STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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 Annual Licensure Survey Violations cited 295.2000a)c)1)e) 295.2040b)5) 295.3030c)e)1)2) 295.4010d)e) 295.6000a)1)13) 295.6010a)1)2)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 1	A2000		

authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act)

TYPE 1 VIOLATION

Based on observation, interview and record review the establishment failed to ensure two residents met residency requirements when R4 and R5 were admitted with severe cognitive impairment, required wearing wandering devices due to wandering, and began displaying multiple sexual abusive behaviors towards one another posing a serious threat to other residents. This failure has the potential to affect all 44 residents residing in the establishment and creates a substantial probability of severe harm to a resident or residents.

Findings include:

The establishment is licensed for Assisted Living, NOT a Memory Care unit.

The establishment's license documents "Category: Assisted Living License."

On 4/30/26, at 1:41pm, E1 Executive Director/ED confirmed that this establishment does not have a Memory Care unit, but that they are a locked community. E1 provided their Special Care Disclosure at this time.

The establishment's undated Special Care Disclosure documents "This philosophy is to provide a safe environment for the individual with dementia while maintaining maximum independence, dignity, and individuality." "In addition to the initial physician's initial assessment, the resident's physician shall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 2 provide an assessment of the appropriateness of the resident's continued residency in the special care unit on an annual basis and at such time that a change in resident's condition is identified by a family member, (Named establishment) staff, or resident's physician." "Admission: Individuals with a diagnosis of Alzheimer's or dementia from his/her physician are admitted to the special care unit." "The Executive Director and/or Health & Wellness Director will evaluate the individual, utilizing the Service Assessment, Nursing Assessment, Mini Mental State Examination and/or the Global Deterioration Scale. This assessment evaluates man issues, including the individual's need for assistance in such areas as evacuation procedures, orientation and redirecting to exhibit appropriate behavior. An individual may be appropriate for the special care unit if any of the following exist: 4. The individual exhibits inappropriate behavior. 7. The individual exhibits wandering behavior." "Discharge or Transfer: Discharge or transfer of the resident from the special care unit will occur when the legally capable resident and/or the legal representative request such discharge or transfer, or when any of the following issues arise. 2. The health, welfare or safety of the resident is endangered and (Named establishment) cannot eliminate the danger through the use of appropriate treatment modalities;" During this investigation, on 4/28/26 and 4/29/26 during various times between 10:30am and 3:30pm, R4 and R5 were each separately independently ambulating throughout the building wearing wandering devices. When spoken to, neither R4 nor R5 were able to answer questions appropriately.	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 3 R4 moved into the establishment on 12/29/25 with diagnoses of Hypertension, Dementia, and Insomnia. R4's Mini Mental State Examination/MMSE, dated 12/26/25, documents R4's score as 12/30 (0-17=severe cognitive impairment). R4's Resident Assessment, dated 2/3/26, documents the following: Moderate assistance is needed due to cognitive impairment "frequent help due to disorientation, memory loss, and difficulty completing tasks." R4 is disoriented to person/time/place, has memory impairment, and is a poor historian regarding information or events. R4's GDS (Geriatric Depression Scale) is a 4. Related to this, R4 is unable to be outside of the branch unattended. Moderate assistance is needed due to wandering and elopement risk: "Occasional redirection if wandering or approaching exits, requires a monitoring device if MMSE is 15 or less or had GDS of 4 or greater after 30 days of admission. Consideration for Mary B's placement if triggers met." R4 will have a wandering device in place. R4 current Service Plans document "Objective/Plan: The Care Team provides redirection when I am wandering or attempting to leave the building unassisted in order to help keep me safe. Frequency: Daily." R5 moved into the establishment on 3/19/26 with diagnoses of Alzheimer's Disease, Hypertension, and OSA (Obstructive Sleep Apnea). R5's Mini Mental State Examination/MMSE, dated 3/13/26, documents R5's score as 10 (0-17=severe cognitive impairment).	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 4 R5's Resident Assessment, dated 4/19/26, documents the following: Moderate assistance is needed due to cognitive impairment "frequent help due to disorientation, memory loss, and difficulty completing tasks." R5 is disoriented to person/time/place, has memory impairment, and is a poor historian regarding information or events. R5's GDS (Geriatric Depression Scale) is a 4. Related to this, R5 is unable to be outside of the branch unattended. R5 requires minimal assistance of cueing or reminders if wandering. R5 wanders throughout the building. R5 wanders into resident rooms. R5 will have a wandering device in place. R5's current Service Plan documents "Objective/Plan: The Care Team provides redirection when I am wandering or attempting to leave the building unassisted in order to help keep me safe. Frequency: Daily." On 4/28/26, at 10:40am, R2 sat in her apartment. R2 stated the following: (R4) who has dementia has a man friend (R5) who also has dementia. One day about two weeks ago they were sitting out in the main area, and (R5) had his hand up (R4's) shirt and was fondling (R4). I didn't used to have to keep my door locked but now I do or (R4) will come in. I want to be able to keep my door open, so I don't feel so confined. I only have one window clear back in the bedroom. One day (R4) was in my room while I was helping pass out the mail. When I came back (R4) was sitting at my table eating my piece of cake making a mess! (R4) has dementia. (R4) comes into my room a lot. It is annoying. R2's Mini Mental State Examination/MMSE dated 4/17/26 documents a score of 29/30 which means R2 has no cognitive impairment.	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 5 On 4/29/26, at 11:20am, E8 Licensed Practical Nurse/LPN stated E8 has witnessed R4's shirt up and (R5's) hands on R4's breasts twice since last week. E8 stated "They are both very confused." "It seems like they need to be in a locked Memory Care." On 4/29/26, at 1:36pm, E9 Certified Nursing Assistant/CNA stated the following: Two weeks ago E9 caught R5 fondling R4's breasts while sitting in the foyer together. Last week R4 had R4's tongue down R5's throat kissing. (R4) and (R5) both wander. Recently they have been going into resident rooms if they don't keep their doors locked. (R2) has said (R2) feels like (R2) is in prison because (R2) has to keep (R2's) door shut and locked. On 4/30/26, at 12:23pm, Z1 R4's Power of Attorney/POA/family member stated the following: (R4) is there due to (R4's) dementia. (R4's) dementia may have progressed a little bit more since admission. (R4) is never in (R4's) own room; (R4) is always out and about all the time. On 4/30/26, at 12:40pm, Z2 R5's Power of Attorney/POA/family member stated the following: (R4) has been in (R5's) room and staff came to get (R4) out. That was last Sunday (4/26/26). They (R4 and R5) sit in the foyer out front together. (R5) likes to walk around. On 4/30/36, at 6:43pm, E1 Executive Director/ED confirmed that there have not been any re-evaluations completed for R4 or R5 for residency requirements. E1 stated "At the time, the information that I had did not necessarily show the need for (R4) and (R5) to have re-evaluations for residency requirements. E1	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2000	Continued From page 6 confirmed that these types of sexual behaviors could pose a serious threat to the other residents. The establishment's Resident Roster, dated 4/28/26, documents 44 Assisted Living residents currently reside in the establishment.	A2000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Section 295.2040 Disaster Preparedness b) Each establishment shall: 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. TYPE 1 VIOLATION Based on interview and record review the establishment failed to complete resident orientation for three (R2, R3, and R4) of four residents reviewed for resident orientation in a sample of five. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R2's clinical record documents R2 moved into the establishment on 10/12/22. R2's Resident Orientation Checklist - Assisted Living form is not	A2040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A2040	Continued From page 7 dated or signed by R2 or R2's representative. R3's clinical record documents R3 moved into the establishment on 9/20/19. R3's Resident Orientation Checklist - Assisted Living form was completed and signed on 3/10/23. R4's clinical record documents R4 moved into the establishment on 12/18/25. R4's Resident Orientation Checklist - Assisted Living form was completed and signed on 1/26/26. On 4/29/26, at 3:15pm, E1 Executive Director confirmed that R2's Resident Orientation form is not signed or dated. E1 also confirmed that R3 and R4's Resident Orientations were not completed within 10 days after their arrival.	A2040		
A3030	Section 295.3030 Initial Health Eval for Dir Care and FS empl This Regulation is not met as evidenced by: Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees c) The initial health evaluation shall include the employee's immunization status. e) Each employee shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames: 1) The test must be completed no more than 90 days prior to the date of initial employment in the establishment; or	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A3030	Continued From page 8 2) The test must be commenced no more than ten days after the date of initial employment in the establishment. VIOLATION Based on interview and record review, the establishment failed to ensure employee immunizations were a part of the pre-employment health evaluations for four (E1, E2, E7, and E9) and failed to complete TB (tuberculin) testing timely and/or screening for four (E1, E2, E7 and E9) of five employees reviewed for health evaluations and TB testing. This could affect all 20 residents currently residing in the establishment. Findings include: The establishment's Tuberculosis Screening - (named establishment Family Member) policy, dated 04/2025, documents "Policy: Tuberculosis (TB) screening will be done at the time of hire and annually. Procedure: Initially: Upon hire all (Named establishment) Family Members must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis." The establishment's pre-employment health evaluations filed for E2 Health & Wellness Director, E3 Licensed Practical Nurse/LPN, E4 and E5 Caregivers, and E6 Cook do not include their immunization status. The establishment's Employee Phone list, dated 3/23/26, documents E6 was hired on 1/21/26. E6's personnel file documents E6's TB testing was initiated on 2/27/26.	A3030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A3030	Continued From page 9 On 4/29/26, at 2:30pm, E1 Executive Director confirmed that E2, E3, E4, E5, and E6's initial health evaluations do not include their immunization status and that E6's TB testing was initiated late. The establishment's Resident Roster, dated 4/28/26, documents 44 Assisted Living residents currently reside in the establishment.	A3030		
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 3 VIOLATION Based on interview and record review the establishment failed to ensure Service Plans were revised to include wound care for one (R3) of four residents reviewed for cares in a sample	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A4010	Continued From page 10 of five. Findings include: The establishment's Service Planning and Agreements policy, dated 03/2024, documents "Policy: A service plan will be developed and maintained for each resident that corresponds with their individual needs and preferences." "5. Resident's Service Plan/Level of Care shall be reviewed and updated every 180 days, or as needed, due to the Resident's needs or preferences." On 4/28/26, at 10:27am, R3 sat in R3's apartment. R3 has a bordered foam dressing to back and lateral side of his head dated 4/28/26. R3's Physician Order Sheet/POS dated 4/3/26, documents orders including but not limited to soaking the occipital wound, applying a fiber dressing then covering the wound with bordered foam daily. R3's current Service Plan does not include R3's wound or any wound care. On 4/29/26, at 12:03pm, E7 Health & Wellness Coordinator stated the following: The last update for (R3's) Service Plan was in December. (R3's) wound orders started in February. (R3's) Service Plan should have been updated with the change of condition.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by:	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 11 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 observation, interview and record review, the establishment failed to protect residents from resident-to-resident sexual abuse for two known cognitively impaired residents (R4 and R5) and failed to ensure resident privacy for one (R2) of five residents reviewed for resident rights in a sample of five. These failures resulted infringing upon other residents' privacy and dignity, have the potential to affect all 44 residents living in the establishment, and create a substantial probability of severe harm to a resident or residents. Findings include: 1. The establishment's Abuse, Neglect and Financial Exploitation, Prevention and Reporting policy, dated 02/2025, documents "Policy: (Named establishment) does not tolerate abuse,	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 12	A6000		

neglect and/or exploitation of residents by anyone and will do all within its powers to prevent it from occurring."

The establishment's undated Resident Bill of Rights policy documents "13. The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor."

During this investigation, on 4/28/26 and 4/29/26 during various times between 10:30am and 3:30pm, R4 and R5 were each separately independently ambulating throughout the building wearing wandering devices. When spoken to, neither R4 nor R5 were able to answer questions appropriately.

R4's current Physician Order Sheet documents R4 with diagnoses of Hypertension, Dementia and Insomnia.
R4's Mini Mental State Examination/MMSE, dated 12/26/25, documents R4's score as 12/30 (0-17=severe cognitive impairment).

R5's current Physician Order Sheet documents R5 with diagnoses of Alzheimer's Disease, Hypertension, and OSA (Obstructive Sleep Apnea).

R5's Mini Mental State Examination/MMSE, dated 3/13/26, documents R5's score as 10 (0-17=severe cognitive impairment).

On 4/28/26, at 10:40am, R2 sat in her apartment. R2 stated the following: (R4) who has dementia has a man friend (R5) who also has dementia. One day about two weeks ago they were sitting out in the main area, and (R5) had his hand up (R4's) shirt and was fondling (R4).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 13 On 4/29/26, at 11:05am, E3 Licensed Practical Nurse/LPN stated the following: "Some of the residents sitting in the dining room told me just today that (R4) was sitting in the foyer beside (R5) and (R4) lifted (R4's) top up twice." E3 confirmed that R4 does not wear a bra. "(E8 LPN) told me last week that (R4 and R5) were right there at the corner of resident rooms. (R5) had (R5's) hands on (R4's) breasts." "A CNA (Certified Nursing Assistant) said they were in the living room fireplace area and (R5) had (R5's) hands on (R4's) breasts up in (R4's) shirt." On 4/29/26, at 11:20am, E8 LPN stated the following: "I have witnessed twice, and it has progressively gotten worse. It started out that (R4 and R5) would be sitting on a couch together holding hands. Then, I hadn't seen it, but CNAs (Certified Nursing Assistants) would tell me that (R5) had (R4's) shirt up and (R5) was fondling (R4's) breasts. They brought (R4) to the nurse's station, and we had (R4) sit with us." "Last week, I was coming out of a corner resident room, and both (R4 and R5) were hiding and standing in that corner. (R5) had (R4's) shirt up again and (R5) was fondling her." "They are both very confused. A couple of days after that they were sitting on the couch in the TV (television) room. I came out of a resident's room and (R5) had (R4's) shirt up and (R5) was fondling (R4) again." "I consider it a form of abuse, and we should do something to preserve her dignity. We catch them all the time, one of them trying to go into the other's room. We know if that happens who knows what they might do? We are told to keep them out of each other's rooms. Their rooms are pretty close - they just have to walk across the dining room. It is kind of close and makes it hard to catch them with the short distance." E8 confirmed that E8 did not document these incidents and should have.	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 14 On 4/29/26, at 12:04pm, E1 Executive Director/ED stated the following: Both (R4 and R5) are cognitively impaired, and both are under the impression that the other one is their spouse from conversation with them. It's a lot of hand holding and just sitting with each other a lot. Any inappropriate things are stopped pretty quickly. I was told of an incident with (R4) pulling up (R4's) shirt and (R4) trying to get physical with (R5) and that it was stopped by a CNA (Certified Nursing Assistant). It may have been E9 CNA. This happened either last week or the week before. On 4/29/26, at 12:19pm, E7 Health & Wellness Coordinator stated the following: "I know (R5) will try to give (R4) a kiss or vice versa. I re-direct it and stop it. Residents have told me (R4) has lifted (R4's) shirt up. Staff have said that (R5) had (R4) in the corner over there lifting (R4's) shirt up and I can't remember exactly what they said." "In a way it is abuse because neither one can consent. (R5) calls (R4) his girlfriend. Neither one can consent based on their cognition." On 4/29/26 at 1:36pm, E9 Certified Nursing Assistant/CNA was asked by this writer if there is anything inappropriate going on between R4 and R5. E9 stated "It is every day. A couple weeks ago (R4) sat in the foyer with a pillow over her and she had her boobs hanging out and he was grabbing them. I grabbed the pillow, asked her to stand up, pulled her shirt down and moved her." "We were told to keep an eye on them and try to keep them separated, which is what we are doing but it is really not working. I have seen them together with her tongue down his throat (kissing). That was last week in the corner. I yelled (R4's) name and said, 'that is inappropriate' and said to get away. I would consider this abuse." "That same day I saw (R5) by the	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 15	A6000		

fireplace standing behind the couch. (R5) was messing with his pants and then (R4) came out from behind the couch. They go into the bathroom together and I do not know what they do in there. Or they try to sneak into each other's room. We caught (R4) in (R5's) room before."

2. The establishment's undated Resident Bill of Rights policy documents "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."

On 4/28/26, at 10:34am, R2 sat in her apartment. R2 complained that her next-door neighbor resident (R4) wanders into R2's room. R2 stated the following: "I didn't used to have to keep my door locked but now I do or (R4) will come in. One day (R4) was in my room while I was helping pass out the mail. (R4) was sitting at my table eating my piece of cake making a mess! (R4) has dementia. (R4) comes into my room a lot. It is annoying. They say that (R4) has the right to roam. What about my right to privacy in my own apartment?"

R2's Mini Mental State Examination/MMSE dated 4/17/26 documents a score of 29/30 which means R2 has no cognitive impairment.

On 4/28/26 and 4/29/26 at various times between 10am and 3:30pm R4 independently ambulated around the Assisted Living establishment and at times with a staff member, sat in the front foyer with other residents, was in activities, sat for meals in the dining room at a table with other residents, and sat in the nurse's office with staff present.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 16 On 4/28/26 and 4/29/26, at various times between 10:00am and 3:30pm, R5 independently ambulated around the building. On 4/29/26, at 11:20am, E8 LPN stated that we have gotten in report that one or both of them have wandered quite a bit at night. Some of the residents are mad that (R5 and/or R4) wander into their rooms so they keep their doors locked during the day. On 4/29/26, at 12:19pm, E7 Health & Wellness Coordinator stated that they (R4 and R5) both wander and have tried to go into other resident rooms not knowing if it is their room. E7 has heard residents complain about (R4) wandering into their rooms. On 4/29/26, at 1:36pm, E9 Certified Nursing Assistant/CNA stated the following: (R4) and (R5) both wander. Recently they have been going into resident rooms if they don't keep their doors locked. (R2) has said (R2) feels like (R2) is in prison because (R2) has to keep (R2's) door shut and locked. On 4/30/29, at 11:42am, E14 Caregiver stated the following: (R4) is a wanderer. No matter where we sit (R4) she gets up and walks throughout the building. (R5) is a wanderer too. So, we have to cue them and give a lot of verbal re-direction. A lot of residents have locked their doors because (R4) will go in. I have seen (R4) enter other resident rooms. R4 and R5's current Service Plans both document "Objective/Plan: The Care Team provides redirection when I am wandering or attempting to leave the building unassisted in order to help keep me safe. Frequency: Daily."	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6000	Continued From page 17 R5's also documents that R5 wanders throughout the building and into residents' rooms. The establishment's Resident Roster, dated 4/28/26, documents 44 Assisted Living residents currently reside in the establishment.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: 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. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. TYPE 1 VIOLATION	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6010	Continued From page 18 Based on observation, interview, and record review, the establishment failed to identify, report to State Agency, and investigate allegations of resident-to-resident sexual abuse and failed to follow their Abuse policy to notify residents' contact person or legal representative for two known cognitively impaired residents (R4 and R5) of five residents reviewed for abuse in a sample of five. These failures have the potential to affect all 44 residents living in the establishment and create a substantial probability of severe harm to a resident or residents. Findings include: The establishment's Abuse and Neglect policy, dated 02/205, documents "Policy: (Named establishment) Executive Directors and other health care professionals who have reasonable cause to believe that a Resident is being, or has been, abuse, neglected or exploited shall report the information immediately to the State licensure authority and Branch Support." "An internal investigation must be completed and documented on the Investigation Report form." "Reporting procedure will be to call: A report will be called to the State office(s) within 24 hours by the Executive Director." And "The resident's contact person or legal representative, when a report is made related to the resident, without identifying any confidential information." The establishment's State Reportables do not include any sexual abuse allegations regarding R4 and R5. R4's clinical record documents R4 has diagnoses including but not limited to dementia and is severely cognitively impaired.	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6010	Continued From page 19	A6010		

R5's clinical record documents R5 has diagnoses including but not limited to Alzheimer's Disease and is severely cognitively impaired.

On 4/28/26, at 10:40am, R2 sat in her apartment. R2 stated the following: (R4) who has dementia has a man friend (R5) who also has dementia. One day about two weeks ago they were sitting out in the main area, and (R5) had his hand up (R4's) shirt and was fondling (R4). I reported it to the staff (unsure of who). Staff are aware and they try to keep them apart.

On 4/29/26, at 11:20am, E8 LPN stated the following: "I have witnessed twice, and it has progressively gotten worse. It started out that (R4 and R5) would be sitting on a couch together holding hands. Then, I hadn't seen it, but CNAs (Certified Nursing Assistants) would tell me that (R5) had (R4's) shirt up and (R5) was fondling (R4's) breasts. They brought (R4) to the nurse's station, and we had (R4) sit with us. I told (E1 Executive Director/ED) each time. Last week, I was coming out of a corner resident room, and both (R4 and R5) were hiding and standing in that corner. (R5) had (R4's) shirt up again and (R5) was fondling her." "A couple of days after that they were sitting on the couch in the TV (television) room. I came out of a resident's room and (R5) had (R4's) shirt up and (R5) was fondling her again. Again, I took (R4) with me to the nurse's station. I reported it to (E1 ED). They (Management) are well aware.

On 4/29/26, at 12:04pm, E1 Executive Director/ED stated the following: Both (R4 and R5) are cognitively impaired. I was told of an incident last week or the week before about (R4) pulling up (R4's) shirt and (R4) trying to get physical with (R5). If I had known there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6010	Continued From page 20	A6010		

fondling it should have been reported to (State Agency). E1 confirmed E1 did not send any report to State Agency regarding R4 and R5.

On 4/29/26, at 12:19pm, E7 Health & Wellness Coordinator stated the following: "I know (R5) will try to give (R4) a kiss or vice versa ...Residents have told me (R4) has lifted her shirt up. Staff have said that (R5) had (R4) in the corner over there lifting (R4's) shirt up or can't remember exactly what they said ...I was a floor nurse at the time, and I mentioned that to (E1 ED). I believe we mentioned at the all-staff meetings that (R5) has tried to kiss (R4) and holding hands then also about them being in the corner. In a way it is abuse because neither one can consent.

On 4/29/26, at 12:50pm, E8 LPN confirmed that E8 immediately reported to E1 ED in E1's office. E8 stated the following: "It was also discussed at the daily staff meeting. (E1) knows. All of management know."

On 4/29/26 at 1:36pm, E9 Certified Nursing Assistant/CNA was asked by this writer if there is anything inappropriate going on between R4 and R5. E9 stated "It is every day. A couple weeks ago (R4) sat in the foyer with a pillow over her and she had her boobs hanging out and he was grabbing them. I grabbed the pillow, asked her to stand up, pulled her shirt down and moved her. I went and told the nurses. I also told (E1 Executive Director)." "I have seen them together with her tongue down his throat (kissing). That was last week in the corner. I yelled (R4's) name and said, 'that is inappropriate' and said to get away. After I separate them, I go and report to whom I find first - it was one of the nurses. I would consider this abuse." "That same day I saw (R5) by the fireplace standing behind the couch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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
A6010	Continued From page 21	A6010		

(R5) was messing with his pants and then (R4) came out from behind the couch. They go into the bathroom together and I do not know what they do in there. Or they try to sneak into each other's room. We caught (R4) in (R5's) room before."

On 4/29/26, at 2:22pm, E1 Executive Director/ED confirmed E1 does not have any notes or investigation for these allegations.

On 4/30/26, at 12:23pm, Z1 R4's Power of Attorney/POA/family member stated the following: Z1 has not had anyone state that (R4) is having issues with any residents. Z1 has not been made aware of any concerns. Z1 denies knowing of any behaviors by R4 and stated "Nothing inappropriate."

On 4/30/26, at 12:40pm, Z2 R5's Power of Attorney/POA/family member stated that no one has brought any concerns to Z2 about R5 and a female resident (R4). Z2 just had a meeting with another family member and E1 ED yesterday and it was not talked about.

The establishment's Resident Roster, dated 4/28/26, documents 44 Assisted Living residents currently reside in the establishment.