	epartment of Public			a harry to true to the first of the second o	FORM	APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6013312	B. WING			C 06/2022	
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
JERSEY	VILLE MANOR		RTH STATE /ILLE, IL 62				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Complaint Investig 2247471/IL15133 2247869/IL151819	8					
S9999	Final Observations		S9999				
	Statement of Licensure Violations		. * /4			i	
	300.610a)					:	
	300.1210b)						
	300.1210d)6)						
	a) The facility shall procedures govern facility. The written be formulated by a Committee consist administrator, the a medical advisory of nursing and other policies shall comp. The written policies the facility and shall procedure in the state of the shall comp.	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed			24		
	Nursing and Person b) The facility shall and services to atta practicable physical well-being of the re- each resident's con-	General Requirements for mal Care provide the necessary care all or maintain the highest l, mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing		Attachment A Statement of Licensure Violation	IS	3	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	Pepartment of Public NT OF DEFICIENCIES			Attend of the part of the	25.5	MAPPROVED	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY	
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ļ		IL6013312	B. WING			/06/2022	
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S9999	Continued From page 1		S9999				
	care and personal or resident to meet the care needs of the re	eare shall be provided to each a total nursing and personal esident.					
	care shall include, a and shall be practic						
	taken to assure that remains as free of a All nursing personne see that each reside	pasis: sary precautions shall be the residents' environment accident hazards as possible. el shall evaluate residents to ent receives adequate istance to prevent accidents.					
(a (These requirements by:	were not met as evidenced					
	review, the facility fa prevent falls for 1 of falls in the sample o	on, interview and record illed to supervise residents to 3 residents (R6) reviewed for f 12. This failure resulted in ken finger and facial bruising ek and chin.					
	Findings include:	·					
	wheelchair. R6 had	AM, R6 was sleeping in her purple and fading yellow right eye, cheek and chin. R6 on her right hand.					
	9/22/22 documents I	r Report, dated 9/1/22 - R6 was admitted on 1/7/2019 ongestive Heart Failure, Type a and depression.					
	R6's Minimum Data documents that R6 is decision making, req	Set, dated 7/22/22, s independent of daily uires extensive assistance of					

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6013312 B. WING 10/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 NORTH STATE STREET JERSEYVILLE MANOR JERSEYVILLE, IL 62052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 2 staff members for bed mobility and transfer, extensive assistance of one staff member for toileting, personal hygiene and dressing and limited assistance of one staff member for locomotion on the unit. This MDS also documents R6 is not steady and only able to stabilize with staff assistance and that she uses a wheelchair. This MDS also documents R6 is occasionally incontinent of bowel and bladder. R6's Nurse's Note, dated 9/14/22, documents, "Resident found on floor in bathroom, laying on R (right) side in front of toilet. Floor is clean, dry, and free of clutter. Resident states she did hit her head. Resident assisted to bed via 3 staff members. Skin tear to R wrist noted measuring 2cm (centimeters) x 1cm. Edges approximated and (brand) thin adhesive bandages applied. Hematoma noted to R side of forehead measuring 4cm x 3cm. Small open area to bridge of nose. Resident states that she was putting pants on in bathroom unassisted prior to falling. Stated "I think I lost consciousness for a few minutes." VS (vital signs) as follows- 134/88, P (pulse) 71, R (respirations) 22, T (temperature) 97.8, O2 (oxygen) 93% on 3L (liters) per NC (nasal canula). Resident requesting transfer to (local) ER Emergency Room) for evaluation. Ambulance paged at this time. V25 (R6's Power of Attorney) called and notified, verbalized appreciation of call." R6's Fall investigation, dated 9/14/22, documents that R6 was on the toilet trying to put her pants on herself when she fell off the toilet. Sent to the Emergency Department. R6 came back with bruising and swelling to right 5th finger, bruising to her right forehead and a skin tear to her chest. X-ray was obtained and findings showed

suspicious for acute fracture of the distal aspect

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013312 NAME OF PROVIDER OR SUPPLIER STREET AL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			C 40/08/0000	
		DDRESS, CITY, STATE, ZIP CODE			10/06/2022	
JERSEY	VILLE MANOR		RTH STATE S			
			VILLE, IL 620	52		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BF	(X5) COMPLETE DATE
\$9999	Continued From page 3 of the proximal phalanx of the 5th digit.		S9999			
2	9/14/22, documents today for the following	discharge instructions, dated s, " You have been evaluated ng conditions: Multiple t tissue hematoma to the right hand."		14		
	Neck, dated 9/14/22	Tomography) Head and 2, documents, "Scalp ght supraorbital region noted.				
	PM, documents, "Fi fracture of the distal phalanx of the 5th d	ingers, dated 9/14/22 at 8:46 ndings suspicious of acute aspect of the proximal sigit with some ventral n on lateral projection view."		5 1		
	Assistant/CNA) state anything for herself. We dress her. We washe can't go with you call light and tell her in there, so you gottowill also get tired of light, and she will try	PM, V6 (Certified Nurse ed, "R6 really doesn't do She is a two-person assist. will take her to the bathroom; u in there, so we give her the to call us. She will fall asleep a go and wake her up. She waiting for us to answer the to stand, which she can't, ainks she can stand and				
	to the toilet and som the staff get me dres aide came in and too told me to get mysel because I like to do	AM, R6 stated, "They take me etimes I take myself. Usually, ssed, but that morning an ok me to the bathroom and f dressed. I said "okay" things for myself or at least was trying to put my pants on, t."				
	On 10/4/22 at 9:00 A	M, V24 (Licensed Practical				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С B. WING IL6013312 10/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1251 NORTH STATE STREET** JERSEYVILLE MANOR JERSEYVILLE, IL 62052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION Œ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 Nurse/LPN) stated, "(R6) cannot dress herself. We encourage her to help with the top, but the pants, no, she couldn't do that because, of course, she can't stand by herself." On 10/4/22 at 10:00 AM, V23 (Certified Nursing Assistant/CNA) stated, "I was the aide the morning R6 fell and got the black eye. I went in in the morning, and I used the stand-aide to take her to the bathroom. I put her on the toilet. I left her with her clothes to put on. The next thing I know, she is on the floor. She would get dressed in the bathroom on the toilet by herself, but somedays she needed help. On those days, I would help her." On 10/4/22 at 10:10 AM, V27 (Certified Nursing Assistant/CNA) stated, "I was on the hall that day (9/14/22) but I don't remember getting her up. When I get her up. I take her to the bathroom using the sit-to-stand and get her on the toilet. I would stand outside with my arm in the door. I like to give her privacy, but I am not leaving her alone on the toilet. She will not use the call light. She will take herself to the bathroom. I have caught her. I tell her she shouldn't do that and that she is going to fall, and she says, "I know." I put her pants on her while she is in bed; it is just easier that way. She might be able to put on her shirt, but I always help her." On 10/4/22 at 10:59 AM, V28 (Licensed Practical Nurse/LPN) stated, "I was the nurse the morning R6 fell and needed to go to the hospital. I was sitting at the desk and heard an awful scream from R1 (R6's roommate). I went running; actually, we all did. I went in the room, R1 said 'It's R6. She is hurt.' I opened the bathroom door and R6 was on the floor. I didn't see any blood.

but she did start to have a goose egg on her

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6013312 10/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 NORTH STATE STREET JERSEYVILLE MANOR JERSEYVILLE, IL 62052 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 head. I asked her if she wanted to go to the hospital; she said 'No.' Myself and other staff got her up and back in bed. I assessed her. She said she had fallen off the toilet. She then told me that she wanted to go to the hospital and be checked out. I called 911 and called V25 (R6's POA) and left a message about the fall and that I was sending her out and I would keep her updated. When R6 came back, I called V25 and left a message that R6 was back. The paramedics had R6 all wrapped up in a blanket; when I unwrapped R6, I noticed how swollen R6's hand was. I knew something was wrong. I called the Nurse Practitioner, and she gave me an order to get an X-ray. Which I did. I had left several messages for V25, and she never called me back. A few days had gone by and V25 called and told me she was concerned because R6's sister had been in to visit and her sister told her how bad R6 looked. I explained to V25 that bruising always gets worse before it gets better and that she (R6) is on aspirin and Plavix, which is going to make her bruise more easily. R6 will not use the call light. She always says she does not want to bother us. R6 is not able to dress herself." On 10/4/22 at 2:30 PM, V2 (Director of Nurses/DON), stated that R6 should not be left alone to dress herself because R6 does need assistance. The facility policy Emergencies, dated 4/3/2018. documents, "A. Falls. 1. Check the resident immediately for ability to move extremities; check for bruised areas and / or cuts. 2. Check resident's ability to explain what happened: evaluate resident's condition before fall. 3. Check if, or with anyone who witnesses the accident. Determine, if possible, where, how, and when the

accident occurred."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C IL6013312 B. WING 10/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1251 NORTH STATE STREET JERSEYVILLE MANOR** JERSEYVILLE, IL 62052 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 (B)

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