STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510529	A. BUILDING: _____ B. WING _____	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK SPRINGFIELD	3401 HEDLEY ROAD SPRINGFIELD, IL 62711

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A 000	Initial Comment Original investigation of Complaint 2548917/IL197576 - No findings. Facility Reported Incident Investigation to incident of 08-10-25/IL197469 295.6000 a) 5) 295.4010 a) d) e) g) 1) A)	A 000		
A4010	Section 295.4010 Service Plan This Regulation 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. 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).	A4010		

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A4010	Continued From page 1 g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; Based on interview and record review, the establishment failed to revise a care plan to address resident falls and interventions implemented following falls for two of three residents (R1 and R3) reviewed for falls that caused harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: The establishment's Fall risk Management policy (revised 10/26/23) documents the following: "A fall risk assessment will be conducted on residents that are at risk for falls, to determine his/her potential tendency to fall. The results will be reflected in the resident's Service Plan. The Executive Director or designee should ensure staff members are trained on what can be done to prevent falls and identify fall risks." 1. R1's Fall Investigation (dated 08/28/25) documents the following: "This nurse was giving medications at the dining room when I heard a noise from the bistro area. Went to area to observe (R1) lying on the floor on his left side. He was moving his arms and legs. I felt his head on his left side and did not feel any raised areas. No signs or symptoms of pain. RA (Resident Aide) and this nurse assisted resident to chair. At that time I noticed blood to a small area on his neck and a small amount on his ear. Unable to clearly	A4010		

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A4010	Continued From page 2	A4010		

identify the source. At that time RCC (Resident Care Coordinator) arrived and was given gauze to apply pressure to resident's neck on left side. EMS (Emergency Medical Services) was activated. Fire department arrived first to assess resident. Cognition was difficult to assess, (R1) kept his eyes closed and did not verbally respond. Ambulance arrived to transport (R1) to (local hospital) for evaluation. WD (Wellness Director)/MOD (Manager on Duty), ED (Executive Director), PCP (Primary Care Physician), and POA (Power of Attorney) notified. Vitals: Temperature 97.8, Pulse 92, Respirations 24, Blood Pressure 140/86, Pulse Oximetry 96% on room air. Resident was dressed, wearing tennis shoes, floor was dry and uncluttered, area was well lit, resident was continent. Recent diagnosis of UTI (urinary tract infection) and is currently on ABT (antibiotic). Resident did have aggressive behaviors just prior to fall."

This investigation does not document a root cause determined for R1's fall, or a new fall prevention intervention that was implemented after R1's fall.

R1's most current fall prevention Service Plan has no mention of R1's 08/28/25 fall at the establishment.

On 09/22/25 at 01:00 PM, E2 (Wellness Director) stated a root cause of R1's 08/28/25 was not determined and a new fall prevention intervention was not implemented following R1's fall. E2 stated R1's Service Plan was not revised to reflect R1's 08/28/25 fall.

2. R3's Fall Investigation (dated 08/08/25) documents the following: "Wellness Nurse was called to resident's room. Resident was lying on

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A4010	Continued From page 3	A4010		

he floor in the kitchen. Caregiver witnessed fall. He hit his head when going forward and hit it on the shelf and fell backwards and was lowered to the ground by the caregiver. EMS (Emergency Medical Services) was called and arrived and took resident to (local hospital)." This investigation also documents, "Resident Description: Resident stated that he got weak and dizzy and hit his head on the shelf and fell backwards. He complained of headache and pressure."

R3's current Service Plan documents, "I am a low fall risk." R3's Service Plan has no mention of R3's 08/08/25 fall, and no documentation of any fall prevention interventions implemented following R3's fall.

On 09/22/25 at 02:00 PM, R3 was sitting in his rocking recliner watching television. R3 stated he recalls the 08/08/25 incident when he was lowered to the ground. R3 stated, "I was leaning on the cabinet and I got dizzy. I think I passed out. The staff member helped lower me to the ground, so I went down slow onto the floor. The sent me to the hospital, which I didn't even think was necessary. I was sent back here once they discharged me from the hospital."

On 09/22/25 at 01:15 PM, E2 (Wellness Director) confirmed R3's Service Plan was not revised following R3's 08/08/25 to reflect his fall at the establishment and stated it should have been. E2 then stated that no new fall prevention interventions were implemented after R3's fall, and therefore, no fall prevention interventions are documented on R3's Service Plan.

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A6000	Continued From page 4	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 2 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:

5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;

Based on interview and record review, the establishment failed to implement interventions specified in the Service Plan for one resident (R2) at risk for falls that caused harm to a resident or creates a substantial probability of harm to a resident or residents.

Findings include:

The establishment's Fall Risk Management Policy (revised 10/26/23) documents the following: "A fall risk assessment will be conducted on residents that are at risk for falls, to determine his/her potential tendency to fall. The results will be reflected in the resident's Service Plan."

R2's current Service Plan documents the following: "I require assistance with transfer with

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A6000	Continued From page 5	A6000		

one care team member for assistance with transfers," and "I require moderate assistance with ambulation/mobility."

R2's Fall Investigation (dated 08/10/25) documents the following: "This nurse was called to the Bistro Dining Room. Upon observation, (R2) was lying on her left side with her left arm under her. Staff had placed towels under her head to support her head. No active bleeding observed. Resident complained of pain to left arm and left knee. EMS (Emergency Medical Services) was activated and resident was transported to (local hospital) by ambulance. Resident was observed getting up from activities at the table. Resident turned and placed her left hand on the back of the chair she had been sitting in and leaned against it. The chair fell backward and the resident fell onto her left side. She did not hit her head. Resident was wearing tennis shoes, the floor was dry, resident was continent." This investigation also documents that R2's fall was unwitnessed.

On 09/23/25 at 09:35 AM, E1 (Executive Director) stated R2 was assessed as an assist of one staff with transfers at the time of R2's 08/10/25 fall. E1 verified that no staff member was present to assist when R2 stood and fell on 08/10/25. E1 stated R2 was sent to a local hospital for evaluation following her fall at the establishment, and was diagnosed with a compression in her back from the fall.

R2's (local hospital) Discharge Instructions (dated 08/10/25) documents the following: R2 sustained a Vertebral Compression Fracture of her spine, and instruction for R2 to wear wear a TLSO (thoracolumbosacral orthosis) brace and to follow-up with an orthopedic surgeon was given.

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