STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510064	A. BUILDING: _____ B. WING _____	C 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - ROCKFORD HOUSE	960 N MULFORD RD ROCKFORD, IL 61107

(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 Incidents IL 201716 and IL 201713. IL 201716 - 295.6000 a) 13) IL 201713 - 295.2050 a) and 295.6000 a) 13)	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 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. VIOLATION Based on record review and interviews, the establishment failed to report a resident elopement for one of two sampled residents. (R1) Findings include: On 5/11/26 at 1:28 P.M., E5 (Administrative Assistant) stated that on the morning of 4/3/26, E5 was coming into work when she noticed R1 was outside in the side parking lot, trying to get into E3's (LPN) car. E5 stated she was able to redirect R1 back into the facility without difficulty.	A2050		

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A2050	Continued From page 1 Review of R1's incident reports provided by E2 (Health and Wellness Director) noted elopements on 4/16/26 and 5/2/26. No incident report was noted for the elopement on 4/3/26. On 5/10/26 at 2:05 P.M., E2 stated that R1 did elope from the facility on 4/3/26, but the facility failed to report this incident to I.D.P.H. as required.	A2050		
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 record review, interviews, and observation the establishment neglected to prevent one of two sampled residents from eloping from the facility. (R1) This failure had the probability to cause serious harm or even death. Based on record review and interviews, the establishment neglected to provide supervision	A6000		

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A6000	Continued From page 2	A6000		

during toileting in order to prevent falls for one of two sampled residents. (R2) This failure resulted in R2 sustaining fractured back vertebrae.

Findings include:

1) R1's service plan that R1 was admitted to the establishment on 12/30/20. Service plan notes that R1 has advanced Dementia with poor safety awareness and poor judgement. Service plan notes that R1 is a high risk for eloping from the facility. Service plan notes that R1 wears a electronic device that will alarm if he exits the facility unsupervised.

R1's progress notes and incident reports note that R1 eloped from the facility on 4/3/26, 4/16/26, and 5/2/26. Incident reports for the elopements on 4/16/26 and 5/2/26 noted that the electronic device alarmed and staff responded immediately and were able to get to R1 quickly and return him inside without any difficulty. No incident report was completed for the elopement on 4/3/26.

On 5/11/26 at 1:28 P.M., E5 (Administrative Assistant) stated that she happened to be coming into work on 4/3/26 around 7:30 A.M., when she noticed R1 was outside in the side parking area, trying to get into E3's (LPN) car. R1 was confused saying he needed to get to school. E5 stated she was able to redirect R1 back into the facility without an issues. E5 stated that there were no alarms going off and staff were unaware that R1 had gotten outside unsupervised.

On 5/10/26 at 2:05 P.M., E2 (Health and Wellness Director) confirmed that R1 did get out of the facility unsupervised on 4/3/26 and was attempting to get into E3's car. E2 was unable to

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A6000	Continued From page 3	A6000		

provide a reason that the alarms were not sounding to let staff know that R1 had eloped out of the facility.

On 5/10/26 at 12:35 P.M., E3 stated that she was working on 4/3/26 when R1 eloped from the facility. E3 stated that staff did not know that R1 had eloped until E5 brought R1 back inside and informed E3 of the incident.

Observations on 5/10/26 noted that the street directly in front of the establishment is a four lane road with a 45 mile an hour speed limit.

2) R2's service plan notes R2 was admitted to the establishment on 12/3/25 and is a high risk for falls. R2's service plan notes that R2 requires staff assistance for mobility, transferring, and toileting. R2's service plan notes that R2 has poor safety awareness, poor judgment, and will attempt to get up on his own.

R2's incident report dated 4/28/29 at 6:00 P.M., reads, "Resident (R2) was found by caregiver on the floor next to his toilet. Complaints of low back pain and right leg pain. Hospice evaluated and sent out 911 to (Local Hospital) for evaluation. Admitted for a fracture in his back."

On 5/11/26 at 6:05 P.M., Z1 (R2's Wife) stated that R2 has Dementia and Parkinson's. Z1 stated she does not understand why staff would leave R2 unsupervised on the toilet when he is confused and such a high fall risk. Z1 stated that R2 is still in the hospital with a fractured back and two broken ribs. He is getting therapy there.

On 5/10/26 at 2:05 P.M., E2 (Health and Wellness Director) stated that on 4/28/26 at approximately 6:00 P.M.. a caregiver had

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A6000	Continued From page 4 assisted R2 onto the toilet. The caregiver left R2 unattended. When the caregiver returned to R2's bathroom, R2 was on the floor complaining of lower back and leg pain. R2 was sent to the hospital for evaluation, where it was determined that R2 had fractured his back. E2 stated that R2 was not safe to be left alone on the toilet due to his poor safety awareness. On 5/10/26 at 12:35 P.M., E3 (LPN) stated that R2 is a high fall risk and should not be left alone on the toilet unsupervised. E3 stated that R2's wife had informed them that R2 has sustained compression fractures in his back.	A6000		