STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510289	A. BUILDING: _____ B. WING _____	C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS MEMORY CARE - HERRIN	517 RUSHING DRIVE CARTERVILLE, IL 62918

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A 000	Initial Comment Complaint Investigation 2554951/IL193566 Violations cited: 295.4060h)3)A) 295.6010c)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: TYPE 2 VIOLATION 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; Based on interview and record review the facility failed to provide adequate monitoring/supervision of a resident who wanders to prevent them from entering other residents' rooms in a dementia unit. This failure resulted in a resident entering another resident's room and putting resident at risk for agitation, aggression or unpredictable harmful behavior from others. This creates a substantial probability of harm to residents in the facility.	A4060		

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A4060	Continued From page 1 Findings include: R1's Nurses Note created by E2 (Licensed Practical Nurse) dated 5/24/25, documents, "5/24/25 13:57:27. resident not in the best of moods today, res keeps door open, other resident that wonders (sp) unit went into res room, said resident slapped res in face and shove res out of room. I went in to talk to res and asked if possible to keep door shut so others don't wonder (sp) and resident screamed in my face and stated "f***, no this is my room" and "get the hell out". Will continue to monitor res." R1's Nurses Note created by E1 (Executive Director) dated 5/27/25, documents, "5/27/25 10:04. As per follow up investigation, No witness of incident. Resident unable to confirm and other resident denies." On 6/2/25 at 1:38 PM, E1 (Executive Director) stated she was not aware of the incident on 5/24/25 between R1 and R2 until the morning of 5/27/25 when it was reported to her. E1 stated she then started the investigation and determined nobody witnessed that R1 slapped R2, and there was no mark or injury to R2. E1 stated E5/Caregiver reported hearing a noise like skin on skin. and heard R2 yelp which she does when being redirected and found R1 removing R2 from his room. R1 frequently claps his hands to remove residents or get their attention. E1 stated no injury or mark to face was noted at that time or any day after said event. R2 was fully clothed, with no exposed skin except for the face. E1 stated she explained to E2 that any resident to resident incident must be reported to her as it would need to be investigated. On 6/2/25 at 1:15 PM, both E3 (Resident	A4060		

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A4060	Continued From page 2 Assistant) and E4 (Certified Nursing Aide/CNA) stated R1 wanders around all the time, goes in and out of other residents' rooms and staff keep other residents' rooms doors shut if they allow it. Both stated there are times R1 refuses to keep his door shut when he is inside and that's when R2 tries to go in. Both stated they make sure to avoid R2 enter R1's room or be near R1. On 6/3/25 at 10:38 AM, E5 (CNA) stated she worked on 5/24/25 in R1's unit. E5 stated she was at the end of the hallway several feet away, saw R2 enter R1's room and knowing R1 was inside, she immediately ran to get R2 and before she could reach R1's door, she heard a noise like skin on skin contact and saw R1 shoving R2 out of his room. E5 stated she noted R2's face was flushed but there was no indication R2 was hurt or in pain, she was not agitated and did not have any marks on her face. E5 stated she immediately reported it to E2. E5 stated R2 wanders around the unit and would enter other residents' rooms if the door is open that's why they try to keep other residents' rooms closed. R1's Service Plan dated 3/24/25 documents, "I have memory loss/dementia. Goal: I will live in a safe, nurturing and stimulating environment. I will wander within the community. I will not wander without staff or family outside of the community. Interventions (in part): I like to wander within the community, please allow me to do this while supervising from a distance."	A4060		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

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A6010	Continued From page 3 This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. Based on interview and record review the facility failed to internally report an alleged resident to resident slapping incident to the Executive Director. This failure resulted in delayed investigation to determine if there was actual harm done and subsequently protect R1 from future harm. This creates a substantial probability of harm to residents in the facility. Findings include: The Facility Policy on Abuse, Neglect and Financial Exploitation revised 11/2/23, documents, " Policy: The Community will ensure 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	A6010		

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A6010	Continued From page 4	A6010		

resident, other than by accidental means, in an establishment. Reporting: 1. Any employee witnessing, suspecting, or having knowledge of abuse is required to report it immediately to the Executive Director or designee. "

R1's Nurses Note created by E2 (Licensed Practical Nurse) dated 5/24/25, documents, "5/24/25 13:57:27. resident not in the best of moods today, res keeps door open, other resident that wonders (sp) unit went into res room, said resident slapped res in face and shove res out of room. I went in to talk to res and asked if possible to keep door shut so others don't wonder (sp) and resident screamed in my face and stated "f***, no this is my room" and "get the hell out". Will continue to monitor res."

R1's Nurses Note created by E1 (Executive Director) dated 5/27/25, documents, "5/27/25 10:04. As per follow up investigation, No witness of incident. Resident unable to confirm and other resident denies."

On 6/2/25 at 1:38 PM, E1 (Executive Director) stated she was not aware of the incident on 5/24/25 between R1 and R2 until the morning of 5/27/25 when it was reported to her. E1 stated she then started the investigation and determined nobody witnessed that R1 slapped R2, and there was no mark or injury to R2. E1 stated E5/Certified Nursing Assistant/CNA reported hearing a noise like skin on skin. and heard R2 yelp which she does when being redirected and found R1 removing R2 from his room. R1 frequently claps his hands to remove residents or get their attention. E1 stated no injury or mark to face was noted at that time or any day after said event. R2 was fully clothed, with no exposed skin except for the face. E1 stated she explained to E2

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A6010	Continued From page 5	A6010		

that any resident to resident incident must be reported to her as it would need to be investigated. E1 stated she did not report the alleged incident to IDPH since it was unwitnessed and could not be proven from investigation that it happened.

On 6/2/25 at 1:15 PM, both E3 (Resident Assistant) and E4 (CNA) stated R2 wanders around all the time, goes in and out of other residents' rooms if doors were open and staff keep other residents' rooms doors shut if residents allow it. Both stated there are times R1 refuses to keep his door shut when he is inside and that's when R2 tries to go in. Both stated they make sure to avoid R2 entering R1's room or be near R1.

On 6/3/25 at 10:38 AM, E5 (CNA) stated she worked on 5/24/25 in the unit R1 and R2 live. E5 stated she was at the end of the hallway several feet away, saw R2 enter R1's room and knowing R1 was inside, she immediately ran to get R2 and before she could reach R1's door, she heard a noise like skin on skin contact and saw R1 shoving R2 out of his room. E5 stated she noted R2's face was flushed but there was no indication R2 was hurt or in pain, she was not agitated and did not have any marks on her face. E5 stated she immediately reported it to E2. E5 stated R2 wanders around the unit and would enter other residents' rooms if the door is open that's why they try to keep other residents' rooms closed.

R1's Service Plan dated 3/24/25 documents, "I have memory loss/dementia. Goal: I will live in a safe, nurturing and stimulating environment. I will wander within the community. I will not wander without staff or family outside of the community. Interventions (in part): I like to wander within the

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A6010	Continued From page 6 community, please allow me to do this while supervising from a distance."	A6010		