STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510533	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK DANVILLE	2215 NORTH BOWMAN AVENUE DANVILLE, IL 61832

(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 Incident Report Investigation IL 183173	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Violation Section 295.4010 Service Plan 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 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed by the resident; h) The service plan shall include all support services provided or arranged for by the establishment. Based on record review and interview the establishment failed to ensure R1's service plan was revised immediately after a significant	A4010		

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A4010	Continued From page 1 change in R1's condition. The establishment failed to ensure R1's service plan was updated to include: R1's special accomodation of a required brace, one to one staffing to provide cares and ensure safety, and therapy services. The establishment failed to ensure R1's service plan was updated to include additional fall and behavior interventions. Findings include: R1 was admitted to the establishment on 06-27-2022. R1's diagnoses include hypertension and dementia. R1 resides in the establishment's memory care unit. R1's December 2024 progress notes were reviewed and include documentation of R1 being aggressive towards staff and residents for the majority of the month. Documentation also incudes that R1 was started on divalproex, received treatment for a urinary tract infection, and being sent to the local emergency room for behaviors on 12-05-2024, 12-16-2024, and 12-17-2024. The progress notes also include documentation that R1 was enrolled in physical therapy, occupational therapy, and speech therapy on 12-19-2024. R1's progress notes include an unwitnessed fall documented on 12-19-2024 with R1 no having any injuries noted. R1's 12-21-2024 progress note includes documentation that R1 had a fall and was noted with bleeding to the left side of the forehead and a skin tear to the left forearm. Further documentation is that staff noted R1 lost consciousness and had altered breathing. R1 was sent to the local emergency room per	A4010		

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A4010	Continued From page 2	A4010		

emergency medical services. R1 was transferred to another hospital later that day for a parenchymal bleed. R1's 12-23-2024.

R1's 12-23-2024 progress note includes documentation that R1 returned to the establishment from the hospital with a "TLSO (thoracic-lumbar-sacral orthosis,) brace" in place and that R1 is to wear the brace while up as tolerated.

R1's 12-26-2024 progress notes include documentation of R1's power of attorney being notified that R1 requires one to one care for behaviors.

R1's 12-31-2024 progress note includes documentation that R1's one to one care has ended and that R1 was admitted to hospice with a diagnosis of Parkinson's disease.

R1's 11-13-2024 service plan includes documentation that R1 requires assistance with all activities of daily living. R1's service plan includes documentation that R1 is a fall risk with interventions including to ensure R1 has a clear pathway to the bathroom, offer fluids, monitor R1 for pain, provide R1's nighttime sleep aid, allow R1 to wander with supervision, and to remind R1 to use the wheelchair for mobility. All of the interventions are dated 11-13-2024. R1's service plan also includes documentation that R1 has the potential to be physically aggressive due to R1's dementia. Documented interventions in the service plan are dated 11-13-2024 which includes for staff to anticipate R1's needs and to provide redirection to R1's room with the tool gadget board. R1's service plan does include documentation dated 01-16-2025 that R1 is receiving hospice services and will not be sent to

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A4010	Continued From page 3 the emergency room unless there is a serious injury. The service plan does not include documentation of R1 requiring one to one care, that R1 received therapy services, or of R1 requiring the use of a TSLO brace. On 01-16-2025, approximately 11:50am, E1 (Executive Director,) presented a video showing when R1 falls on 12-21-2024. E1 states that R1 was toileted by staff prior to the fall occurring. R1 is seen in the video footage self-propelling in a wheelchair down a hallway. R1 can be viewed stopping outside of a doorway where R1 attempted to stand up from the wheelchair and fell. The video footage shows staff attending to R1 after the fall and the emergency medical service staff attending to R1 then pushing R1 down the hallway on a stretcher. On 01-21-2025, at 2:47pm, E2 (Wellness Director,) stated in electronic mail that there establishment never did get a physician order for the brace and that a hospital nurse stated in report that R1 could wear the brace while up as tolerated. E2 states that R1 was not able to tolerate the brace for more that a day after returning to the establishment. E2 also states they were trying to get R1 to be seen by the nurse practicioner and that they were waiting for insurance approval on the therapy services. E2 states that they were trying to get either an admission for behavioral health, approval for therapy services, or an admission to hospice and that is why the service plan was not updated sooner. E2 also states that the one to one intervention was for a short time frame and should have been added to the service plan.	A4010		