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PEORIA BICKFORD COTTAGE	2000 W WILLOW KNOLLS DR PEORIA, IL 61614

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A 000	Initial Comment Original Complaint #2528620/IL197428 Section 295.1100 e) - Type 1 Violation Section 295.4000 b) - Type 2 Violation Section 295.4060 a) h) 3) 4) - Type 1 Violation Section 295.6000 a) 1) 5) - Type 1 Violation	A 000		
A1100	Section 295.1100 Alzheimer's and Related Dementias Special Car This Regulation is not met as evidenced by: Type 1 Violation Section 295.1100 Alzheimer's Disease and Related Dementias Special Care Disclosure An establishment that offers, advertises or markets to provide care for persons with Alzheimer's disease and related dementias through an Alzheimer's special care program shall disclose to the Department and to a potential or actual resident of the establishment the following information in writing: e) The establishment's minimum and maximum staffing ratios, specifying the general licensed health care provider to resident ratio and the trainee health care provider to resident ratio; Based on interview and record review, the establishment failed to have licensed health care provide to resident ratios included in their Special Care Disclosure. This failure creates a substantial probability of severe harm to a resident or residents.	A1100		

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A1100	Continued From page 1 Findings include: The establishment provided Special Care Disclosure revised 3-2-25 documents "There will be a minimum staff to resident ratio of 1:8 on the day and evening shifts and 1:12 on the night shift." There is no licensed health care provided ratio included. On 9-17-25 at 3:15 pm, E1 Executive Director reviewed the Special Care Disclosure and verified it did not contain the licensed health care to resident ratios.	A1100		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Section 295.4000 Physician's Assessment b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. Type 2 Violation Based on interview and record review, the establishment failed to have a physician complete the annual assessment for two of three residents (R1 and R2) in a sample of three. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1's annual "Physician's Certification" dated 5-15-25 was not completed and signed by a	A4000		

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A4000	Continued From page 2 physician.. R2's annual "Physician's Certification" dated 1-10-25 was not completed and signed by a physician.. On 9-17-25 at 3:15 pm, E1 Executive Director acknowledged R1 and R2's physician assessments should be completed by a physician.	A4000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 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; and B) May need supervision and assistance	A4060		

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A4060	Continued From page 3 when evacuating the building in an emergency; 4) Provide coordination of communications with each resident, resident's representative, relatives and other persons identified in the resident's service plan; Based on interview and record review, the establishment failed to follow their policies and procedures regarding door alarms, resident elopement and incident notification for one (R1) of three residents reviewed in a sample of three. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1's 7-27-25 progress note completed by E10 LPN/License Practical Nurse at 9:20 pm, documents "(R1) exited the facility from the front door. Staff heard the door alarm and found resident outside on the sidewalk. Easily redirected back into the building. No injuries." No other documentation of this incident could be found. The Establishment's Investigation Form documents on 9-4-25, R1 was found outside the building having been seen thru the dining room window by staff. Alarms went off, staff investigated, went through both doors, did not see any residents. A headcount was completed. On 9-17-25 at 12:30 pm, E7 CNA/Certified Nursing Assistant stated about 6:00 pm on 9-4-25, she heard a faint alarm coming from the end of the hall SE/southeast door. E7 stated the first interior door was not alarming but the second door to the exterior was alarming softly. E7 went thru the doors and checked outside the building.	A4060		

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A4060	Continued From page 4	A4060		

She heard another staff calling R1's name so she went back inside. E7 stated floor staff have pagers that alert them if doors are opened but she did not have a pager that night. E7 stated the first door alarms loudly when the door is opened but did not sound that night. E7 stated later that night, they completed a resident a head count and checked all the door alarms. One to two days later, they checked door alarms again and the SE interior door did not alarm.

On 9-17-25 at 11:05 am, E10 LPN stated she does not remember what happened on 7-27-25 when R1 was found outside the building. E10 stated on 9-4-25, after the incident, she notified R1's POA. E10 also stated she notified R1's POA of his 7-27-25 incident. E10 did not call E1 or E2 for either incident.

On 9-18-25 at 2:30 pm, E1 stated she was not notified about the 9-4-25 until E2 called her. E1 stated she was not employed at the establishment for the 7-27-25 incident but could find no other documentation for it except E10's progress note.

On 9-16-25 at 10:30 am, R1's route of 9-4-25 was walked with E1. The interior SE door alarmed loudly when opened and had to be reset with a key. A small hallway followed then the exterior door opened and alarmed much less loudly after pushing on the exit bar for 15 seconds. Outside was a sidewalk which led up almost the entire side of the building, step off onto drive then back onto another sidewalk and around to the front of the building where R1 was seen out the kitchen/dining room windows. The parking lot backs up to the front sidewalk.

On 9-17-25 at 10:25 am, E2 (Health & Wellness

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A4060	Continued From page 5 Director) stated the evening of 9-4-25, she was notified about 7:45 pm by a staff member who was not working, that R1 was found outside the front of the building. E2 called the establishment and had staff do a head count and check the operation of all the door alarms which should have been completed immediately after the incident. . E2 stated they completed an investigation finding that R1 exited the SE doors at 6:04 pm and was returned via the front doors at 6:07 pm as documented in their door monitoring system. The interior SE door did not alarm. That alarm is loud and can be heard throughout most of the establishment. This door has to be reset with a key once opened. They also determined staff pagers were set on vibrate not sound notification. Pagers should sounds when a resident with a wanderguard tries to open an alarmed door. All their residents have wanderguards. E2 stated she was not aware of the 7-27-25 incident. E2 stated staff are to notify her or E1 (Executive Director) immediately of an incident so they can give direction and ensure things are completed. They then do an investigation to see what happened, correct and/or implement new interventions for the service plan. E10 should have immediately reported the incidents to management and notified the resident's family, POA/Power of Attorney. On 9-16 and 9-17-25, E6, E7, and E9 (CNAs) all stated they were working that night but did not have their pagers. E5 (Cook) stated she does not utilize a pager and did not hear an alarm on 9-4-25. She did see R1 out the kitchen/dining room window and went out to help get him inside. R1 stated he said he was outside "doing paperwork."	A4060		

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A4060	Continued From page 6 On 9-17-25 at 12:20 pm, Z3 (R1's POA) stated on the evening of 9-4-25 at 6:47, she was notified by another resident's family that R1 had gotten out of the building and returned. Z3 stated she was not notified of this incident until she came in about 7:15 pm that night. Z3 stated this is the first and only time R1 had gotten out of the establishment that has been reported to her. The establishment's Unwitnessed Door Alarm policy revised 7-2025 documents "If a door alarm occurs and a staff member does not witness the events, immediately check pagers to determine the type of alarm." Staff are to initiate missing resident procedure and account for all residents "as quickly as possible." The establishment's Incident and Accident Report policy revised 12-2024 document incidents include resident elopements. "Resident or (staff) incidents or accidents are to be reported and documented immediately after they occur." "All incidents or accidents involving resident are to be reported to the Executive Director or Health and Wellness Director/Health and Wellness coordinator of the Branch." "Resident incidents or accidents shall be documented in the Electronic Health Record immediately following the occurrence. The Health and Wellness Director shall review incident/accident documentation within 24 hours." The revised 4-2014 Missing Resident policy documents "Call the Director immediately for further instructions. The Director must be notified even if the resident is found." "the family, or designated agents, shall be immediately notified about the situation."	A4060		

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A6000	Continued From page 7	A6000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 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: 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; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; Based on interview and record review, the establishment staff failed to receive medication as outlined in the service plan for one (R1) of three residents reviewed for medications in a sample of three. The establishment failed to consistently provide real plates and silverware for supper. This failure creates a substantial probability of severe harm to a resident or residents. Findings include:	A6000		

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A6000	Continued From page 8	A6000		

1. R2's 4-11-25 Service Plan documents R2 "Licensed Nurse to administer medications per doctor orders and as written. "These medications come from (pharmacy)."

R2's Physician Order Sheet documents R2 has an dated 1-22-24 to receive Acetaminophen 500 mg/milligrams every night at bedtime. R2's August 2025 MAR (Medication Administration Record) documents R2's 8-5 and 8-6-25 Acetaminophen dose was circled indicating it was not given. The reason given was "no supply."

On 9-17-25 at 2:55 pm, E4 LPN/Licensed Practical Nurse stated on the above dates, she could not find R2's Acetaminophen's card so on 6-5-25 she gave him one out of the PRN (as needed) supply. She did not give the 6-6-25 dose. E7 stated the did not call the pharmacy for the medication, did not notify E2, did not chart that she gave one on 6-5-25 and is unsure if she reordered the medications.

On 9-17-25 at 2:30 pm, E2 (Health and Wellness Director) stated when she talked with E4, E4 stated she gave the Acetaminophen from R2's stock but did not chart it, did not call pharmacy, reorder the medications or contact her.

The establishment's Medication Administration policy date 4-2025 documents nurses are required to "The resident is identified prior to administration of the drug and the dose administered to the Resident is recorded on the Resident's eMAR by the person who administers the drug."

On 9-17-25 at 11:35 am, Z1 (R2's family) stated there have been numerous instances when residents are served meals on disposable plates

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A6000	Continued From page 9 and siverware. On 9-17-25 at 2:55 pm, E4 LPN/Licensed Practical Nurse stated there have been about three times in the last two months that supper has been served using disposable dinnerware she thinks because the dishes were not washed on first shift. On 9-17-25 at 12:30 am E7 CNA/Certified Nursing Assistant stated disposable dinnerware was used one or two times in the last few months for supper. Sometimes it is because the dishes have not been done and once there was a boil order. On 9-16-25 at 1:00 pm E6 CNA stated one or two days when she worked in the last few months they have used disposable dinnerware for supper due to either water trouble or dishes not being done.	A6000		