STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5104291	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK MONTICELLO	901 MEDICAL CENTER DR MONTICELLO, IL 61856

(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 Complaint Investigation of 12/29/25-Violation Type One: 295.5000 c) 2) 5) 7) e) h) 1) Type Two: 295.4010 g) 5)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Violation Type 2 Section 295.4010 Service Plan g) Service plans shall address: 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. Based on interview and record review the establishment failed to provide the accurate supervision for self-administered medications as directed by the service plan for four (R1, R2, R3 and R4) of four residents reviewed for service plans. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1.) R1's service plan dated 10/29/25 documents that R1 requires medication administration and medication supervision assistance.	A4010		

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A4010	Continued From page 1 R1's medication order sheet dated 12/8/25 documents narcotic orders for Lorazepam (anti-anxiety)0.5Milligrams (MG) 1/2 tablet to be taken twice daily as needed, Oxycodone (narcotic)5MG every eight hours as needed, and Trazodone (anti-depressant)150MG before bedtime. On 12/10/25 the establishment submitted a report to the state agency documenting that R1's Oxycodone (narcotic) five Milligrams (MG) went missing at approximately 3:00PM and that after an investigation, the medication was not located. On 12/29/25 at 10:35AM, E4 Caregiver stated that R1's cabinet medication lock had been broken and that their medications were not secured on the date the medicine went missing. 2.) R2's service plan dated 12/29/25 documents that R2 requires medication assistance and supervision. R2's medication order sheet dated 12/8/25 documents the following medications for the morning medication pill pack: Diltazem (calcium channel blocker) 60MG twice daily at 8:00AM and 8:00PM, Eliquis (blood thinner) 5MG twice daily at 8:00AM and 8:00PM, Escitalopram (anti-anxiety) 5MG daily at 8:00AM, Hydrochlorathiazide (diuretic)12.5 MG daily at 8:00AM, and Valcyclovir (anti-viral) 500MG daily at 8:00AM. R2's care notes dated 12/14/25 document that two white pills were left in R2's left 8am medication pack. The pills were behind where they punch the pills out. No documentation of whether the medications were later given, the physician was notified, or further training was provided regarding medication administration.	A4010		

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A4010	Continued From page 2 On 12/29/25 at 1:25PM, E1 Executive Director stated that she was unaware of these medications being found in the opened pill packs and that no investigation had been conducted regarding physician notification, impact to the resident or if reimbursement to the resident was made. On 12/29/25 at 2:15PM, E2 Wellness Director stated, "No follow up was done on this. I don't know what pills were missed." 3.) R3's service plan dated 10/29/25 documents that R3 requires medication assistance and supervision. R3's medication order sheet dated 10/17/25 documents Gabapentin (anti-convulsant) 600MG to be given twice daily at 6:30AM and 8:00PM. R3's care notes dated 12/16/25 document that R3 has missed "quite a few doses of Gabapentin." R3's medication administration record dated 12/15/25 and 12/16/25 document missed doses of Gabapentin. On 12/29/25 at 1:00PM, E2 stated that R3's medications were missed because the time in the electronic medical record and the time documented on the pill packs were different and so E6 Caregiver did not give them. "This isn't ok. The medication errors are a problem and I am working to figure out how to decrease them." 4.) R4's service plan dated 12/29/25 documents that R4 requires assistance with medication administration and supervision.	A4010		

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A4010	Continued From page 3 R4's medication order sheet dated 10/17/25 documents Tramadol (narcotic) 50MG, one tablet every six hours as needed. 12/29/25 at 10:35AM, E4 Caregiver stated that R4's cabinet medication lock had been broken and that R4's medications were not secured. On 12/29/25 at 10:40AM, R4's medication cabinet lock was loose and could be opened with fingers. Inside contained a card of twenty tablets of Tramadol 50MG. On 12/29/25 at 1:55PM, E9 Maintenance Director confirmed that R4's lock was broken today and that it was able to be opened without a key.	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Violation Type 1 Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage c) Supervision of self-administered medication means assisting the resident with self-administered medication using any combination of the following. Supervision of self-administered medication by unlicensed personnel shall be under the direction of a licensed health care professional. 2) Confirming that residents have obtained and are taking the dosage as	A5000		

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A5000	Continued From page 4 prescribed; 5) Opening the medication container for a resident who is physically unable to do so; 7) Documenting in writing that the resident has taken (or refused to take) the medication. e) Medication stored by a resident in the resident's unit shall be stored and controlled as stated in the resident's service plan and shall be inaccessible to other residents. h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; Based on interview and record review the establishment failed to ensure that medications were supervised, provided the correctly, documented, and stored in a secure cabinet for four (R1, R2, R3 and R4) of four residents reviewed for medication supervision and storage. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: 1.) R1's service plan dated 10/29/25 documents that R1 requires medication administration and medication supervision assistance. R1's medication order sheet dated 12/8/25 documents narcotic orders for Lorazepam 0.5Milligrams (MG) 1/2 tablet to be taken twice	A5000		

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A5000	Continued From page 5 daily as needed, Oxycodone Hydrochloride 5MG every eight hours as needed, and Trazodone 150MG before bedtime. On 12/10/25 the establishment submitted a report to the state agency documenting that R1's Oxycodone (narcotic) five Milligrams (MG) went missing at approximately 3:00PM and that after an investigation, the medication was not located. On 12/29/25 at 10:30AM, E4 Caregiver stated that she worked on 12/9/25 and on that dayshift, R1's narcotic count was correct. R1's individual resident controlled substance record dated 12/9/25 at 12:10PM documents 35 tablets remain. R1's individual resident controlled substance record dated 12/9/25 at 8:30PM documents 34 tablets remain, and it was then crossed out with 33 tablets remain with no explanation for the discrepancy. On 12/29/25 at 10:35AM, E4 Caregiver stated that R1 cabinet medication lock was broken on 12/10/25 and their medications were not secured. The establishment provided maintenance request form dated 12/12/25 documents R1's medicine cabinet was replaced due to trouble locking. 2.) R2's service plan dated 12/29/25 documents that R2 requires medication assistance and supervision. R2's medication order sheet dated 12/8/25 documents the following medications for the morning medication pill pack: Diltazem (calcium	A5000		

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A5000	Continued From page 6	A5000		

channel blocker) 60MG twice daily at 8:00AM and 8:00PM, Eliquis (blood thinner) 5MG twice daily at 8:00AM and 8:00PM, Escitalopram (anti-anxiety) 5MG daily at 8:00AM, Hydrochlorathiazide (diuretic)12.5 MG daily at 8:00AM, and Valcyclovir 500MG daily (anti-viral) 8:00AM.

R2's care notes dated 12/14/25 document that R2 had two white pills left in his 8am medication pack. The pills were behind where they punch the pills out. No documentation of whether the medications were later given, the physician notified, or further training was provided regarding medication administration.

On 12/29/25 at 1:25PM, E1 Executive Director stated that she was unaware of these medications being found in the pill packs and that no investigation had been conducted regarding physician notification, resident impact, or if the resident was reimbursed for the missed medications.

On 12/29/25 at 2:15PM, E2 Wellness Director stated, "No follow up was done on this. I don't know what pills were missed."

3.) R3's service plan dated 10/29/25 documents that R3 requires medication assistance and supervision.

R3's medication order sheet dated 10/17/25 documents Gabapentin (anti-convulsant) 600MG to be given twice daily at 6:30AM and 8:00PM.

R3's care notes dated 12/16/25 document that R3 has missed "quite a few doses of Gabapentin."

On 12/29/25 at 1:00PM, E2 stated that R3's medications were missed because the time in the

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A5000	Continued From page 7	A5000		

electronic medical record and the time documented on the pill packs were different and so E6 Caregiver did not give two days worth of doses. "This isn't ok. The medication errors are a problem and I am working to figure out how to decrease them."

R3's medication administration record dated 12/15/25 and 12/16/25 document missed doses of Gabapentin

4.) R4's service plan dated 12/29/25 documents that R4 requires assistance with medication administration and supervision.

R4's medication order sheet dated 10/17/25 documents Tramadol (narcotic) 50MG, one tablet every six hours as needed.

12/29/25 at 10:35AM, E4 Caregiver stated that R4's cabinet medication lock had been broken and that R4's medications were not secured.

On 12/29/25 at 10:40AM, R4's medication cabinet lock was loose and could be opened with fingers. Inside contained contained a card of twenty tablets of Tramadol 50MG.

On 12/29/25 at 1:55PM, E9 Maintenance Director stated that he was told today that R4's lock was broken and confirmed that it was able to be opened without a key, but that he fixed it today.