

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510490	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/16/2024
NAME OF PROVIDER OR SUPPLIER VILLAS OF HOLLY BROOK BLOOMINGTON FC		STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FOX CREEK ROAD BLOOMINGTON, IL 61701		
(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 Original investigation of Complaint 2468398 / IL 179385 and FRI IL 178699. Complaint IL 179385 - No violations cited. FRI IL 178699 - 295.6000 a) 13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; VIOLATION Based on record review and interviews, the establishment failed to prevent physical abuse of one of three sampled residents. (R1) Findings include: According to R1's current Facesheet, R1 resides on the memory care unit in the facility. R1 has Diagnosis including but not limited to Alzheimer's Disease and Dementia, Facility incident report dated 9/13/24 reads,	A6000		

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

TITLE

(X6) DATE

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A6000	Continued From page 1 "Resident (R1) became combative during morning cares. While changing resident's (R1) brief, Resident (R1) began to swing her hands and arms towards staff. During the incident, one staff member (E3 CNA) swatted residents (R1) hand and forearm. No bruising or injury to resident." Page 2 reads, "Investigation of incident on 9/13/24 was conducted and completed. Results concluded that said employee (E3) did violate residents rights and violated abuse and neglect policies. Employee (E3) was terminated on 9/16/24. All staff was inserviced and re-educated on Abuse and Neglect Abuse and Neglect Reporting, and Resident Rights." On 10/15/24 at 10:24 A.M., E4 (Caregiver) stated that early on 9/13/24 E3 came out of R1's room and asked E4 to help get (R1) up. When they went back into R1's room, R1 was upset and yelling. E3 sat down with R1 and tried to explain to her that they needed to get her up to the bathroom and change her. R1 raised her hand and told us to get out. E4 then slapped R1's hand down. E4 told E3 that she couldn't do that and to leave the room. E5 (Maintenance Director) was in the room and witnessed this. E3 sat with R1 to help calm her down. E3 said that E5 said he had to go report this to the Executive Director. On 10/15/24 at 9:40 A.M., E5 stated that on the morning of 9/13/24 he was in R1's room when E3 and E4 were trying to persuade R1 to get up. E5 stated that R1 was visibly upset. E5 stated that he was standing behind E3. E5 stated that he actually heard the slapping noise when E3 hit R1's hands. E5 stated that he immediately called E1 (Executive Director), who instructed E5 to escort E3 out of the facility and send E3 home pending an investigation.	A6000		

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A6000	Continued From page 2 On 10/16/24 at 10:00 A.M. E1 confirmed the allegation of abuse by E3 against R1 did occur. E1 stated that E3's employment was terminated due to these actions.	A6000		