STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145465	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerseyville Nsg & Rehab Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews the facility failed to evaluate, implement and monitor effectiveness of fall interventions to prevent falls for 1 out of 3 residents (R2); reviewed for accident hazards/supervision/devices in a sample of 4. This failure resulted in R2 sustaining depressed skull, orbital, maxillary and temporal fractures, a scalp laceration, a subdural hematoma, a subarachnoid hematoma and an intraparenchymal hematoma of the brain. Findings include:R2's Face Sheet documented she was admitted to the facility on [DATE] and was discharged on [DATE] with diagnosis of, in part, dementia with agitation, history of falling, hypothyroidism, and anxiety disorder.R2's Minimum Data Set (MDS) dated [DATE] documented she was rarely/never understood and her cognitive skills were severely impaired. It continued to document that R2 required the use of a wheelchair, substantial/maximal assistance from staff to stand, and partial/moderate assistance to sit up on the side of the bed from a lying position.R2's Care Plan started on [DATE] documented she was at risk for injuries related to history of falls secondary to unsteady gait and the interventions added to this care plan included: ([DATE]) use proper assistive device wheelchair/walker as needed, rest periods as needed, proper footwear as indicated, invite/escort to activities of choice as tolerated as desired, cues/redirect as needed, clutter free environment, call light within reach while in room and remind resident to call for assistance as needed; ([DATE]) staff will have the tv on when she is laid down in bed; ([DATE]) bed/chair alarm placed on residents bed and wheelchair, however, this was already care planned on [DATE] in a separate care plan; and ([DATE]) staff will place bed in lowest position and place a fall mat beside the residents bed.R2's Progress Note from her admission date on [DATE] at 8:00 PM, documented R2 was at the facility for reoccurring falls. R2's Fall Risk Assessments dated [DATE], [DATE], [DATE] and [DATE] all documented she was a high fall risk.The facility's Fall Report documented R2 fell on [DATE], [DATE] and [DATE].The facility's Fall Investigation Report dated [DATE] documented R2 received an injury to her head, and the root cause was R2 wanting to watch tv (television) and that staff will have the tv on when R2 is laid down in bed. The report also included a progress note dated [DATE] documenting R2 had an alarm in place to her wheelchair. The facility's Fall Investigation Report dated [DATE] documented R2 received an injury to her head and arm then sent to the ER (emergency room). The report documented the root cause was R2 trying to stand and for bed/chair alarm to be placed on her bed and wheelchair. The report documented a progress note stating R2 had been sitting in her wheelchair with seatbelt on and had a contusion to her head that was bleeding out onto the floor. The report concluded that R2 was evaluated at the ER, scans were normal, and she sustained a contusion to her head. The facility's Fall Investigation Report dated [DATE] documented R2 had an injury to her head and was bleeding. The report documented the root cause of R2's fall was attempting to get out of bed without assistance and that staff will place bed in lowest position with fall mat beside it. The facility's Investigation Narrative Summary initiated on [DATE] documented V5 certified nursing assistant (CNA) and V6 (CNA) put R2 in her bed from 1:45-1:50 PM. At 1:50 PM, V3 (CNA) walked down the hall and saw R2 lying on her left side on the floor with a puddle of blood under her head, 911 was called and EMS (emergency medical services) arrived at 2:00 PM. All responsible parties were notified. On [DATE] the facility was informed that R2 had expired at the hospital on [DATE]. On [DATE] at 2:16 PM, V1 (Administrator) and V2 (Director of nursing/DON) presented video footage of R2's hallway prior to, during and after her fall on [DATE]. The facility's video footage documented the following: on [DATE] at 12:45 PM, V5 (CNA) wheeled R2 into her room. At 12:47 PM, V6 entered R2's room also. At 12:53 PM, V5 exited R2's room and seconds later V6 (CNA) exited. At 1:10 PM, V10 (Activities Director) entered R2's room and exited at 1:11 PM. At 1:43 PM, V3 (CNA) walked by R2's room and then entered it; V1 stated this was when R2 was found after falling.R2's Emergency Department Records dated [DATE] documented R2's assessment/plan included: fall, scalp laceration, depressed skull fracture, orbital fracture, subdural hematoma, subarachnoid hematoma, intraparenchymal hematoma of brain, maxillary fracture and temporal bone fracture. R2's Intensive Care Hospital Note dated [DATE] documented, admitted with severe TBI (Traumatic Brain Injury) and altered mental status superimposed on chronic neurocognitive disorder. Concern for impending uncal herniation syndrome. After discussion with family, transitioned to comfort-oriented care.On [DATE] at 11:27 AM, V8 (ER Nurse) stated R2 presented to her emergency department with an abrasion to her forehead, her nose was bleeding, both eyes swollen and purple from bruising. V8 stated the facility claimed R2 was found lying on the ground in her blood from falling