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A 000	Initial Comment Incident Report Investigation IL 197422 Type 1 Violation 295.4010 a) d) e) g) 1) B) C) 2) h) 295.6000 a) 1) 2) Type 3 Violation 295.2050 a) b)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting 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. Based on record review and interview the	A2050		

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A2050	Continued From page 1 establishment failed to report serious incidents to the Department within 24 hours after the incident occurs. Findings include: R3's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R3 was seated in the dining room and waiting for dinner when R2 went over and kissed R3 on the cheek. R2 was removed from the area. R2's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R2 went over to another resident in the dining room and kissed the resident on the cheek. R2 was removed from the area and redirected. R2's primary care physician and power of attorney were notified. Further documentation is that R2 will be monitored while in the common area and redirected. R4's 09-17-2025 Incident and Accident Report includes documentation that at 5:00pm, R4 was wandering on the memory care unit. R4 was approached by another resident who then grabbed R4 around the waist and touched R4's buttocks. Documentation includes that the other resident was removed from the area. R2's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R2 approached another resident who was wandering on the memory care unit, R2 grabbed the resident around the waist and touched the residents buttocks. Further documentation is that R2 was removed from the area and redirected. Documentation includes that R2 will be monitored while in the common area and redirected when needed.	A2050		

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A2050	Continued From page 2 R3's 09-17-2025 Resident Incident Report contains documentation that at 5:00pm "resident on resident sexual intimacy" occurred in the dining room. Documentation includes that R3 does not have any visible injury after the incident. Documentation also includes that, "(R3) was getting ready to eat and (R2) rolled over to (R3) and gave (R3) a kiss on (R3's) cheek. R2's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm "resident on resident sexual intimacy" occurred in the dining room. Further documentation includes that R2 "went up and kissed (R3) on the cheek." R4's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm, R4 was in the hallway walking and R2 grabbed R4 around the waist and touched R4's buttocks. R4's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm, R2 had resident on resident sexual intimacy in the resident common area. Documentation also includes that "(R2) was trying to feel up on (R4) and kissed another resident." On 09-22-2025 at approximately 11:20am, E2, (Director of Nursing,) states that the incident reports involving R2, R3, and R4 were not reported to her until Friday the 19th and that is why the incidents were reported to the Department late. On 09-22-2025 at approximately 2:20pm, E3, (Resident Care Coordinator,) was questioned regarding the incidents with R2 and R3. E3 states that she knows to report alleged abuse and neglect to management as soon as possible. E3	A2050		

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A2050	Continued From page 3 states that she was working overtime that day and it didn't cross her mind to report these incidents. E3 states that R2 touched R4 in the hallway as she was walking down the hall to assist another resident. E3 states that R4 scooted away from R2 upon R2 touching R4. E3 states that about 15 minutes later, that R2 was seen kissing R3 on the cheek in the dining area. E3 states that she has not noticed any other behaviors like this from R2. On 09-22-2025, at approximately 2:30pm, E2 states that she went over reporting issues with E3; like this situation, on reporting right away to a nurse and ensuring that management is notified.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident	A4010		

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A4010	Continued From page 4 (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: B) dietary needs, if the establishment provides therapeutic diets; C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed by the resident; h) The service plan shall include all support services provided or arranged for by the establishment. Based on record review, observation, and interview the establishment failed to ensure R1's service plan included documentation of R1's special diet or R1's preference of eating in R1's bed in R1's apartment. The establishment failed to revise and update R1's service plan following an incident of R1 obtaining burns to the upper body after spilling hot coffee. The establishment failed to ensure R2's service plan was revised and updated to include documentation of R2's sexual behaviors and interventions to help prevent the behavior from occurring again. This failure creates a substantial probability of severe harm to a resident or residents.	A4010		

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A4010	Continued From page 5 Findings include: 1. R1 was admitted to the establishment on 10-27-2023. R1's diagnoses include unspecified Parkinsonism, primary hypertension, and peripheral vascular disease. R1's 09-06-2025 incident report contains documentation that at 630pm, R1 called staff to R1's apartment due to spilling coffee. Staff cleaned R1 up and changed R1's bedding. Documentation includes that the staff called the nurse to assess R1's left chest and rib area due to redness. Documentation also includes that the nurse assessed, cleaned and covered the area and notified R1's hospice agency of the incident. R1's 09-06-2025 Facility Reported Incident contains documentation that R1 spilled hot coffee while eating and drinking in bed. The report also contains documentation that R1 is a hospice resident who eats in bed for every meal; refusing to get up into a recliner or the wheelchair due to being in pain. The incident investigation determined that R1 was served coffee in a styrofoam cup with a lid attached. The coffee was sent from the kitchen and was not reheated by staff. The dietary manager reports that the coffee comes out of the machine at 170 degrees Fahrenheit, and that the temperature would be hot enough to cause R1's 2nd degree burn. The report also contains documentation that the establishment will ensure that ice is placed in R1's coffee before serving it to R1. Hospice also placed orders for Silvadene cream with a non-stick covering to be changed daily and as needed. The establishment provided an internal Resident	A4010		

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A4010	Continued From page 6 Incident Report dated 09-06-2025 for R1. The report includes documentation that R1 sustained a coffee burn on 09-06-2025 at 6:30pm in R1's apartment. Documentation includes that R1 has a blister and redness from the coffee on R1's left side and that R1 states the area burns. The internal documentation includes that R1 had a food tray and that R1 is "bed bound" due to receiving hospice services. Further documentation is that R1 will not have coffee that is super hot in R1's room, that ice will be put into R1's coffee to prevent this from occurring again. E6, (Resident Care Associate,) provided a written statement dated 09-06-2025 that includes documentation that she got coffee for R1in a styrofoam cup and asked another staff person to take the coffee to R1. Documentation also includes that R1 is aware of coffee being hot. R1 pressed the call pendant about five minutes later and told staff that coffee was spilled. Documentation includes that R1's shirt was wet in the front and that R1 did not have a "burn on the front of (R1)." Documentation includes that E6 and the nurse assessed R1 noting that R1 was fine. Documentation also includes that E6 started to change R1 and noted that R1's "left side looked really red and blisters so (E6) called nurse back to look and she said it did look like a burn." R1's 08-08-2025 service plan includes documentation that R1 requires assistance with eating, transferring, and requires wheelchair escorts to meals and activities. The same service plan also includes documentation that R1 requires wellness checks every one to two hours and that R1 is receiving hospice services. The service plan does not include documentation that R1 chooses to eat all meals in bed, or that R1 is now to receive coffee that has been cooled down	A4010		

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A4010	Continued From page 7	A4010		

with ice before serving the coffee to R1. The service plan does not include any information regarding R1's diet.

R1's 09-06-2025 11:14pm progress note includes documentation that at about 6:30pm when the nurse was called to R1's room and it was reported to the nurse that R1 had spilled hot coffee on self. Documentation also includes that during the initial assessment of R1, that no injuries were observed. Documentation also includes that the caregivers then noted that R1 had a red area to the left side of the rib cage that wrapped around to R1's back; red areas and blisters were noted on the back portion of R1's rib cage and a blistered portion on the back was open. Documentation includes that the area was cleansed and the hospice nurse was notified.

R1's 09-12-2025 progress note includes documentation that the hospice nurse was at the establishment. Documentation includes that the hospice nurse reminded the staff that R1 is on a puree diet with nectar thick liquids and that orders will be sent again to the establishment. Documentation also includes that R1 is on an antibiotic for an infected chest wound.

On 09-22-2025, at approximately 2:00pm, E5, (Dietary Manager,) states that they use concentrate coffee and that the coffee is not brewed. E5 states if it was brewed, that the water would be at 200 degrees or higher. E5 states that their water temperature for the coffee is 170 degrees and that the coffee loses some temperature as soon as it hits the cup. E5 states that the temperature on their machine cannot be lowered.

On 09-23-2025, at approximately 9:45am, E1,

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A4010	Continued From page 8 (Executive Director,) states that the nurses just gave R1 pain medicine and they would like to wait about half an hour before doing the dressing change to R1's wounds. On 09-23-2025, at approximately 10:10am, E2, (Director of Nursing,) was observed removing the dressing to R1's left rib cage and left mid back area. The old dressing had some yellowish drainage from R1's left upper rib wound. The wound area is approximately palm size with slight pinkness surrounding the open wound area. E2 cleaned the wound bed and applied silvadene cream as ordered. R1's left middle back was observed with a pink healed area and no drainage was noted from this area. The back was cleansed and silvadene cream was applied. Non-stick pads were applied with paper tape over the open rib wound and to the mid-back area. R1 was calm and had some pain during the dressing change. 2. R2 was admitted to the establishment on 08-15-2025. R2's diagnoses include type two diabetes mellitus and mild cognitive impairment. R3 was admitted to the establishment on 05-19-2023. R3's diagnoses include Parkinson's disease and hyperlipidemia. R3's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R3 was seated in the dining room and waiting for dinner when R2 went over and kissed R3 on the cheek. R2 was removed from the area. R2's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R2 went over to another resident in the dining room and kissed the resident on the cheek. R2 was	A4010		

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A4010	Continued From page 9	A4010		

removed from the area and redirected. R2's primary care physician and power of attorney were notified. Further documentation is that R2 will be monitored while in the common area and redirected.

R3's 09-17-2025 Resident Incident Report contains documentation that at 5:00pm "resident on resident sexual intimacy" occurred in the dining room. Documentation includes that R3 does not have any visible injury after the incident. Documentation also includes that, "(R3) was getting ready to eat and (R2) rolled over to (R3) and gave (R3) a kiss on (R3's) cheek.

R2's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm "resident on resident sexual intimacy" occurred in the dining room. Further documentation includes that R2 "went up and kissed (R3) on the cheek."

R2's 08-18-2025 service plan includes documentation that R2 is independent with transfers and ambulating with a wheeled walker. The service plan also includes documentation that R2 is in the memory care unit and requires one to two hour wellness checks. The service plan includes documentation for behavior management of interventions that are: provide a calm environment, provide person-centered care to decrease behaviors, provide redirection when the resident displays behaviors. The service plan does not include any documentation for sexual behaviors or interventions for sexual behaviors.

R2's 08-20-2025 "Care Concern Form For Staff Reporting" contains documentation completed by a female staff person. Documentation includes that at around 12:45pm the staff person was bent over and cleaning plates when R2 came over and

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A4010	Continued From page 10 "slapped my butt. (R2) laughed and said 'oops!' Further documentation is that the staff person told R2 that it is not appropriate and that this was the first time for R2 to display this behavior. On 09-22-2025 at approximately 11:20am, E2, (Director of Nursing,) states that the incident reports involving R2 and R3 were not reported to her until Friday the 19th and that is why the incidents were reported to the Department late. On 09-22-2025 at approximately 2:20pm, E3, (Resident Care Coordinator,) was questioned regarding the incidents with R2 and R3. E3 states that she knows to report alleged abuse and neglect to management as soon as possible. E3 states that she was working overtime that day and it didn't cross her mind to report these incidents. E3 states that R2 touched R4 in the hallway as she was walking down the hall to assist another resident. E3 states that R4 scooted away from R2 upon R2 touching R4. E3 states that about 15 minutes later, that R2 was seen kissing R3 on the cheek in the dining area. E3 states that she has not noticed any other behaviors like this from R2. On 09-22-2025, at approximately 2:30pm, E2 states that she went over reporting issues with E3; like this situation, on reporting right away to a nurse and ensuring that management is notified.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation	A6000		

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A6000	Continued From page 11 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: 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; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; Based on record review and interview, the establishment failed to ensure R3 and R4 maintained their bodily privacy and dignity. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R2 was admitted to the establishment on 08-15-2025. R2's diagnoses include type two diabetes mellitus and mild cognitive impairment. R3 was admitted to the establishment on 05-19-2023. R3's diagnoses include Parkinson's disease and hyperlipidemia. R4 was admitted to the establishment on 01-26-2024. R4's diagnoses include Alzheimer's disease with early onset.	A6000		

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A6000	Continued From page 12	A6000		

R3's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R3 was seated in the dining room and waiting for dinner when R2 went over and kissed R3 on the cheek. R2 was removed from the area.

R2's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R2 went over to another resident in the dining room and kissed the resident on the cheek. R2 was removed from the area and redirected. R2's primary care physician and power of attorney were notified. Further documentation is that R2 will be monitored while in the common area and redirected.

R4's 09-17-2025 Incident and Accident Report includes documentation that at 5:00pm, R4 was wandering on the memory care unit. R4 was approached by another resident who then grabbed R4 around the waist and touched R4's buttocks. Documentation includes that the other resident was removed from the area.

R2's 09-17-2025 Incident and Accident Report contains documentation that at 5:00pm R2 approached another resident who was wandering on the memory care unit, R2 grabbed the resident around the waist and touched the residents buttocks. Further documentation is that R2 was removed from the area and redirected. Documentation includes that R2 will be monitored while in the common area and redirected when needed.

R3's 09-17-2025 Resident Incident Report contains documentation that at 5:00pm "resident on resident sexual intimacy" occurred in the dining room. Documentation includes that R3 does not have any visible injury after the incident.

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A6000	Continued From page 13	A6000		

Documentation also includes that, "(R3) was getting ready to eat and (R2) rolled over to (R3) and gave (R3) a kiss on (R3's) cheek.

R2's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm "resident on resident sexual intimacy" occurred in the dining room. Further documentation includes that R2 "went up and kissed (R3) on the cheek."

R4's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm, R4 was in the hallway walking and R2 grabbed R4 around the waist and touched R4's buttocks.

R2's 09-17-2025 Resident Incident Report contains documentation that at 4:45pm, R2 had resident on resident sexual intimacy in the resident common area. Documentation also includes that "(R2) was trying to feel up on (R4) and kissed another resident."

R2's 08-18-2025 service plan includes documentation that R2 is independent with transfers and ambulating with a wheeled walker. The service plan also includes documentation that R2 is in the memory care unit and requires one to two hour wellness checks. The service plan includes documentation for behavior management of interventions that are: provide a calm environment, provide person-centered care to decrease behaviors, provide redirection when the resident displays behaviors. The service plan does not include any documentation for sexual behaviors or interventions for sexual behaviors.

R3's 01-28-2025 service plan includes documentation that R3 requires stand by assistance with transfers and that R3 requires a gait belt and stand by assistance with ambulating.

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 _____	09/23/2025

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 14 The service plan also includes documentation that R3 is in a memory care unit and requires wellness checks every one to two hours. The service plan includes documentation on behavior management interventions that are: to provide one to one sessions with R3, to provide a calm environment for R3, and to provide reorientation for confusion. R3's service plan does not include any documentation regarding sexual behaviors/intimacy or interventions. R4's 03-13-2025 service plan includes documentation that R4 requires verbal cues with transfers and that R4 is independent with ambulation. The service plan includes documentation that R4 is in a memory care unit and require one to two hour wellness checks. The service plan also includes documentation for behavior management interventions that are: move resident to a less stimulating environment, provide 1:1 sessions with the resident, provide a calm environment for R4, provide medications as ordered to assist with behaviors, provide person-centered care, provide redirection when R4 is displaying behaviors, and provide reorientation for confusion. R2's 08-20-2025 "Care Concern Form For Staff Reporting" contains documentation completed by a female staff person. Documentation includes that at around 12:45pm the staff person was bent over and cleaning plates when R2 came over and "slapped my butt. (R2) laughed and said 'oops!' Further documentation is that the staff person told R2 that it is not appropriate and that this was the first time for R2 to display this behavior. On 09-22-2025 at approximately 11:20am, E2, (Director of Nursing,) states that the incident reports involving R2, R4, and R4 were not	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 _____	09/23/2025

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 15 reported to her until Friday the 19th and that is why the incidents were reported to the Department late. On 09-22-2025 at approximately 2:20pm, E3, (Resident Care Coordinator,) was questioned regarding the incidents with R2 and R3. E3 states that she knows to report alleged abuse and neglect to management as soon as possible. E3 states that she was working overtime that day and it didn't cross her mind to report these incidents. E3 states that R2 touched R4 in the hallway as she was walking down the hall to assist another resident. E3 states that R4 scooted away from R2 upon R2 touching R4. E3 states that about 15 minutes later, that R2 was seen kissing R3 on the cheek in the dining area. E3 states that she has not noticed any other behaviors like this from R2. On 09-22-2025, at approximately 2:30pm, E2 states that she went over reporting issues with E3; like this situation, on reporting right away to a nurse and ensuring that management is notified.	A6000		