

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/07/2025
NAME OF PROVIDER OR SUPPLIER BICKFORD - BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 14 HEARTLAND DR BLOOMINGTON, IL 61704		
(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 Complaint Investigation #2460385/IL182955	A 000			
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Section 295.4000 Physician's Assessment b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. Type 3 Violation Based on interview and record review, the establishment failed to obtain annual physicina assessments for three of three residents (R1, R2 and R3) reviewed for physician assessmnts in a sample of six. Findings include: 1. R1's face sheet documents she moved into the establishment on 10-21-21. R1's most current physician assessment found is dated 11-16-23, about 13 months overdue. 2. R2's face sheet documents she moved into the establishment on 6-2-21. R2's most current physician assessment found is dated 10-9-23, about 14 months overdue. 3. R3's face sheet documents she moved into the establishment on 4-2-21.	A4000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A4000	Continued From page 1 R3's most current physician assessment found is dated 10-9-23, about 14 months overdue. On 1-3-23 at 11:45 am, E1 (Executive Director) stated the above physician assessments were the most current that she could find.	A4000		
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 a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) g) If an establishment accepts any individuals with cognitive impairments that prevent them from safely evacuating the establishment independently, sufficient staff members shall be present and awake 24 hours a day to assist in evacuation. 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; Violation	A4060		

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A4060	Continued From page 2 Based on observation, interview and record review, the establishment failed to have sufficient staff on duty in their alzheimer's unit as detailed in their Alzheimer's Special Care Disclosure. This has the potential to affect all 13 residents currently residing in the Alzheimer's unit. Findings include: The establishment Special Care Disclosure dated 5-2018 documents "There will be a minimum staff to resident ratio of 1.8 on the day and evening shifts and 1:12 on the night shift. This ratio will include a minimum of 1 licensed nurse for each shift.) On 1-3-24 at 4:30 am, there were three caregivers on duty in the establishment and one nurse (E5). E5 stated she was not acting as the nurse but as a caregiver as she was new and was orientating to the shift. The establishment provided staff time worked report from 12-7-24 to 12-27-24 was reviewed. Day shift identified as 6:00 am to 2:00 pm, second shift 2:00 pm to 10:00 pm and night shift as 10:00 pm to 6:00 am. On 12-7, 12-8, 12-9, 12-14, and 12-22-24, there was no nurse on duty in the establishment during the night shift. On 12-11, 12-12, 12-17, 12-20, 12-21, and 12-23 through 12-27-24, there was no nurse on duty for the nights shift and approximately half the second shift. On 12-17-24, there was no nurse documented on duty from 7:00 am to 10:00 am, part of the evening shift and none for the night shift. Six days were spot checked on the staff time worked report for all staff worked. On 12-7-24, there are only two staff clocked in as working the	A4060		

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A4060	Continued From page 3 night shift for the entire establishment. On 12-23-24, there were three staff recorded for the day shift, one nurse and two caregivers. One caregiver working on for the assisted living side and one for the memory care side and one nurse passing medications and working both sides. On 12-20-24, there were two caregivers on duty from 6:30 am until 7:08 am, and then only one caregiver for the establishment until the nurse came in at 7:33 am. On 1-2-24 at 1:10 pm E4 (CNA/Certified Nursing Assistant), stated there have been several times she has been one of two caregivers working at the establishment with no nurse on duty. E4 stated one day recently, she was the only caregiver present in the establishment until the nurse came in after about an hour. E4 stated it is not safe to work with so little staff. On 1-3-24 at 5:00 am, E10 (CNA) stated there are at least three residents on the memory care unit who need the assistance of two caregivers for transfers and some care with one using a mechanical lift. E10 stated there are at least two residents on the assisted living side who require the assistance of two staff for care. On 1-3-24 at 6:10 am, E7 and E9 (CNAs) stated they have worked the day shift on the memory care unit as the only caregiver on many occasions. Both stated it is not possible to get all the resident's care completed with just one caregiver. Both stated this has happened "a lot" recently. Both stated sometimes a non caregiver/nurse will be told to come and sit on the unit as another staff member but they are not able to help with patient care. On 1-2-24 at 2:00 pm, E2 (Acting Health and Wellness Director) stated they always have a day	A4060		

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A4060	Continued From page 4 nurse and have a night nurse working about four nights a week. The nurse on duty covers both the memory care unit and the assisted living side. The establishment provided census dated 1-2-24 documents there are a total of 51 residents residing in the establishment of which 13 reside on the memory care unit.	A4060			
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 2) Storing and controlling medication; Violation Based on observation, interview and record review, the establishment failed to accurately control/count their scheduled II medications. This has the potential to affect all six residents on the assisted living side receiving narcotic medications. Findings include: On 1-2-25 at 2:20 pm, E2 (Acting Health and	A5000			

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A5000	Continued From page 5 Wellness Director) completed a narcotic count for six residents receiving controlled narcotic medications on the AL (Assisted Living) side of the building. E2 counted the medications and then entered the amount into the computer system. When done, the computer displayed that the counts for R7's Tramadol 50 mg, R8's Norco 5/325 mg, and R9's Norco 5/325 and Tramadol 50 mg were all off. The computer system did not display what the system count was. E2 stated he could not access that information without another nurse present to access the computer. E2 stated that they should be doing controlled substance counts at the beginning and end of each shift. E2 stated they have not been doing this consistently. E2 was unable to say if there had been drug diversion or just mistaken documemtation. On 1-3-25 at 9:40 am, E1 (Executive Director) presented a "Shift Change History Log" documenting three controlled substance counts for December 19, 2024 and two for January 2, 2025 on of which one was observed by surveyor. Three months of counts were requested several times but only one was received. All three counts showed four failed "items." At 10:20 am, E2 (Acting Health and Wellness Director) verified those were all the controlled substance reports for 30 days as that is all he could run. On 1-7-25, a shift Change Detail Report was presented for shifts on 11-25 and 11-27-24 with no reconcilliation of the controlled substances present. The facility's "Medication and Nursing policy dated January of 2021 documents "Accountability of Medication and Controlled substances. A system shall be maintained that ensure Schedule	A5000			

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A5000	Continued From page 6 II controlled substances or as determined by (nursing management) in accordance with federal and state law and regulations." "Controlled substances shall be counted at the end of each shift and documented by each (staff member) involved in the process, per state regulations."	A5000			