STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510569	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE CROSSING SENIOR LIVING	1121 COMMUNITY DRIVE ROCHESTER, IL 62563

(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 Incident Report Investigation IL 176458	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation 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; The establishment failed to ensure R1 was free of abuse while R1 was receiving care from a staff member. Findings include: R1 was admitted to the establishment on 04-22-2024. R1's diagnoses include other symptoms and signs involving cognitive functions and awareness, depression, insomnia, and reduced mobility. R1 resides in the establishment's memory care unit. R1's 01-12-2024 Mini Mental Status Exam score is 2 out of 30. R1's 08-04-2024 Incident Report contains documentation that a family member brought to	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510569	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE CROSSING SENIOR LIVING	1121 COMMUNITY DRIVE ROCHESTER, IL 62563

(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
A6000	Continued From page 1 the establishment's attention with camera footage that a staff person was being verbally and physically aggressive with R1. Further documentation is that R1 was on R1's knees at the side of the bed and that the staff person roughly picked up R1 and put R1 in bed without calling for assistance. Further documentation is that on another date the same staff person was verbally aggressive with R1. The incident report also contains documentation that the staff person was sent home immediately, R1 was assessed and no injuries were noted, and that the staff person was terminated after an investigation was done. The establishment's 08-04-2024 typed investigation report contains documentation that about 11:50am, R1's daughter called about R1 stating that she did not want E3, Resident Care Assistant, in R1's room caring for R1 anymore. R1's daughter stated that she had seen an incident involving R1 on R1's knees beside R1's bed on the camera monitors in R1's room. The camera footage was sent to E2, Wellness Director. The same report contains documentation that E2 observed R1 on R1's knees beside the bed and that E3 came in and pulled R1 up by the back of R1's pants and leg in an awkward position. Further documentation is that R1 appeared uncomfortable after being put back in bed. The report contains documentation that E3 should have gotten a nurse immediately to assess R1 for injuries prior to assisting R1 up with a gait belt and two-person assistance, and that E3 never reported the fall. The same report also contains documentation that R1's daughter showed some more footage that occurred on another day involving the same caregiver assisting R1 in the bathroom. The footage shows E3 using inappropriate language and showing	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510569	A. BUILDING: _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE CROSSING SENIOR LIVING	1121 COMMUNITY DRIVE ROCHESTER, IL 62563

(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
A6000	Continued From page 2 disrespect to R1. Further documentation is that E3 was asked to clock out pending an investigation and that E3 was terminated from her position. During interviews with E2 on 08-12-2024, E2 states that they retrained staff with role-play using scenarios of the incident involving R1, that they went over the abuse and neglect policy and who to report to and when, and that they went over resident falls and lifting techniques. This training was reviewed. E2 also states that the caregiver involved, E3, was terminated. E2 states that R1's daughter sent her video footage of the 08-04-2024 incident and of footage from another date involving E2 caring for R1. E2 states the family has three cameras in R1's room and that all staff are aware of this. E2 states that there is signage on the outside of R1's room about camera footage. R1's door was observed during the investigation and signage documenting that camera and audio footage is in R1's room. E2 states that E3 did not have any previous discipline and that E3's discipline form is marked previous counseling because E3 received training on abuse and neglect in her orientation. E3's 08-05-2024, Discipline Action Form contains documentation that E3 was terminated from her position as a Resident Care Assistant for being verbally and physically aggressive with a resident.	A6000		