STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Complaint Survey 2543252/IL190129	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 5 300.610a) 300.1210b) 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

These requirements are not meet as evidenced by:

Based on Interview, Observation, and Record Review, the Facility failed to maintain a resident's privacy and dignity for 4 of 6 residents (R18, R38, R56, R63) reviewed for resident privacy and dignity in the sample of 79. This failure resulted in R18 and R63 feeling embarrassed and uncomfortable. A reasonable person would expect to have privacy in their home and would experience anxiety, humiliation, and embarrassment if their privates were exposed.

The Findings Include:

1. R18's Admission Record, dated 4/22/25, documents R18 was admitted to the facility on 8/24/2018 with diagnosis of Cerebral Infarction, Dysphagia, Dementia, Major Depressive Disorder, Anxiety Disorder, Trigeminal Neuralgia, and Morbid Obesity.

R18's Care Plan, dated 11/6/24, documents R18 has an ADL (Activities of Daily Living) self-care performance deficit related to Limited Mobility. Interventions: Toilet Use: R18 is not toileted, she is frequently incontinent, unable to transfer to toilet, use of bedpan encouraged, incontinent care per staff. It continues (4/7/25) R18 has potential for impairment to skin integrity related to impaired mobility, current medications, incontinence of B&B (bowel and bladder). Interventions: Complete pressure ulcer risk assessment quarterly and PRN (as needed), observe skin daily with care, notify MD (medical doctor)/NP (nurse practitioner) of any abnormal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 2	S9999		

findings, pressure redistribution mattress to bed, provide diet as ordered, RD (registered dietitian) to follow related to wound care and nutrition, refer to Specialized Wound Management, staff to assist with turning and repositioning as tolerated, staff to provide incontinent care after each incontinent episode, weekly skin assessment.

R18's Minimum Data Set (MDS), dated 3/24/25, documents R18 has severe cognitive impairment and is dependent on staff for toileting and bathing. R18 is always incontinent of both bowel and bladder.

On 4/22/25 at 10:00 AM, V12, Certified Nursing Assistant (CNA), provided incontinence care on R18. The window blinds were left open with R18 lying in the bed by the door with the curtain between the beds not pulled to obstruct the view from the window. There is a patio where residents can sit outside, as well as cars seen parked in a parking lot outside her window.

On 4/23/2025 at 9:57 AM R18 stated that she doesn't really pay attention to the CNAs if they pull the curtain or not. R18 stated that she would not feel comfortable if she was exposed to other people. R18 stated that with the staff she must be ok, but with other people she would be embarrassed and would not like it.

On 4/24/25 at 9:40 AM, V14, CNA, stated "Any time I am providing care to a resident in their room, I make sure the blinds are closed, the curtains are pulled, and the door is shut."

2. R63's Admission Record, dated 4/22/25, documents R63 was admitted to the facility on 7/26/23 with diagnosis of Cerebral Vascular Accident (CVA) affecting dominant side,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 3	S9999		

Hemiplegia, Hemiparesis, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Generalized Anxiety Disorder, Polyneuropathy, Respiratory Failure with Hypoxia, Dependence on Supplemental Oxygen, Overactive Bladder, Chronic Kidney Disease-stage 4, Morbid Obesity, and Type 2 Diabetes Mellitus (DM).

R63's Care Plan, dated 11/13/24, documents R63 requires assistance with ADLs related to impaired mobility. Diagnosis Cerebrovascular Accident (CVA)/hemiplegia. R63 has shortness of breath (SOB) with exertion, when lying flat R63 uses oxygen. Interventions: Assist with all ADLs as needed, provide setup assist and encouragement for those task that resident can perform independently, observe for signs/symptoms or complaint of shortness of breath, elevate head of bed as needed/requested, administer oxygen as ordered per MD (Medical Doctor). It continues (1/13/25) R63 is at risk for skin issues related to impaired mobility. Interventions: Staff to provide incontinent care after each incontinent episode, weekly skin assessment, staff to assist with turning and repositioning as tolerated, pressure redistribution mattress to bed.

R63's MDS, dated 3/18/25, documents R63 is cognitively intact and is dependent on staff for toileting.

On 4/22/25 at 9:25 AM, V12, CNA, was seen providing incontinence care for R63. The window blinds were left open with R63 lying in the bed by the window. There is a patio where residents can sit outside, as well as cars seen parked in the parking lot outside the window.

On 4/22/2025 at 1:20 PM, R63 stated that she did not pay attention to the CNA and if she closed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 4	S9999		

blinds or not. R63 stated that she would expect them to close the blinds, and she assumed that they do. R63 stated that her window is facing the patio and there are people out there at times. R63 stated at night with the light on, and during the day with the sun, you can see directly in her room. R63 stated that she would not want her privates to be exposed to the outside. R63 stated that this would be a problem for her. R63 stated that it would be embarrassing.

On 4/28/25 at 11:00 AM, V2, Director of Nursing (DON), stated "I would expect staff to provide privacy for the resident at all times, including closing the blinds and curtains during care."

The Facility's "Incontinent Care" Policy, dated 1/2015, documents in part "Procedure: 6. Provide Privacy. 9. Avoid unnecessary exposure of the resident during the procedure."

3. R38's Care Plan, dated 1/23/2025, documents that R38 has an ADL self-care performance deficit r/t Aggressive Behavior, Confusion, Hemiplegia, Impaired balance, Cerebral Infarction, aphasia. It also documents TOILET USE: (R38) requires a 1 person assist toileting.

04/24/25 12:47 PM entered open room door and observed V17, CNA, assisting R38 with toileting. V17 was in bathroom, door open with R38 in a standing position, pants down exposing R38's buttocks and scrotum to R38's roommate.

On 4/24/2025 at 1:00 PM R36 stated that he does not like watching his roommate going to the bathroom and does not want to look at his genitals.

On 4/24/2025 at 12:45 PM V45, R38's sister in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 5	S9999		

law, stated that R38 would not like to be exposed to others and would want the door closed when going to the bathroom.

4.R56's face sheet documented he was admitted to the facility on 11/18/21 with diagnosis of, in part, rhabdomyolysis, Alzheimer's disease and dementia.

R56's Minimum Data Set (MDS) dated 2/25/25 documented he was severely cognitively impaired and requires partial/moderate assistance for toileting hygiene and shower/bathing self and is frequently incontinent of bladder.

On 4/23/25 at 10:45 AM, V26, CNA, and V24, CNA, left the blinds to R56's room and curtain open while having his peri-region exposed during peri care. V26 stated he forgot to close the blinds. V24 then went over to the blinds and closed them.

The Residents' Rights for People in Long-term Care Facilities brochure, undated, documented that residents have the right to privacy, including medical and personal care.

(B)

2 of 5

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 6	S9999		

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 abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent abuse for 4 of 4 (R36, R38, R88, R90) residents reviewed for abuse in the sample of 79. This failure resulted in R36 suffering psychosocial harm and feeling scared, unsafe, unable to protect himself and less of a man. This failure also resulted in R90

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 7	S9999		

suffering harm and being hit in the face, stomach and leg by another resident and R88 having a scratch to upper lip.

1. R36's Care Plan, not dated, does not document R36's risk for or interventions to prevent abuse.

R36's Minimum Data Set (MDS), dated 3/9/2025, moderately cognitively impaired.

On 4/21/2025 at 9:27 AM observed R36 and R38 striking each other with closed fist. R38 yelled out and struck R36 repeatedly, with closed fist on the arm, hand and shoulder. R36 then grabbed R38's arm and swung closed fist at R38, making contact with R38's chest. R38 continued to yell out and push the door into R36's wheelchair and R36's arm. V29, Safety Aide, intervened and attempted to calm the residents. V29 instructed the residents to stop then removed R38's hand from R36's arm. R38 was then taken from room.

On 4/21/2025 at 3:50 PM reviewed R36's medical record. No documentation of the resident to resident altercation.

On 4/22/2025 at 11:30 AM R36's medical record reviewed. No documentation of the resident to resident altercation.

The facility's Midnight Census report dated 4/24/2025 at 9:54 AM documents that R38 and R36 remain roommates.

On 4/23/2025 at 1:30 PM the facility provided documentation of resident to resident abuse reported to IDPH.

On 4/22/2025 at 1:10 PM R36 stated that his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 8	S9999		

roommate is still in the room. R36 stated that his roommate is mean. R36 stated that R38 has been mean and hitting him since moving to the room. R36 stated that he is scared and does not feel safe in the room. R36 stated that he feels that he can't protect himself. R36 stated that he feels less of a man because he can't really defend himself. R36 stated that he has notified V31, Social Services Director (SSD), about he and his roommate not getting along and feeling scared.

On 4/22/2025 at 1:14 PM V4, Registered Nurse (RN), stated that she was not aware of a resident to resident altercation that occurred between R36 and R38. V4 stated that R38 does have aggressive and combative behaviors. V4 stated that R38 is usually the aggressor. V4 stated that R36 is quiet and doesn't bother anyone. V4 stated that R36 has not had any behaviors of aggression towards staff and or resident.

On 4/23/2025 at 11:45 AM V4, RN, stated that she notified V2, DON, of the resident to resident altercation that was reported to her yesterday.

On 4/23/2025 at approximately at 12:30 PM V1, Administrator, stated that she was not aware of a resident to resident altercation that occurred between R36 and R38 until today. V1 stated that when the state surveyor reported it; V1 that is the time it was reported to the state. V1 stated that she was not notified by the staff that were present. V1 stated that V29 is not a CNA. V1 stated that V29 is a safety aide and here to help monitor the residents to keep them safe. V1 stated that V29 did not report the abuse.

On 4/28/2025 at 11:00 AM V4 stated that R36 is alert and oriented and able to voice needs. V4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 9	S9999		

stated that he can answer questions appropriately.
R38's Care Plan, dated 12/30/2024, documents that R38 BEHAVIOR: (R38) has a hx (history) of physical aggression towards peers. i.e. (for example) on 12/1/24 (R38) grabbed another resident's arm causing him to bleed.
2. R88's face sheet documented he was admitted to the facility on 9/10/24 with diagnosis of, in part, osteoarthritis, degenerative disease of nervous system, and psychosis not due to a substance or known physiological condition.

R88's MDS, dated 3/11/25, documented he is severely cognitively impaired.

R88's Care Plan does not include him to be at risk for abuse.

R90's face sheeting documented he was admitted on 10/24/24 with diagnosis of, in part, osteoarthritis, dementia with moderate agitation, and psychosis.

R90's MDS, dated 1/20/25, documented he is severely cognitively impaired.

R90's Care Plan dated 12/12/24 documented he is at risk for abuse and/or neglect related to impaired cognitive skills, diagnosis of Alzheimer's and Dementia.

The facility's Initial Event Reporting dated 2/7/25, documented, "Please find this as the initial reporting related to an allegation of a resident to resident physical altercation. R90 and R88, two cognitively impaired male residents of the facility locked dementia care unit, were reported to have had an altercation resulting in a small scratch to R88's upper lip. Staff intervened to ensure safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 10	S9999		

with assessments and notifications completed. R90 was transferred for evaluation related to his behaviors and remains at the ER (emergency room) at this time."

The facility's final report regarding the allegation of resident-resident physical altercation occurring on 2/7/25 documented, "On 2/7/25 at approx. (approximately) 1830 (6:30 PM), memory unit staff heard a commotion from the room of R88. Staff responded to the room urgently. As they were approaching R88 was exiting his room reporting R90 had entered his room and became agitated when he was asked to leave. R88 states that R90 had entered his room and became agitated when he was asked to leave. R88 states that R90 hit him three time(sic). R88 reports that R90 hit his face, stomach, and leg. Staff separated resident's immediately."

The facility's interview statement with V42, CNA, dated 2/8/25 documented, "R88 was wandering said looking for his wife last I saw by shower room. We heard some yelling, rushed to them. R90 said he hit him. We got R88 away and watched him until he went out. He thought they were sleeping with his wife or something." V42 documented that R90 was last seen wandering.

The facility's interview statement with V43, LPN, dated 2/8/25, documented, "R90 was wandering looking for his wife. When we heard the commotion and got to the room they were just yelling. R88 said R90 hit him. We got them away, did assessments and notified and sent R90 out. R88 was okay. He said he thinks he was looking for his wife and he didn't have her." V43 documented R88 was last seen wondering.

The facility's interview statement with R90 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 11 2/8/25, documented he had no recollection of the event. (B) 3 of 5 300.610a) 300.1210b) 300.1210d)5) 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 12	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Based on Interview, Observation, and Record Review, the facility failed to identify and treat a resident's wounds for 1 of 4 residents (R18) reviewed for wound care in the sample of 79. This resulted in R18 experiencing severe excoriation, including skin breakdown and pain.

The Findings Include:

R18's Admission Record, dated 4/22/25, documents R18 was admitted to the facility on 8/24/2018 with diagnosis of Cerebral Infarction, Dysphagia, Dementia, Major Depressive Disorder, Anxiety Disorder, Trigeminal Neuralgia, and Morbid Obesity.

R18's Care Plan, dated 11/6/24, documents R18 has an ADL (Activities of Daily Living) self-care performance deficit related to Limited Mobility. Interventions: Toilet Use: R18 is not toileted, she is frequently incontinent, unable to transfer to toilet, use of bedpan encouraged, incontinent care per staff. It continues (4/7/25) R18 has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 13	S9999		

potential for impairment to skin integrity related to impaired mobility, current medications, incontinence of B&B (bowel and bladder). Interventions: Complete pressure ulcer risk assessment quarterly and PRN (as needed), observe skin daily with care, notify MD (medical doctor)/NP (nurse practitioner) of any abnormal findings, pressure redistribution mattress to bed, provide diet as ordered, RD (registered dietitian) to follow related to wound care and nutrition, refer to Specialized Wound Management, staff to assist with turning and repositioning as tolerated, staff to provide incontinent care after each incontinent episode, weekly skin assessment.

R18's Minimum Data Set (MDS), dated 3/24/25, documents R18 has a severe cognitive impairment and is dependent on staff for toileting and bathing. R18 is always incontinent of both bowel and bladder.

R18's Physician Order, dated 2/10/25, documents "Skin assessment weekly every Tuesday day shift. Every day shift every Tuesday for weekly skin check. Please complete skin checks in (computer system)."

R18's Physician Order, dated 4/22/25, documents "Cleanse bilateral buttocks with NS (normal saline) or WC (wound cleaner), apply barrier cream daily and PRN (as needed). Every Day shift for incontinence dermatitis."

R18's Physician Order, dated 7/19/24, documents "Cleanse peri area with mild soap and water or facility wipes, pat dry, apply Calazinc cream to buttocks, peri area, and inner thighs PRN."

R18's Weekly Skin Assessment, dated 4/15/25, documents Incontinence Dermatitis to left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 14	S9999		

buttock, right thigh, and left thigh.

R18's Weekly Wound Assessment, dated 3/11/25, documents R18 had a Pressure Ulcer to left buttock that was healed. There is no further wound notes completed.

R18's (Wound Management Specialist) Note, dated 3/18/25, documents in part "Visit Date: 3/18/25, DC (discontinue) (Wound Management Specialist) services, Nursing to continue to monitor and notify me of changes."

On 4/22/25 at 10:00 AM, V12, Certified Nursing Assistant (CNA), in to do peri-care on R18, and during incontinent care, R18 was rolled to her right side, and her buttocks appeared very reddened with open sores that appear like skin tears with slight bleeding from areas. V12 continued to wipe R18, causing even more bleeding. A clean brief was applied with no moisture barrier cream applied to R18 and no drying seen done.

On 4/22/25 at 10:18 AM, V12, CNA, stated "(R18) did not have these sores on her bottom the last time I was working here. It looks like it is from sitting in wetness, especially when sitting her in her wheelchair."

On 4/23/25 at 9:10 AM, V19, Wound Nurse, stated "(R18) did have sores on her buttock before and the (Wound Management Specialist) was working with her, but that was all healed. The CNAs are supposed to be putting moisture barrier on her with each incontinence care." When told that R18's buttocks were excoriated and bleeding, V19 stated "No one has told me about that, I was not aware of it. I will check her out this morning and probably have (Wound Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 15 Specialist) look at her again." On 4/23/25 at 9:48 AM, V15, CNA, stated "If I'm doing incontinent care and the resident has redness or open sores, I would use a barrier cream and will tell the nurse about it." On 4/23/25 10:50 AM, V19 gathered supplies to assess R18's wounds with V22, CNA, assisting. V19 opened R18's legs to expose her inner thighs and perineum area which were very bright red and excoriated. V22 turned R18 to her right side exposing her buttocks which showed three open wounds to her back side with the entire buttocks, anal area, gluteal creases all red and excoriated. V19 stated "I was not aware of any of these wounds. R18 has been red for quite a while, and we were supposed to be using moisture barrier cream for it because she is a heavy wetter and is always saturated. I will have to call the physician now and get some orders for wound treatment. This looks very painful, and she should be in pain the way it looks." V19 measured R18's wounds which was the right buttock 2 CM (centimeters) X 5 CM X 1.0 CM, the left inner thigh 1.0 CM X 4.3 CM, and the right gluteal fold 0.4 CM X 3.7 CM. On 4/23/25 at 10:55 AM, V22 stated "I just did peri-care on (R18), and she was yelling that it hurt every time I would wipe her. She was definitely in pain." On 4/28/25 at 11:00 AM, V2, Director of Nursing (DON), stated "I would expect the CNAs to report any resident's change in skin condition to the nurse and I would expect the nurses to perform skin and wound assessments and provide appropriate treatments as ordered by the physician."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 16	S9999		

On 4/23/25 at 11:30 AM, V19 stated "I just spoke with the physician and (R18) will be followed up with (Wound Management Specialist) again and he gave me orders to take care of her wounds."

On 4/23/25 at 11:35 AM, V19 gathered her supplies for wound care. V19 sprayed 4X4 gauze with wound cleaner and right buttock wound wiped, then Collagen and Calcium Alginate and foam dressing applied. R19 started to have a loose bowel movement so the wound care paused for peri-care.

On 4/23/25 at 11:53 AM, V19 continued wound care on R18. Previous dressing was replaced due to feces on it. Wound cleanser sprayed on 4X4, wound wiped, then patted dry. Cavalon wiped on left inner thigh and right gluteal fold wounds, allowed to dry, then V19 wiped barrier cream all over R18's buttock/anal area. The previous dressing on R18's right buttock was falling off, V19 removed the old dressing, recleaned site, applied Collagen and Calcium Alginate and foam dressing again. While R18 was turned to her right, a small thin open slit was noticed on R18's gluteal cleft, V19 made aware and wiped barrier cream on it. R18 rolled back to her back side and covered up. There was no cleaning, or wound care provided to R18's front inner thighs or peri-area.

R18's New Physician Order, dated 4/23/25, documents "Cleanse bilateral buttocks with NS or WC, apply barrier cream Q shift and PRN. Every shift for incontinence dermatitis/excoriation/ MASD (moisture associated skin dermatitis)."

R18's New Physician Order, dated 4/23/25, documents "Cleanse wound to right buttock NS or WC, apply Collagen, Calcium Alginate, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 17	S9999		

cover with a foam dressing daily and PRN. Every Day shift for open area to right buttock."

R18's New Physician Order, dated 4/23/25, documents "Cleanse anterior inner things with NS or WC and apply barrier cream Q shift and PRN. Every shift for excoriation/MASD to BIL (bilateral) inner thighs."

R18's New Physician Order, dated 4/23/25, documents "Cleanse BIL posterior inner thighs with NS or WC and apply barrier cream Q shift and PRN. Every shift for excoriation/MASD to inner thighs."

R18's New Physician Order, dated 4/23/25, documents "Cleanse BIL posterior inner thighs/gluteal folds with NS or WC, pat dry, and apply Cavilon once weekly and PRN. Every day shift every Wed (Wednesday) for excoriation/MASD to BIL thighs."

The Facility's "Guide for Wound Evaluation", undated, documents in part "Procedure: 1. Upon identification of a pressure ulcer/injury (arterial, venous, or neuropathic), regardless if developed in-house or upon admission, the area is to be documented on the Wound Evaluation Form or in the electronic format. 2. Non-Ulcers are to be documented weekly on a Skin Condition Form or in electronic format. 3. Contact physician, interdisciplinary team, family members, and significant others as indicated. 4. Initiate appropriate treatment per treatment protocol and physician order. 5. Evaluate further interventions that may be indicated to promote healing and prevent infection. 6. Documentation of wound status will occur at least once a week. This weekly evaluation will be documented electronically or on the Wound Evaluation Form /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 18	S9999		

Skin Condition Form as appropriate. 7. The physician is to be notified if there is no improvement in area, signs and symptoms of infection or signs of deterioration. 10. The Director of Nursing Services and/or designated Licensed Nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be addressed. Resident lack of progress will be evaluated. Directives may be given for further interventions and changes in plan of care."

The Facility's "Wound Care Treatment Protocol", dated 11/2012, documents in part "Evaluate the wound daily for signs and symptoms of infection and for signs of healing. Document / Report findings. Provide treatment as per physician's order."

(B)

4 of 5

300.610a)
300.1010b)
300.1210b)
300.1210c)
300.1210d)6)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 19	S9999		

the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 20	S9999		

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not meet as evidenced by:

Based on interview, observation, and record review the facility failed to ensure safety as indicated per plan of care for 4 of 4 (R11, R17, R53, R72) residents reviewed for accidents and hazards in the sample of 79. This failure resulted in R72 suffering multiple falls and receiving a skin tear to her right knee.

Findings include:

1. R72's face sheet documented she was admitted to the facility on 1/16/24 with diagnosis of, in part, neoplasm of brain, dementia, and neoplasm of lung.

R72's MDS dated 3/14/25 documented she is moderately cognitively impaired and required supervision or touching assistance for all transfers, walking, and going from a sitting to a standing position.

R72's Care Plan dated 1/7/25 documented she has high risk for falls related to confusion, gait/balance problems, psychoactive drug use, mood adjustment disorder and anxiety. Fall risk interventions put in place included: for 2/25 0900: provide sign on walker to remind resident to use walker when ambulating added on 3/4/25, for 2/25 1200: place in-room signage to remind

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 21	S9999		

resident to request help from staff when feeling tired/weak added on 3/4/25, anticipate and meet R72's needs added on 1/7/25, ensure that she is wearing appropriate footwear i.e. shoes/non-skid socks) when ambulating with wheeled walker added on 11/19/24, evaluate the effectiveness and side effects of psychoactive drugs for possible decrease in dosage/elimination of drug on 11/19/24, follow facility fall protocol added on 11/19/24, hospice to provide Bolstered mattress for increased safety and to avoid rolling out of bed when resting added on 4/15/25, increase safety observations: staff to check room during routine rounding and PRN for environment safety, ensure no clothing are left on the floor added on 3/4/25, observe for removal of shoes when sitting in chair, re-direct resident to ensure shoes remain in place when OOB (out of bed) added on 4/15/25, Pt (physical therapy) evaluate and treat as ordered or PRN (as needed) added on 11/19/24, review information on past falls and attempt to determine cause of falls, record possible root causes, alter remove any potential causes if possible, educate resident/family/caregivers/IDT (interdisciplinary team) as to causes added on 11/19/24, and R72 needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach added on 1/7/25. R72's fall care plan had interventions added on the following dates: 11/19/24, 1/7/25, 2/25/25, 3/4/25, and 4/15/25.

R72's Morse Fall Risk Assessment dated 3/14/25 documented she is a high fall risk and to implement high fall risk interventions.

The Facility's Incidents by Type Report from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 22	S9999		

1/21/25 to 4/21/25 documented R72 had 8 total falls on 2/25/25 (twice), 3/9/25, 4/13/25, 2/23/25, 2/27/25, 3/31/25, and 4/4/25.

R72's Progress Notes documented her having a total of 12 falls on the following dates: 1/10/25, 1/16/25, 2/23/25, 2/25/25 (twice), 3/10/25, 3/12/25, 3/17/25, 4/4/25, 4/13/25, 4/19/25, and 4/23/25.

R72's Progress Note dated 4/19/25 at 2:59 PM, documented R72 obtained a skin tear to her right knee after being found laying on the floor next to her bed on the left side of her face.

R72's Progress Note dated 4/19/25 at 6:27 PM, documented she returned from the hospital with diagnosis of pneumonia and a urinary tract infection.

On 4/21/25 at 8:59 AM, on 4/22/25 at 9:23 AM, 11:39 AM and at 2:55 PM R72 was observed not wearing non-slip socks or shoes.

On 4/21/25 at 8:59 AM, R72 had a bruised left eye with bloody sclera. R72 does not remember what from; she did not have non-slip sock on and was sitting in her wheelchair.

On 4/22/25 at 9:04 AM R72's door was closed, this surveyor knocked, and walked in. R72 was lying in bed awake, call light on floor, fall mat on left side, no mat on right side, bed in low position, and no footwear on and her bed did not have a bolster mattress in place.

On 4/22/25 at 9:23 AM, R72 was in wheelchair at dining area in front of nurse's station with a snack after her morning medications; R72 was not wearing non-slip socks or shoes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 23	S9999		

On 4/22/25 at 2:55 PM, V23, R72's daughter, stated her mother came here with lung cancer and it has since metastasized to her brain. Since the metastasis, V23 stated she thinks R72 has had increased falls. V23 stated her mother doesn't have non-slip socks on and she is supposed to. V23 stated she requested the facility try to utilize an alarm system for R72 but was told they couldn't. V23 stated she does not feel like R72 has enough supervision to prevent falls and would like to know if the bolster mattress will be put in place soon. V23 stated she does like the fall mats in place.

On 4/23/25 at 10:26 AM, V24, CNA, stated fall interventions for R72 include floor mats, frequent checks, and assistance to the bathroom, as well as offering the restroom often.

On 4/23/25 at 10:28 AM V25, CNA, stated fall interventions for R72 include floor mats by bed, providing assistance.

On 4/23/25 at 10:29 AM V5, LPN, stated fall interventions for R72 include having the bed in low position, use of fall mats, observation, keep closer to nurse's station, non-slip socks, and fall interventions for R10 include bed in low position, reminders for safety, offering help fast. V5 stated she is new to the facility and since working here for about 2 weeks she has not seen any concerns between R88 and R90. V5 stated interventions for wandering include offering lots of activities, keeping the residents busy, toileting them and providing naps with frequent assistance of needs.

On 4/23/25 at 2:24 PM, V2 DON (director of nursing) stated there was no fall for R72 on 4/19/25 after a fall investigation was requested for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 24	S9999		

that date and would have to check back after this surveyor mentioned there was one documented in the progress notes.

On 4/23/2025 at approximately 2:40 PM V2, Director of Nursing, stated that initially she did not remember what fall that occurred on 4/19/2025 until she read the note in the computer. V2 stated that R72 was sent to the hospital for a change in condition. V2 stated that she remembered at that time R72 was on the floor. V2 stated that they thought R72 had a stroke. V2 stated that the hospital determined that R72 did not have a stroke and was diagnosed with pneumonia.

2.R53's face sheet documented he was admitted to the facility on 12/28/23 with diagnosis of dementia with severe agitation and psychotic disturbance, and schizoaffective disorder.

R53's MDS dated 2/25/25 documented he was severely cognitively impaired and exhibits wandering behavior daily.

R53's Care Plan dated 1/13/2025, documented he is an elopement risk due to the following behaviors: exit seeking, confusion, wandering aimlessly and he resides on a secured unit. Interventions for this care plan included encourage R53 to verbalize through one-to-one interaction added on 1/8/2025, place R53 in area where observation is possible added on 1/8/2025, and provide diversional activities for resident when anxious, offer resident a snack added on 12/4/2024.

On 4/21/25 at 9:30 AM, R69 stated R53 wanders into his room and takes things so they keep his door closed, he needs to be watched.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 25	S9999		

On 4/22/25 at 9:00 AM, R53 was observed walking up and down the hallway. At 9:07 AM, R53 walked into R90's room then came back out and walked into R80 and R33's room, closed the door and came back out within a couple minutes. This surveyor observed no staff intervene while R53 walked into other resident's room.
3. R17's Admission Record, dated 4/24/25, documents R17 was admitted to the facility on 6/29/24, with diagnosis of Alzheimer's Disease, Dementia, Major Depressive Disorder, Anxiety Disorder, HTN, Encephalopathy, Spinal Stenosis, Thoracolumbar and Lumbar Region, Low Back Pain, Radiculopathy Lumbar Region.

R17's Care Plan, dated 1/13/25, documents R17 has potential for acute risk for falls related to Confusion, Deconditioning, Psychoactive drug use. Interventions: Anticipate and meet R17's needs, educate R17/family/caregivers about safety reminders and what to do if a fall occurs, encourage R17 to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that R17is wearing appropriate footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks when ambulating or mobilizing in wheelchair, follow facility fall protocol, PT (physical therapy) evaluate and treat as ordered or PRN (as needed), review information on past falls and attempt to determine cause of falls, record possible root causes, alter/remove any potential causes if possible, educate R17/family/caregivers/IDT (interdisciplinary team) as to causes.

R17's MDS, 3/19/25, documents R17 has a moderate cognitive impairment and requires supervision/touching assistance for toileting, and supervision/touching assistance for sit-to-stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 26	S9999		

and toilet transfers.

R17's Fall Risk Assessment, dated 3/20/25, documents R17 is a High Fall Risk.

R17's EZ Move Assessment, dated 3/21/25, documents in part "Device Required: Gait Belt."

On 4/21/25 at 9:02 AM, R17 put her call light on with V12, CNA, entering to assist. R17 stated she needed to use the restroom and V12 assisted R17 to side of her bed, R17 stood and pivoted into her wheelchair with V12 holding onto R17 by under her arm and down into the wheelchair, then pushed R17 into restroom. R17 stood and pivoted to the toilet again with V12 holding onto under R17's arm. V12 had a gait belt around her waist, and it dropped to the floor with V12 picking it back up and putting it around her waist again, but never used it on assisting R17 in her transfers.

4. R11's Admission Record, dated 4/23/25, documents R11 was admitted to the facility on 6/17/2021 with diagnosis of Alzheimer's Disease, Dementia, Major Depressive Disorder, Psychosis, Generalized Osteoarthritis, and Vertigo.

R11's Care Plan, dated 1/20/25, documents R11 is at moderate risk for falls related to gait/balance problems, incontinence, psychoactive drug use, behaviors. Interventions: Follow facility fall protocol.

R11's MDS, dated 4/11/25, documents R11 has a severe cognitive impairment and requires partial/moderate assistance for sit-to-stand and bed to chair transfers.

R11's EZ Move Assessment, dated 1/24/25, documents in part "Lifting/Mobility Required:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 27	S9999		

one-person, Device Required: Gait Belt."

R11's Fall Risk Assessment, dated 1/24/25, documents R11 is a High Fall Risk.

The Facility's Fall Log, documents R11 had a fall on 3/21/25, and 3/26/25.

On 4/23/25 at 8:55 AM, R11 was seen in bed with V20, CNA, assisting to get her out of bed. V20 had R11 sit up on side of bed, held R11 under her right arm, while R11 stood up and pivoted to her wheelchair. V20 had a gait belt wrapped around herself and did not use on R11.

On 4/24/25 at 9:40 AM, V14, CNA, stated "Any time I am assisting a resident with a transfer, I always carry a gait belt around my waist and will use it while assisting the resident."

On 4/28/25 10:35 AM, V25, CNA, stated that she uses a gait belt on residents during transfers.

On 4/28/25 10:40 AM, V12, CNA, stated that she uses her gait belt when transferring residents.

On 4/28/25 at 11:00 AM, V2, DON, stated "I would expect all staff to maintain resident safety and perform safe resident transfers by using the gait belt for high fall risk residents."

The Facility's "Transfer Belts/Gait Belts" Policy, dated 4/2014, documents in part "To promote safety in transferring residents, a gait belt is utilized when deemed appropriate."

The Facility's "Fall Prevention Strategies and Interventions" undated in part "Transfer Assistive Devices: Ensure staff uses gait belt, transfer resident with gait belt."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 28	S9999		

The Facility's "Elopement Guidelines", dated 8/2017, documents in part "The Elopement Risk Evaluation is to be done upon admission and quarterly and as needed with exit seeking behaviors. At the beginning and end of each shift the charge nurse is to make visual rounds on each high risk resident to ensure that they can be located in the facility. When exit seeking activity occurs consider 1:1 supervision or 15-minute checks."

(B)

5 of 5

300.650d)

Section 300.650 Personnel Policies

d.) The facility shall check the Health Care Worker Registry for the work eligibility status of all applicants who are under the jurisdiction of the Healthcare Worker Background Check Act prior to hiring.

This Requirement is NOT MET as evidence by:

Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs), dietary personnel, and housekeeping personnel had been searched on the Illinois Department of Public Heath-Healthcare worker registry and background checks prior to hire for 7 out of 10 employees.

Findings include:

V26, Certified Nurse Assistant (CNA), had a hire dated of 4/17/2025 and V26's Healthcare Worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 29 Registry was searched on 4/21/2025. V33, Activity Assistant, had a hire date of 4/1/2025 and her Healthcare Worker Registry was searched on 3/13/2025. V34, Laundry Aide, had a hire date of 3/12/2025 and the Healthcare Worker Registry was searched on 3/13/2025. V35, CNA, had a hire date of 3/27/2025 and the Healthcare Worker Registry was searched on 4/2/2025. V36, CNA, had a hire date of 11/7/2025 and his Healthcare Worker Registry was searched on 12/22/2025. V37, CNA, had a hire date of 2/14/2025 and her Healthcare Worker Registry was searched on 3/7/2025. V38, CNA had a hire date of 12/11/2025 and her Healthcare Worker Registry was searched on 12/22/2025. On 04/24/2025 at 1:00 PM, V32, Human Resources, stated that she checks the Healthcare Workers Registry on the day of the new employee's orientation and that she does not check the Registry prior to offering a position to them. On 04/24/2025 at 1:14 PM, V2, Director of Nurses, stated that she checks the Healthcare Workers Registry prior to the new employee being offered a position but does not print it off and does not have documentation of it being checked.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010441	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 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) COMPLETE DATE
S9999	Continued From page 30 The facility's policy, "Human Resources Policies and procedures Manual," dated 5/01/2014, documented, " Policy: It is the Facility's policy to verify possible criminal backgrounds of pending new hires prior to the commencement of employment." (C)	S9999		