STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510135	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES OF KNOXVILLE	415 EAST MAIN STREET KNOXVILLE, IL 61448

(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 FRI IL 197167 and FRI IL 197176. FRI IL 197167 - TYPE 3 VIOLATION 295.4010 a) d) FRI IL 197176 - TYPE 3 VIOLATION 295.4010 a) d), and TYPE 1 VIOLATION 295.6000 a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: 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. 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). VIOLATION	A4010		

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A4010	Continued From page 1 Based on interviews and record reviews, the establishment failed to develop service plans with interventions and failed to review and revise service plans for two of three sampled residents at risk for falls. (R1, R2) Findings include: 1) R1's Admission Face Sheet notes that R1 was admitted on 1/25/24 with Diagnosis including Cerebral Infraction, Hypertension, and Cystoid Macular Degeneration. R1's incident reports note that R1 has fallen six times since March 2025. R1's current service plan dated 7/23/25 notes, "Resident is at risk for falls." Service plan only notes one intervention that was initiated on 7/17/25, "Assistive device will be within reach while they are in the recliner / lift chair." No other interventions put into place after any of the previous falls. On 8/28/25 at 12:25 P.M., E1 (Executive Director) stated that the establishment does not have a Wellness Director at this time but they have hired one that will be starting shortly. R2's progress notes, note that R2 was admitted to the establishment on 7/30/25. On 8/28/25 at 12:25 P.M., E1 (Executive Director) stated that R2 had a history of falls prior to R1's admission to the establishment. R2's current service plan dated 8/7/25 reads, "Resident is at risk for falls." but list no	A4010		

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A4010	Continued From page 2 interventions to help reduce the risk. R1's incident report and hospital Emergency room reports dated 8/22/25 notes that R1 suffered a fall in her room at 9:10 P.M., resulting in multiple rib fractures, fractured 5th and 12th thoracic vertebra, and Hemothorax.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION 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; These requirements were not met as evidenced by: Based on record review and interviews, the establishment neglected to properly assess a resident for injuries after a fall for one of three sampled residents. (R2) This failure creates a substantial probability of severe harm to a resident or residents. Findings include:	A6000		

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A6000	Continued From page 3 R2's current service plan notes that R2 was admitted to the establishment on 7/31/25. On 8/28/25 at 12:25 P.M., E1 (Executive Director) stated that R2 has a history of falls prior to her admission to the establishment. R2's "Resident Incident Report" notes that on 8/22/25 at 9:10 P.M., "This nurse received phone call that resident (R2) had fallen. CNA's heard resident (R2) yelling. Upon entering, resident laying on back, legs straight out with hands on walker. Pendant wrapped around handle of walker. CNA's assisted resident (R2) up. Resident c/o pain in back and head hurting. CNA's instructed to call 911 and emergency contact. Resident transported to hospital." R2's hospital Emergency Room Report notes that R2 had sustained multiple fracuted ribs, Hemothorax, fracture of the 5th thoracic vertebra and fracture of the 12th thoracic vertebra. On 8/28/25 at 12:25 P.M., E1 stated that at the time of R2's fall on 8/22/25 there was no licensed nurse in the establishment. E2 stated that the two CNA's that assisted R2 up off the ground that night were agency staff and not employed by the establishment. E2 stated that they should have called the nurse on call before assisting R2 up from the ground in case of injuries. On 8/29/25 at 11:45 A.M., Z1 (Advanced Pratice Nurse Specialist with Neurosurgery), stated that the caregivers should never physically lift a patient / resident off the floor after a fall prior to a licensed professional (Nurse) completing a head to toe assessment focusing on possible injuries.	A6000		