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	ASL510478	A. BUILDING: _____ B. WING _____	C 12/03/2025

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VILLAS OF HOLLY BROOK TOWANDA BARNES	1815 N TOWANDA BARNES ROAD BLOOMINGTON, IL 61701

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A 000	Initial Comment Original Complaint Investigation IL198697 Violation cited: 295.6000a)1)2)6)7)8) Facility Reported Incident IL198749 Violations cited: 295.4060h)3) 295.6010a)2)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: Violation Type 1 Based on observation, interview and record review the establishment failed to follow policy and procedures for falls for one (R4) of three residents reviewed for incidents and accidents. This failure caused pain and bruising to R4 with a substantial probability of severe harm to a resident or residents. Findings include: The establishments undated Incident Reporting policy documents "All incidents or unusual	A4060		

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occurrences at the (establishment) will be documented in a timely manner and appropriate action taken according to established procedures and state regulations." "Staff will take immediate and proper steps to see that residents or parties involved receive necessary intervention, including emergency medical treatment as needed. The Wellness Director or trained designee will complete an incident report after taking proper steps to see that the resident or parties involved receive necessary intervention." The list of incidents includes falls and bruising.

The establishments onboard training includes fall training which includes "When a resident appears to have fallen, if a nurse is available, contact them immediately to assess."

The Progress Note for R4 dated 11/4/25 at 2:00 pm documents E2 MCD/Memory Care Director was called to R4's room and upon entering the room R4 was lying in bed on her right side. Caregivers stated that R4 started to slide out of the bed while sitting on the edge to get dressed and Caregivers were able to lift R4 back into bed safely and resident did not fall to the floor. Caregivers were educated to stay next to resident when sitting on side of bed to ensure safety.

The Progress Notes for R4 dated 11/5/25 at 8:56 am document R4 with bruising noted around right eye, right chin area. Unknown how long it has been there. The Note dated 11/5/25 at 9:31 am documents more bruising noted to right buttock and left middle finger has swelling and bruising. The Note dated 11/6/25 at 6:18 pm document hospice ordered x-rays.

The Progress Note for R1 dated 11/6/25 at 4:30 pm, documents R4 body assessment was

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completed with the following bruising and measurements as: right eye and right cheek bone approximately 3 inches by 2.5 inches. Bruising to right upper eyelid and lower eyelid. Sclera bilaterally is white; Right side of chin approximately 0.5 inches by 0.5 inches; Left hand third finger approximately 3 inches by 1.5 inches; Right flank three small, scattered bruises 1 inch by 1.25 inches, 0.5 inches by 0.5 inches, and 0.5 inches by 0.5 inches; Right buttock approximately 6 inches by 4.5 inches; Left calf 4 inches by 2.25 inches.

On 12/2/25 at 12:50 pm, R4 sat in high back reclining wheelchair with an attached chair alarm, feeding herself the noon meal with staff encouragement. R4 had no visible bruising at this time. R4's room has fall mats to the floor next to the bed.

On 12/2/25 at 3:15 pm, E10 RA/Resident Assistant stated E9 Former CNA/Certified Nursing Assistant came out of R4's room and said she needed the nurse because R4 was on the floor, so I told E2 MCD.

On 12/3/25 at 9:13 am, E2 MCD/Memory Care Director stated on 11/4/25 she was called to R4's room due to R4 being "on the floor" and when E2 got to R4's room R4 was lying in bed. E8 Former CNA and E9 Former RA were in R4's room and stated R4 did not fall and was not on the floor. The following day on 11/5/25 bruising was noted to R4's chin, right cheek, buttocks, back, and one of her left finger and an investigation was initiated for bruising of unknown origin. E2 MCD stated she spoke to E9 Former RA on 11/6/25 who then reported that R4 had fallen onto the floor on 11/4/25, was put back to bed by E8 Former CNA, and E9 Former RA was told by E8 Former CNA

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not to report it because "it's a skilled nursing thing." E2 MCD stated she reported to E1 ED/Executive Director who was already investigating R4's bruising and started the fall investigation. E2 MCD confirmed the Caregivers should not have moved or put R4 back to bed until after E2 MCD assessed R4. E2 MCD stated she does not know why E8 Former CNA and E9 Former RA lied about R4 falling.

On 12/2/25 at 9:35 am E1 ED/Executive Director stated on 11/5/25 E2 MCD reported R4 with bruising of unknown origin and E1 ED immediately started an investigation for the bruising. On 11/6/25 E9 Former RA reported R4 had a fall on 11/4/25 that was not reported. E1 ED stated she continued to investigate and determined that R4's bruising was a result of R4's fall in her room on 11/4/25. E1 ED stated the staff should have reported R4's fall on 11/4/25 and does not know why they didn't. E1 ED stated the staff are educated on what to do if a resident falls and should not have gotten R4 up off the floor prior to the nurse assessing R4. E1 ED stated there was no fall incident report started because there was no fall reported and R4 should not have been put to bed until she was assessed by the Nurse. E1 ED stated E8 Former CNA was terminated for not following policy and procedures.

The Corrective Action Form dated 11/10/25 documents E8 Former CNA was terminated with Corrective action as: "Employee is being terminated because of the investigation findings. The investigation determined that the employees' actions were in violation of company policy and did not meet the standards of conduct required for their position. Due to the substantiated findings and seriousness of the violation,

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A4060	Continued From page 4 continued employment is no longer appropriate.	A4060		
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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 6) The right to direct his or her own care and negotiate the terms of his or her own care; 7) The right to refuse services unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal, and to be advised of the consequences of that refusal; 8) The right to exercise free choice in selected activities, schedules, and daily routine; Violation Type 1 Based on observation, interview, and record review the establishment failed to ensure Resident Rights' policies were implemented for one (R1) of three residents reviewed for Resident	A6000		

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Rights in the sample of four. This failure resulted R1s increased agitation, combativeness and undue stress to with a substantial probability of harm to a resident or residents.

Findings include:

The establishments Resident Bill of Rights, dated 8/25/2016, documents "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: 1. The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. 2. The right to respect for bodily privacy and dignity at all times, especially during care and treatment ... 6. The right to direct his or her own care and negotiate the terms of his or her own care. 7. The right to refuse services unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal, and to be advised of the consequences of that refusal. 8. The right to exercise free choice in selected activities, schedules, and daily routine."

The Incident Report for R1 dated 11/20/25 at 2:07 pm, documents R1 exhibiting physical behavior while in her bathroom receiving a shower. The shower was being completed by E3 RA, E4 CNA, and E5 CNA with E6 CNA being present. "Resident became aggressive during her shower, hitting, punching, and scratching staff."

The current Service Plan for R1 documents R1 is

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independent with bathing, personal hygiene, toileting, transfers, and ambulation. R1 requires minimal assist with dressing and undressing. R1 prefers to set own bathing schedule and independently bathe without assistance from care team.

The witness statement for E3 RA/Resident Assistant dated 11/20/25 documents E3 RA, E4 CNA/Certified Nursing Assistant, and E5 CNA entered R1's room to assist with R1's shower. E3 RA stated she was able to get R1 partially undressed and R1 stated she could shower herself and R1 went into the bathroom. E3 RA stated "We opened the door to see if she got in (the shower)" then R1 started to become combative, hitting us with wet washcloths. "We were able to redirect her (R1) into the shower and (R1) became combative again." R1's shower was completed by E3 RA, E4 CNA, and E5 CNA as R1 continued to be combative.

The witness statements by E3 RA, E4 CNA, and E5 CNA document they all entered R1's room together to assist R1 with a shower. E6 CNA was "on standby" outside of the bathroom if needed for assist. R1 became combative during undressing and stated she could do her own shower and went into the bathroom. E3 RA opened R1's bathroom door to check on R1 and R1 began throwing wet washcloths at her. E3 RA, E4 CNA, and E5 CNA entered R1's bathroom and proceeded to wash and rinse R1 in the shower while holding R1's arms while R1 continued to yell out, hit at staff and dig (R1's) fingernails into the staff members.

On 11/26/25 at 11:05 am, R1 was sitting in a stationary chair in the memory care unit common area, pleasant, and interacting with R2. R1 got up

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independently without assistance and walked from the common area towards one of the establishments hallways. R1's gait was slow and steady with no concerns identified. R1 exhibiting no behaviors. R1 stated she can do her own cares and doesn't need any help and would ask someone if she needed it. R1 stated she does not have any complaints about anyone. R1 was unable to recall be given a shower by multiple staff members.

On 11/26/25 at 10:54 am, E3 RA stated R1's family requested R1 have a shower so (E3 RA), E4 CNA and E5 CNA assisted R1 to her room to shower. E3 RA stated we got R1 partially undressed and R1 started to be combative, so we left her alone to finish undressing and when we checked in on her she became combative again while we were washing her up, ended up rinsing R1 off and R1 dressed herself. E3 RA stated "it was too much stimulation, I think. Too many people around her." E3 RA stated having "less people helping and earlier in the day probably would have helped."

On 12/3/25 at 9:13 am, E2 MCD/Memory Care Coordinator stated E4 CNA reported R1 being combative during her shower and was hitting and scratching. E2 instructed E4 CNA and any witnesses to write a statement. E2 confirmed E3 RA, E4 CNA, and E5 CNA should not have all been in R1's bathroom giving R1 a shower. E3 through E5 know R1, have had dementia training and should have tried to reapproach R1 at a later time.

On 11/26/25 at 10:10 am, E1 ED stated E3 RA, E4 and E5 CNAs entered R1's room and tried to shower her. R1 is fairly new and has been struggling to adapt and think that R1 may have

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A6000	Continued From page 8 felt attacked and started to act out. Staff have been educated about Resident Rights and that "if it takes two then take five" minutes. E3 RA, E4 and E5 CNAs did receive a final written warning and were educated. All staff have been educated about Resident Rights and that "if it takes two then take five" minutes. All the staff receive dementia training prior to working the dementia unit and periodic training throughout the year. The Corrective Action Forms for E3 RA, E4 CNA, and E5 CNA dated 11/21/25 document a "final written warning" was administered for the 11/20/25 incident and violations of work polices/rules with "Corrective action(s): on 11/20/25, staff entered (R1's) room with three caregivers to provide a shower. During the interaction, the resident became agitated and aggressive, resulting in the resident scratching staff. Upon review of the situation, it was determined that staff did not follow established facility policies and protocols related to resident care, safety, and de-escalation."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department	A6010		

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A6010	Continued From page 9 within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. Violation Based on interview and record review the establishment failed to submit a final investigation report to the State Agency after the initial reporting for one (R4) of three residents reviewed for incidents and accidents. Findings include: The establishments undated Incident Reporting policy documents the initial report "shall be made by contacting the (State Agency) Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident." "A copy of any incident report containing state and reportable information will be sent to the state licensing agency within the required time frame." Staff are to "document as soon as possible after an event occurs to ensure the most accurate recording possible." The initial report to the State Agency for R4 dated 11/6/25 documents bruising of unknown origin was observed on R4. The establishment was unable to provide a final report for this incident. On 12/2/25 at 9:13 am, E2 MCD/Memory Care Director stated she was working as the floor nurse on 11/4/25. E Mykala called E2 MCD over a walkie talkie of someone being on the floor but due to static she didn't know which room. E Amanda approached the Nurses Station and told E2 MCD that R4 was on the floor. E2 MCD stated when she got to R4's room R4 was lying in bed.	A6010		

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A6010	Continued From page 10 E2 MCD stated she asked E Brea and E Mykala if R4 had fallen On 12/2/25 at 9:35 am, E1 ED/Executive Director stated R4's bruising of unknown origin was investigated and determined to have been caused from an unwitnessed fall on 11/4/25 and R4 has not had any other incidents since that time. E1 ED stated she did not submit a final report and not sure why.	A6010		