STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510095	A. BUILDING: _____ B. WING _____	C 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE CROSSING CHAMPAIGN	1701 CONGRESSIONAL WAY CHAMPAIGN, IL 61822

(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 Original investigation of Facility Reported Incident IL 201994. VIOLATION - 295.6000 a) 13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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; TYPE 1 VIOLATION Based on interviews, record reviews and observations, the establishment failed to prevent one of one sampled resident from being verbally and physically abused. (R1) This failure creates a substantial probability of severe harm to a resident. Findings include: R1's Face Sheet and Service Plan notes that R1 has resided in the Memory Care unit of the establishment since her admission on 4/1/26. R1 has Diagnosis including but not limited to Mild Cognitive Impairment, Senile Degeneration of the	A6000		

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A6000	Continued From page 1 Brain, Anxiety and Insomnia. Establishment investigation summary into incident on 5/17/26 reads, "On 5/18/26 approximately 3:30 P.M., daughter (R1's daughter Z1) reported to Executive Director that she had seen concerning cares through resident's camera performed by caregiver (E3) on 5/17/26. (Z1) showed video to Executive Director at this time. (Z1) also reported she also had concern with the same employee on early morning 5/18/26 but did not have the recording on her. *After conversation with daughter (Z1) Executive Director reached out to notify Director of Nursing (E2), who was out of the building at the time. Investigation for allegation of abuse immediately started. Care conference was scheduled with daughter (Z1) on 5/19/26 at 9:00 am. Following steps taken including: Notifying Regional, calling to file police report, filing state reportable to IDPH and calling employee (E3) to suspend her pending investigation immediately. Staff nurse also performed head-to-toe skin assessment on resident (R1) to assess for any concerns. No concerns were found at this time. *Cont'd 5/18/26 after Executive Director called and spoke with (E3) informing her of suspension pending investigation, employee drove to community and gave her verbal immediate resignation from her position. *5/19/26 Executive Director spoke with police department again to finalize report. Reference ID C26-16491. *At care conference (Z1), Executive Director, and Director of Nursing were present. (Z1) verbalized concerns that on video of early morning of 5/17/26 (E3) was yelling at her mother (R1) and being rough which was worsening resident's behaviors and anxiety. She (Z1) states that on video of early morning of 5/18/26 (E3) and another caregiver (E4) were present, and she had concerns that (E3) was	A6000		

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A6000	Continued From page 2	A6000		

possibly using profanity while performing cares. She (Z1) was uncertain and indicated she would send video later today for review. Other concerns discussed and addressed at this care conference as well. *5/21/26 at 10:00 am Executive Director and Director of Nursing met with caregiver (E4) who was the other caregiver present on 5/18/26. She denies that (E3) used any profanity and she (E4) did not witness any concerns in the care performed that early morning. Received written statement. Upon reviewing the video from morning of 5/17/26: Video indicates employee (E3) entered resident's (R1) apartment at 4:02 am and video is 4:39 minutes long. The following are things of noted concern in the video: *Timestamp 2:13 (E3) started raising her voice at (R1) 'Stop, stop hitting me' *Timestamp 2:24 (E3) yells extremely loud at (R1) 'STOP, NOW' *Timestamp 3:47 (R1) smacks (E3's) left arm and (E3) smacks (R1's) hand away. *Timestamp 3:50 (E3) aggressively shoves (R1's) right leg. Upon reviewing video from early morning of 5/18/26: Video indicates employees (E3 and E4) entered (R1's) apartment at 5:06 am and was 5:01 minutes long. Did not note any use of profanity or voices being raised. After completing investigation and reviewing camera footage, determined that substantiated concern of abuse on early AM 5/17/26. Upcoming scheduled training's on 5/26/26 and 5/28/26 to review Abuse & Neglect and resident rights policies. Scheduled Dementia training on 6/9/26 by behavioral health specialist. Final report filed to IDPH on 5/22/26."

On 6/7/26 at 10:48 A.M., E2 (D.O.N.) confirmed that through their investigation they determined that E3 did physically and verbally abuse R1 on the morning of 5/17/26. E2 stated that E3 did resign from employment but E3 would have been terminated from employment for abuse anyway.

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A6000	Continued From page 3 On 6/8/26 at 11:10 A.M., Z1 (R1's Daughter) stated that she did report the abuse to E1 and was upset how her mother (R1) was treated by E3. Videos reviewed and confirmed that E3 did physically and verbally abuse R1 on the morning of 5/17/26.	A6000		