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 _____	C 10/10/2024

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 IL178048 - ALL ALLEGATIONS CANNOT BE SUBSTANTIATED, NO VIOLATIONS CITED COI IL178730 - FALL ALLEGATION IS SUBSTANTIATED, HOWEVER NO VIOLATION CITED. ALLEGATION RESIDENT IS NOT GETTING MEDICATIONS IS SUBSTANTIATED, HOWEVER, NO VIOLATION CITED COI IL178756 - ALLEGATION OF DELAY OF CARE AFTER FALL CANNOT BE SUBSTANTIATED. NO VIOLATION IS CITED. ALLEGATION OF LACK OF STAFF CANNOT BE SUBSTANTIATED. NO VIOLATION IS CITED COI IL179114 - ALLEGATION OF DELAY IN CARE POST FALL CANNOT BE SUBSTANTIATED. NO VIOLATION IS CITED. ALLEGATION FAMILY WAS NOT NOTIFIED OF FALL AND CHANGE OF CONDITION CANNOT BE SUBSTANTIATED. NO VIOLATION IS CITED VILLAS OF HOLLY BROOK COLLINSVILLE is in general compliance with the Requirements of the Assisted Living and Shared Housing Establishment Code for this survey.	A 000		