STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510541	A. BUILDING _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK COLLINSVILLE	121 SOUTH BLUFF ROAD COLLINSVILLE, IL 62234

(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
A 000	Initial Comment COI IL177797 Allegation Substantiated. Violations 295.4010 and 295.4060 cited. COI IL177804 Allegation Partially Substantiated. However, no violations cited.	A 000		
A4010	Section 295.4010 Service Plan This RULE: is not met as evidenced by: TYPE 2 VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract	A4010		

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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A4010	Continued From Page 1 between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview and record review the facility failed to ensure individualized/personalized fall prevention plans are developed for residents identified as at risk for falls and those with actual falls in the facility. This failure creates a substantial probability of harm/injury to residents who are at risk for falls. Findings include: R1's Reportable Incident Report dated 9/9/24 documents, "RA (Resident Assistant)reported while toileting resident, RA turned her back only for a minute and resident fell forward off toilet landing on her right side. Resident denied pain or discomfort at this time but started complaining of pain later in the day and was sent to ER. No injuries noted at ER." R1's Service Plan updated 7/8/24 documents, "I am a high risk for fall. Interventions. Goal: I will remain injury free. Interventions: Encourage me to call for assistance if I feel unsteady or weakness. Monitor my gait and report to nursing team if you notice changes. Resident sustained a fall on 9/9/24. No injury noted." No personalized fall interventions/approaches provided in the service plan when R1 was indentified as a high fall risk. No personalized progressive interventions	A4010		

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A4010	Continued From Page 2 provided in the service plan after R1's 9/9/24 fall. R1's Cognitive Assessment Functional Assessment Staging Tool (FAST) for Dementia dated 7/8/24 has a score of 6 (Severely Impaired Functional Abilities). On 9/16/24 at 11:21 AM, E4 (Resident Assistant/RA) stated R1 is one person assist with walking using a walker and always tries to stand up while in the toilet so she does not leave her alone while she is sitting in the toilet. On 9/16/24 at 11:27 AM, E5 (RA) stated everytime she takes R1 to the toilet R1 will always try to stand up so she stays with her all the time. On 9/16/24 at 11:34 AM, E2 stated R1 should never be left unattended when she is in the toilet. On 9/17/24 at 10:10 AM, E1 (Executive Director/ED) stated E3 and all direct care staff were reeducated regarding safety monitoring while taking care of residents with dementia. On 9/16/24 at 5:05 PM, E3 (RA) stated she walked R1 to use the bathroom at around 3 AM and while R1 was sitting in the toilet, E3 grabbed a gown and incontinent briefs from the other room and when she came back saw R1 fall on her right side. E3 stated she should not have left R1 unattended even for a second. E3 stated R1 gets restless in the toilet and would always attempt to stand up but listens when she is told to sit back down. E3 stated R1 does not understand to call for help/use the call light due to her dementia.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From Page 3 This RULE: is not met as evidenced by: TYPE 2 VIOLATION Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program: 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: iii) identifying and alleviating safety risks to residents with Alzheimer's disease; Based on interview and record review the facility failed to ensure monitoring and supervision is provided to prevent a fall during toilet use for a resident with dementia. This failure caused R1 to be sent out to ER for evaluation with diagnosis of contusion to right shoulder. This failure creates a substantial probability of harm/injury to residents who need adequate safety monitoring and supervision. Findings include: R1's Reportable Incident Report dated 9/9/24 documents, "RA (Resident Assistant) reported while toileting resident, RA turned her back only	A4060		

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A4060	Continued From Page 4 for a minute and resident fell forward off toilet landing on her right side. Resident denied pain or discomfort at this time but started complaining of pain later in the day and was sent to ER. No injuries noted at ER." R1's Service Plan updated 7/8/24 documents, "I am a high risk for fall. Interventions. Goal: I will remain injury free. Interventions: Encourage me to call for assistance if I feel unsteady or weakness. Monitor my gait and report to nursing team if you notice changes. Resident sustained a fall on 9/9/24. No injury noted." No personalized fall interventions/approaches provided in the service plan when R1 was indentified as a high fall risk. No personalized progressive interventions provided in the service plan after R1's 9/9/24 fall. R1's Cognitive Assessment Functional Assessment Staging Tool (FAST) for Dementia dated 7/8/24 has a score of 6 (Severely Impaired Functional Abilities). On 9/16/24 at 11:21 AM, E4 (Resident Assistant/RA) stated R1 is one person assist with walking using a walker and always tries to stand up while in the toilet so she does not leave her alone while she is sitting in the toilet. On 9/16/24 at 11:27 AM, E5 (RA) stated everytime she takes R1 to the toilet R1 will always try to stand up so she stays with her all the time. On 9/16/24 at 11:34 AM, E2 stated R1 should never be left unattended when she is in the toilet. On 9/17/24 at 10:10 AM, E1 (Executive Director/ED) stated E3 and all direct care staff	A4060		

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A4060	Continued From Page 5 were reeducated regarding safety monitoring while taking care of residents with dementia. On 9/16/24 at 5:05 PM, E3 (RA) stated she walked R1 to use the bathroom at around 3 AM and while R1 was sitting in the toilet, E3 grabbed a gown and incontinent briefs from the other room and when she came back saw R1 fall on her right side. E3 stated she should not have left R1 unattended even for a second. E3 stated R1 gets restless in the toilet and would always attempt to stand up but listens when she is told to sit back down. E3 stated R1 does not understand to call for help/use the call light due to her dementia.	A4060		