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 _____	C 07/22/2025

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 Original complaint IL#196469 Violations cited: 295.2000 c) 6 violation 295.2050 all violation 295.4000 b) violation 295.4060 b) c) violation 295.6000 a) 1) 13) violation 295.6010 all violation	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Violation Section 295.2000 Residency Requirements Section 295.2000 c)6) c) A person shall not be accepted for residency if: 6) The person has a severe mental illness, which for the purposes of this Section means a condition that is characterized by the presence of a major mental disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), where the individual is substantially disabled due to mental illness in the areas of self-maintenance, social functioning, activities of community living and work skills, and the disability specified is expected to be present for a period of not less than one year, but does not mean Alzheimer's disease and other forms of dementia based on organic or physical disorders. Nothing in this	A2000		

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A2000	Continued From page 1 Section is meant to prohibit an individual with a diagnosis of depression from living in an establishment so long as the resident is not substantially disabled in the areas of self-maintenance, social functioning, activities of community living, and work skills; These requirements were not met as evidenced by: Based on interview, observation, and record review the establishment failed to follow the residency requirements per regulations. This creates a substantial probability of severe harm to a resident or residents. Record Review: R1 and R2 both have record behaviors in the progress notes. On 7/17/2025 R2 stated that they would "shove this thing up the ass of a staff member." On 7/16/25 the progress notes state that R2 was slamming their walker around. On 7/15/25 R2 threw their walker. On 7/14/25 R2 broke their walker while throwing it. 7/12/25 R2 struck a care taker with a walker in the head. On 7/11/25 R2 claimed to be seeing shadows. On 7/10/25 R2 was noted to be screaming at the staff. R1 was noted to have behavior notes on 7/13/25, 7/12/25, and 7/11/25. The behaviors were described as aggressive, attempting to hit staff, and yelling. Observation: R2 was noticed to be yelling at staff in the hallway on 7/19/25. Interview: During interview with R2, R2 stated that she wanted to "hold a man's balls in her hands." E8 stated that R2 will typically yell at the other residents. E2 stated that R2 has been acting out and that R2 behaviors are not controlled well	A2000		

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A2000	Continued From page 2 during an interview on 7/19/25.	A2000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Violation Section 295.2050 Incident and Accident Reporting Section 295.2050 a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. Based on interview, observation, and record review the establishment failed provide an environment that is free of abuse and treats the residents with consideration and respect. This creates a substantial probability of severe harm to	A2050		

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A2050	Continued From page 3 a resident or residents. These requirements were not met as evidenced by: Based on interview, observation, and record review the establishment failed to report the incident and the injury to the department per the regulations. This creates a substantial probability of severe harm to a resident or residents. Observation: R1 was observed on 7/19/2025. +3 edema was noted to the right hand. R1 was cooperative and allowed an assessment to be completed. The right upper arm had a large hematoma that measured .5 inches deep X 2 inches wide X 3 inches long. The arm was very swollen and noted to be the colors black, dark blue, and yellow from bruising. A small pustule was noted on the right biceps. A crush injury with bruising was noted to the left foot. R1 complained on pain in the right arm and some pain at the left foot. R1 did not recall what had happened. Review of 4 camera views was completed. The footage shows that R1 became aggressive towards E4 around 2:40 PM on 7/13/25. R2 then moved towards R1, trying to control him. In another view its clear that R1 was held firmly against by E2, E3, and E4. R1 was restrained at the upper body and E2 tried to restrain R1's feet by stepping on them. As the video plays, E2 is noted to have fallen on the floor, but the footage of the fall was missing a 10 second frame of R2 falling. E3 assisted R2 back to their feet and escorted R2 into their room. R2 then held the door shut restraining R2 in the room. Documentation review: Review of progress notes were completed. A behavior note was recorded on the evening of 7/12/25. The note explains that	A2050		

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A2050	Continued From page 4 R1 drew back his arm to hit and nurse. R1 failed to hit the nurse and grabbed the nurse on the upper extremity. A note on 7/13/25 at 20:22 explains that R1 became aggravated and attempted to strike a nurse. The note states that R1 was able to collect themselves after a period of de-escalation. E2 stated that no injury was noted. However, a note written at 20:22 by the nurse following E2 stated that R1 has swelling of the right arm. No report was submitted to the department or for review. Interviews: Interviews with E5 and R6 were completed. Both E5 and E6 confirmed that E2, E3, and E4 restrained R1 against the wall and E2 in a room. E6 confirmed that E2, E3, and E5 held R1's upper arms to keep R1 from moving. E1, E2, and E9 stated that a report was not submitted to the department.	A2050		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Violation Section 295.4000 Physician's Assessment Section 295.4000 b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. These requirements were not met as evidenced by:	A4000		

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A4000	Continued From page 5 Based on interview and record review the establishment failed to have a comprehensive assessment completed by a physician per regulations. This creates a substantial probability of severe harm to a resident or residents. Record Review: R1 and R2 both have comprehensive assessments completed by mid levels and not a physician. R2's assessment was completed on 12/2/24 by a mid level. R1's assessment was completed on 11/20/24 by a midlevel. Interview: E9 stated that the establishment is aware that a physician is suppose to complete the assessments.	A4000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Violation Section 295.4060 Alzheimer's and Dementia Programs Section 295.4060 b) c) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate	A4060		

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A4060	Continued From page 6 in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act) These requirements were not met as evidenced by: Based on interview, observation, and record review the establishment failed to follow the residency requirements per regulations. This creates a substantial probability of severe harm to a resident or residents. Record Review: R1 and R2 both have record behaviors in the progress notes. On 7/17/2025 R2 stated that they would "shove this thing up the ass of a staff member." On 7/16/25 the progress notes state that R2 was slamming their walker around. On 7/15/25 R2 threw their walker. On 7/14/25 R2 broke their walker while throwing it. 7/12/25 R2 struck a care taker with a walker in the head. On 7/11/25 R2 claimed to be seeing shadows. On 7/10/25 R2 was noted to be screaming at the staff. R1 was noted to have behavior notes on 7/13/25, 7/12/25, and 7/11/25. The behaviors were described as aggressive, attempting to hit staff, and yelling.	A4060		

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A4060	Continued From page 7 Observation: R2 was noticed to be yelling at staff in the hallway on 7/19/25. Interview: During interview with R2, R2 stated that she wanted to "hold a man's balls in her hands." E8 stated that R2 will typically yell at the other residents. E2 stated that R2 has been acting out and that R2 behaviors are not controlled well during an interview on 7/19/25.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Violation Section 295.6000 Resident Rights Section 295.6000 a) 1) 13) 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.	A6000		

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A6000	Continued From page 8 These requirements were not met as evidenced by: Based on interview, observation, and record review the establishment failed provide an environment that is free of abuse and treats the residents with consideration and respect. This creates a substantial probability of severe harm to a resident or residents. Observation: R1 was observed on 7/19/2025. +3 edema was noted to the right hand. R1 was cooperative and allowed an assessment to be completed. The right upper arm had a large hematoma that measured .5 inches deep X 2 inches wide X 3 inches long. The arm was very swollen and noted to be the colors black, dark blue, and yellow from bruising. A small pustule was noted on the right biceps. A crush injury with bruising was noted to the left foot. R1 complained on pain in the right arm and some pain at the left foot. R1 did not recall what had happened. Review of 4 camera views was completed. The footage shows that R1 became aggressive towards E4 around 2:40 PM on 7/13/25. R2 then moved towards R1, trying to control him. In another view its clear that R1 was held firmly against by E2, E3, and E4. R1 was restrained at the upper body and E2 tried to restrain R1's feet by stepping on them. As the video plays, E2 is noted to have fallen on the floor, but the footage of the fall was missing a 10 second frame of R2 falling. E3 assisted R2 back to their feet and escorted R2 into their room. R2 then held the door shut restraining R2 in the room. Documentation review: Review of progress notes were completed. A behavior note was recorded on the evening of 7/12/25. The note explains that	A6000		

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A6000	Continued From page 9 R1 drew back his arm to hit and nurse. R1 failed to hit the nurse and grabbed the nurse on the upper extremity. A note on 7/13/25 at 20:22 explains that R1 became aggravated and attempted to strike a nurse. The note states that R1 was able to collect themselves after a period of de-escalation. E2 stated that no injury was noted. However, a note written at 20:22 by the nurse following E2 stated that R1 has swelling of the right arm. Interviews: Interviews with E5 and R6 were completed. Both E5 and E6 confirmed that E2, E3, and E4 restrained R1 against the wall and E2 in a room. E6 confirmed that E2, E3, and E5 held R1's upper arms to keep R1 from moving.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting Section 295.6010 a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment	A6010		

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A6010	Continued From page 10 shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department 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. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. These requirements were not met as evidenced	A6010		

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A6010	Continued From page 11 by: Based on interview, observation, and record review the establishment failed to report the incident and the injury to the department per the regulations. This creates a substantial probability of severe harm to a resident or residents. Observation: R1 was observed on 7/19/2025. +3 edema was noted to the right hand. R1 was cooperative and allowed an assessment to be completed. The right upper arm had a large hematoma that measured .5 inches deep X 2 inches wide X 3 inches long. The arm was very swollen and noted to be the colors black, dark blue, and yellow from bruising. A small pustule was noted on the right biceps. A crush injury with bruising was noted to the left foot. R1 complained on pain in the right arm and some pain at the left foot. R1 did not recall what had happened. Review of 4 camera views was completed. The footage shows that R1 became aggressive towards E4 around 2:40 PM on 7/13/25. R2 then moved towards R1, trying to control him. In another view its clear that R1 was held firmly against by E2, E3, and E4. R1 was restrained at the upper body and E2 tried to restrain R1's feet by stepping on them. As the video plays, E2 is noted to have fallen on the floor, but the footage of the fall was missing a 10 second frame of R2 falling. E3 assisted R2 back to their feet and escorted R2 into their room. R2 then held the door shut restraining R2 in the room. Documentation review: Review of progress notes were completed. A behavior note was recorded on the evening of 7/12/25. The note explains that R1 drew back his arm to hit and nurse. R1 failed to hit the nurse and grabbed the nurse on the upper extremity. A note on 7/13/25 at 20:22	A6010		

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A6010	Continued From page 12 explains that R1 became aggravated and attempted to strike a nurse. The note states that R1 was able to collect themselves after a period of de-escalation. E2 stated that no injury was noted. However, a note written at 20:22 by the nurse following E2 stated that R1 has swelling of the right arm. No report was submitted to the department or for review. Interviews: Interviews with E5 and R6 were completed. Both E5 and E6 confirmed that E2, E3, and E4 restrained R1 against the wall and E2 in a room. E6 confirmed that E2, E3, and E5 held R1's upper arms to keep R1 from moving. E1, E2, and E9 stated that a report was not submitted to the department.	A6010		