STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145733	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerseyville Manor	1251 North 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 5 residents (R157) reviewed for abuse in the sample of 42. This failure resulted in R157 fracturing her left hip which required surgical intervention and subsequently led to R157's death.Findings Include:The Facility Investigation, undated, documents the following: R136 pushed R157 causing her to fall to the floor. R157, an alert and confused female. Her BIMS (Brief Interview for Mental Status) score is 3 indicating severe cognitive impairment and her primary diagnosis is Unspecified Dementia. R157 walks independently on the unit with staff supervision. After the fall R157 complained of pain during assessment. Family and physician were notified. Resident was sent to the local hospital and was admitted with a proximal left femur fracture. R157 underwent surgical repair on 10/15/25 which was deemed successful. R157 was continuously monitored for pulmonary edema and advanced COPD. R157's family rescinded R157's DNR (Do Not Resuscitate) status for a 24-hour period to manage initial postop care expectantly. R157 coded and full ACLS (Advanced Cardiac Life Support) protocol was conducted. R157 was pronounced deceased on [DATE] at 10:43 PM. R136, is an alert and confused female. R136's BIMS score is 3 indicating severe cognitive impairment and her primary diagnosis is Alzheimer's Disease. R136 walks independently on the unit with staff supervision. After the incident resident was immediately placed on 1:1 (one on one) supervision. R136 had no explanation for pushing R157 and had very little recall of the incident at all. Family and physician were notified. R136 was immediately sent to the local hospital for evaluation and was returned the same day with a new order to treat UTI Urinary Tract Infection). The Psychiatrist was contacted with new prescription orders given for severe agitation and transfer to outside hospital for inpatient admission. R136 was transferred and admitted for psychiatric hospitalization on 10/15/25 and she remains hospitalized at this time and her return is uncertain at this time. In conclusion, the fall incident has been thoroughly investigated. The root cause of the fall was directly linked to the actions of resident (R136). Due to her (R136) cognitive status, she is unable to account for or explain her actions. R136 has had no prior physical incidents since being admitted to the facility. There is no sufficient evidence to suggest that the reactions were intentional. Will continue to monitor. The Facility Investigation Note, undated, documents the following: Upon investigation, see fall event details, provided by V20, RN (Registered Nurse). Prior to fall, R157 was walking independently on the unit per normal routine. V19, CNA (Certified Nursing Assistant) was down the hall and witnessed R157 and R136 approach. V19 was unable to reach duo in time to prevent R136 from pushing R157 to the floor. While approaching the fall, V19 observed R136 standing over R157 talking nonsensible per her normal routine. V19 did not report witnessing any behaviors that would indicate the event would occur. Neither resident was able to provide credible details of the fall and what lead up to R136 pushing R157 to the floor. V8, CNA, V23, CNA, nor V18, RN, witnessed the fall. V18 assessed R157 and she complained of pain everywhere. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Family and physician were notified. LHNA (Licensed Nursing Home Administrator) notified. R157 was sent to the local ER (Emergency Room) and was admitted with a fractured left hip. Family is pleased with her care and wishes her to return to the facility for rehabilitation after surgical repair. The care plan will be reviewed and updated upon her return. Will continue to monitor.R136's Face Sheet, undated, documents R136 has the following diagnoses, in part, Alzheimer's Disease, Paranoid Schizophrenia, Dementia with Agitation, Delusional Disorders, Depressive Episodes, and Severe Dementia Severe with Psychotic Disturbance. R136's MDS (Minimum Data Set), dated 7/30/25, documents the following: R136 has a BIMS score of 3, indicating severe cognitive impairment, displays verbal behavioral symptoms directed towards others. R136's MDS, dated , 11/26/25, documents the following: R136 has a BIMS score of 2, indicating severe cognitive impairment, displays physical/verbal behaviors directed towards others, other behaviors not directed towards others, wanders, and rejects care. R136's Care Plan, dated, 3/7/25, documents the following: R136 receives psychotropic medications due to having a diagnosis of Schizophrenia and Cachexia. Per family interview, they stated that she was put on medication due to being aggressive. She exhibits verbal, physical behaviors towards others and rejection of care. She shows rejection of care with medications, meals and daily routine and waiting for staff assist. She may become territorial when other residents who enter her room or go through her personal belongings or are in her space. She may wander and has a history of exit seeking. Interventions include: validate where she is trying to go, redirect to room or common area, remind her that her family knows where she is, engage in talk about Spanky, [NAME] or [NAME] to distract, provide strolls in Courtyard or facility if unable to redirect, inform of possible harm to self if ambulating on her own, offer activities food and fluids, likes saxophone music to distract and redirect. R136's Progress Note, dated 8/9/25 at 3:56 PM, documents the following: July Behavior Note- R136 is tracked on the behavior program for showing verbal behaviors and may curse or scream at staff providing care. She shows physical behaviors and may kick or shove staff providing care. She shows rejection of care with meals, and daily routine or ADLs (Activities of Daily Living). She was noted to show no behaviors this month. She has been moved from Memory Lane to Liberty Lane. Staff will continue to monitor resident and use interventions as needed to help decrease the behaviors. R136's Progress Note, dated 8/14/25 at 4:22 PM, documents the following: Behavior note- R136 has been placed on the behavior tracking form for increased wandering/exit seeking potential program. R136's Progress Note, dated 8/16/25 at 9:35 AM, documents the following: Resident was kissing brother-in-law in dining room this morning at breakfast. She had gotten verbally upset that we separated them. Writer took resident to sit on couch while breakfast was being finished. Resident walked back over to brother-in-law; CNAs separated them again and placed wife next to husband. Resident was then walked to her room. R136's Progress Note, dated 9/4/25 at 7:04 AM, documents the following: August Behavior Note: Resident is a recent admit and has been displaying some verbal/physical behaviors related to rejection of care. She may scream or curse, shove, kicking, hitting and or scratching staff providing care. Proactive interventions are in place and if used consistently often prevent the behaviors. Formal programming in place. R136's Progress Note, dated 10/3/25 at 8:46 AM, documents the following: September Monthly Behavior Note: For the month of September, she has met her goal of having a reduction in verbal/physical behaviors related to rejection of care and upon redirection. She may scream or curse, shove, kick, hit and or scratching staff providing care, or toward others. Proactive interventions are in place and if used consistently often prevent the behaviors. Formal programming in place. R136's Progress Note, dated 10/13/25 at 8:00 AM, documents the following: See event note per V20, RN, for resident 4175-01 (R136) on 10/12/25 at 8:00 PM. Resident was immediately placed on 1:1, Administrator, notified per (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V20 immediately, MD (Medical Doctor) and POA (Power of Attorney) were notified. R136's Progress Note, dated 10/13/25 at 8:40 AM, documents the following: Resident resting in bed at his time. She remains 1:1 due to prior incident. R136's Progress Note, dated 10/13/25 at 8:53 AM, documents the following: Behavioral outburst including screaming and slapping at staff member who was attempting to redirect her from another residents room. R136's Progress Note, dated 10/13/25 at 10:15 AM, V23, Psychiatrist, called and was notified of increased behaviors and orders to send resident to ER for psychiatric evaluation. POA called and notified, in agreeance with plan of care. 911 implemented at this time. R136's Progress Note, dated 10/13/25 at 10:50 AM, V23 called facility regarding resident and recent increased behaviors. Stated she would like her to have an inpatient stay and has notified an outside behavioral health center. At this time there is no bed available for her at this time, however she is on the waitlist for a bed when it does become available. Face sheet, recent labs, nurse's notes, and med list faxed to the behavioral health center per their request. R136's Progress Note, dated 10/13/25, at 1:39 PM, documents the following: Resident returned to the community by ambulance at 1:35 PM, accompanied by 3 attendants. Placed on visual 1:1 with staff due to earlier violent outburst. Diagnosed at the local hospital with UTI. IM (Intramuscular) Rocephin administered at the ER. New orders for Augmentin 500mg (milligrams)-125mg oral tablets, 1 tablet every 12 hours for 5 days. Resting in bed at this time. R136's Progress Note, dated 10/13/25 7:06 PM, documents the following: New orders from V23 for Ativan 1mg IM daily PRN (As Needed) for severe agitation, Ativan 1mg po (by mouth) BID (Twice Daily) PRN for severe agitation and Zyprexa 4mg po daily at 4:00 PM. Son informed by phone. R136's Progress Note, dated 10/14/25 at 10:50 AM, documents the following: Staff from behavioral health called facility and informed writer that they would most likely have a bed for resident tomorrow morning. Stated they would call facility to let us know in the morning. POA called and notified, thanked writer for call. R136's Progress Note, dated 10/15/25 at 1:10 PM, documents the following: Spoke with RN at the behavioral health center to give report on resident and to inform them of when she left the facility as requested. Resident left in family vehicle with her son at 12:40 PM.R157's Face Sheet, undated, documents R157 has the following diagnosis, in part, Dementia without Behavioral Disturbance, Cognitive Communication Deficit, Anxiety Disorder, Unspecified Psychosis, Repeated Falls, Weakness, Unsteadiness on Feet, Reduced Mobility, Schizoaffective Disorder, COPD (Chronic Obstructive Pulmonary Disease), Depression, Age Related Osteoporosis, Heart Failure, Hyperlipidemia, Vitamin Deficiency, Iron Deficiency Anemia, and Cough.R157 MDS, dated [DATE], documents the following: R157 has a BIMS score of 3, displays verbal behaviors towards other and other behaviors not directed towards others, requires assistance with ADLs, and has a history of falls.R157's Care Plan, dated 6/6/22, documents the following: R157 is at risk for falls related to diagnoses, cognitive deficits which may alter safety awareness, needing assistance with ADL care, B&B (Bowel & Bladder) incontinence, and use of psychotropic medications & opioid medications.R157's Care Plan, dated 6/6/22, documents the following: R157 receives psychotropic medications due to having a diagnosis of Anxiety, Schizoaffective Disorder, and Psychosis. Family stated resident was anxious and pacing at previous facility. She is delusional in her thought process at times evidenced by thinking she does not live here. Resident displays anxiety with pacing from nurses' station to room with repetitive questioning. She has shown an increase in verbal/physical expressions related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. [NAME] does not retain info and is unaware of her safety needs.R157's Progress Note, dated 8/6/25 at 7:00 AM, documents the following: July Behavior Note: For the month of July, resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. [NAME] does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place for verbal/physical behaviors and rejection of care, will continue with.R157's Progress Note, dated 8/12/25 at 1:24 PM, documents the following: Resident restless/anxious most of the day, continuing to pace, delusional in her thoughts, asking about how she goes about getting the lighting ordered and taken care, she is easily redirected for a moments time.R157's Progress Note, dated 9/4/25 at 6:56 AM, documents the following: August Behavior Note: For the month of August, resident has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Resident does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place for verbal/physical behaviors and rejection of care, will continue with.R157's Progress Note, dated 10/3/25 at 9:33 AM, documents the following: September Monthly Behavior Note: For the month of September, resident has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place and will continue with. [NAME] displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Goal and approaches in place.R157's Progress Note, dated 10/12/25 at 8:00 PM, documents the following: Loud noise heard in hallway by nurse's desk. Resident observed on the floor lying on left side. ROM (Range of Motion) x (times) 4 with pain and limitation to LLE (Left Lower Extremity). Shallow skin tears present to left eyebrow and left forearm. Resident c/o (complains of) severe pain everywhere. Vitals pulse 66, respirations 22, temperature 98.0, SpO2 94% RA (Room Air), unable to obtain blood pressure due to resident moving arms. CNA witnessed another resident come out of their room and push resident to the floor unprovoked. CNA stated resident's head hit the floor very hard. Ambulance paged per nursing judgement.R157's Progress Note, dated 10/13/25 at 12:08 AM, documents the following: Received call from the local ER nurse. Resident is being admitted with Dx (Diagnosis) of fractured left hip.R157's Progress Note, dated 10/13/25 at 11:55 AM, documents the following: Spoke with POA, he stated resident was going to have surgery on Wednesday. Gave him my condolences and will keep them in my prayers. He thanked this writer for calling.R157's Progress Note, dated 10/15/25 at 11:41 PM, documents the following: Call received from the local hospital that resident has expired.R157's Fall Safety Event, dated 10/12/25 at 8:00 PM, documents the following: location: hallway; resident was pushed by another resident; CNA witnessed another resident come out of their room and push resident to the floor unprovoked; c/o severe pain everywhere; Shallow skin tear to left eyebrow and left forearm. ROM painful/limited to LLE; immediate intervention: Ambulance was paged due to painful/limited ROM to LLE and possible head/neck injury from hitting head on the floor.R157's Hospital Records, document the following: ER Note, dated 10/12/25, Patient was at a memory care unit when another resident pushed her and the resident fell in an unsupervised context. Assessment/plan - Lt femur fracture. Operative Note, dated 10/15/25, ORIF (Open Reduction Internal Fixation) of the left hip. Patient was sent to PACU (Post Acute Care Unit) in stable condition. MD Progress Note dated (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	10/15/25 at 11:05 PM, I was called to evaluate the patient during code. BP (Blood Pressure) unresponsive to escalating doses of Levophed given through the IO (Intraosseous) line. Three liters of fluid were also given prior to the code in resuscitation efforts postop via the IO line placed in the right tibia. A sat was never identified due to the profound unresponsive hypotension consistent with overwhelming cardiac failure as a primary feature of her neurologic condition preop. Patient never responded to any bedside interventions. Epinephrine and shocks delivered during the AED (Automated External Defibrillator) application prior to the arrest. Ventricular Fibrillation degenerated very quickly to PEA (Pulseless Electrical Activity) which sustained on two checks. Code was called due to anticipated demise in an agonal rhythm that would predictably degenerate to asystole in a short time frame. Expired on 10/15/25 at 10:53 PM, full ACLS protocol followed. R157's Death Certificate, dated 10/20/25, documents the following: date of death : 10/15/25; immediate cause of death: acute displaced left femur intertrochanteric fracture, conditions leading to the cause of death: status post insertion intramedullary nail of the left femur, underlying cause: dementia moderate, significant conditions contributing to death: pulmonary edema, schizoaffective disorder.On 1/22/26 at 8:10 AM, V4, LPN (Licensed Practical Nurse), stated R157 would walk around the unit, she was up, down, up down and would ask repetitive questions. V4 stated R157 could have verbal and physical behaviors towards staff but not any of the residents. V4 stated she is not familiar with R136.On 1/22/26 at 8:25 AM V15, Memory Care Specialist, stated she was not working when the incident between R136 and R157 occurred. V15 stated R157 would occasionally have behaviors but not directed towards others. V15 stated R136 wound have verbal behaviors towards the staff but not towards the other residents. V15 stated she does not recall any other incidents involving R136 or R157.On 1/22/26 at 9:13 AM V19, CNA, stated she was working and witnessed the incident between R136 and R157 on 10/12/25. V19 stated R157 was walking laps towards the doors and walked past room [ROOM NUMBER], R136's room. V19 stated R157 stopped approximately 5-6 feet outside of R136's doorway and was saying something and pointing her finger. V19 was unable to hear what R136 was saying. V19 stated R136 came out of her room running with both of her arms out in front of R157 and pushed her to the ground. V19 stated after this occurred R136 ran back into her room and when V19 approached, R136 was laughing and shut the door to her room. V19 stated R157 hit her head hard on the floor, was bleeding and crying in pain. V19 stated prior to this incident, R136 had a few issues at the supper table, where she would put her hands on the residents that would annoy her. V19 stated R136 was easily annoyed by the other residents. V19 stated they have a couple of residents that have behaviors that could potentially be physical towards other residents but they intervene prior to an incident occurring. On 1/22/26 at 9:25 AM, V8, CNA, stated she was working but did not witness the incident between R136 and R157. V8 stated R136 stayed in her room most of the time, she would verbally cuss or tell other residents to stay away, and they would try to intervene. V8 stated they would redirect R136 to her room, give her a snack, have her watch TV and divert her away from the situation. On 1/22/26 at 11:20 AM, V22, Medical Director, stated the incident between R136 and R157 was unexpected. R136 nor R157 had displayed any physical behaviors towards others. V22 stated in her opinion R157 due to poor postoperative monitoring after hip surgery. V22 stated R157 was cleared by the Cardiologist for the surgery, came through the surgery just fine, her blood pressure was to be checked every 30 minutes, it was fine and then it wasn't checked for 2 hours and during that time her blood pressure crept down, R157 coded and died. The Abuse Prohibition and Reporting Policy, with a revision date of 11/18/19, documents, in part, the following: The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation and use of any physical or (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	chemical restraint not required to treat resident's symptoms. The purpose of the policy is to protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Special attention will be given to identifying behavior that increases the residents potential for abusing self or others or being the victim of abuse. These behaviors would include residents with a history of aggressive behaviors such as entering other residents rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.