

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/11/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CARRIAGE CROSSING SENIOR LIVING

**909 GREEN MILL RD
ARCOLA, IL 61910**

(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 Investigation IL199950 Violations: 295.2000 a) 3) 5) 295.4010 d) e) g) 1) A) 2)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 1 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) 3) The person requires total assistance with 2 or more activities of daily living; 5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building;	A2000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A2000	Continued From page 1 Based on interview and record review the establishment failed to ensure the safety for two (R1 and R2) of three residents reviewed for residency requirements. These failures create a substantial probability of severe harm to both residents. Findings include: 1.) R1's service plan dated 9/23/25 documents admission to the establishment on 8/8/25. R1's medical record documents diagnoses of Parkinson's Disease, Dementia, Depression, Glaucoma, Pancreatic insufficiency, disc degeneration, osteoporosis, and major osseous defect of pelvic region. R1's service plan dated 9/23/25 documents that R1 requires total assistance for bathing, oral hygiene, dressing, and personal hygiene. R1's progress notes dated 8/25/25 document that R1 was confused and did not recognize her husband all shift. R1's progress notes dated 9/12/25 R1 fell out of bed and is wearing only a shirt and is incontinent of urine on the bed. R1's progress notes dated 9/16/25 document R1 cursing at staff. R1's progress notes dated 9/17/25 document R1 is soiling the bed and mattress, and placing her hands in her briefs. R1's progress notes dated 9/18/25 document R1 fell out of bed and was laying in cold, wet, urine.	A2000		

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A2000	Continued From page 2 R1's progress notes dated 9/23/25 document R1 was resistive to care, refusing to toilet and using the bed to toilet. R1's progress notes dated 9/29/25 document R1 laying in a soiled bed, naked. Sanitary pads stuck to items around the apartment. R1's progress notes dated 10/8/25 document R1 fall. R1's progress notes dated 11/1/25 document that R1 is incontinent of bowl and bladder. R1's progress notes dated 11/3/25 document R1 fell out of bed. R1's progress notes dated 11/3/25 document that R1's physician wants R1 evaluated due to behaviors. Family refuses. R1's progress notes dated 11/14/25 and 11/15/25 document falls. R1's progress notes dated 11/22/25 document R1's refusal to walk. The establishment provided incident and accident report documents that R1 fell on 12/18/25 resulting in a hematoma, R1's progress notes dated 1/11/26 document a fall resulting in a left hip fracture. R1's progress notes document a fall on 1/17/26. R1's progress notes document a fall on 1/19/26. R1's progress notes dated 1/20/26 document a	A2000		

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A2000	Continued From page 3 fall. R1's progress notes dated 1/24/26 document R1 requires a total assist for bathing. R1's progress notes dated 1/29/26 document a fall resulting in a Lumbar 3 fracture, Thoracic 11 and 12 fractures, and a pelvic fracture. After a review of the above incidents, accidents, and behaviors on 2/11/26 at 10:25AM, E2 Nurse Manager stated, "With (R1's) falls, we could not keep her safe and I don't know why we didn't discuss moving her to another facility, but we didn't." On 2/11/26 at 10:52AM, E1 Executive Director confirmed that R1 was not appropriate for the establishment. 2.) R2's medical record documents diagnoses including: Alzheimer's Dementia, Hypothyroidism, Depression, Insomnia, Hypertension, and Heart Failure. The establishment provided incident and accident log documents R2 falls dated: 10/18/25, 10/28/25, 11/1/25, 11/3/25, 11/6/25, 11/10/25, 11/13/25, 12/24/25, 12/27/25 and 1/23/26. R2's progress notes dated 12/24/25 document that at 9:01PM R2 was found in the courtyard, outside of the establishment, and when asked why she was outside, R2 stated that she wanted to turn the fireplace up. On 2/11/26 at 11:45AM, E1 Executive Director confirmed that R2 is a concern after her falls and exiting the building into the courtyard in the cold. "For her safety, we will be moving her to the	A2000		

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A2000	Continued From page 4 Memory Care Unit as soon as we can meet with the family."	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 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 (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: A) assistance with activities of daily living; 2) The amount, type, and frequency of health-related services needed by the resident; Based on interview and record review the	A4010		

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A4010	Continued From page 5 establishment failed to ensure the accuracy of two (R1, R2) of three service plans reviewed for service plans. This failure creates a substantial probability of harm to a resident or residents. Findings include: 1.) R1's service plan dated 9/23/25 documents admission to the establishment on 8/8/25. R1's medical record documents diagnoses of Parkinson's Disease, Dementia, Depression, Glaucoma, Pancreatic insufficiency, disc degeneration, osteoporosis, and major osseous defect of pelvic region. R1's service plan dated 9/23/25 documents R1 is at risk for falls dated 1/11/26 and that R1 needs monitoring for falls with interventions including education and exercise classes. R1's progress notes from 8/8/25 to 2/2/26 document multiple falls with injury, episodes of resistance to care, consistent confusion, not following directions, and having poor safety awareness. R1's service plan dated 9/23/25 documents that R1 needs minimal assistance with evacuation from the establishment but requires no assistance with mobility and moderate assistance with transferring. On 2/11/26 at 8:54AM, E2 Nurse Manager stated that the service plans are not correct for R1 and that the reason R1 fell so much was because of a lack of safety awareness and confusion. E2 then confirmed that education is not an effective intervention for those who lack safety awareness and are confused.	A4010		

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A4010	Continued From page 6 2.) R2's medical record documents diagnoses including: Alzheimer's Dementia, Hypothyroidism, Depression, Insomnia, Hypertension, and Heart Failure. The establishment provided incident and accident log documents R2 falls dated: 10/18/25, 10/28/25, 11/1/25, 11/3/25, 11/6/25, 11/10/25, 11/13/25, 12/24/25, 12/27/25 and 1/23/26. R2's progress notes dated 12/24/25 document that at 9:01PM R2 was found in the courtyard, outside of the establishment, and when asked why she was outside, R2 stated that she wanted to turn the fireplace up. R2's service plan dated 9/24/25 does not document any interventions for elopement. On 2/11/26 at 11:45AM, E1 Executive Director confirmed that R2 is a concern after her falls and exiting the building into the courtyard in the cold. "For her safety, we will be moving her to the Memory Care Unit as soon as we can meet with the family."	A4010			