

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Grove Health & Rehab Ctr, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer call lights in a timely manner in 2 of 3 residents (R109, R131) when reviewed for accommodation of needs in the sample of 32. Findings Include: On 08/26/2025 at 10:50 AM, R109 was observed in her room, in the wheelchair, clean, dry, without odors, and call light within reach. R109 stated sometimes she will have to press her call light 2-4 times to get someone to come in. R109 stated it has taken over 2 hours for the staff to provide care. R109 stated she has a bed sore on her bottom from not being cleaned up timely. R109 stated she goes to dialysis 3 days per week and has to sit up for the 3 hours she is there, so when she gets back to the facility, she's ready to lay down and it takes a long time. R109's Face Sheet, undated, documents R109 has the following diagnoses: Osteomyelitis of the Vertebrae, Type 2 Diabetes, End Stage Renal Disease, Dependence on Renal Dialysis, Urinary Retention, Back Pain, and Disc Degeneration. R109's MDS (Minimum Data Set), dated 7/22/25, documents R109 has modified independence with daily decision making, is dependent with toileting, is frequently incontinent of bowel & bladder, and has a stage 2 pressure ulcer that was present upon admission. R109's Care Plan, dated 5/14/25, documents R109 requires assistance with ADLs (Activities of Daily Living). On 08/26/2025 at 11:10 AM, R131 was observed in her room in recliner, clean, dry, without odors, walker beside recliner, and call light within reach. R131 stated it takes 1-2 hours sometimes to get her call light answered. R131 stated she fell recently and hurt her tailbone and hip because she was waiting so long for the staff to take her to the bathroom, so she got up by herself and tripped over her oxygen tubing causing her to fall. R131 stated she is mostly continent but when she has an accident it will take 1-2 hours for someone to help her because they don't answer the call light. R131's Face Sheet, undated, documents R131 has a diagnosis of Hemiplegia/Hemiparesis following a Cerebral Infarction affecting the Left Side. R131's MDS, dated [DATE], documents R131 has a BIMS (Brief Interview of Mental Status) score of 12, indicating R131 has moderate cognitive impairment, utilizes a walker and wheelchair, requires substantial/maximal assist with toileting, requires partial/moderate assist with transfers, and is occasionally incontinent of urine. R131's Care Plan: dated 10/25/24, documents R131 has a Self-Care Deficit related to weakness, terminal condition, is under hospice care, and has a history of stroke with left sided hemiparesis. R131's Progress Note, dated 8/16/2025 at 5:45 AM, documents the following: Resident found sitting on floor on her buttocks between her butt and bed. Resident assisted to w/c (wheelchair), neuros initiated, ROM (Range of Motion) and VS (Vital Signs) are all WNL (Within Normal Limits) for this resident. Management, family and on call aware of fall with no injury. Resident denies pain. R131's Progress Note, dated 8/18/2025 at 4:09 PM IDT (Interdisciplinary Team) met to discuss recent fall. RCA (Root Cause Analysis): Resident noted to have been attempting to transfer self, and lost balance. Intervention: call don't fall sign hung, and resident educated. The Resident Council Minutes, dated 6/17/24, document under nursing concerns: call lights are not being answered in a timely manner. Call lights being turned off and not returning to assist resident. The Resident Council Minutes, dated 7/15/25, document under nursing concerns: call light wait time is too long. The Resident Council Minutes, dated 8/19/25, document under nursing concerns: call light wait time is too long. Concerns with people walking by when call lights are on. On (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/29/25 at 11:47AM, V1, Administrator, stated she has not had anyone specifically complain to her about the call light response time, but there have been complaints made in resident council. V1 stated when that happens, V2, DON (Director of Nurses), will do call light audits and will educate management, ancillary staff, and the nursing staff, not to walk by a call light, anyone can answer the light. The Call Light Guidance Policy, dated 7/1/23, document resident call lights shall be responded to within a reasonable amount of time.		

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F 0600 Level of Harm - Minimal harm or potential for 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. Based on Interview, and Record Review the facility failed to ensure physical abuse did not occur for 1 of 2 (R88) residents reviewed for abuse in the sample of 32. Findings Include: R112's Face sheet documents an admission date of 10/10/2023. Diagnosis include Heart failure, Dementia, Anemia, Dysphagia, and Hypertension. R112's Minimum Data Set, MDS, updated 6/25/2025 documents R112 is moderately cognitively impaired. R112's Care Plan updated 7/10/2025 documents R112 has a behavior problem of hitting others related to: Cognitive Impairment/Dementia. Interventions include: If reasonable/appropriate, discuss R112's behavior. Explain/reinforce why behavior is inappropriate and or unacceptable to R112. Monitor for behavior of hitting. Praise R112 for appropriate behavior. R88's Face sheet documents an admission date of 5/12/2023. Diagnosis include Dementia, Type 2 Diabetes, Osteoarthritis, Dysphagia, Hearing Loss, R88's MDS updated 8/1/2025 documents R88 is severely cognitively impaired. R88's Care Plan updated 8/1/2025 documents R88 has a behavior problem of hollering out related to Alzheimer's or related Dementia. Interventions include monitor for behavior of hollering out. Ensure physical safety of resident and others when behavior is seen. Facility's Verification of Incident Investigation/Administrative Summary dated 7/6/2025 documents A comprehensive investigation was initiated on 7/6/2025 and showed that staff reported that one resident (R112) with a BIMS of 8 had a hold of a puzzle book which made contact with fellow resident (R88) with a BIMS of 5 on the right side of her head. Upon interview R88 could not recall the incident stating 'No' when asked if she was hit by another resident. R112 could not recall the incident stating 'I never hit her and would never hit anyone.' Neither resident shows any signs of Psychosocial/mental anguish. Other staff were interviewed with no negative findings of anyone willfully striking another resident. The allegation of willful physical abuse is unsubstantiated. The facility finds the allegation of willful abuse unsubstantiated. All appropriate parties have been notified of the outcome. On 8/28/2025 at 11:35AM when R112 was asked if she had an altercation with another resident R112 stated No nothing has happened. On 8/28/2025 at 11:45AM V21, Certified Nursing Assistant, CNA, unable to contact. Facility incident report undated signed interview documents I walked around the corner, and the aids were asking R112 to move so she can get other residents through for lunch on East Hall. She yelled No and hit another resident with her book twice. She then began to yell and hit the aids (both of them) and calling everyone b#####s. Then she pulled her pants down and said see my p##### b#####. Interview signed by V21. On 8/28/2025 at 12:30PM V19, Registered Nurse, RN, stated I was working the floor that day, but I don't exactly remember what happened. R112 has behaviors all the time so I don't remember this one in particular. On 8/28/2025 at 12:50PM V20, CNA, stated the day R112 hit R88 I was pushing a resident down the hall when R88 bumped into R112. R112 took her book and hit R88 in the shoulder area with it. V22 and I separated the 2 residents and got the nurse. On 8/28/2025 at 12:53PM V22, CNA, stated the day R112 hit R88 I was in the hall and saw R88 self-propelling her wheelchair up the hallway. R88 bumped R112's wheelchair and that set R112 off. I saw R112 hit R88 with her book. R112 hit R88 in the shoulder. We then separated them and got the nurse. Facility abuse policy with a revision date of 1/9/2024 states 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, deprivations of goods and services by staff and mistreatment of residents. This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including but not limited to facility, staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual family members or legal guardian friends or another other individual.		

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F 0689 Level of Harm - Minimal harm or potential for 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, observation, record review, the facility failed to attach mechanical lift sling in the appropriate manner to prevent 1 resident (R12) of 8 residents from experiencing a fall from the mechanical lift out of a sample of 32. Findings include: R12's undated Face Sheet documents an initial admittance dated of 03/01/2025 with pertinent medical diagnoses Other Acute Osteomyelitis Right Humerus, Arthritis due to other bacteria right elbow, Unspecified fracture of Upper end of Right Humerus, Subsequent encounter for fracture with Routine Healing, low back pain R12's Minimum Data Set (MDS) dated [DATE] documents R12 is cognitively intact, she does not exhibit any behaviors that reject care, R12 is on as needed pain medication, R12 is dependent on staff for toileting, showering, lower body dressing, rolling left and right, and transferring from chair/bed to chair and is frequently incontinent of urine and always incontinent with bowels. On 8/28/25 at 9:15 AM R12 stated she was afraid of transferring with the mechanical lift. R12 stated she had fallen because the loops on the sling were rotten. and she fell to the floor. Talk to my daughter she can explain every thing On 8/28/25 2:00 P V27 daughter of R12 stated that her mother (R12) actually fell from the mechanical lift sometime last year. She (V27) was told by nursing home staff (R12) was lowered to the floor when the sling straps came loose. (R12) was not taken to the hospital (R12) has always complained of pain so it was difficult to tell if she (R12) was actually injured. R12's Nurse Progress notes dated 10/23/24 document a late entry of staff transferring (R12) using a mechanical lift did not ensure the loops to the sling were attached properly. Staff were educated. On 8/29/25 at 9:17 AM V1 Administrator stated the staff involved in the incident are no longer with the facility. all staff were educated on the proper use of any transferring of resident. The facility's Transfer Policy dated 07/01/2023 documents , It is the responsibility of all nursing staff to ensure the use of safe transfer techniques when transferring a resident. When using a mechanical lift, pay close attention to be sure that the mechanical lift sling is properly positioned and the straps are securely in the strap holder.		