

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047597		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/23/2026	
NAME OF PROVIDER OR SUPPLIER JERSEYVILLE MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1251 NORTH STATE STREET , JERSEYVILLE, Illinois, 62052			
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S0000	Initial Comments Annual Licensure and Certification Survey-		S0000			01/29/2026	
S9999	Facility Reported Incident of October 13, 2025/2690927 Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These regulations were not met as evidence by:		S9999			01/29/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 5 residents (R157) reviewed for abuse in the sample of 42. This failure resulted in R157 fracturing her left hip which required surgical intervention and subsequently led to R157's death. Findings Include: The Facility Investigation, undated, documents the following: R136 pushed R157 causing her to fall to the floor. R157, an alert and confused female. Her BIMS (Brief Interview for Mental Status) score is 3 indicating severe cognitive impairment and her primary diagnosis is Unspecified Dementia. R157 walks independently on the unit with staff supervision. After the fall R157 complained of pain during assessment. Family and physician were notified. Resident was sent to the local hospital and was admitted with a proximal left femur fracture. R157 underwent surgical repair on 10/15/25 which was deemed successful. R157 was continuously monitored for pulmonary edema and advanced COPD. R157's family rescinded R157's DNR (Do Not Resuscitate) status for a 24-hour period to manage initial postop care expectantly. R157 coded and full ACLS (Advanced Cardiac Life Support) protocol was conducted. R157 was pronounced deceased on 10/15/25 at 10:43 PM. R136, is an alert and confused female. R136's BIMS score is 3 indicating severe cognitive impairment and her primary diagnosis is Alzheimer's Disease. R136 walks independently on the unit with staff supervision. After the incident resident was immediately placed on 1:1 (one on one) supervision. R136 had no explanation for pushing R157 and had very little recall of the incident at all. Family and physician were notified. R136 was immediately sent to the local hospital for evaluation and was returned the same day with a new order to treat UTI Urinary Tract Infection). The Psychiatrist was contacted with new prescription orders given for severe agitation and transfer to outside hospital for inpatient admission. R136 was transferred and admitted for psychiatric hospitalization on 10/15/25 and she remains hospitalized at this time and her return is uncertain at this time. In conclusion, the fall incident has been thoroughly investigated. The root cause of the fall was directly linked to the actions of resident (R136). Due to her (R136) cognitive status, she is unable to account for or explain her actions. R136 has had no prior physical incidents since being admitted to the facility. There is no sufficient evidence to suggest that the reactions were intentional. Will continue to monitor.		S9999				

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S9999	Continued from page 2 The Facility Investigation Note, undated, documents the following: Upon investigation, see fall event details, provided by V20, RN (Registered Nurse). Prior to fall, R157 was walking independently on the unit per normal routine. V19, CNA (Certified Nursing Assistant) was down the hall and witnessed R157 and R136 approach. V19 was unable to reach duo in time to prevent R136 from pushing R157 to the floor. While approaching the fall, V19 observed R136 standing over R157 talking nonsensical per her normal routine. V19 did not report witnessing any behaviors that would indicate the event would occur. Neither resident was able to provide credible details of the fall and what lead up to R136 pushing R157 to the floor. V8, CNA, V23, CNA, nor V18, RN, witnessed the fall. V18 assessed R157 and she complained of pain everywhere. Family and physician were notified. LHNA (Licensed Nursing Home Administrator) notified. R157 was sent to the local ER (Emergency Room) and was admitted with a fractured left hip. Family is pleased with her care and wishes her to return to the facility for rehabilitation after surgical repair. The care plan will be reviewed and updated upon her return. Will continue to monitor. R136's Face Sheet, undated, documents R136 has the following diagnoses, in part, Alzheimer's Disease, Paranoid Schizophrenia, Dementia with Agitation, Delusional Disorders, Depressive Episodes, and Severe Dementia Severe with Psychotic Disturbance. R136's MDS (Minimum Data Set), dated 7/30/25, documents the following: R136 has a BIMS score of 3, indicating severe cognitive impairment, displays verbal behavioral symptoms directed towards others. R136's MDS, dated, 11/26/25, documents the following: R136 has a BIMS score of 2, indicating severe cognitive impairment, displays physical/verbal behaviors directed towards others, other behaviors not directed towards others, wanders, and rejects care. R136's Care Plan, dated, 3/7/25, documents the following: R136 receives psychotropic medications due to having a diagnosis of Schizophrenia and Cachexia. Per family interview, they stated that she was put on medication due to being aggressive. She exhibits verbal, physical behaviors towards others and rejection of care. She shows rejection of care with medications, meals and daily routine and waiting for staff assist. She may become territorial when other residents who		S9999				

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S9999	Continued from page 3 enter her room or go through her personal belongings or are in her space. She may wander and has a history of exit seeking. Interventions include: validate where she is trying to go, redirect to room or common area, remind her that her family knows where she is, engage in talk about Spanky, Dianne or Judy to distract, provide strolls in Courtyard or facility if unable to redirect, inform of possible harm to self if ambulating on her own, offer activities food and fluids, likes saxophone music to distract and redirect. R136's Progress Note, dated 8/9/25 at 3:56 PM, documents the following: July Behavior Note- R136 is tracked on the behavior program for showing verbal behaviors and may curse or scream at staff providing care. She shows physical behaviors and may kick or shove staff providing care. She shows rejection of care with meals, and daily routine or ADLs (Activities of Daily Living). She was noted to show no behaviors this month. She has been moved from Memory Lane to Liberty Lane. Staff will continue to monitor resident and use interventions as needed to help decrease the behaviors. R136's Progress Note, dated 8/14/25 at 4:22 PM, documents the following: Behavior note- R136 has been placed on the behavior tracking form for increased wandering/exit seeking potential program. R136's Progress Note, dated 8/16/25 at 9:35 AM, documents the following: Resident was kissing brother-in-law in dining room this morning at breakfast. She had gotten verbally upset that we separated them. Writer took resident to sit on couch while breakfast was being finished. Resident walked back over to brother-in-law; CNAs separated them again and placed wife next to husband. Resident was then walked to her room. R136's Progress Note, dated 9/4/25 at 7:04 AM, documents the following: August Behavior Note: Resident is a recent admit and has been displaying some verbal/physical behaviors related to rejection of care. She may scream or curse, shove, kicking, hitting and or scratching staff providing care. Proactive interventions are in place and if used consistently often prevent the behaviors. Formal programming in place. R136's Progress Note, dated 10/3/25 at 8:46 AM,		S9999				

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S9999	Continued from page 4 documents the following: September Monthly Behavior Note: For the month of September, she has met her goal of having a reduction in verbal/physical behaviors related to rejection of care and upon redirection. She may scream or curse, shove, kick, hit and or scratching staff providing care, or toward others. Proactive interventions are in place and if used consistently often prevent the behaviors. Formal programming in place. R136's Progress Note, dated 10/13/25 at 8:00 AM, documents the following: See event note per V20, RN, for resident 4175-01 (R136) on 10/12/25 at 8:00 PM. Resident was immediately placed on 1:1, Administrator, notified per V20 immediately, MD (Medical Doctor) and POA (Power of Attorney) were notified. R136's Progress Note, dated 10/13/25 at 8:40 AM, documents the following: Resident resting in bed at his time. She remains 1:1 due to prior incident. R136's Progress Note, dated 10/13/25 at 8:53 AM, documents the following: Behavioral outburst including screaming and slapping at staff member who was attempting to redirect her from another residents room. R136's Progress Note, dated 10/13/25 at 10:15 AM, V23, Psychiatrist, called and was notified of increased behaviors and orders to send resident to ER for psychiatric evaluation. POA called and notified, in agreeance with plan of care. 911 implemented at this time. R136's Progress Note, dated 10/13/25 at 10:50 AM, V23 called facility regarding resident and recent increased behaviors. Stated she would like her to have an inpatient stay and has notified an outside behavioral health center. At this time there is no bed available for her at this time, however she is on the waitlist for a bed when it does become available. Face sheet, recent labs, nurse's notes, and med list faxed to the behavioral health center per their request. R136's Progress Note, dated 10/13/25, at 1:39 PM, documents the following: Resident returned to the community by ambulance at 1:35 PM, accompanied by 3 attendants. Placed on visual 1:1 with staff due to earlier violent outburst. Diagnosed at the local			S9999			

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S9999	Continued from page 5 hospital with UTI. IM (Intramuscular) Rocephin administered at the ER. New orders for Augmentin 500mg (milligrams)-125mg oral tablets, 1 tablet every 12 hours for 5 days. Resting in bed at this time. R136's Progress Note, dated 10/13/25 7:06 PM, documents the following: New orders from V23 for Ativan 1mg IM daily PRN (As Needed) for severe agitation, Ativan 1mg po (by mouth) BID (Twice Daily) PRN for severe agitation and Zyprexa 4mg po daily at 4:00 PM. Son informed by phone. R136's Progress Note, dated 10/14/25 at 10:50 AM, documents the following: Staff from behavioral health called facility and informed writer that they would most likely have a bed for resident tomorrow morning. Stated they would call facility to let us know in the morning. POA called and notified, thanked writer for call. R136's Progress Note, dated 10/15/25 at 1:10 PM, documents the following: Spoke with RN at the behavioral health center to give report on resident and to inform them of when she left the facility as requested. Resident left in family vehicle with her son at 12:40 PM. R157's Face Sheet, undated, documents R157 has the following diagnosis, in part, Dementia without Behavioral Disturbance, Cognitive Communication Deficit, Anxiety Disorder, Unspecified Psychosis, Repeated Falls, Weakness, Unsteadiness on Feet, Reduced Mobility, Schizoaffective Disorder, COPD (Chronic Obstructive Pulmonary Disease), Depression, Age Related Osteoporosis, Heart Failure, Hyperlipidemia, Vitamin Deficiency, Iron Deficiency Anemia, and Cough. R157" MDS, dated 8/20/25, documents the following: R157 has a BIMS score of 3, displays verbal behaviors towards other and other behaviors not directed towards others, requires assistance with ADLs, and has a history of falls. R157's Care Plan, dated 6/6/22, documents the following: R157 is at risk for falls related to diagnoses, cognitive deficits which may alter safety awareness, needing assistance with ADL care, B&B (Bowel & Bladder) incontinence, and use of psychotropic medications & opioid medications. R157's Care Plan, dated 6/6/22, documents the		S9999				

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S9999	Continued from page 6 following: R157 receives psychotropic medications due to having a diagnosis of Anxiety, Schizoaffective Disorder, and Psychosis. Family stated resident was anxious and pacing at previous facility. She is delusional in her thought process at times evidenced by thinking she does not live here. Resident displays anxiety with pacing from nurses' station to room with repetitive questioning. She has shown an increase in verbal/physical expressions related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Nettie does not retain info and is unaware of her safety needs. R157's Progress Note, dated 8/6/25 at 7:00 AM, documents the following: July Behavior Note: For the month of July, resident has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Nettie does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place for verbal/physical behaviors and rejection of care, will continue with. R157's Progress Note, dated 8/12/25 at 1:24 PM, documents the following: Resident restless/anxious most of the day, continuing to pace, delusional in her thoughts, asking about how she goes about getting the lighting ordered and taken care, she is easily redirected for a moments time. R157's Progress Note, dated 9/4/25 at 6:56 AM, documents the following: August Behavior Note: For the month of August, resident has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Resident does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place for verbal/physical behaviors and rejection of care, will continue with. R157's Progress Note, dated 10/3/25 at 9:33 AM,		S9999				

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S9999	Continued from page 7 documents the following: September Monthly Behavior Note: For the month of September, resident has shown a decrease in verbal/physical behaviors related to rejection of care and upon redirection from her delusions. She may reject care with taking meds, toileting, changing clothes, showers and ADL care. She does not retain info and is unaware of her safety needs. Proactive interventions are in place and if used consistently, may often prevent the expressions. Formal programming in place and will continue with. Nettie displays other behaviors evidenced by pacing, picking at skin causing bruising and bleeding. Goal and approaches in place. R157's Progress Note, dated 10/12/25 at 8:00 PM, documents the following: Loud noise heard in hallway by nurse's desk. Resident observed on the floor lying on left side. ROM (Range of Motion) x (times) 4 with pain and limitation to LLE (Left Lower Extremity). Shallow skin tears present to left eyebrow and left forearm. Resident c/o (complains of) severe pain "everywhere." Vitals pulse 66, respirations 22, temperature 98.0, SpO2 94% RA (Room Air), unable to obtain blood pressure due to resident moving arms. CNA witnessed another resident come out of their room and push resident to the floor unprovoked. CNA stated resident's head hit the floor very hard. Ambulance paged per nursing judgement. R157's Progress Note, dated 10/13/25 at 12:08 AM, documents the following: Received call from the local ER nurse. Resident is being admitted with Dx (Diagnosis) of fractured left hip. R157's Progress Note, dated 10/13/25 at 11:55 AM, documents the following: Spoke with POA, he stated resident was going to have surgery on Wednesday. Gave him my condolences and will keep them in my prayers. He thanked this writer for calling. R157's Progress Note, dated 10/15/25 at 11:41 PM, documents the following: Call received from the local hospital that resident has expired. R157's Fall Safety Event, dated 10/12/25 at 8:00 PM, documents the following: location: hallway; resident was pushed by another resident; CNA witnessed another resident come out of their room and push resident to the floor unprovoked; c/o severe pain everywhere; Shallow skin tear to left eyebrow and left forearm. ROM painful/limited to LLE; immediate intervention: Ambulance was paged due to painful/limited ROM to LLE and possible head/neck injury from hitting head on the floor.		S9999				

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S9999	Continued from page 8 R157's Hospital Records, document the following: ER Note, dated 10/12/25, Patient was at a memory care unit when another resident pushed her and the resident fell in an unsupervised context. Assessment/plan - Lt femur fracture. Operative Note, dated 10/15/25, ORIF (Open Reduction Internal Fixation) of the left hip. Patient was sent to PACU (Post Acute Care Unit) in stable condition. MD Progress Note dated 10/15/25 at 11:05 PM, I was called to evaluate the patient during code. BP (Blood Pressure) unresponsive to escalating doses of Levophed given through the IO (Intraosseous) line. Three liters of fluid were also given prior to the code in resuscitation efforts postop via the IO line placed in the right tibia. A sat was never identified due to the profound unresponsive hypotension consistent with overwhelming cardiac failure as a primary feature of her neurologic condition preop. Patient never responded to any bedside interventions. Epinephrine and shocks delivered during the AED (Automated External Defibrillator) application prior to the arrest. Ventricular Fibrillation degenerated very quickly to PEA (Pulseless Electrical Activity) which sustained on two checks. Code was called due to anticipated demise in an agonal rhythm that would predictably degenerate to asystole in a short time frame. Expired on 10/15/25 at 10:53 PM, full ACLS protocol followed. R157's Death Certificate, dated 10/20/25, documents the following: Date of Death: 10/15/25; immediate cause of death: acute displaced left femur intertrochanteric fracture, conditions leading to the cause of death: status post insertion intramedullary nail of the left femur, underlying cause: dementia moderate, significant conditions contributing to death: pulmonary edema, schizoaffective disorder. On 1/22/26 at 8:10 AM, V4, LPN (Licensed Practical Nurse), stated R157 would walk around the unit, she was "up, down, up down" and would ask repetitive questions. V4 stated R157 could have verbal and physical behaviors towards staff but not any of the residents. V4 stated she is not familiar with R136. On 1/22/26 at 8:25 AM V15, Memory Care Specialist, stated she was not working when the incident between R136 and R157 occurred. V15 stated R157 would occasionally have behaviors but not directed towards others. V15 stated R136 would have verbal behaviors towards the staff but not towards the other residents. V15 stated she does not recall any other incidents involving R136 or R157. On 1/22/26 at 9:13 AM V19, CNA, stated she was working		S9999				

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S9999	Continued from page 9 and witnessed the incident between R136 and R157 on 10/12/25. V19 stated R157 was walking laps towards the doors and walked past room 502, R136's room. V19 stated R157 stopped approximately 5-6 feet outside of R136's doorway and was saying something and pointing her finger. V19 was unable to hear what R136 was saying. V19 stated R136 came out of her room running with both of her arms out in front of R157 and pushed her to the ground. V19 stated after this occurred R136 ran back into her room and when V19 approached, R136 was laughing and shut the door to her room. V19 stated R157 hit her head hard on the floor, was bleeding and crying in pain. V19 stated prior to this incident, R136 had a few issues at the supper table, where she would put her hands on the residents that would annoy her. V19 stated R136 was easily annoyed by the other residents. V19 stated they have a couple of residents that have behaviors that could potentially be physical towards other residents but they intervene prior to an incident occurring. On 1/22/26 at 9:25 AM, V8, CNA, stated she was working but did not witness the incident between R136 and R157. V8 stated R136 stayed in her room most of the time, she would verbally cuss or tell other residents to stay away, and they would try to intervene. V8 stated they would redirect R136 to her room, give her a snack, have her watch TV and divert her away from the situation. On 1/22/26 at 11:20 AM, V22, Medical Director, stated the incident between R136 and R157 was unexpected. R136 nor R157 had displayed any physical behaviors towards others. V22 stated in her opinion R157 due to poor postoperative monitoring after hip surgery. V22 stated R157 was cleared by the Cardiologist for the surgery, came through the surgery just fine, her blood pressure was to be checked every 30 minutes, it was fine and then it wasn't checked for 2 hours and during that time her blood pressure crept down, R157 coded and died. The Abuse Prohibition and Reporting Policy, with a revision date of 11/18/19, documents, in part, the following: The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation and use of any physical or chemical restraint not required to treat resident's symptoms. The purpose of the policy is to protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Special attention will be		S9999				

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S9999	Continued from page 10 given to identifying behavior that increases the residents potential for abusing self or others or being the victim of abuse. These behaviors would include residents with a history of aggressive behaviors such as entering other residents rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (A) (2 of 2) 300.610a) 300.1210b) 300.1210d)2) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable			S9999			

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S9999	Continued from page 11 physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These regulations were not met as evidence by: 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 4/11/2025 and has a medical diagnosis of Dementia, Weakness, and Alzheimer's Disease. R118's Minimum Data Set dated 10/8/2025 documents R118			S9999			

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S9999	Continued from page 12 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 mattress R118'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 505. 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 505. 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		S9999				

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S9999	Continued from page 13 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. Walker was at bedside and did not appear to be in use at the time of the fall. Resident was 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 505. 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			S9999			

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S9999	Continued from page 14 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		S9999				

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S9999	Continued from page 15 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 individual resident assessment and care plan." (B)		S9999				