STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510383	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK CHATHAM	825 EAST WALNUT CHATHAM, IL 62629

(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 investigation of Complaint#2642420/IL#200407. 295.4000 b) 295.4010 a) d) e) g) 1) A) C) 2) 3)	A 000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Type 2 violation Section 295.4000 Physician's Assessment b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. Based on interview and record review, the establishment failed to ensure a Physician's Assessment was completed annually for one of three residents (R2) reviewed for falls in the sample of three. This failure creates a substantial probability of harm to a resident or residents. Findings include: R2's medical record documents R2's most recent Physician's Assessment was completed on 12/08/23. On 03/10/26 at 10:40 AM, E1 (Executive Director) stated R2's most recent Physician's Assessment was completed on 12/08/23, and verified that R2 has not had a Physician's Assessment completed in over two years.	A4000		

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A4010	Continued From page 1	A4010		
A4010	Section 295.4010 Service Plan	A4010		

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).

g) Service plans shall address:

1) The level of service the resident is receiving, including:

A) assistance with activities of daily living;

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A4010	Continued From page 2 C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. Based on interview, observation and record review, the establishment failed to ensure a Service Plan was revised following resident falls for two of three residents (R2 and R3) reviewed for falls in the sample of three. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1. R2's Fall Risk Assessment (dated 02/05/26) documents a score of 14. (Score >10 considered at risk for falls). R2's Progress Note (dated 10/31/25) documents, "Resident used pendant to alert staff that she had fallen onto her kitchen floor. She stated she did hit her head on the floor, denies pain, alert and oriented, able to respond appropriately to questions. Refused further treatment at ER (Emergency Room). No other injury noted at this time. (R2's Daughter) made aware, MD (Medical Doctor) aware. Note made for maintenance to assess threshold for defective parts if any." R2's Progress Note (dated 11/17/25) documents the following: "Resident walking in back hallway,	A4010		

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A4010	Continued From page 3	A4010		

turned around and lost balance fell to the floor. Resident stated she hit her head on the floor, no other injury apparent. No redness, swelling, bleeding noted to head. MD (Medical Doctor) aware, POA (Power of Attorney) aware. Resident refusing further evaluation at ER (Emergency Room). Resident educated to turn with her whole body versus her head when looking behind her. Service plan updated."

R2's current Service Plan was reviewed and did not document the above interventions implemented after R2's 10/31/25 and 11/17/25 falls.

On 03/10/26 at 10:40 AM, E1 (Executive Director) stated that R2's Service Plan was not revised to reflect the fall prevention interventions implemented following R2's falls on 10/31/25 and 11/17/25. E1 stated, "The interventions should have been added."

2. On 03/09/26 at 01:45 PM, R3 was sitting in his wheelchair in his apartment. R3 was dressed, groomed and wearing glasses. R3's call pendant was hanging from the handlebar of his wheelchair within his reach. An electric scooter was parked in the corner of R3's living room and R3 explained he utilizes the scooter when going longer distances within the establishment. R3 stated, "I haven't fallen recently, but I fell a couple months ago and skinned up my elbow. I lost my balance in the bathroom."

R3's Fall Investigation (dated 01/05/26) documents the following: "Resident was using scale in his bathroom to check his weight, lost his balance and fell to the floor."

R3's current Service Plan has no mention of R3's

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A4010	Continued From page 4 01/05/26 fall, or the new fall prevention intervention that was implemented following R3's fall. On 03/10/26 at 10:40 AM, E1 (Executive Director) verified that R3's Service Plan had not been revised to reflect his 01/05/26 fall and stated it should have been.	A4010		