STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510246	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK ALZHEIMER'S SCC	3319 GINGER CREEK DR SPRINGFIELD, IL 62711

(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 Incident IL202625 Section 295.4060 h) 3)	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: Violation Based on interview and record review, the establishment failed to follow their fall policy for falls for R1, one of three residents reviewed for falls in a sample of three. Findings include: The establishment's 5-15-23 Fall Management and Post Fall Investigations policy documents "Falls are investigated, reported and documented using the incident report and QAPI/Quality Assurance tool Post Fall tools. The administrator or designee is ultimately responsible for instituting/commencing the investigation process. A careful review and analysis of the possible	A4060		

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A4060	Continued From page 1	A4060		

contributing factors to the fall with or without injuries is completed using QAPI Post Fall Investigation Tool." The policy continues that trends and patterns in falls will be analyzed. Fall interventions will be placed on the service plan.

R1's face sheet documents R1 resides on a memory care unit with a diagnosis of vascular dementia.

R1's service plan dated 6-2-26 documents R1 needs assistance with most activities of daily living, ambulates via wheelchair, is at moderate risk for and has a history of falls.

R1's 4-29-26 progress at 8:00 pm documents R1 was found sitting on the floor of her room yelling for help. R1 was assisted to bed.

R1's 4-29-26 progress note at 11:55 am documents R1 was found on the floor of her bedroom appearing to have slid from her bed to the floor. No injuries were noted.

R1's two 4-29-26 falls were not documented on the establishment provided incident report from 3-1-26 to present date of 7-6-26. No incident report into these two falls was provided upon request.

On 7-6-26 at 1:30 pm, E1 Executive Director stated she did not have any incident reports for R1 for 4-29-26. E1 stated without an incident report alerting them to a fall, they are unable to investigate the falls, develop new interventions for safety and reduction of falls, and update the service plan. E1 confirmed this process was not followed as incidents reports were not generated for R1's 4-29-26 falls.