| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510382 | A. BUILDING: _____ B. WING _____ | C 05/21/2026 |

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| VILLAS OF HOLLY BROOK & REFLECTIONS PEKIN | 2720 S 14TH STREET PEKIN, IL 61554 |

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| A 000 | Initial Comment<br><br>Facility Reported Incident to 5/9/26 incident IL201887<br>Violations: 295.6000a)1)13)<br>295.6010a)c)d) | A 000 | | |
| A6000 | Section 295.6000 Resident Rights<br><br>This Regulation is not met as evidenced by:<br>Section 295.6000 Resident Rights<br>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:<br>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;<br>13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;<br><br>Type 1 Violation<br><br>Based on observation, interview, and record review the establishment failed to prevent abuse for one (R2) of three residents reviewed for abuse in the sample of six. This failure creates a substantial probability of severe harm to a resident or residents.<br><br>Findings include:<br><br>The establishments Resident Rights policy and procedure dated 3/26/2019 documents "No | A6000 | | |

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| A6000 | Continued From page 1 | A6000 | | |

residents shall be deprived of any rights, benefits, or privileges guaranteed by law, and residing State, or the Constitution of the United States solely on account of his or her status as a resident of a Community, 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, 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."

The establishments Abuse, Neglect, and Financial Exploitation policy and procedure dated 4/2026 documents "The Community will make every effort possible so that residents are free from mental, emotional, and physical abuse, neglect, and financial exploitation." Abuse is defined as: "Abuse-any physical or mental injury or sexual assault inflicted on a resident, other than by accidental means, in an establishment."

On 5/10/26 at 1:22 pm, E2 HWD/Health and Wellness Director stated the following: An incident occurred in the dementia unit one evening involving R2, E4 RA/Resident Assistant, and E5 LPN/Licensed Practical Nurse. There were CNA/Certified Nursing Assistant Students in the establishment at the time who witnessed the altercation. E4 RA and E5 LPN were suspended pending the investigation. Video camera footage was watched and shows R2, E4 RA, and E5 LPN interacting. Witness statements were obtained from the students and E1 ED/Executive Director did the investigation.

The establishment's initial and final reports dated 5/11/26 to the State Agency document allegations

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| A6000 | Continued From page 2 | A6000 | | |

of "inappropriate interactions" were made by E5 LPN/Licensed Practical Nurse involving R1, R2, and R6 and with E4 RA/Resident Assistant involving R2.

The establishments abuse investigation documents interviews were obtained and video camera footage was watched in regard to the allegation involving R1 and R6 by E5 LPN and resulted in the allegations being unsubstantiated. The abuse allegation involving R2 by E5 LPN and E4 RA was substantiated. E4 RA was terminated and E5 LPN suspended and to be terminated. Both are no longer allowed to be in the establishment.

The Witness Statement dated 5/9/26 from Z1 through Z4 CNA Students documented witnessing E4 RA and E5 LPN in altercation with R2. R2 was standing with his walker and turned off one of the light switches. E4 RA approached R2, stood with her back to the wall near light switch next to R2, and began yelling for R2 to back off and yelling for E5 LPN. E5 LPN approached becoming "irate" and got into R2's face, pointed her finger in R2's face and yelling that R2 did not own the place that (E5) owned the place. R2 was trying to move away with his walker and E5 LPN put her feet in between one of walker legs making R2 unable to get away. E4 RA stated if R2 swung at E5 LPN (E4) would swing back, kick R2 out of the facility, and call 911 before anyone got there. E5 LPN was also heard telling R2 that R2 had dementia, was in a nursing home, and continued to keep R2 from moving. E4 RA and E5 LPN were heard calling R2 "an ass."

On 5/20/26 at 10:25 am, E9 CNA stated she worked until 10:00 pm on 5/9/26 and witnessed everything that happened between E4 RA, E5

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| A6000 | Continued From page 3 | A6000 | | |

LPN, and R2. E9 CNA stated the following: E4 RA had been sitting at a dining room table with (E9 CNA) when R1 shut off the lights. E4 RA approached R2 and started yelling at R2 about turning the lights off and started yelling at R2 that he had (E4 RA) blocked in and to back up. E4 RA was standing against the wall, not blocked in, and could have moved. E4 RA hollered for R5 LPN who then approached and was hollering at R2 about why (R2) shut the lights off, that the lights are supposed to be on. E4 RA told E5 LPN that (E5) had a worse temper than (E4) did and to go away. E5 LPN then walked behind R2 and continued yelling at (R2) about shutting the lights off and if (R2) wanted the lights off, (R2) should go to (R2's) room and shut the lights off. E4 RA went and got Z6 CNA Instructor to help with the situation and R2 was assisted to his room. Shortly after, R2 came back out to the dining area and E4 RA stated, "Someone else can deal with him." R2 sat down at a table with E9 CNA and E4 RA and looked at E4 RA and asked (E4) if (E4) was still mad at him. E4 RA said "No, if you do what your told and don't turn the lights off."

On 5/20/26 at 10:15 am, This writer observed video camera footage was observed with E1 ED and E2 HWD. Footage shows R2 walking to the end of the memory care hallway with his walker, stopping at the light switch, reaching up and turning off the light, and video appeared darker. E4 RA is seen approaching R2, walking to R2's right side and standing with E4's back to the wall with the switch to E4's left side. There are multiple people seen approaching, watching interaction, backing up, walking away, and reappearing. E5 LPN (identified by E1 ED) is seen approaching, stopping in front of R2, shaking her head back and forth and shaking her right index finger in R2's face, inaudible mouth

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| A6000 | Continued From page 4<br>movements, and putting her hands on her hips. E5 LPN then walks behind R2 and stands behind R2. E4 RA then walks away shortly after and Z6 CNA Student Instructor (identified by E1 ED) approaches and walks away with R2 towards R2's room.<br><br>On 5/20/26 at 10:30 am This writer walked to Memory Care Unit with E1 ED and E2 HWD to area where altercation occurred. All parties walked to the end of the Memory Care Unit 1 hallway, just past the dining room area and across from a television and sitting area. Multiple light switches noted to the wall. This area is at the turning area to go left towards another hallway, near R2's room. There is no corner or area where R2 could have pinned E4 RA in.<br><br>The employee file for E4 RA documents E4 was terminated on 5/15/26 for "Misconduct" for "Alleged Verbal Abuse to resident." The employee file for E5 LPN does not contain a Termination Check List.<br><br>On 5/21/26 at 9:23 am, E1 ED stated both E4 RA and E5 LPN were terminated for "Gross Misconduct" but on their termination paperwork it is documented they were terminated for "abuse." E5 does not yet have a Termination Check List due to another HR (Human Resource) issue but remains suspended, not allowed in the establishment, and will be terminated when HR issue is resolved. | A6000 | | |
| A6010 | Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr | A6010 | | |

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| A6010 | Continued From page 5<br><br>This Regulation is not met as evidenced by:<br>Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting<br>a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:<br>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.<br>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.<br><br>Type 1 Violation<br><br>Based on interview, and record review the establishment failed to report a witnessed allegation of abuse and remove perpetrators to prevent further abuse for three (R1, R2, and R3) of three residents reviewed for abuse in the sample of six. These failures resulted in undue mental stress and creates a substantial probability of severe harm to a resident or residents.<br><br>Findings include:<br><br>The establishments Abuse, Neglect, and Financial Exploitation policy and procedure dated 4/2026 documents "Any employee witnessing, suspecting, or having knowledge of abuse is required to report it immediately to the Executive Director or designee." "Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the | A6010 | | |

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| A6010 | Continued From page 6 | A6010 | | |

appropriate state agency. When the Community has a reasonable belief that abuse, neglect, or financial exploitation occurred, the accused, if an employee or volunteer, shall be removed from the Community. Suspended immediately pending investigation."

The establishments abuse investigation dated 5/10/26 documents allegations of abuse were reported against E4 RA/Resident Assistant and E5 LPN/Licensed Practical Nurse. This investigation documents the following allegations of abuse: On 5/8/26 by E5 LPN to R1; On 5/9/26 by E4 RA and E5 to R2; on 5/9/26 by E5 LPN to R6. This investigation includes written statements dated 5/10/26 by Z1 through Z5, Z7, and Z8 CNA Students and by Z6 CNA Student Instructor of allegations of abuse by E4 RA and E5 LPN from the evening of 5/9/26.

During this writer's investigation another allegation of abuse was noted in E9 CNA's witness statement against E4 RA to R3.

On 5/20/26 at 10:25 am, E9 CNA stated she did work on the evening of 5/9/26 and witnessed E4 RA and E5 LPN in an altercation with R2 and witnessed E4 RA in an altercation with R3. E9 CNA stated E4 RA is always yelling at the residents, no one in particular, and would consider E4 RA's behavior to be abuse. E9 CNA stated she was trying to give E4 RA the benefit of the doubt but "(E4) was horrible." E9 CNA stated she did not report any allegations of abuse to E1 ED or E2 HWD because her shift ended at 10:00 pm and "I hate to call and wake management up during the night and report things," and forgot to report the allegations the following day. E9 CNA stated she has never reported abuse to E1 ED or E2 HWD until she was asked about the 5/9/26

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| A6010 | Continued From page 7<br>incident with R2.<br><br>On 5/20/26 at 9:18 am, E3 RCC/Resident Care Coordinator stated she was called in to work on 5/10/26 and upon entering CNA Students asked to speak with (E3) about the prior evening. CNA Students reported observing and hearing a Nurse and CNA being inappropriate with R2, trying to block R2 from moving, and talking loudly at R2. One of the allegations had to do with someone playing loud music at R1. E3 RCC stated she immediately reported to E1 ED, the abuse coordinator, and was instructed to start getting statements from the students. E3 RCC stated no staff reported anything to her.<br><br>On 5/20/26 at 10:15 am, E1 ED and E2 HWD verified no one reported anything to them on 5/9/26 and should have. | A6010 | | |