

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2025
NAME OF PROVIDER OR SUPPLIER  Jerseyville Nsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1001 South State Street Jerseyville, IL 62052	

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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility failed to ensure its door alarms were loud enough to be heard from areas away from the 200 hall exit door and its outside gait latch was in working order to prevent elopement in 1 of 4 residents (R2) reviewed for elopement in the sample of 4. This led to R2 eloping from the facility, which is located on a busy intersection and approximately 100 yards from an active railroad track. The Immediate Jeopardy began on 8/22/25, when R2 eloped from the facility. On 9/16/25 at 10:45 AM, V1, Administrator, and V2, DON, were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on 9/16/25 but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings Include: On 9/16/25 at 8:20 AM, this surveyor went to the 100/300 nurse's station and V7 activated the 200-hall door alarm, it could not be heard from the 100/300 hall nurse's station until approximately 20 feet down the 200 hallway, and when it was heard, the surveyor was unable to discern what type of alarm it was. On 9/16/25 at 8:00 AM, 8:20 AM, and 8:29 AM, there were no staff observed at the 200 hall nurses' station next to the 200-hall exit door. There was only one therapy staff in the building, and she was at the front of the building in the main dining room, not near the 200-hall exit door or the 200-hall nurses' station. R2's Progress Note, dated 8/22/25 at 7:16 PM, documents the following: Writer and (V3, R2's Son) were down 300 hall looking for patient as another resident told us she had come past desk and went down 300. Room search did not come up with patient. As writer and son rounded 100/300 nurses' desk, writer heard alarm going off from 200/400. (V3), writer, and (V6, CNA (Certified Nursing Assistant) started running. Writer and (V3) went out 200-hall door, (V6) went to 400 south to search for patient. Writer searched courtyard, to the outside of fence to front parking lot not locating resident. When writer entered front door, nursing staff was calling writer STAT to 200/400 hall doors. Another patient's family member stated they saw resident behind the building walking down the street. Writer, (V3), and 2 CNA staff took off running to patient. Samaritan was standing with patient. (V3) got truck from parking lot and drove over. (V3) and writer picked patient up and placed in passenger seat of truck. DON notified. POA (Power of Attorney) present. Full body check done. Patient has no open areas or areas of concern. R2's Progress Note, dated 9/3/25 at 2:32 PM, documents the following: This nurse spoke to (V3), who stated he was going to discharge his mother home to his house on 9/5/25. (V3) stated he feels that if he takes her home, she would be safer, and he wouldn't have to worry about her. (V3) stated he didn't feel safe with the facilities back fence being open. I let (V3) know I understand, and we would do what we could to make the transition for this resident to go home as successful as possible. R2's Progress Note, dated 9/5/25 at 2:22 PM, documents the following: (V3) and his wife in building to discharge patient home. Medications and treatment order gone over with POA, he understood. Orders printed individually for POA to take to pharmacy to fill. Medications were sent with patient, including Nystatin powder. POA wants patient to continue to see (V10, R2's Physician). Phone number was provided. Discharge instructions were gone over and POA understood. All belongings sent with patient. R2's MDS (Minimum Data Set), 7/9/25, documents R2 has severe cognitive impairment and ambulates with supervision. R2's Care Plan, dated 8/22/25, documents the following: Resident got out of the facility via 200-hall door. Staff placed resident on 15-minute checks. Starting 8/25/25, resident placed on 30-minute checks. R2's Elopement Assessment, dated 8/22/25, documents R2 is ambulatory, independent with wheelchair mobility, has cognitive impairment, and a history of wandering - elopement care plan initiated. R2's Elopement Investigation, dated 8/22/25 at 7:35 PM, documents the following: Patient got out the 200-hall door. Patient was found by another patient's family member on the street behind the facility. No behaviors prior to elopement. No changes in mental status. Contributing factors - Alzheimer's Disease, Dementia. No mood indicators present. Recent event, trauma, new diagnosis or other stressors/losses. Recent change in medications or new medications added. Abnormal lab values in the past 30 days. Immediate intervention - 15-minute checks. Interventions effective. The Final Report to IDPH (Illinois Department of Public Health), dated 8/22/25, documents the following: On 8/22/25, R2 exited the facility without staff knowledge while her son was visiting in the building. Staff immediately initiated the elopement protocol, and the resident was located nearby and safely returned to the facility without injury. The resident was assessed by nursing staff, family and Physician were notified, the care plan was updated, staff were re-educated on elopement prevention, door/alarm systems were verified to be functioning. Resident remains safe in the facility with enhanced monitoring in place. On 9/12/25 at 11:20 AM V3, R2's Son, stated on that Friday 8/22/25, he had</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>Based on interview and record review, the facility failed to ensure its courtyard gait latch was in proper working order when reviewing for mechanical equipment in working order. This failure has the potential to affect all 50 residents residing in the facility. Findings Include: On 9/12/25 at 11:20 AM, V3, R2's Son, stated on that Friday 8/22/25, R2 had exited the facility without staff and he and V4, LPN (Licensed Practical Nurse) went outside to the fenced in courtyard and did not see her. A young lady called and stated the facility had a patient out on the road behind the facility. V3 stated the courtyard gate to the fenced in area outside the 200-hall door was not locked or latched. V3 stated when he asked about this, he was told that they could not lock/latch it because it was illegal because it could prevent residents from exiting in the event of a fire. V3 stated he had decided at that time to take R2 home to live with him, they had several care concerns and this just placed it over the top. On 9/12/25 at 1:10 PM, V2, DON (Director of Nurses), stated the latch to the gait off of the 200-hall exit door was broken and has been fixed. V2 stated V3 asked her why it wasn't latched, and she told him because they weren't required to. R2's Progress Note, dated 9/3/25 at 2:32 PM, documents the following: This nurse spoke to (V3), and he stated he was going to discharge his mother home to his house on 9/5/25. (V3) stated he feels that if he takes her home, she would be safer, and he wouldn't have to worry about her. (V3) stated he didn't feel safe with the facilities back fence being open. The Safety and Supervision of Residents Policy, dated 12/31/25, documents the following: Our facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified in an ongoing basis through a combination of employee training, employee monitoring, and reporting processes, reviews of safety and incident/accident report, and a facility-wide commitment to safety at all levels of the organization. The Resident Census Report, dated 9/12/25, documents there are 50 residents residing in the facility.</p>		