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 03/20/2026

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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 Investigations #2622668/IL200526-no violations cited. #2622811/IL200590-no violations cited. #2622925/200631 - 295.4010d)e); 295.4060h)3) #2623108/IL200769 - 295.2050a)b); 295.4010d)e); 295.4060h)3); 295.6000a)13) Facility Reported Incident IL200685 - 295.4010d)e); 295.4060h)3)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. Type 3 Violation Based on observation, interview, and record review the establishment failed to report a fall with head injury to the State Agency for one (R1)	A2050		

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A2050	Continued From page 1	A2050		

of three residents reviewed for accidents/incidents in a sample of three.

Findings include:

The establishment's Incident and Accident State Reporting policy, dated 12/2024, documents "Policy: An establishment shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required." "Procedure: 3) Submit incident or accident within 24 hours to (State Agency) through electronic state database."

On 3/18/26, at 10:52am, R4 sat in a wheelchair in the Memory Care unit with a fresh suture line on the top lateral side of R4's head approximately three inches in length.

R4's incident note, dated 3/10/26, at 4:30am, documents R4 found on the floor next to the toilet in R4's bathroom with a large amount of blood noted on floor and toilet. Active bleeding noted from the side of R4's head. R4 sent to Emergency room.

During the investigation on 3/13/26, the establishment is unable to provide any report submitted to the State Agency regarding R4's fall with head injury.

On 3/18/26, at 1:30pm, E2 Health & Wellness Director stated E2 could not find the report to State Agency so E2 sent it in on 3/17/26. E2 confirmed the report should have been sent in

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A2050	Continued From page 2 within 24 hours.	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: 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). Type 2 Violation - Repeat Based on interview, and record review the establishment failed to ensure Service Plans were revised to include fall interventions for two (R2 and R4) of three residents reviewed for falls in the sample of four. This failure creates a substantial probability of harm to a resident or residents. Findings include: The establishments Fall Policy, dated 10/2024, documents ""Establishment will follow guidelines	A4010		

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A4010	Continued From page 3 outline in policy to implement effective interventions to minimize falls." E1 ED (Executive Director) and E3 HWD (Health and Wellness Director) are responsible for ensuring this policy is carried out. "While all falls cannot be prevented, certain interventions may reduce the risk of falling." "Procedure: 1) Falls Risk Evaluation. D) Consider this form together with the Resident Assessment in completing the Service Plan for fall interventions." The fall notes for R2 dated 3/4/26 at 3:15pm, 3/4/26 at 9:30pm, and 3/6/26 at 11:23am document R2 had unwitnessed falls and was found on the floor. R2's current Service Plan does not include any fall interventions to prevent recurrent falls. 2. The fall notes for R4 dated 3/9/26 at 8:30pm and 3/10/26 at 4:30am document R4 had unwitnessed falls and was found on the floor. R4's current Service Plan does not include any fall interventions added after R4's 3/9/26 fall or 3/10/26 fall. On 3/18/26 at 10:10 am E2 HWD/Health and Wellness Director confirmed when a resident falls the fall intervention should be added to the residents Service Plan. E2 also confirmed fall interventions were not updated on R2 and R4's service plans.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 4 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 1 VIOLATION-Repeat This requirement is not met as evidenced by: Based on observation, interview, and record review the establishment failed to ensure resident injuries/bruises of unknown origin were investigated, a fall intervention was put in place to ensure resident safety, and post fall evaluations were completed as per fall policy for two (R2 and R4) of three residents reviewed for falls in the sample of four. The failure to implement a fall intervention resulted in R4 sustaining a fall with head laceration, being sent out to the hospital, and receiving staples for the laceration. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishment's undated Special Care Disclosure documents its philosophy of care "is to provide a safe environment for the individual with dementia while maintaining maximum independence, dignity and individuality." The establishment's Fall Policy, dated 10/2024, documents "Establishment will follow guidelines	A4060		

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A4060	Continued From page 5	A4060		

outline in policy to implement effective interventions to minimize falls." E1 ED (Executive Director) and E3 HWD (Health and Wellness Director) are responsible for ensuring this policy is carried out. "While all falls cannot be prevented, certain interventions may reduce the risk of falling." "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. Best practice includes: an evaluation of the resident and any injuries that require immediate treatment; an initial evaluation completed by the (establishment staff member) who was first on the scene of the fall; A secondary evaluation is completed by the Health & Wellness Director (HWD) or nurse; After reviewing the current fall, the HWD should review the resident's history of falls and identify any trends; Interventions identified are implemented, documented in the resident record and on the service plan."

The establishment's Falls with Possibly Head Injury policy, dated 2/2025, documents "Procedure: If the resident was transported for evaluation of the head injury, upon returning to the branch, the HWD (Health & Wellness Director) will complete a Falls Risk Evaluation Form, review the Service Plan, and add interventions and complete a significant change assessment, if appropriate."

1. On 3/13/26, at 1:35pm, R2 was in bed in the Memory Care unit with multiple bruises in various stages/colors of purple, yellow, and green on R2's body including but not limited to R2's right lower abdomen, left inner thigh, right arm, left shin, right hip, and right outer thigh. R2 cried out in pain as staff rolled her during incontinence care.

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R2's clinical record documents the following: R2 had incident notes for two falls, each while attempting to get out of bed per self on 3/4/26; one at 3:15pm and the other at 9:30pm. No injuries documented on R2's first fall note; bruising to bilateral hips documented on R2's second fall note.

R2's clinical record does not include any post fall evaluation forms.

On 3/5/26 R2 was sent to the Emergency Room for evaluation due to increased confusion and safety concerns related to being a fall risk. R2 returned from the hospital on 3/6/26 with diagnoses of thoracic vertebral fractures and a closed fracture of R2's left hip. At this time R2's family opted not to treat and placed R2 on Hospice care for comfort. R2's clinical record does not include any investigation of the bruises or reported injuries.

R2's hospital After Visit Summary, dated 3/5/26, documents reason for visit "fall and altered mental status" with diagnoses of a new left hip fracture, liver laceration, and thoracic vertebral fracture.

On 3/18/26, at 1:45pm, E2 Health & Wellness Director stated R2 admitted to the establishment on 3/4/26. E2 confirmed R2's 3/4/26 falls and reported injuries upon returning from the hospital. E2 confirmed E2 did not do an investigation for the injuries/bruises of unknown origin or post fall evaluations for R2's falls. E2 stated the following: It is possible they occurred from (R2's) falls since (R2) had bruising to (R2's) hips.

2. On 3/18/26, at 10:52am, R4 sat in a wheelchair in the Memory Care unit with a fresh suture line

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A4060	Continued From page 7	A4060		

on the top lateral side of R4's head approximately three inches long with one staple noted. At this time E6 CNA stated R4 had staples, but she pulled out all but the one, so they had to suture from the inside.

R4's fall note, dated 2/16/26 at approximately 4:41am, R4 fell as R4 was exiting her bathroom with R4's wheelchair just outside the bathroom door. No injuries.

R4's incident note, dated 3/9/26 at 8:30pm, documents R4 was sitting on the floor with panties down to her feet; R4 stated R4 fell. No injuries.

R4's incident note, dated 3/10/26, at 4:30am, documents R4 found on the floor next to the toilet in R4's bathroom with a large amount of blood noted on floor and toilet. Active bleeding noted from the side of R4's head. R4 is on blood thinners. R4 sent to Emergency room.

R4's current Service plan documents "Intervention: Add scheduled toileting at 4am."

R4's current task record does not include a scheduled time of 4am for toileting.

R4's clinical record does not include any post fall evaluation forms.

On 3/18/26, at 1:35pm, E2 Health & Wellness Director stated the following: (R4's) fall happened in bathroom, unattended; (R4) attempted to transfer and fell. (R4) is supposed to have assistance in bathroom. E2 confirmed that R4's fall on 3/10/26 at 4:30am resulted in R4 sustaining a head laceration that required an emergency room visit and staples placed. E2

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A4060	Continued From page 8 confirmed that R4's task record does not document a 4am toileting schedule for R4. E2 stated that it should have been added after R4's 2/16/26 fall. Therefore, R4 would not have been toileted that day at 4am prior to R4's fall at 4:30am. E2 stated that R4 always tries to get up about that time - 4:30 in the morning. E2 did not complete any post fall evaluations for R4's falls.	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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Type 1 Violation-Repeat Based on observation, interview and record review, the facility staff neglected to keep a resident safe with implementation of a fall intervention for scheduled 4am toileting for one (R4 who had a fall at 4:30 am, resulting in a head injury/laceration) of three residents reviewed for neglect in a sample of four. This failure resulted in R4 sustaining a fall with head laceration, being sent out to the hospital, and receiving staples for the laceration. This failure creates a substantial	A6000		

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A6000	Continued From page 9	A6000		

probability of severe harm to a resident or residents.

Findings include:

The establishment's Resident Bill of Rights, revised 4/2014, documents "13. The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;"

The establishment's Fall Policy, dated 10/2024, documents "Establishment will follow guidelines outline in policy to implement effective interventions to minimize falls." E1 ED (Executive Director) and E3 HWD (Health and Wellness Director) are responsible for ensuring this policy is carried out. "While all falls cannot be prevented, certain interventions may reduce the risk of falling." "2) Fall Interventions: Level 1, 2, and 3. d) Additional considerations for fall interventions may be: ii. Schedule a toileting plan for residents with incontinence." "xii. More frequent nighttime checks."

On 3/18/26, at 10:52am, R4 sat in a wheelchair in the Memory Care unit with a fresh suture line on the top lateral side of R4's head approximately three inches long.

R4's incident note, dated 3/10/26, at 4:30am, documents R4 found on the floor next to the toilet in R4's bathroom with a large amount of blood noted on floor and toilet. Active bleeding noted from the side of R4's head. R4 is on blood thinners. R4 sent to Emergency room.

R4's current Service plan documents the following: R4 has memory impairment, poor safety awareness, poor judgement, and requires assistance with incontinent care. R4 is a Level 3

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A6000	Continued From page 10 fall risk and includes "Intervention: Add scheduled toileting at 4am." R4's current task record does not include a scheduled time of 4am for toileting to be provided. On 3/18/26, at 1:35pm, E2 Health & Wellness Director stated the following: E2 confirmed that R4's fall on 3/10/26 at 4:30am resulted in R4 sustaining a head laceration that required an emergency room visit and staples placed. E2 confirmed that R4's task record does not indicate a 4am toileting schedule for R4 and it should have been added. E2 confirmed that R4 should have been toileted that day at 4am to possibly have prevented R4's 4:30am fall.	A6000		