STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510062	A. BUILDING: _____ B. WING _____	C 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEORIA BICKFORD COTTAGE	2000 W WILLOW KNOLLS DR PEORIA, IL 61614

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A 000	Initial Comment Original investigation of Complaint 25210859 / IL 198426. Violations: 295.4060 h) 3) TYPE 2 VIOLATION 295.6000 a) 1) 13) TYPE 1 VIOLATION 295.7000 c) 5) VIOLATION	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: 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: TYPE 2 VIOLATION Based on record review and interviews, the establishment failed to follow their fall policies regarding post fall evaluations and documentation for one of three sampled residents. (R1) This failure had the probability to cause harm. Findings include:	A4060		

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A4060	Continued From page 1	A4060		

On 10/6/25 at 5:20 P.M., Z1 (R1's Son-in-law) stated that R1 has had 5 falls since September 2025. Z1 stated that on 11/2/25, R1 had fallen off of his couch in the middle of the night. Three staff responded including the nurse (E6). Z1 stated that he was informed of the fall and since they have a camera in room, he reviewed the footage of the fall. Z1 stated that E6 did not do any type of physical assessment or vitals on R1 before staff got R1 up and back on the couch.

Review of the video footage from the night of 11/2/25, noted R1 fall off the couch. Within a few minutes three staff including E6, responded to assist R1. E6 did not perform any physical assessments or get any vitals on R1 before they assisted R1 back up to the couch.

On 11/14/25 at 10:05 A.M., E1 (Executive Director) stated that per their policy, E6 should have done an assessment of R1 and vitals before getting R1 up off the ground.

Z1 stated that they have requested paperwork regarding the details of these falls but was told that was internal information that could not be provided to him.

Establishment "Fall Policy" reads, "3) Post Fall Evaluation Form : A Post Fall Evaluation Form is completed after a resident fall and individualized interventions are considered. The Post Fall Evaluation Form is part of the resident record. An evaluation of the resident and any injuries that require immediate treatment."

On 11/14/25 at 10:05 A.M., E1 confirmed that R1 had fallen five times since September of 2025 and they had failed to complete the "Post Fall Evaluation Forms" as per the establishment

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A4060	Continued From page 2 policy.	A4060		
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: 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; TYPE 1 VIOLATION Based on record review, interviews, and observations, the establishment neglected to monitor and respond to the door alarms for one of three sampled residents. (R1) This resulted in R1 walking outside in the courtyard unsupervised and falling. This failure had the probability to cause significant harm. The establishment neglected to safely transfer one of three sampled residents off the floor after a fall. (R1) This failure had the probability to cause significant harm. The establishment failed to use normal dishware and	A6000		

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A6000	Continued From page 3	A6000		

utensils for one meal for all residents in the establishment.

Findings include:

1) R1's Face Sheet and Service plan notes that R1 has diagnosis including but not limited to Dementia and Neurocognitive Disorder with Behavioral Disturbance. R1 requires "frequent help due to disorientation, memory loss, and difficulty completing tasks." Service plan notes that R1 wanders throughout the community and needs to be "redirected if approaching an EXIT door."

R1's progress note on 10/24/25 at 8:00 P.M. reads, "Resident (R1) was found in the courtyard without his walker and had fallen to the ground. Assessed by this nurse, LPN. (R1) Has scattered abrasions to the outside of left knee. No evidence of hitting his head, no bumps or abrasions to head. Two assist to get him up to wheelchair. Walker was found in the dining room. Able to move all extremities without pain or discomfort. Family notified."

On 11/6/25 at 5:20 P.M., Z1 (R1's Son-in-law) stated that they were notified that R1 had gotten outside unsupervised in the courtyard and fallen on 10/24/25. Z1 stated that R1 is not safe to be outside in the courtyard by himself.

On 11/14/24 at 9:11 A.M., E4 (Caregiver) stated that she was working on the evening of 10/24/25 when R1 got out in the courtyard unsupervised and had fallen. E4 stated that the door alarm had sounded but no staff responded to the alarm. E4 stated that once the door closes again, the door will stop alarming, so it was not until they noticed that R1 was not in the facility that they searched

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A6000	Continued From page 4	A6000		

and found R1 out in the courtyard on the ground.

On 11/14/25 at 10:05 A.M., E1 (Executive Director) stated that on the night in question the staff should have responded to the courtyard door alarm immediately to prevent R1 from going out in the courtyard unsupervised.

Local weather history noted that 10/24/25 sunset was at 7:26 P.M. and the temperature at approximately 8:00 P.M. was 44 degrees Fahrenheit.

2) On 11/6/25 at 5:20 P.M., Z1 stated that they were informed by staff that R1 had fallen in his room on third shift on 10/2/25 without injury. Z1 stated since they have a camera in the room, he watched the video when R1 had fallen. Z1 stated that R1 fell out of the couch onto the floor. Z1 stated that two caregivers and a nurse responded. Z1 stated that the three staff just grabbed R1 under his armpits and lifted him off the ground back to the couch. Z1 stated they did not use a gait belt and this appeared very unsafe.

R1's progress note on 10/24/25 at 2:10 A.M., "Fall" reads, "Resident (R1) found sitting on his bottom in front of his couch. No injuries noted. Resident was assisted off the floor and to his couch with three assist."

Z1's video was reviewed by this surveyor and noted the three staff did not use a gait belt and did just grab R1 under his armpits to lift him off the floor. The staff struggled to get R1 onto the couch.

On 11/14/25 at 10:05 A.M., E1 stated that the staff should have used a gait belt to transfer R1 off the floor after a fall and not grabbed R1 under

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A6000	Continued From page 5 the armpits. 3) On 11/12/25 at 2:31 P.M., Z1 stated that on evening of 11/2/25 they were visiting R1 and they noted that the residents were eating diner using Styrofoam plates and plastic utensils. Z1 stated that he asked the E5 (Cook) why they were not using regular dishware and E5 told him they did not have the staff to clean all the dishware that night. On 11/14/25 at 10:05 A.M., E1 stated that she had talked to E5 about the evening in question and E5 confirmed that they did use Styrofoam plates and plastic utensils.	A6000		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Section 295.7000 Resident Records d) An establishment shall ensure that a resident's record is: 5) Available for review by the resident or the resident's representative during normal business hours or at a time agreed upon by the resident and the manager. VIOLATION Based on record review and interviews, the establishment failed to provide one of three sampled resident's (R1) family / POA requested resident records. Findings include:	A7000		

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A7000	Continued From page 6 On 11/6/25 at 5:20 P.M., Z1 (R1's Son-in-law) stated that R1 has fallen five times since September 2025. Z1 stated that they have requested documentation of the falls and that the establishment corporate staff tell him that that information is internal information that they are not required to give them. The establishment "Fall Policy" reads, "3) Post Fall Evaluation Form: A Post Fall Evaluation Form is completed after a resident fall and individualized interventions are considered. The Post Fall Evaluation Form is part of the resident record." On 11/14/25 at 10:05 A.M., E1 (Executive Director) stated they have not been doing the "Post Fall Evaluation Forms" after resident falls as per facility policy. E1 stated confirmed that according to facility policy the "Post Fall Evaluation Forms" should have been done for R1's falls and available for R1's representatives (Z1) review.	A7000		