STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510246	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK ALZHEIMER'S SCC	3319 GINGER CREEK DR SPRINGFIELD, IL 62711

(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 Facility Reported Incident Investigation to incident of 09-23-25/IL#197721. 295.6000 a) 5) 13) - T2 Violation	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: 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Type 2 Violation These requirements were not met as evidenced by: Based on interview, observation and record review, the facility neglected to ensure that fall prevention interventions in place were implemented to prevent further falls for one of three residents (R1) reviewed for falls that caused	A6000		

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harm to a resident or creates a substantial probability of harm to a resident or residents.

Findings include:

The establishment's Fall Management and Post Fall Investigations policy (dated 05/15/23) documents the following: "(Establishment) utilizes all reasonable efforts to provide a system to review residents' risk for falls and provide a proactive program of supervision, assistive devices, and interventions to manage and minimize falls and identify residents continued needs." This same policy also documents, "The health services director will update the resident service/care plan. Changes in fall interventions will be communicated to all appropriate community team members, resident and resident responsible party."

R1's current medical record documents a diagnosis of Vascular Dementia and a SLUMS (Saint Louis University Mental Status) Assessment score of 7/30, indicating severe cognitive impairment/Dementia. R1's medical record also documents R1 fell twice on 09/23/25, at 12:00 PM and again at 07:20 PM.

R1's Fall Investigation Incident Report (dated 09/23/25 at 12:00 PM) documents, "At 12:00 PM, (R1) had a fall at the back television room whom witnessed by (E6, Activities). Per (E6), (R1) was just next to her, a little bit after she saw resident rolling her wheelchair around the couch towards the back of the couch. (E6) stated the next thing she knew (R1) was on the floor. (R1) stated she was cleaning up the white spot on the floor. White tiny tissue paper on the floor noted. No injury noted. No complaints of pain. (E2, Health Services), R1's Primary Care Physician, and POA

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A6000	Continued From page 2	A6000		

(power of attorney) notified. Vitals: blood pressure 147/82, temperature 96.8, pulse 71, respirations 16, pulse oximetry 98%."

R1's current Fall Prevention Service Plan documents the following fall prevention interventions were in place at the time of R1's 09/23/25 fall at 12:00 PM: Increase observation of resident during waking hours; Encourage resident to remain in common area for closer observation. This same Service Plan documents the following fall prevention intervention was implemented after R1's fall on 09/23/25 at 12:00 PM: "Staff to offer assistance to prevent resident from reaching to floor."

R1's Fall Risk Evaluation (dated 09/23/25, conducted after R1's 12:00 PM fall) documents a score of 12, indicating moderate risk for falls.

R1's Fall Investigation Incident Report (dated 09/23/25 at 07:20 PM) documents the following: R1 was observed on the floor lying next to her wheelchair on her right side with skin tears present to both of her elbows; R1's skin tears were cleansed and dressed by the nurse; R1 was taken to the common area for closer observation; both R1's POA (power of attorney) and R1's Physician were notified of the fall; an order for a portable x-ray of R1's right elbow was received; (Local x-ray company) completed the x-ray of R1's right elbow on 09/24/25, and findings revealed a transverse fracture of the distal humerus as well as an apparent radial head fracture.

R1's current Fall Prevention Service Plan documents the following fall prevention interventions were in place at the time of R1's 09/23/25 fall at 12:00 PM: "Increase observation

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of resident during waking hours; Encourage resident to remain in common area for closer observation; Staff to offer assistance to prevent resident from reaching to floor." This same Service Plan Service Plan documents the following fall prevention intervention was implemented following R1's fall on 09/23/25 at 07:20 PM: "Resident to be brought to common area after meals for closer observation."

On 09/29/25 at 02:10 PM, E3 (Caregiver) pointed out R1, who was sitting in a wheelchair in the front television lounge watching television with other residents present. R1 was dressed, groomed and E3 stated R1 is typically pleasantly confused and cannot answer questions appropriately when asked. R1 was wearing a long-sleeved shirt, and appeared to have her right arm positioned against her chest, with her right elbow bent at a 90 degree angle at this time. E3 stated, "We have to watch her (R1) pretty closely. She can be impulsive and is definitely a fall risk."

On 09/29/25 at 02:35 PM, E4 (Registered Nurse) stated she was the nurse working when R1 fell at the establishment on 09/23/25 at 07:20 PM. E4 stated, "Another resident of the community notified me that there was someone on the floor. (R1) was located on the carpeting in the back hallway, and she was unattended. She had fallen out of her wheelchair. She had skin tears on both of her elbows that I cleaned and dressed. She complained of pain in her right arm, and I notified the doctor of this. I received an order for an x-ray, which was completed at some point after I finished working my shift, and I believe that is when they discovered her fracture. (R1) is a fall risk so we have to keep an eye on her."

R1's (mobile radiology company) Patient Report

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A6000	Continued From page 4 (dated 09/24/25) documents the following: "Procedure: right elbow, two views. Impression: Transverse fracture of the distal humerus as well as an apparent radial head fracture." On 09/29/25, E2 (Wellness Director) stated R1 was self-propelling in her wheelchair unattended at the time of her 09/23/25 fall that occurred at 07:20 PM, and should have been in an area of high visibility to ensure staff could closely monitor her and intervene if she attempted to lean forward to pick something up from the floor. E2 stated R1's fall was unwitnessed and R1 should not have been allowed in the establishment's hallway unsupervised. E2 verified R1's Service Plan has interventions in place to increase supervision of R1, and those interventions were not implemented at the time of R1's 09/23/25 fall at 07:20 PM.	A6000		