

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2025
NAME OF PROVIDER OR SUPPLIER  Jacksonville Skld Nur & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1517 West Walnut Street Jacksonville, IL 62650	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40650</p> <p>Based on interview and record review, the facility failed to have interventions in place to prevent a fall, for 1 of 3 (R2) residents, reviewed for falls in a sample of 4.</p> <p>This past non-compliance occurred from 2/19/2025 to 3/10/2025.</p> <p>Findings include:</p> <p>On 3/6/2025 at 11:15 AM, R2 was sitting up in his recliner, sleepy. Pad alarm was in place and call light was within reach. Easily awoken, there was a scabbed area to his chin but R2 has a full beard. Indwelling urinary catheter, was hanging on the side rail of the bed, below his recliner. R2 was asked what happened when he fell , he stated that he really didn't remember. He then stated that his sister was visiting him, he thought when he fell . He was asked if he fell in the morning or in the evening and he stated that he thought it was in the evening, but he really didn't remember.</p> <p>On 3/10/2025 at 10:00 AM, V4, Licensed Practical Nurse (LPN), stated that she was just getting her day started, it was right after shift change, when she heard R2 fall. She found R2 face down by his dresser. She continued to state that he did not have his alarms on, nor did he have his nonskid footwear on, and that he had on his regular socks. V4, also stated that he was up to his recliner prior to his fall.</p> <p>On 3/10/2025 at 3:45 PM, V5, LPN, stated that she didn't work on 2/19 but was there the night of 2/18, she stated that they do walking rounds and R2 wasn't having any behaviors. V5, LPN also stated that she doesn't remember him having an alarm pad on his bed or in his chair that night but also stated that it has been a long time ago.</p> <p>On 3/10/2025 at 12:50 PM V7, Certified Nurse Assistant (CNA), returned a call and stated that she did not recall if R2's pad alarm was in place that night while in bed or up to his recliner on 2/18. V7 stated that when there is a new fall intervention put in place, they are told in shift report of changes with residents. She continued to state that she did not recall if she was told that he required a pad alarm when in bed or when up to his recliner.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/6/25 at 2:00 PM, V8, CNA stated the pull tap alarms put in place need to be clipped on to the resident for it to function correctly. If they are not in place if they are dangling on the ground behind the wheelchair. V8 stated the alarm will blink when it needs a new battery. The pad chair alarms will typically show a green light when they are first applied to know it is turned on.</p> <p>On 3/6/25 at 2:05 PM, V6, CNA stated that the pull tab alarm needs to be attached to the resident in order for it to be effective and work.</p> <p>R2's Minimum Data Set, dated [DATE] documented that his cognition was severely impaired.</p> <p>R2's Fall risk Assessment, dated 2/12/2025, documented that he was a high risk for falls and that he was chair bound and /or assist with elimination.</p> <p>R2's Physician's orders dated 3/2025, documented diagnosis of Wedge Compression Fracture of T5-T6 and T11-T12, Lymphoid Leukemia and Neurocognitive Disorder with Lewy Bodies. It also documents an order on 2/18/2025 for Device: Alarm: To Bed and Chair as resident will allow. Check for placement and functioning every shift.</p> <p>R2's Care Plan, dated 2/8/2025, documented, Transfer: One person physical assistance required.</p> <p>R2's Care Plan, dated 2/11/2025, prior to a fall on 2/19/2025, documented, fall interventions of 2/11 Fall Mats, 2/11 Low bed, 2/18 Personal alarm at all times as resident will allow. It continues, Provide/Reinforce use of non-skid footwear.</p> <p>R2's Progress note, dated 2/19/2025 at 7:13 AM, documented, Resident found on floor in room face down near dresser. Laceration to chin and above left eye, hematomas started on forehead at this time. Right sided jaw pain and right shoulder pain. Wife notified, on call nurse aware, MD aware. Sent out for eval and treatment. Resident is alert x 4 at this time with paramedics. Unwitnessed fall and hit head. All paperwork sent with resident.</p> <p>R2's General Note, dated 2/19/2025 at 12:56 PM, documented, Resident returned from hospital. Closed comminuted fracture of right sided mandibular alveolar bone; Atypical syncope; chin laceration. Remove sutures in 5 days Ciprofloxacin 500 mg, 1 tab BID 14 days Potassium chloride 20 meq oral tab extended release po q day follow up with (Unknown Physician) within 1-2 days for worsening/continued problem. Call to schedule appointment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Fall investigation with root cause analysis, dated 2/19/2025, documented, Type of incident: fall with injury. It continued, Pertinent Diagnosis: Neurocognitive Disorder with Lewy Bodies. Resident Status/Description of injuries (If Any): Laceration, mandibular FX. It continues, 78 y/o male who is non independent with ambulation. Resident got up to use the bathroom despite the indwelling catheter, became dizzy and fell . Laceration noted to chin and above left eye, right sided jaw pain, right shoulder pain. EMS was called to the facility and transported resident to (local hospital) for evaluation and treatment. (R2) returned from (local hospital) to the facility with sutures to close the laceration to chin. CT was negative for intracranial abnormality but did reveal an acute fracture of the right sided mandibular condyle. Resident returned to facility on 2/19/2025 and remains at baseline. Care Plan updated. Resident assessed for pain. Fall intervention updated and in place. It continues, Conclusion: IDT discussion on fall. Root cause: Bladder spasms. Upon investigation, resident recently returned to facility from hospitalization . During hospital stay, previous medications used to treat bladder spasms and hypotension had been discontinued. Intervention: Medication review. Problem Statement: Resident stood up to go to the restroom, got dizzy and fell forward. Why 1: bladder spasms, urge to void. Why 2: bladder spasms r/t indwelling foley cath.</p> <p>R2's Hospital record, dated 2/19/2025, documented, History of Present illness: Patient is a 78- year old male who presents emergency department after fall. According to the patient who resides in a nursing home currently and he reports that he blacked out and fell but this was witnessed. It continues, CT facial bones: It continues, . There is an acute comminuted and displaced fracture of the right mandibular condyle and there is right temporal mandibular dislocation. The right mandibular condyle is displaced medially and anteriorly with the jaw in a closed position.</p> <p>On 3/10/2025 at 2:55 PM, V2, Assistant Administrator, stated that they do not have a fall prevention policy.</p> <p>The facility's Policy, Accidents and Incidents, dated 9/7/2023, documented, 5. the Interdisciplinary Team (IDT) will conduct a thorough investigation of the accident/incident. Findings of the investigation, including root cause of the accident/incident and appropriate interventions will be indicated in the incident report and implemented.</p> <p>Prior to the survey date of 3/12/2025, the facility had taken the following actions to correct the noncompliance.</p> <ol style="list-style-type: none"> <li>1. All staff inserviced on Fall interventions that need to be in place at all times and where to find this information.</li> <li>2. House wide fall interventions audit and care plans reviewed.</li> <li>3. Alarms were added to CNA task.</li> </ol>		