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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility failed to implement current fall interventions for 1 (R118) of 9 resident reviewed for accidents in a sample of 42. This failure resulted in R118 sustaining a Left Patellar Fracture.Findings Include:R118's Undated Face Sheet documents R118 was admitted to the facility on [DATE] and has a medical diagnosis of Dementia, Weakness, and Alzheimer's Disease.R118's Minimum Data Set, dated [DATE] documents R118 is severely cognitively impaired, uses a walker, and needs substantial/maximal assistance with lying to sitting on side of bed, sitting to standing, chair/bed to chair transfers, and walking 10 feet.R118's Care Plan Last Reviewed/Revised 1/15/2026 documents Problem: R118 is at risk for falls related to diagnoses, cognitive deficits which may alter safety awareness, needing assistance with Activities of Daily Living (ADL) care, Bowel and Bladder (B&B) incontinence, and use of psychotropic medications & potential use of opioid medication related to end of life care. R118 is unaware of her safety needs and often ambulates without assist and device. Interventions Dated 12/6/2025 documents Approach: Concave mattressR118's Care Plan Last Reviewed/Revised 1/14/2026 documents Problem: Resident Care Information. Interventions Dated 12/6/2025 documents Approach: Fall Approaches: Concave Mattress, Neon tape to walker, walker to kept beside R118 at all times and encourage R118 to ask for assist when ambulating. Alternate call and offer res to toilet with each alternate call round. Staff to put lighter weight pj's on resident during bed time.R118's Progress Note dated 12/6/2025 at 11:30 PM documents Noise heard from room [ROOM NUMBER]. Resident observed on the floor lying on left side with her head against the closet door. Range of Motion (ROM) x4 without pain or limitation. No shortening, rotation, or deformity present. No redness or swelling noted. Resident was incontinent of bladder and urine was on the floor next to the bed. Resident was wearing a hospital gown and grip socks. Resident was previously resting in bed.R118's Event Report Dated 12/7/2025 documents R118 had a fall on 12/6/2025 in room [ROOM NUMBER]. Interventions immediate measure taken documents rest, increased toileting, low bed, alternate call.R118's Fall Investigation Dated 12/8/2025 documents upon entering, resident was noted of floor lying on left side with her head against the closet door. Resident incontinent of bladder. Previously seen resting in bed in lowest locked position. Blankets appear disheveled, as though resident slid out of bed. Call light was within reach but not activated. Resident is confused and does not always remember to ask for assistance. Root Cause Analysis: resident slid out of bed. Resident placed on concave mattress.R118's Nursing Note dated 12/15/2025 at 10:01 AM documents Resident found on floor of bedroom on her Left (LT) side. Roommate came to this nurse and informed that someone was on her bedroom floor. Upon assessment small hematoma noted to back of head, and small abrasion noted to LT knee. ROM x4 without pain or limitations while laying down however when stood to ambulate to bed resident seemed to limp from RT hip/leg. No shortening/rotations/ deformities. Resident states only pain on her head.R118's Fall Investigation Dated 12/15/2025 documents at approximately 10 AM staff was called to room by roommate stating someone was on the floor in her room. Staff responded noting resident on the floor lying on her left side near the closet. [NAME] was at bedside and did not appear to be in use at the time of the fall. Resident was (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 0689 Level of Harm - Actual harm Residents Affected - Few	assessed with small abrasion to left knee and hematoma to the back of her head. No rotation and/or shortening to left lower extremity. Resident was able to bear weight. Staff noted unsteady gait with a slight limp which is common for her.R118's Event Report Dated 12/15/2025 documents R118 had a fall in room [ROOM NUMBER]. Body assessment: small hematoma to back of head, abrasion to left knee.R118's Nursing Note dated 12/16/2025 at 9:53 AM documents Resident up to breakfast this am, staff reporting resident reluctant to ambulate so resident was pushed to table in wheelchair. ROM in lower extremities stiff, resident is inconsistent with location of pain related to fall yesterday. No bruising or swelling noted to lower extremities.R118's Nursing Note dated 12/17/2025 at 12:31 PM documents x-ray results mentions a patellar fracture but not specifying if old or new or acknowledging in findings.R118's Nursing Note dated 12/17/2025 at 3:51 PM documents This nurse called to inquire clarification on x-ray results. They stated radiologist had reread the x-ray and it shows an acute patellar fracture.R118's Left Radiologic Examination, femur, minimum 2 views Report Dated 12/17/2025 documents Impression: acute patellar fracture.R118's Nursing Note dated 12/17/2025 at 6:46 PM documents X-ray clarification results show Fracture of Left Patella.R118's X-ray Knee 1 or 2 Views Left dated 12/18/2025 documents Impression: Transverse fracture of the patella with apex anterior angulation and articular surface step-off.R118's Nursing Note dated 12/18/2025 at 7:33 PM documents Resident returned from Local Hospital emergency room with a diagnosis of Left Patellar Fracture. Immobilizer brace in place on left leg.On 1/22/2026 at 8:24 AM no concave mattress observed on R118's bed.On 1/22/2026 at 9:29 AM R118 resting in bed with a regular mattress noted on the bed.On 1/21/2026 at 3:02 PM V2, Director of Nursing (DON) stated when a resident falls the facility will start an event note regarding the fall and an immediate intervention will be put into place. V2 stated an intervention is placed after every fall and the resident's Care Plan is updated with the interventions.On 1/22/2026 at 9:24 AM V15, Certified Nursing Assistant (CNA), stated R118 needs assistance with getting up out of bed and walking. V15 stated R118 always gets up on her own and has had recent falls. V15 stated R118 is always incontinent and never uses her call light when she needs assistance. V15 stated R118 has not had a special mattress the whole time she has worked on the hall and R118 has a regular mattress. V15 denied R118 having a concave mattress in place.On 1/22/2026 at 9:29 AM R118 R6 was not interviewable due to his cognitive status and medical condition.On 1/22/2026 at 9:32 AM V24, CNA, stated R118 needs assistance to get out of bed and with walking. V24 stated R118 tries to get out of bed by herself a lot.On 1/22/2026 at 9:36 AM V4, Licensed Practical Nurse, LPN, stated R118 currently has a knee immobilizer in place due to a fractured knee from a fall. V4 stated 118 gets up all the time on her own and R118 does require assistance to get up.On 1/22/2026 at 11:28 AM V21, Medical Doctor, (MD), stated the facility should have interventions ordered and in place after every resident fall. V21 stated if R118 had an order for a concave mattress after a fall, she would expect the facility to have the mattress in place to help prevent falls. V21 stated R118's Dementia is so bad that R118 does not know what she is doing at times or what is going on.On 1/22/2026 at 1:30 PM V30, CNA, stated R118 likes to get up at the spur of the moment and R118 does require assistance to get out of bed and ambulate.On 1/22/2026 at 10:11 AM V2 stated the Facility does not have a policy on Fall Prevention. On 1/22/2026 at 10:27 AM V2 provided an Accident/incident Prevention document and stated the document is part of the facility's nursing manual. The Accident/Incident Prevention document is undated and had no facility name listed. The Accident/Incident Prevention states When a resident has been identified as a high risk for accident/incident, interventions will be put into place per the induvial resident assessment and care plan.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff were knowledgeable and competent to utilize a deep brain stimulator (DBS) and know signs and symptoms of internal generator not charged for 1 of 1 resident (R79) in the sample of 42.Findings include: R79's Undated Face Sheet documents he was initially admitted to the facility on [DATE] with diagnosis including Parkinson's disease and deep brain stimulator. R79's Care Plan dated 8/7/2024 documents problem: resident care information: no documentation. Goal: long term goal target date: 3/16/2026 no information documented. Approach start date: 8/29/2024: brain stimulator - charge every Wednesday and Sunday. Place round disk on right side of chest and charge for approximately 2 hours or until fully charged. R79's Physician Order Sheet (POS), dated 1/2026 physician's order to charge brain stimulator every Monday/Wednesday/Sunday. Place round disk to right side of chest and charge for approximately 2 hours or until fully charged. Disk must be charged before placing on chest. R79's Treatment Administrator Record (TAR) dated 1/2026 staff document R79's DBS is charged three times a week per physician's orders on night shift. On 1/19/2026 at 11:00 AM R79 observed sitting up in wheelchair and stated he has Parkinson's and staff are supposed to charge his DBS but staff don't what they are doing with it and sometimes his DBS isn't charged. On 1/21/2026 at 11:37 AM V9, Licensed Practical Nurse (LPN) stated she used to work night shift, and she used to charge R79's deep brain stimulator at night. V9 stated she wasn't inserviced on how to charge it but followed the directions from R79's family on how to use the device. V9 stated the family and R79 told her if his DBS wasn't charged he would be lethargic and possibly unresponsive. On 1/22/2026 at 8:00 AM V13, LPN stated she hasn't been inserviced on how to use, read or charge R79's DBS device. V13 stated she knows when R79's DBS needs charged when his left arm starts shaking more and he has difficulty swallowing. On 1/22/2026 at 9:55 AM, V18, RN (Registered Nurse) stated she just graduated a few months ago and she hasn't been inserviced on anything to do with a DBS and would read the manufacture's booklet if needed but she would feel more comfortable if she got a formal inservice from management on how to use the device. V18 stated she didn't know what symptoms R79 would exhibit if his DBS wasn't charged. On 1/22/2026 at 10:00 AM V32, LPN stated she hasn't been inserviced on R79's DBS or how to use the device at all and wouldn't know if it was charging the device or what symptoms R79 would exhibit if his DBS wasn't charged. On 1/22/2026 at 10:03 AM V31, LPN stated she hasn't been inserviced on R79's DBS. V31 didn't know how to use the device at all and wouldn't know if it was charger was charging the device or what symptoms R79 would exhibit if his internal battery was not charged. On 1/22/2026 at 10:16 AM V29, LPN stated she hasn't been inserviced on DBS and she doesn't know anything about the DBS including how to charge it, how to tell if the device is charging R79's DBS or what symptoms R79 would exhibit if the DBS wasn't charged. On 1/22/2026 at 10:20 AM V28, LPN stated she hasn't been inserviced on the deep brain stimulator by facility staff and stated R79's family takes care of it and they charge the device and R79 charges his DBS. V28 stated when R79's DBS isn't charged R79 starts to cough more while eating and has increased delayed speech and increased tremors. V28 stated she keeps a close eye on R79 because she knows if his DBS needs charged when he exhibits slurred/slow speech, increased coughing and increased tremors. On 1/22/2026 at 10:19AM V26, MDS Coordinator/RN stated she works the floor occasionally. V27 stated doesn't recall being inserviced on a DBS and stated there is a light on the charging device to show it is charging the DBS and if it's not working R79 can become lethargic. On 1/22/2026 at 10:23 AM V27, MDS Coordinator/RN stated she works the floor occasionally and she hasn't been inserviced on DBS anything regarding a DBS including how to charge it or how to ensure it is charging the resident's DBS. V26 stated there is a light on the device to show it is charging. V26 stated if the resident's DBS isn't working, he can become lethargic. On 1/21/2026 at 1:33 PM V2, Director of Nurse (DON) stated if R79's DBS isn't charged he exhibits symptoms of slow speech and difficulty (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	swallowing but she doesn't know the extent of his symptoms that could occur if his DBS isn't charged. V2 stated she has been the DON at the facility for over 10 years, and she hasn't inserviced staff on how to use R79's DBS. On 1/21/2026 at 1:36 PM V3, Assistant Director of Nurses (ADON) stated when R79's DBS isn't charged his Parkinson's symptoms i.e. difficulty swallowing and slow movements return like they were before the stimulator was placed. V3 stated she recalled when R79 was initially admitted to the facility in 8/2024 and his family showed her how to charge and read his DBS device and she wasn't inserviced on how to use the DBS device. On 1/22/2026 at 3:32 PM V36, R79's Neurologist's Medical Assistant stated she has worked with R79's neurologist for over 10 years and she had permission to speak to me on behalf of R79's neurologist. V36 stated R79 has a DBS because he has severe Parkinson's and it decreases his Parkinson's symptoms including tremors, slurred speech and shuffling gait. V36 stated if R79's DBS isn't charged then his Parkinson's symptoms increase. V36 stated she has never seen a resident's DBS not being charged that the resident becomes lethargic, there was no correlation to a resident's DBS not being charged to them being lethargic. V36 stated they don't have a lot of patients that reside in a nursing home that have a DBS but she assumes management would show staff how to charge his DBS and to educate staff on symptoms he would exhibit if the DBS isn't charged. On 1/22/2026 at 11:35 AM V21, Medical Director stated when R79's DBS isn't charged he would exhibit symptoms of Parkinson's i.e. out of control tremors and increased Parkinson's symptoms. V21 stated R79's DBS not being charged doesn't result in R79 being lethargic. 21 stated she expected staff to be inserviced on how to use R79's DBS charger and stated she expected the facility has a policy on how to use the DBS device as well. A DBS Policy revised 1/2013 documents objective: to provide necessary care to the resident with a DBS. Equipment: DBS. Procedure: keep equipment dry and hand it gently to avoid damage and follow manufacturer's instructions as indicated by specific device manual. Nursing consideration: charge as often as your doctor recommends and notify physician of any change of condition related to device as indicated. This policy didn't have the facility name documented on it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to evaluate swallowing function of a resident who choked a timely manner for 1 of 9 residents (R3) reviewed for accidents and hazards in the sample of 42.Findings include: 1-R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, cerebral infarction, and dysphagia (difficulty swallowing). R3's Minimum Data Set (MDS) dated [DATE] documented R3 was severely cognitively impaired, required setup or clean-up assistance with eating, was on a mechanically altered therapeutic diet, had holding of food in mouth/cheeks or residual food in mouth after meals, and had coughing or choking during meals or when swallowing medications. R3's Care Plan initiated 3/8/23 documents R3 has a diagnosis of dysphagia which increases risk of aspiration, choking, and swallowing difficulties. R3's Diet Order dated 7/31/25 documents mechanical soft. R3's Progress Note dated 1/10/26 at 12:58 PM documents during noon meal, R3 had an episode where a piece of bread became lodged in throat. On 1/23/26 at 8:10 AM, V6, Licensed Practical Nurse (LPN), stated on 1/10/26 she was notified by staff she needed to go check on R3 in the dining room. V6 went to the dining room and R3 had already expelled the bread. On 1/20/26 at 12:33 PM, R3 was sitting at a table in the dining room with a plate of food in front of her. There was a slice of bread in a wax paper bag next to the plate. V33, Cook, stated residents on mechanical soft diets are allowed to get bread. R3's Physician Order dated 1/15/26 documents ST (Speech Therapy) to evaluate and treat as indicated. On 1/20/26 at 2:50 PM, V34, Speech Language Pathologist (SLP), stated V6 made a referral for R3's swallow to be evaluated after R3 had her recent episode. V6 has not evaluated her yet but plans to do that sometime this week. On 1/21/25 at 2:50 PM, V2, Director of Nursing (DON), stated if a resident chokes the team discusses it at a morning meeting and V34 will evaluate them, but was unsure how soon residents should be evaluated in this situation. On 1/22/25 at 11:25 AM, V21, Medical Director, stated she was aware of R3 choking and was unsure why it took V34 so long to evaluate her because it is normally the next day. R3's SLP Evaluation and Plan of Treatment dated 1/21/26 documents R3's swallowing function was evaluated on 1/21/26. The Facility's Therapy Evaluation/Reassessment Policy revised 2/2005 does not address a time frame in which residents should be evaluated following a speech therapy referral for choking.