STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106270	A. BUILDING: _____ B. WING _____	C 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF GURNEE	301 S HUNT CLUB ROAD GURNEE, IL 60031

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A 000	Initial Comment Facility reported incident /IL201844 of April 24, 2026. The following violations were cited: 1.Section 295.3000 a) h) 1) 2) 3) 7) 2. Section 295.6000 a)13)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a, h (1) (2)(3)(7) a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services; 2) Services established in each resident's service plan. 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; 7) Any optional services to be provided by the establishment as stated in the service plan.	A3000		

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A3000	Continued From page 1 These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Employ skilled staff to appropriately care for residents. 2. Implement the plan of care, as identified in the service plan. a. Assist residents with toileting. b. Provide proper hygiene during incontinence care. 3. Maintain R1's dignity by keeping R1 clean and dry. 4. Provide supervision and assistance, as requested by the caregiver. These failures resulted in an incident of: 1. Verbal abuse from E3/caregiver on April 24, 2026. 2. Neglect by E3 and E4 (RN) on April 24, 2026. Neglect by failing to provide incontinence care and hygiene to R1 to promote comfort. R1 was left in urine-soaked clothing for over 1 hour and was laid back into a bed with urine-soaked linens. This failure creates the substantial probability of severe harm to a resident or residents. This applies to one of one (R1) reviewed for abuse and neglect. The findings include: R1 moved into the establishment on January 22, 2024, with diagnoses to include dementia-related psychosis, benign prostatic hypertrophy, and chronic obstructive pulmonary disease. On May 20, 2026, at 8:30 AM, E1 (Executive	A3000		

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A3000	Continued From page 2	A3000		

Director) described R1 with cognitive deficit, and requiring a one to two staff assist with activities of daily living.

On May 22, 2026, at 11:00 AM, E2 (Health and Wellness Director/LPN) stated, "[R1] ambulates with an ambulation device (walker) with standby assistance from the staff. R1 has periods of aggression, history of falls that triggers safety checks." A fall mat was placed as intervention for fall prevention which was implemented on July 3, 2025. E2 also disclosed that R1 has "incontinence issues throughout the night and requires rounds every two hours."

I. A reportable incident submitted to the Department related to an incident on April 24, 2026, identified as verbal abuse by E3 (caregiver) and neglect by E3 and E4 (RN) on R1. The incident was captured through a authorized electronic monitoring device in R1's room.

On May 22, 2026, at 1:04 PM, E1 (Executive Director) and E2 (Health and Wellness Director/LPN) discussed the video recording presented to them on the flash drive. The incident occurred during the overnight shift on April 24, 2026. This recording started at 3:33 AM and ended at 5:31 AM. E1 and E2 provided a summary of the event and said that in the video, "E3 went into R1's room and found R1 soaked and wet with urine. E3 was nice at the beginning of the video, then you can hear the verbal abuse start. E3 was not speaking right to R1. E3 was very condescending. It disgusted me to watch and hear what E3 said to R1. E3 uses the words like, 'What's your f***ing problem?' After seeing R1, E3 left the room, then came back. R1 was soaked with urine, including the bed, yet R1 was put back to bed with the wet sheet and shirt."

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A3000	Continued From page 3 E2 said, "That's a long hour that R1 was wearing the wet sweatpants and R1's shirt was soaked too. It's probably up to, I would say like up on my bra line. No, they didn't change the sheet, and they put R1 back on that wet bed. They (E3 and E5/caregiver) took a towel, laid it on top of the sheet instead of stripping the linen which is what they should have done before putting R1 back to bed." II. R1's undated service plan addresses R1's toileting needs as follows: 1. Help with bathroom activities and hygiene. 2. Assistance with nighttime toileting and care. 3. Caregivers are to ensure R1 is being escorted to the restroom in his toileting schedule to assist with incontinence. 4. Provide proper hygiene, skin remains clean and dry. 5. Confirm R1 feels clean and comfortable. 6. Respond promptly to toileting needs to reduce fall risk. These care services were not followed. This finding was discussed and confirmed by both E1 and E2 on May 22, 2026, at 3:18 PM, E2 stated, "Yes, I have a detailed toileting schedule for R1. Yes, the staff need to clean them (residents) up. Obviously that night it didn't happen." III. E4/RN written statement dated April 24, 2026, explained that R1 sustained an unwitnessed fall. E3 (caregiver assigned) called and notified E4 that she (E3) needed assistance and was unable to lift R1 by herself ... R1 managed to reach the bed remote and lifted the bed about a foot off the ground ... R1 continued to attempt to get out of bed."	A3000		

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A3000	Continued From page 4 June 2, 2026, at 9:55 AM, E2 (Health and Wellness Director/LPN) described E4 and said, "E4 interviewed very well (started on November 2025). The only thing that we really had to worry about is E4 was not able to lift people, so we always had to make sure we had two people that can lift. E4's disability doesn't hinder E4 from doing assessments. It doesn't hinder E4 from doing med pass or documentation; it might take a little bit longer but E4 was doing fine!" E2 continued and said, "When there is a nurse in the building and a resident was found on the floor, yes they (nurses) should be doing their assessment, whether they rolled over or fell, you know, I go in assess them, that's nursing 101!" On May 31, 2026, at 8:00 AM (via phone interview), E4 stated, "I didn't go because I am disabled. I use a cane to walk, and I am a new nurse. As a new nurse with limited experience, I didn't know I had to go and see the resident. This is my first job as a nurse but now I know. I've learned as far as you know."	A3000		
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	A6000		

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A6000	Continued From page 5 the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Maintain the rights of the residents to be free from abuse and neglect. 2. Maintain residents' dignity by providing the necessary care and appropriate services during incontinence care. 3. Provide clean sheets and unsoiled clothing to promote comfort. 4. Provide assistance and supervision to caregivers as requested. 5. Respect R1's request to remove a blanket and to hold the bed remote control. These failures resulted in: 1. R1 being verbally abused by E3 (caregiver) during care on April 24, 2026. 2. Neglect, for the following reasons: a. R1 was left wearing clothing that was saturated with urine, from below the armpit down to the thigh, for 1 hour and 18 minutes (at 3:33 AM through 4:51 AM). b. A new disposable adult incontinence brief was applied without drying R1's skin and without providing incontinence care to R1. c. R1 was put back into bed, without changing the soiled linens, and still wearing the urine-soaked shirt. 3. E4 (nurse) failed to respond and assess the situation, as requested by the caregiver (E3). This failure creates the substantial probability of severe harm to a resident or residents.	A6000		

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A6000	Continued From page 6 This applies to one of one resident reviewed for abuse and neglect (R1). The findings include: I. The reportable incident dated April 24, 2026, was submitted to the Department related to an employee-to-resident abuse and resident's rights issue. The incident was captured from an authorized electronic monitoring device installed in R1's room. R1's family member made a copy of the recording and saved it to a flash drive that was presented to the community. On May 20, 2026, at 9:18 AM, E1 (Executive Director) explained, "R1 has a camera in the room. Upon receiving the drive from the family, we (with E2/ Health and Wellness Director/LPN) watched the video. This happened on the overnight shift. On the video it shows how E3 (assigned caregiver) verbally abuses R1. E3 went into R1's room and found R1 soaked and wet with urine. E3 was nice at the beginning of the video, then you can hear the verbal abuse start. E3 was not speaking right to R1. E3 was very condescending. It disgusted me to watch and hear what E3 said to R1. E3 used words like, 'What's your f***ing problem?' After seeing R1, E3 left the room, then came back. R1 was soaked with urine, including the bed [being soaked with urine], yet R1 was put back into bed with the wet sheet and shirt. I suspended E3 at first. I tried to call E3 to discuss the incident. E3 didn't call back. E3 didn't care. I called again but E3 never called back. Yes, everybody knows there's a camera in R1's room." On May 26, 2026, at 12:18 PM, the issue of abuse and neglect was discussed with E1. E1 confirmed and stated, "Yes, we considered it	A6000		

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A6000	Continued From page 7	A6000		

verbal abuse but yes, it could be neglect too. The way E3 spoke to R1 ... it was unacceptable. E3 had a very short tone, not friendly, tempered and not kind at all. E3 was saying, 'What's the problem? We're not going to do this,' and 'What's your f***ing problem?' R1's shirt and bedding was soaked and all; they didn't change R1. Yes, the nurse (E4) was informed by E3 and E5 (assisted living caregiver) about the situation regarding R1 but E4 never came to check on what was going on. E3 was told R1 was on the floor. E4 could have evaluated the problem and gave E3 directions. E4 never went and that upset me too. E4 never set foot in R1's room!" When asked, E4 said 'I trusted my caregivers!' E4 should have gone to evaluate the situation and to make sure everyone was okay!"

II. The establishment questionnaire regarding the incident on April 24, 2026, documented that E4 was informed by the caregivers (E3 and E5) that R1 was found on the floor, yet E4 did not go and assess the incident. E4 answered and said, "I had to stay in MB [memory care unit]. I didn't think it was that serious," without conducting an assessment of R1. When E4 was asked if they understood that if a staff member failed to follow the proper procedures, it would be considered neglect. E4 said, "Yes."

III. On May 31, 2026, at 8:00 AM (via phone interview), E4 recounted the events during the night of April 24, 2026. E4 explained, "I received a call from E3 regarding the situation with R1 being on the floor and wet with urine. Yes, the caregiver asked me to assess. No, I did not go myself to see what was going on because I was in the memory care area [R1 resides in the Assisted Living section of the establishment] and I was told we were not supposed to leave the area (unit)

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A6000	Continued From page 8	A6000		

without any supervision. I was the only nurse. Yes, I was told that if the resident is found on the floor, it's considered a fall."

IV. The authorized electronic monitoring device/camera recorded on April 24, 2026, started at 3:33 AM through 5:31 AM (1 hour and 58 minutes) show that at 3:33 AM, R1 is seen lying partially in bed, with both feet on the ground, trying to get up from bed. As R1 turned more onto their right side to get out of bed, R1's pants, shirt, and disposable bed pad becomes visible to the authorized electronic monitoring device/camera, and is clearly soaked with urine. At 4:00 AM, R1's urine-soaked pants were removed with the assistance of E5 (caregiver). E3 is heard saying, "[R1] is the most difficult resident. This is the part of the job that I do not like. It makes me sweat." At 4:04 AM, R1's saturated adult disposable adult incontinence brief was removed and thrown onto the floor. A new diaper was applied. R1 was not provided with incontinence care (e.g., drying or cleansing of the skin). As the staff was turning R1, the bed was noted to have a circular wet area on the sheet. The soiled linens were not changed; a towel was placed on top of the soaked wet area and R1 was assisted back on the wet bed.

At 4:45 AM, E3 came into the room and found R1 lying on the right side with both feet resting on the pillow on top of the floor mattress. E3 said to R1, "You crawled again? This is hard man. Did you do this?" As R1 was repositioned back into bed by E3, R1 made audible expressions of acute pain and vocalized, "Stop, stop." E3 proceeded to complete the task.
At 4:57 AM, R1's shirt was changed. R1 told E3, "Take the blanket off me, I don't want it!" E3 did not comply with R1's request.
At 5:10 AM, E3 came into R1's room. R1 was

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A6000	Continued From page 9	A6000		

found holding the bed remote. E3 asked R1 "Did you figure that [the remote] out yet?" E3 grabbed the remote away from R1. R1 said, "Give me that." and E3 responded, "No ... We are going to talk about this. Why you so mean? What's with the attitude. Do you have an attitude?" R1 said, "Not as much as you." E3 responded, "Why are you on the floor then? Let me know when you wanna talk nice to me ... Would you like to get off the floor? Let me know when you're done talking crap, because you're not gonna do this. I got a lot of patience ... [E3 and R1 unintelligibly argue about the remote] ... and I'm supposed to be a machine and pick people off the floor. Just lay down. Lay down. That's what you want. Let's talk about it. You wanna get up off the floor?"
At 5:12 AM, E3 was holding the cord of the bed remote and R1 tried to pull the cord. E3 pushed R1's hand away and stated, "Stop touching me or you gonna hurt yourself." R1 was not visibly touching E3. E3 would not give R3 the remote and kept grabbing it away from R1 and said, "Stop. What is wrong with you today man? You're gonna break your face because you're on the floor." E3 finally gave the remote to R1. R1 held the remote quietly. E3 said, "Ok I'm gonna call the nurse." E3 then tugged the remote back from R1 and went back on the phone. E3 threw the remote on the ground, which R1 picked up. E3, on the phone with E4, stated "[R1's] on the floor, cursing me out, playing with the remote."

V. The recording shows E4 was notified at least twice, at 4:06 AM and 5:12 AM. E3 was waiting for E4 to assess the situation and provide guidance; E4 never came to evaluate R1.

On May 31, 2026, at 8:00 AM (via phone interview), E4 stated, "I didn't go because I am disabled. I use a cane to walk and I am a new

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A6000	Continued From page 10 nurse. As a new nurse with limited experience, I didn't know I had to go and see the resident. This is my first job as a nurse but now I know. I've learned as far as you know."	A6000		