PD as well. No concerns were made by any parties. Management arrived and took over and I went back to work on the rest of my med pass and the other stuff for everyone on my unit." On 12/5/2025 at 1:22 PM, V6, Licensed Practical Nurse (LPN), stated, "I have worked here for five years. I was not on here when something went down between (R2) and (R3). I know they moved (R3) to the dementia unit and (R2) was put on 15 minutes checks for something inappropriate but I could not tell you what. That was my weekend off. I only know she was on 15-minute checks when I came back because of inappropriate behavior. (R2) can walk and move around if she wants to." On 12/12/2025 at 2:17 PM, V9, LPN stated, "(R3) is unable to talk and/or tell you what is going on with her. I was working the day she was moved over here. I was told her and her roommate, (R2), that there was an inappropriate incident between them and they separated them and moved (R3) over to the memory care unit. I was told the nurse found (R2) on (R3's) side of the room and the nurse walked in on them." On 12/12/2025 at 3:24 PM, V11, Registered Nurse (RN) stated, "(R3) use to be on this side of the building (100 hall). I was not working when they moved (R3). I was told they moved her because a nurse (V4) walked in when (R2) was touching (R3's) private parts. They moved (R3) over to the dementia unit after that." R2's Police Report dated 11/22/2025 at 5:22 PM, (V4) while conducting rounds at (R2's) room two residents with severe dementia performing sex acts. (V4) observed (R2) digitally manipulating (R3's) vagina and anus.		S9999				

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S9999	Continued from page 6 (V4) immediate contacted her supervisors and the police. Residents were separated. On Saturday, 11/22/2025 at approximately 4:28 PM, I, (V8), Local Police Officer responded to (Facility) in reference to two residents with cognitive disabilities performing sexual acts on each other. Upon arrival, I made contact with the caller, (V4). She stated she is a nurse employed by (Facility). (V4) stated while she was conducting her rounds on (R2 and R3's) room, she observed the two patients engaged in sexual activities. (V4) stated (R2) was knelt down near the bed of her roommate (R3) with her pants and underwear removed. (V4) stated (R2's) finger was inserted into (R3's) anus with fecal matter on the bed. (V4) stated medical staff separated (R2) and (R3), advising will no longer reside in the same room. (V4) stated (R3) was recently placed in (R2's) room on 11/3/2025. (V4) stated (R3) suffered from severe dementia and was unable to exit her bed by herself. (V4) stated (R3) was not communicative and could not provide a statement. (V4) stated (R2) was also diagnosed with a lesser severity of dementia, but also had severe cognitive decline. (V4) described (R2's) current limited mental/physical capabilities as able to use the restroom by herself. (V4) stated she contacted her immediate supervisor to conduct an internal investigation of the incident. (V4) also stated she would be contacting the Power of Attorney for both subjects to make them aware of the investigation." On 12/15/2025 at 10:24 AM, V12, Certified Nursing Assistant (CNA) stated I know (R3) was moved off the 100 hall because they said she was assaulted by (R2). They then put (R2) on one on ones and moved (R3) to a different hall. I am not sure what happened and/or the details." On 12/15/2025 at 11:38 PM, V4, Licensed Practical Nurse (LPN) stated, "I told the police officer when I went to do accu checks (R2) was over by (R3's) bed and was on the floor. I gave a statement to the facility and to the police. I did see (R2) when I entered the room. (R2) was on her knees next to (R3's) bed on the floor mat resting her knees. (R3) was in bed, lying on her left side face towards the wall. (R2) had her left hand in (R3's) buttocks region and was lifting her buttocks at which point she placed her middle finger near (R3's) rectum and I asked her to stop immediately at which time (R2) stopped and stood up, fixing her pants from their lowered position and sent over to her bed. I called (V1) immediate after it happened. They said nothing like this had have happened before. The CNAs		S9999				

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S9999	Continued from page 7 then got (R3) cleaned up. (R3) cannot talk or tell you anything. When I asked (R2) what she was doing she did not respond to me at all. I don't know (R2's) behaviors but she can get up on her own and she does have some confusion but at that time she did not respond and just said she was cold. I asked her what she was doing, and she never said anything in that moment and would not respond to me." On 12/15/2025 at 1:31 PM, V14, Family of R2 stated I originally got a call from the facility, and they told me they caught (R2) masturbating her roommate (R3). Then they called me back later and told me they were not sure that was what happened because (R2) use to be a CNA in the facility and they thought maybe she was just trying to help (R3). Honestly, I am not sure what happened because I was not in the room." On 12/15/2025 at 1:49 PM, V8, Local Police Officer stated he has been called to the facility on 11/22/2025 for an allegation of sexual assault between two residents and everything was in the report. The nurse had reporting while conducting rounds two residents both with severe dementia performing sexual acts." On 12/15/2025 at 2:17 PM, V15, Family of R3 stated, "The Facility called me and told me they found another resident in bed with (R3). (R3) can't talk or tell you anything so I was not sure what happened. I was never told (R3) was touched inappropriately or anything related to a sexual nature." On 12/15/2025 at 3:03 PM, V16, Medical Director stated he had just started at the facility on 11/21/2025 and he got a call from the facility the next day (11/22/2025) and was told another resident (R2) had sexually touched another resident (R3). In this case it is difficult because both residents have dementia. I made sure both residents were separated and (R3) was moved to the locked dementia unit and (R2) was placed on one on ones. I did all the appropriate measures one can do in a situation like this. At no time is it acceptable and it is completely forbidden for another resident to touch another resident in a sexual nature without consent. The Facility Abuse Policy with a reviewed date of 12/2/2025 documents, "Purpose: To ensure that the facility establishes, operationalizes, and maintains an		S9999				

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S9999	Continued from page 8 Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero- tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment. Or misappropriation of resident property. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being. The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems. (B)		S9999				