STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510478	A. BUILDING: _____ B. WING _____	C 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK TOWANDA BARNES	1815 N TOWANDA BARNES 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 Facility Reported Incidents IL202490 - 295.6000a)13) cited IL202544 - 295.4060h)3)A) and 295.6000a)13) cited	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and TYPE 1 VIOLATION Based on interview, and record review, the establishment failed to keep a known wandering, exit-seeking, cognitively impaired resident from leaving the Memory Care unit unsupervised for one (R5) of three residents reviewed for elopement. This failure resulted in R5 exiting the establishment, walking approximately 117 yards and stood within less than 12 yards from a busy four lane road with a 45 mph (mile per hour) speed limit, and creates a substantial probability of severe harm to a resident or residents.	A4060		

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A4060	Continued From page 1 Findings include: The establishment's undated Memory Care Disclosure Statement documents "The Community has designed a secure community for resident safety. All exit doors will be equipped with an electronic entry and exit. In addition, the doors are wired to our nurse call system as well as our fire system and are monitored by our staff. Due to the elopement and security risk to our residents, we do not provide the code to enter or exit these doors to family, guests, or visitors." R5's clinical record documents R5 resides in the secured Memory Care unit and has moderate-severe cognitive impairment with diagnoses including but not limited to: Unspecified dementia, mild with other behavioral disturbance, Anxiety, Restlessness, and Agitation. R5's Service plan, dated 6/15/26, includes memory loss, Hospice, and Wandering Risk - intervention: Supervision and monitoring to help manage/redirect self-harm behavior; Frequency - as needed every day; Service Provider Responsible - Staff. The establishment's Initial State Reportable for R5, dated 6/20/26, documents "Resident was found out in the parking lot by another resident's family member. Unknown how resident got out of the community. Caregivers went outside and brought resident back inside. Resident has been exit seeking for hours and has refused to take any prn (as needed) medication. Resident has also been throwing things today. Emergency exit found to not be working properly." R5's Initial State Reportable included a written statement by a witness to R5's elopement (Z3): "I	A4060		

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A4060	Continued From page 2	A4060		

was leaving (named establishment Memory Care) on Saturday June 20th around 4pm. As I was headed to exit I saw (R5) stumbling around on the exit road. I recognized her and stopped and called Memory Care. No answer after two tries. Struggled to get (R5) in car. This was just a few feet east of main entrance sign, very close to Towanda Barnes Road. I drove up to handicapped spot at Memory Care. Twice calling again for help, no answer. So went running in yelling for help. Aides came running out and had a difficult time getting (R5) out of my car. They had been looking for help. I was so shook up, I then left without going back into building."

During this investigation Z3 (witness to R5's elopement) was not available for interview.

On 6/25/26, at 1:08pm, E4 Registered Nurse/RN stated the following: (R5) had been exiting-seeking all day on 6/20/26. While (E4, E5 and E6 Certified Nursing Assistants/CNAs) were all assisting another resident, (R5) was unsupervised and got out of the Memory Care unit.

On 6/30/26, at 9:59am, E5 CNA stated the following: On that Saturday (R5) was having some behaviors all day - exit-seeking. Around 4:15pm (E5) was on the way to assist (E6 and E4) in another resident's room. (E5) had noticed at that time that (R5) was walking back towards (R5's) room. When (R5) starts having behaviors the first thing (R5) does is start to speed walk to the exit door and (R5) tries to get out. (R5) was by the television area towards (R5's) room. When I came out of this other resident's room and was at nurse's station (R5) had gotten out. One of us definitely should have stayed with (R5) while (R5) was having behaviors.

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A4060	Continued From page 3 On 6/30/26, at 12:17pm, E4 RN confirmed that R5 had been exit-seeking all day and stated "I should have had one of the CNAs stay with (R5) and gotten someone to come over and assist with getting the other resident off the floor." On 6/30/26, at 10:23am, E7 Maintenance Assistant and this writer stood outside of the exit door to Memory Care that E7 confirmed was the exit door R5 walked out of. E7 measured the distance from this door to the main entrance sign = 117 yards. The distance from this sign (approximate location of R5) to the road measured 11.7 yards. This road has four lanes of traffic moving at speeds up to the speed limit of 45 mph (miles per hour).	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; TYPE 1 VIOLATION Based on observation, interview, and record	A6000		

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A6000	Continued From page 4	A6000		

review, the establishment failed to provide supervision and safety precautions for one known demented resident (R5) and failed to prevent staff-to-resident verbal and emotional abuse for one (R1) of six residents reviewed for abuse and neglect in a sample of seven. These failures create a substantial probability of severe harm to a resident or residents.

Findings include:

The establishment's Resident Rights policy, revised 3/26/19, documents "Policy: The Community will guarantee the resident his/her rights as mandated by state regulations. 13) The right to be free of abuse, neglect or financial exploitation or to refuse to perform labor."

The establishment's Abuse, Neglect, and Financial policy documents "Policy: The Community will make every effort possible so that residents are free from mental, emotional, and physical abuse, neglect, and financial exploitation. Definitions: 1. Abuse - any physical or mental injury or sexual assault inflicted on a resident, other than by accidental means, in an establishment."

1. On 6/25/25, at 1:03pm, R5 was in her room on the secured Memory Care unit lying in bed.

R5's clinical record documents R5 has moderate-severe cognitive impairment with diagnoses including but not limited to: Unspecified dementia, mild with other behavioral disturbance, Anxiety, Restlessness, and Agitation. The establishment's Initial State Reportable for R5, dated 6/20/26, documents "Resident was found out in the parking lot by another resident's family member. Unknown how resident got out of

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A6000	Continued From page 5	A6000		

the community. Caregivers went outside and brought resident back inside. Resident has been exit seeking for hours and has refused to take any prn (as needed) medication. Resident has also been throwing things today. Emergency exit found to not be working properly."

R5's Initial State Reportable included a written statement by a witness to R5's elopement (Z3): "I was leaving (named establishment Memory Care) on Saturday June 20th around 4pm. As I was headed to exit I saw (R5) stumbling around on the exit road. I recognized her and stopped and called Memory Care. No answer after two tries. Struggled to get (R5) in car. This was just a few feet east of main entrance sign, very close to Towanda Barnes Road. I drove up to handicapped spot at Memory Care. Twice calling again for help, no answer. So went running in yelling for help. Aides came running out and had a difficult time getting (R5) out of my car. They had been looking for help. I was so shook up, I then left without going back into building."

On 6/25/26, at 1:08pm, E4 Registered Nurse/RN stated the following: (R5) had been exiting-seeking all day on 6/20/26. Another resident had fallen so (E4, E5 and E6/Certified Nursing Assistants) were all in that room assisting the fall resident up off of the floor when (R5) got out of the Memory Care unit. Afterwards, (E5 and E6) checked the exit door near (R5's) room and it did not alarm. It had malfunctioned.

On 6/25/25, at 2:04pm, E6 CNA stated the following: (On 6/20/26) before and after lunch (R5) had been actively wandering, exit-seeking, and trying to escape. (R5) had gotten out of Memory Care while (E5, E6 and E4) were in another resident's room. The exit door did not

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A6000	Continued From page 6 alarm. On 6/30/26, at 9:59am, E5 CNA stated the following: On that Saturday (R5) was having some behaviors all day - exit-seeking and trying to hit windows with her purse. Around 4:15pm (E5) was on the way to assist (E6 and E4) in another resident's room. (E5) had noticed at that time that (R5) was walking back towards (R5's) room. When (R5) starts having behaviors the first thing (R5) does is start to speed walk to the exit door and (R5) tries to get out. (R5) was by the television area towards (R5's) room. When I came out of this other resident's room and was at nurse's station, (Z3 witness to R5's elopement) had come in through side door and said she found (R5) by (named road) and had (R5) in (Z3's) car. E6 and E5 went outside to get (R5) back in. Once in we tried to figure out how (R5) got out without alarms. We checked the door by (R5's) room and pushed it open and there was no alarm. One of us definitely should have stayed with (R5) while (R5) was having behaviors. On 6/30/26, at 12:17pm, E4 RN confirmed that R5 had been exit-seeking all day and stated "I should have had one of the CNAs stay with (R5) and gotten someone to come over and assist with getting the other resident off the floor." The establishment's created work order, dated 6/20/26, documents "Memory Care West exit emergency exit door alarm not engaged." On 6/30/26, at 10:23am, E7 Maintenance Assistant and this writer stood outside of the exit door to Memory Care. E7 confirmed this was the exit door R5 walked out of that did not alarm as it should have. E7 measured the distance from this door to the main entrance sign = 117 yards. The distance from this sign (approximate location of	A6000		

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A6000	Continued From page 7 R5) to the road measured 11.7 yards. This road has four lanes of traffic moving at speeds up to the speed limit of 45 mph (miles per hour). 2. The establishment's Initial State Reportable for R1, dated 6/17/26, documents "On June 16, 2026, at approximately 12:38pm, an interaction involving (Z1 former Dietary Director) and (R1) was reported in the lobby area of the community. (E2) Business Office Manager/ Dietary Manager, reported to the Executive Director (E1) that (E2) observed (Z1) speaking with (R1) in a raised voice that was louder than (Z1's) normal speaking tone. The interaction occurred in the lobby area of the community. The interaction is being investigated for potential verbal, physical, and/or emotional abuse." The establishment's Final State Reportable for R1, dated 6/22/26, included the same verbiage as in the Initial State Reportable plus the following: "An investigation was initiated immediately to determine whether verbal, physical, and/or emotional abuse had occurred. (Z1 former Dietary Director) was interviewed regarding the allegation and was suspended pending the outcome of the investigation. The investigation has been completed. Based on witness statements, interviews, and investigative findings, the facility substantiated allegations of verbal and emotional abuse involving resident (R1). As a result, (Z1's) employment was terminated on 6/19/26." On 6/24/26, at 11:12am, R1 sat in his apartment visiting with Z2 R1's family member. R1 stated the following: I had a concern with dietary staff, but I reported it to (E1 Executive Director) and it has been taken care of. It was (Z1 former Dietary Director.) I told (Z1) she had a bad attitude. (Z1)	A6000		

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A6000	Continued From page 8	A6000		

was disrespectful towards another staff member (E3 Dietary Cook.) (E3) and I were playing pool and (Z1) told (E3) to stop and get back to work. I didn't like (Z1's) tone. That's when I told (Z1) she had a bad attitude. (Z1's) response was that it wasn't my place. I felt (Z1's) tone was harsh.

R1's MMSE (Mini-Mental State Examination), dated 2/25/26, documents R1 is cognitively intact with a score of 25/30.

On 6/24/26, at 10:40am, E1 Executive Director stated that Z1 former Dietary Director got termed; E1 substantiated the incident as emotional and verbal abuse towards R1.

On 6/24/26, at 12:53pm, E2 Business Office Manager/BOM stated the following: Last week in the front area (R1) and (E3 Dietary Cook) were shooting pool. (Z1 former Dietary Director) went up to (E3) and told (E3) that (E3) needs to get back to the Dining Room and why (E3) was not supposed to be on break. (Z1) had a rude tone, kind of motherlike scolding your children. (Z1's) voice was raised a little bit. Then (R1) told (Z1) that (Z1) shouldn't talk to (E3) like that. (Z1's) voice got louder and tone ruder when (Z1) said to (R1) "(E3) is my employee and (E3) needs to be in the kitchen." (Z1) headed back to the kitchen. (R1) said he needed to sit down and calm down. (R1) was flustered and red in the face. (R1) was upset. I told (E1 Executive Director/ED) it was very rude the way (Z1) talked to (R1). I feel it was abuse - verbal abuse because of the tone. (R1) wanted to sit down, was very upset, and needed to collect his thoughts so it was emotional/mental abuse too.

On 6/24/26, at 1:10pm, E3 Dietary Cook stated the following: I was involved since I was on break.

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A6000	Continued From page 9 I was on break playing pool with (R1). V1 (former Dietary Director) showed up not casually; (Z1) was yelling at me saying I can't take breaks during lunch period, that resident needed bread sticks. (E3) told (Z1) there was another cook down in the kitchen. Then all of a sudden (R1) said to (Z1) that (Z1) can't talk to people like that, that's not fair. (Z1) basically told (R1) it's none of (R1's) business. (R4) was doing a puzzle and turned around to see what the yelling was about. (R1) was red in the face and very angry, anxious type. On 6/24/26, at 1:30pm, R4 stated the following: (E3 Dietary Cook) was playing pool with (R1) while I was working a puzzle. I often have breakfast with (R1) and have gotten to know (R1). The third person was the (former) Dietary Director (Z1). I did not hear what (Z1) said to (R3) but (R3's) reaction was as if (Z1) was scolding (E3). (R1) told (Z1) that (R1) felt (Z1) was being rude or unkind. After (R1) told (Z1) that, I thought to myself that this is not going to turn out good for somebody. (Z1's) response to (R1) was something like "stay out of this" in a loud tone.	A6000		