STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146059	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Health & Rehab Ctr, The	873 Grove 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)
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 interview and record review the Facility failed to provide a safe transfer for 1 of 3 residents (R1) reviewed for transfers in the sample of 10. This failure resulted in R1 being left unattended as staff left the room and R1 fell out of the bed and sustained an Intracranial hemorrhage (head injury).Findings include:R1's Physician Order Sheet (POS) for November 2025 documents a diagnosis of unspecified sequelae of unspecified cerebrovascular disease, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side; dementia in other diseases classified elsewhere; unspecified severity without behavioral disturbances, psychotic disturbance, and insomnia. R1's Minimum Data Set (MDS) dated [DATE] document R1 was moderately impaired for cognition for activities of daily living. Under Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed- R1 was documented as Dependent. Dependent documents the Helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity.R1's Care Plan with the date initiated of 11/19/2021 documents, Fall Risk: (R1) is at risk for falls due to confusion, gait/balance problems. He has history of syncope, seizure disorder, stroke with right-sided weakness, history of falls. He has weakness/unsteady, incontinent of bowel/bladder. He leans in his wheelchair when he is tired.R1's Fall Risk assessment dated [DATE] documents R1 was high risk for falls.R1's Health Status Note dated 11/8/2025 at 9:45 PM, Note Text: CNA (Certified Nursing Assistant) reported she had resident on bed and resident had extra large bm (bowel movement), she walked away to get toilet paper from bathroom and observed resident falling off bed, resident did not become unconscious, alert and responding appropriately with clear speech, CNA states resident was on right side and rolled himself over to his left side, states he is not in pain, no abnormalities noted to head, skin intact, resident remained in position this writer first observed him in, resident contracted and has limited ability to move limbs, order to send resident for evaluation to rule out injury, echo transport notified, residents POA (Power of Attorney) updated on incident per phone call and agrees to bed hold policy at this time.R1's Health Status Note dated 11/9/2025 at 1:09 PM, Note Text: called ER (Emergency Room) for follow up, resident being transferred, call placed to POA (Power of Attorney) and he is aware of transfer, and dx (diagnosis of) right frontal lobe hemorrhage.On 11/13/2025 at 2:05 PM, V12, CNA stated, I am familiar with (R1). He is not able to turn himself. I was performing incontinent care on him, and he had a large BM and I went to get toilet paper. (R2) usually does not move but when I left his bed he rolled over and fell off the bed. I have been trained and I never should have left him unattended, and I feel bad. I know they sent him out to the hospital. We are not supposed to ever leave resident unattended while providing incontinence care. On 11/13/2025 at 3:15 PM, V14, CNA stated If we are providing incontinent care, we are never to leave the resident even for a minute unless we put the bed down all the way, put resident back on their back and give them the call light. (R1) is not able to turn himself over.On 11/13/2025 at 3:24 PM, V15, CNA stated when we are providing incontinent care, we are never ever supposed to leave the resident unattended ever, even for a second. If we need help, we are supposed to push the call light (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	and/or put the resident's call light on and wait for help. If we can't wait, we are supposed to put the bed down all the way down to the floor, position the resident on their back, and give them their call light before we ever leave the room. (R1) is not able to turn himself.On 11/13/2025 at 3:27 PM, V16, CNA stated, We are never to leave a resident unattended while providing incontinent care. If we need supplies and I did not bring them, then I would put the call light on and wait for help. If nobody came, then I would put the resident on their back, cover them up, lower the bed all the way to the floor and hand them the call light.On 11/13/2025 at 4:18 PM, V17, Corporate Nurse stated, (V12) should have put on the call light and waited for help. She should have never left the resident unattended.R1's emergency room Visit date reviewed 11/10/2025 document hospital problem, (Principal) Intracranial hemorrhage. [AGE] year old male presents to the emergency department as a trauma transfer. The patient fell at the nursing home CAT scan obtained in outlying facility was suspicious for a frontal confusion. Patient was transferred here to be seen by neurosurgery. History mainly EMS patient has dementia. Minor head injury.On 11/20/2025 at 8:39 AM, V26, Nurse Practitioner stated, During incontinent care if a staff member raised the bed, then I would expect the staff to lower the bed and place the resident on their back and or call for assistance before leaving the room. The resident should never be left with the bed raised unattended. I would not expect staff to leave the room with the bed up because it puts the resident at risk for falling out of the bed and they could sustain any injury from the fall.The Facility Fall Policy with a date initiated of 7/1/2023 documents, To provide staff with guidelines for investigating, reporting, and recording Accidents and Incidents. An accident/incident is any occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. It may involve injury or damage to property. It may involve residents, visitors, or volunteers.