STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510490	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK BLOOMINGTON FOX CRE	2016 FOX CREEK ROAD BLOOMINGTON, IL 61701

(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 Annual Licensure Survey entered on 1/21/26 and exited on 1/22/26 Violations cited: Type 2 295.3030a)b)c)e)1)2)	A 000		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors. b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment. c) The initial health evaluation shall include the employee's immunization status. e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: 1) The test must be completed no more than 90 days prior to the date of initial employment in	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510490	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK BLOOMINGTON FOX CRE	2016 FOX CREEK ROAD BLOOMINGTON, IL 61701

(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
A3030	Continued From page 1 the establishment; or 2) The test must be commenced no more than ten days after the date of initial employment in the establishment. Violation Type 2 Based on interview and record review the establishment failed to ensure initial health evaluations were conducted and included employee immunization status and failed to perform tuberculosis annual screenings. This creates a substantial probability of harm to a resident or residents. Findings include: The establishments Pre-hire/New hire requirements policy and procedures dated 3/26/2019 documents the establishment will maintain a file on all employees. "All Company personnel must demonstrate that their health condition allows them to perform the duties of their position. The Company will pay for a health examination and tuberculosis (TB) screening for each new employee at a Company approved facility." 1. The establishments' current employee roster documents E6 RA's date of hire date of hire as 12/17/25. The establishment was unable to provide a Medical Disposition Report for E6 RA 2. The Medical Disposition Report for E9 RA dated 11/6/25 does not address E9"s immunization status. The Medical Disposition Report for E1 ED/Executive Director dated 1/12/26 does not	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510490	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK BLOOMINGTON FOX CRE	2016 FOX CREEK ROAD BLOOMINGTON, IL 61701

(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
A3030	Continued From page 2 address E1's immunization status. 3. The establishments Annual TB Signs/Symptoms Screening form for E4 Dietary Director signed and dated the form on 5/20/25, however, the screening was not completed. The establishments Annual TB Signs/Symptoms Screening form for E5 LPN/Licensed Practical Nurse signed and dated the form on 10/15/25, however, the screening was not completed. The establishments Annual TB Signs/Symptoms Screening form for E7 RA/Resident Assistant signed and dated the form on 7/1/25, however, the screening was not completed. On 1/22/26 at 2:00 am, E2 HWD/Health and Wellness Director confirmed E6 RA's hire date as 12/17/25 and E6 has not yet had her initial health evaluation. E2 confirmed E9 RA and E1 ED initial health evaluations do not address their immunization status. E2 HWD also confirmed the Annual TB screening questions were not completed for E4 Dietary Director, E5 LPN, and E7 RA.	A3030		