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	03/26/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to prevent misappropriation of resident's medication for 5 of 8 residents (R4, R5, R6, R7, and R13) reviewed for misappropriation of personal property in the sample of 19.Findings include:1. The facility's document Report Form/IDPH (Illinois Department of Public Health) Notification dated 2/26/2025 documents alleged abuse/misappropriation of personal property and identifies the names of the residents involved as R4, R5, R6, and R7. This report identifies a brief description of the incident/event as, On 2/26/2025 a facility nurse alleged that the residents' Morphine is miscolored and not correct. The report's Summary of Investigative Findings documents, A comprehensive investigation was initiated. Results of investigation concluded that the morphine in seven bottles were clear where morphine should have been pink in color. Narcotic counts were immediately conducted on remaining narcotic with no discrepancies noted. It was verified with V2 RN (Registered Nurse) that morphine that she administered on 2/24/2025 was pink in color. V2 had counted with on coming nurse V23 RN at shift change. V23 verified color of morphine was pink when she administered on 2nd shift. At the end of shift V23 counted with on coming nurse V22 LPN (License Practical Nurse); no discrepancies noted. Approximate 8:30 am V2 was going to administer morphine (liquid) when she noted the color of the morphine was clear not pink. She notified V21, DON. Conclusion of investigation is that the morphine liquid had been switched for clear liquid sometime after count on 3rd shift. Police report case number 2025-003839 dated 2/26/2025 at 9:29 AM documents On Wednesday, February 26th, 2025, at approximately 9:29 a.m., I was dispatched to (facility) for a Theft of medication report. Once on scene, I activated my Body Worn Camera and spoke with employee, V24 (Social Service Director). V24 explained she suspected LPN (V22) of stealing 100 milligrams (mg) of liquid Morphine. V24 explained that V22 worked last night and was in charge of giving four residents their Morphine, however, when the day time nurse went to give the residents their next round of Morphine, she discovered the Morphine bottles had been filled with water. V24 said the business was going to cover the cost to replace the medication, but she was not sure of the total cost. I asked V24 if she wanted to pursue charges, to which she said she did not and only wanted the information.R4's physician order dated 9/16/2024 documents R4 was taking Morphine Sulfate (Concentrate) oral solution 20mg/mL (milliliter), give 0.25 mL by mouth every 1 hour as needed for pain or shortness of breath.R4's face sheet dated 3/23/26 documents a diagnosis of polyneuropathy.R5's physician orders dated 8/7/2024 documents R5 was taking Morphine Sulfate oral solution 10 mg/5mL, give 0.25 mL every 2 hours as needed for pain or shortness of breath. R5's face sheet dated 3/25/26 documents a diagnosis of partial intestinal obstruction and palliative care.R6's physician orders dated 9/11/2024 document R6 was taking Morphine Sulfate oral solution 20mg/5mL, give 0.25 mL by mouth every two hours as needed for severe pain or air hunger. R6's face sheet dated 3/23/26 documents a diagnosis of compression fracture of thoracic vertebra.R7's physician orders dated 2/29/2024 documents R7 was taking Morphine Sulfate (Concentrate) Oral Solution 100mg/5mL, give 0.25 mL by mouth every 1 hours as needed for pain. R7's face sheet dated 3/23/26 documents a diagnosis of diabetic neuropathy and history of healed traumatic fracture.2. On 3/23/26 at 11:09 AM R13 stated she has chronic back pain and she takes scheduled pain medication for pain relief. R13's physician orders (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

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	03/26/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 8/29/2025 show R13 is taking Hydrocodone-Acetaminophen oral tablet 10-325 mg, give one tablet by mouth three times daily for pain not to exceed 4g (gram)/day. R13's care plan dated 11/1/2023 states R13 is at risk for pain related to Chronic Physical Disability, on hospice for diagnosis of heart failure and dysphagia.On 3/23/2026 at 10:19 am, V8 RN states more than six months ago V2, Director of Nursing (DON), who at that time was a floor nurse, noticed that a resident's liquid morphine was lighter in color than normal and that it had been tampered with. V8 states that all medication carts in the facility were checked and that the consistency and color of all liquid morphine bottles were different, stating the morphine was not bright pink in color as it usually is. V8 states they were able to identify the nurse who did it and since that nurse has been gone there have been no further issues.On 3/23/2026 at 2:52 pm, V1 Administrator provided a document titled Profile Scan by (facility's contracted pharmacy) dated 3/23/2026 which includes R4's, R5's, R6's, and R7's names. V1 stated all these residents were involved with the misappropriation of their morphine. V1 stated they drug tested all the nurses and were unable to determine who had altered the morphine.On 3/24/2026 at 10:40 am V2 states she was working the night that the morphine was discovered as having a different color and consistency than usual. V2 states that the morphine was usually more viscous and this morphine was watery and the color of the morphine was off. V2 states she reported the incident to the nurse on call and an audit of three or four medication carts was done by management and additional bottles of morphine were noted to have been tampered with. V2 states she was drug tested for the morphine incident and had also been drug tested for an incident that happened in June 2025. V2 states in June of 2025, V2 noted an entire card of R13's Norco had went missing. V2 states she reported this, was then drug tested and suspended upon further investigation.On 3/24/2026 at 10:40 am, V3, Assistant Director of Nursing (ADON) confirmed that she was aware of an entire card of R13's Norco going missing in 6/2025 and doesn't think that the card of medication was ever found or that the person responsible was identified. V3 stated she was the Quality Assurance nurse at the time and assisted in the investigation of R13's missing medication.The facility's document Report Form- IDPH Notification dated 6/5/2025 at 3:00 PM documents an allegation of missing medication for R13. The report documents a brief description of the incident/event as On 6/5/2025 a facility nurse alleged that the resident's card of hydrocodone was missing. A summary of this report documents A comprehensive investigation was initiated. Results of investigation concluded that hydrocodone card of 60 tablets was unable to be located. Narcotic counts were immediately conducted on remaining narcotics in the building with no discrepancies noted. It was verified with V2 that during count on evening of 6/3/2025, card was present in narcotic locked box and during count on morning of 6/5/2025, card was not present. She notified V26 (DON at the time of incident) and immediate count of narcotics throughout entire building was conducted. V26 LPN states that during count on morning of 6/4/2025, card was still present and during count on evening shift of 6/4/2025, card was not present. V23 states card was not present during count in the morning of 6/4/2025. Investigation as completed on 6/6/2025, unable to determine who or where the card of hydrocodone went.The facility's policy, Abuse Policy, revised 12/2025 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents and in correspondence with the Elder Justice Act of 2010 that strengthens elder abuse protections and the Illinois Administrative Code.

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	03/26/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure CPR (cardiopulmonary resuscitation) was initiated per physician's orders and resident's wishes for 1 of 3 (R16) residents reviewed for death. This failure resulted in an Immediate Jeopardy on [DATE] at 8:20 AM when R16 was found without a pulse nor respirations by a CNA (Certified Nurse Assistant). CPR was not attempted per R16's wishes. This failure has the potential to affect all 138 residents of the facility.The Immediate Jeopardy began on [DATE] at 8:20 AM when R16 was found without a pulse or respirations by V30 CNA. V30 notified R16's nurse V19 LPN (Licensed Practical Nurse) of R16's condition and V19 failed to initiate CPR per R16's wishes. R16 expired at the facility on [DATE]. On [DATE] at 10:26 AM V1 Administrator, V2 DON (Director of Nursing), V3 ADON (Assistant Director of Nursing), and V4 Regional Nurse were notified of the Immediate Jeopardy. The Immediate Jeopardy was removed on [DATE], but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training.Findings Include:R16's admission Record with a print date of [DATE] documents R16 had diagnoses including hypokalemia, type 2 diabetes mellitus, emphysema, cerebellar stroke syndrome, and congestive heart failure.R16's MDS (Minimum Data Set) dated [DATE] documents R16 was cognitively intact.R16's Order Summary Report print date of [DATE] documents R16 had a Physician's order to be a full code.R16's IDPH (Illinois Department of Public Health) Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form dated [DATE] documents attempt resuscitation/CPR, and medical interventions of full treatment with primary goal of sustaining life by medically indicated means. In addition to treatment described in selective treatment, use intubation, mechanical ventilation and cardioversion as indicated.R16's undated Care Plan documents (R16) desires CPR to be initiated in the event of cardiac arrest. Care Plan Goal: Resident wishes will be honored. In the event of cardiac arrest, CPR will be initiated and continue until EMS (Emergency Medical Services) arrival to take over compressions and/or Physician gives order to stop compressions, if not effective.R16's progress note dated [DATE] at 9:00 AM documents notified Dr. (V15) and (V13) daughter of R16 that resident had expired this AM. Writer was notified by CNA (Certified Nurse Assistant) around 8:20 AM that resident was no longer breathing or had a pulse. Verified with North-South Nurse that there was indeed no pulse/heartbeat and no breathing activity.On [DATE] at 11:44 AM V13 (R16's daughter) stated she was her mom's POA (Power of Attorney) although her mom was completely alert and oriented until she passed away. V13 stated her mom (R16) still wanted to be a full code. V13 stated she discussed her mom's code status within the last year, and her mom (R16) reiterated she still wanted to be a full code.On [DATE] at 12:46 PM V2 DON looked at R16's progress notes along with Surveyor and V2 stated I do not see where CPR was initiated. V2 stated she was not the DON at the time R16 passed away.On [DATE] at 2:31 PM V18 LPN (Licensed Practical Nurse) stated V19 LPN called her to come down to R16's room and verify her death. V18 stated as she was going to R16's room she asked V19 if R16 needs CPR, and she thought V19 went to check R16's medical records to see if she was to receive CPR or not. V18 stated V19 came back in the room, did not say anything about R16 being a full code, so she informed V19 that R16 did not have any heart sounds nor respirations. V18 stated about 2 hours after R16 passed away she overheard V19 speaking on the phone to V15 (R16's Physician) and she heard V19 say R16 was a full code. V18 stated she then looked at R16's Physician orders and saw R16 was a full code, then she went and reported the issue to the DON. V19 stated R16 did not have any signs of rigor mortis nor any signs she had been deceased for a long period of time.On [DATE] at 8:58 AM V15 Physician of R16 stated he would have expected R16's nurse to honor R16's wishes and initiate CPR.On [DATE] at 1:42 PM V19 LPN was asked by Surveyor what he did when he was alerted of R16's condition on [DATE] and V19 stated he did not follow protocol, someone said she (R16) took her last breath, so he (continued on next page)

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	03/26/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	went in there to check, and she wasn't breathing. V19 stated he was not aware there was an issue with R16's death until today ([DATE]). V19 stated he assumed R16 was a no code (no CPR) by the way she looked. Survey team asked V19 what R16 looked like and V19 replied she looked like she took her last breath. V19 then stated, I only received 2 days of orientation, I did not look at her (R16's) paperwork to see if she was a code.On [DATE] at 10:38 AM V30 CNA stated she found R16 unresponsive on [DATE] and she went to get the nurse (V19), and he (V19) told her to get the other nurse (V18). V30 stated V19 informed her R16 was a DNR (Do Not Resuscitate).On [DATE] at 1:55 PM V2 DON stated she expects the facility nurses to follow facility protocols.On [DATE] at 11:26 AM V1 Administrator stated he would have expected the nurses to administer CPR.The facility's CPR Policy dated [DATE] documents Emergency Procedure - Cardiopulmonary Resuscitation. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR. Instruct a staff member to activate the emergency response system (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator (if applicable). Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy:Immediate re-education of all licensed and direct care staff on CPR requirement, including initiation unless a valid DNR order is present [DATE] prior to working the floor.Facility staff educated in-serviced all staff on the code status of facility residents and where to check for code status of resident on [DATE] or prior to working the floor on their next scheduled shift.All agency staff will be checked off on knowledge of CPR and knowledge of code status prior to working the floor on their next scheduled shift.Verification of all residents' code status to ensure accuracy and accessibility [DATE].Removal of any staff involved from resident care pending re-education and competency validation [DATE].Hands-on CPR return demonstrations completed for all staff [DATE] and prior to working the floor.Emergency equipment (crash cart, oxygen) checked and confirmed functional [DATE].Policy reviewed that it clearly requires initiation of CPR unless a valid DNR order is verified [DATE].Code status verification added to shift report and electronic medical record review [DATE].HR (Human Resource) assigned responsibility for CPR compliance and education [DATE].Routine mock code drills scheduled weekly for 4 weeks then monthly x 3 months [DATE] and ongoing.CPR requirements incorporated into orientation for all new hires [DATE].This alleged deficient practice has potential to affect all residents in the facility.R16 no longer resides in the facility.Monitoring:All staff will complete CPR competency validation immediately on [DATE] and ongoing.Weekly audits of code status starting on [DATE] and ongoing verification x4 weeks, new admissions verified upon admission.Monthly mock code drills with documentation starting on [DATE].Quarterly audits of emergency response documentation starting on [DATE].Results will be reviewed in QAPI meetings. The facility's Census Room Roster dated [DATE] documents there are 138 residents residing at the facility.