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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE - ST CHARLES	2875 CAMPTON RD SAINT CHARLES, IL 60175

(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 Facility Reported Incident IL197453/ 9/9/25- substantiated IL197555/ 9/5/25-substantiated Violations 295.2050 295.4010 295.5000	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation 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. These requirements was not met as evidenced by:	A2050		

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A2050	Continued From page 1	A2050		

Based on interview and record review, the establishment failed to report a significant incident(s) within 24 hours for 4 of 4 residents (R1, R2, R3, R5) reviewed for accidents and incidents in the sample of 5.

The findings include:

On 10/6/25 at 10:43 AM, R3, R1's husband, said he knew there were antinausea pills they had in a drawer (in their apartment). R3 said R1 took the pills in a suicide gesture, she knew what she was doing, and she has had suicide gestures before. R3 said they are cries for help, and she got plenty of attention with this one. R3 said R1 got a trip to the ER (emergency room) at the hospital, and within 24 hours she was transferred to a mental health hospital for about a week and a half.

On 10/6/25 at 1:47 PM, E2 said around 7:00 AM on 9/9/25, R3 came to her and told her that he saw R1 ingesting medications. E2 said R1 fully admitted that she took 10 prescription antinausea pills (Zofran). E2 said R1 went to the hospital and was later transferred to a behavioral health facility.

R1's Progress notes dated 9/9/25 at 11:52 AM show R1's husband, R3, reported to E2, Health and Wellness Director, at 7:00 AM he observed R1 ingest 10 pills. R3 gave E2 an empty medication bottle. 911 was immediately called and R1 was transported to the hospital. R1 said she was depressed and can't stand it anymore.

R1's Assisted Living and Shared Housing Incident and Accident Report for IDPH regarding R1's medication ingestion on 9/9/25 has a fax confirmation dated 9/10/25 at 10:58 AM.

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A2050	Continued From page 2 R2's Progress notes dated 9/5/25 at 10:01 PM show R2 was found on the floor at 8:00 PM between her bed and the wall with a bleeding wound to her right forehead. R2 was sent to the hospital. R2's After Visit Summary from the emergency department dated 9/5/25 shows R2 was seen for a fall and diagnosed with a nose fracture. On 10/6/25 at 1:47 PM, E2 said R2 broke her nose (on 9/5/25). R2's Assisted Living and Shared Housing Incident and Accident Report for IDPH regarding R2's fall with resulting nasal fracture has a fax confirmation dated 9/9/25 at 1:07 PM. On 10/6/25 at 10:43 AM, R3 said he has had a couple of falls in the bathroom when he was washing up and one of his legs gave way and he went down. R3 said after the second fall in two weeks, he went to the ER, got a referral from them to a lady in the neurosurgical group and saw a NP (nurse practitioner) over there. R3 said he got some recommendations from them; PT (physical therapy) for his back, or maybe a shot for his back to diminish the pain so he wouldn't fall. R3 said he has prostate cancer, and it has gone to his back. R3's Progress Notes dated 9/7/25 at 4:17 PM show R3 was found on the bathroom floor at 7:08 AM that morning and was sent to the emergency room. R3's After Visit Summary dated 9/7/25 from the ER shows R3 was seen for a fall and diagnosed with a fall on same level from slipping, tripping or stumbling and low back pain radiating to left leg and prostate cancer metastatic to multiple sites. The instructions direct R3 to follow up with neurosurgery as soon as possible.	A2050		

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A2050	Continued From page 3 The establishment was unable to provide an Assisted Living and Shared Housing Incident and Accident Report for IDPH regarding R3's fall and subsequent ER visit from 9/7/25. R5's Progress notes dated 8/9/25 at 10:46 PM show R5 was found on the floor at 8:55 PM. R5 said she fell hard on her back and hit her head when she slid off her bed. R5 screamed in pain due to left hip pain. 911 was called and R5 was sent to the hospital. R5's Progress notes dated 10/3/25 at 11:05 PM show R5 was found on the floor at 7:40 PM. R5 said she slid off her bed and may have hit her head. R5 was sent out to the emergency department. R5's hospital records show R5 was admitted on 8/9/25 with a reason for admission of "unable to ambulate." R5 had presented to the ER after she had an unwitnessed fall with complaints of left buttock pain. R5 was found to have a fracture of her sacrum. R5's After Visit Summary dated 10/3/25 from the ER shows R5 was seen for a fall and diagnosed with a head injury, strain of neck muscle, and hip contusion. R5's Assisted Living and Shared Housing Incident and Accident Report for IDPH regarding R5's fall with resulting hospitalization and sacral fracture has a fax confirmation dated 8/11/25 at 2:34 PM. The establishment was unable to provide an Assisted Living and Shared Housing Incident and Accident Report for IDPH regarding R5's fall and subsequent ER visit from 10/3/25. On 10/6/25 at 1:47 PM, E2 said she does the reporting to the state. E2 said she reports bruising, falls, any elopements, choking, and an incident such as R1's (medication ingestion). E2 said she is supposed to send the report to the	A2050		

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A2050	Continued From page 4 state within 24 hours of an incident. The facility's Incident and Accident State Reporting (revised 12/2024) shows the "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 ...Summit incident or accident within 24 hours to IDPH through electronic state database"	A2050		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan 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). These requirements was not met as evidenced by: Based on interview and record review, the establishment failed to revise a service plan following a fall for 3 of 4 residents (R2, R3, R5) reviewed for falls in the sample of 5. This failure has the substantial probability to cause harm to the resident.	A4010		

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A4010	Continued From page 5 The findings include: 1) R2's Progress notes dated 9/5/25 at 3:02 AM show R2 was found on the floor at 2:00 AM in front of her bed. R2 had a skin tear to her right elbow and right wrist with bruising to her right shoulder. R2's Progress notes dated 9/5/25 at 10:01 PM show R2 was found on the floor at 8:00 PM between her bed and the wall with a bleeding wound to her right forehead. R2 was sent to the hospital. R2's most recent Service Plan signed by the Health and Wellness Director, E2, on 10/6/25 does not show any updates or additional interventions regarding fall prevention after the falls described in the previous paragraph. R2's After Visit Summary from the emergency department dated 9/5/25 shows R2 was seen for a fall and diagnosed with a nose fracture. On 10/6/25 at 1:47 PM, E2 said R2 broke her nose (on 9/5/25). E2 said they updated her service plan after she fell on 8/17/25 and 8/18/25, but there was not an update after she fell on 9/5/25. 2) R3's Progress notes dated 1/10/25 at 11:19 PM show R3 reported he had fallen out of bed during his nap that day around 3:00 PM. R3's Progress notes dated 8/28/25 at 8:54 PM show R3 called for assistance at 8:45 PM and was found on the floor. R3 said he had lost his balance and had fallen to his knees and was unable to get himself off the floor.	A4010		

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A4010	Continued From page 6 R3's Progress Notes dated 9/7/25 at 4:17 PM show R3 was found on the bathroom floor at 7:08 AM that morning and was sent to the emergency room. R3's most recent Service Plan signed by the Health and Wellness Director, E2, on 5/4/25 shows R3 has had "no recent fall" under Mobility. No updates or additional fall prevention interventions were added after the aforementioned falls. 3) R5's Progress notes dated 8/9/25 at 10:46 PM show R5 was found on the floor of her apartment at 2:15 PM. R5 said she was in her wheelchair and tried to walk and fell on the ground. At 8:55 PM that same day, R5 was found on the floor. R5 said she fell hard on her back and hit her head when she slid off her bed. R5 screamed in pain due to left hip pain. 911 was called and R5 was sent to the hospital. R5's Progress notes dated 9/26/25 at 2:59 PM show R5 was found on the floor in front of her bed and wheelchair. R5's Progress notes dated 9/26/25 at 10:53 PM show R5 was found on her bathroom floor at 9:30 PM after she fell. R5's Progress notes dated 10/3/25 at 7:02 PM show R5 was found on the floor at 6:40 PM with a bruise to her left, lateral knee, and a skin tear on her left knee. R5's Progress notes dated 10/3/25 at 11:05 PM show R5 was found on the floor at 7:40 PM. R5 said she slid off her bed and may have hit her head. R5 was sent out to the emergency department.	A4010		

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A4010	Continued From page 7 R5's most recent Service Plan signed by the Health and Wellness Director, E2, on 6/5/25 show her fall prevention interventions have not been updated since she fell on 11/22/24. On 10/6/25 at 1:47 PM, E2 said she is responsible to complete the resident service plans. E2 said they are updated after a hospitalization, any change in condition, when they go on hospice, after any fall regardless of injury status, and routinely every 6 months. The establishment's Service Planning and Agreements Policy (revised 3/24) shows residents' service plan shall be reviewed and updated as needed and significant changes shall be reflected. Staff shall provide services according to the information contained in the Service Plan	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed	A5000		

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A5000	Continued From page 8	A5000		

staff may not administer any medication.
(Section 70 of the Act)

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;
4) Assisting in the self-administration of medication and medication administration, as applicable; and

These requirements was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a resident's medications were administered by a licensed healthcare professional and failed to ensure medications were stored in a medication room for 1 of 5 residents reviewed for medication administration and storage in the sample of 5. This failure has the substantial probability to cause harm to the resident.

The findings include:

On 10/6/25 at 10:43 AM, R3, R1's husband, said he knew there were antinausea pills they had in a drawer (in their apartment) and he would give them to her when she complained of nausea. R3 said R1 took the pills in a suicide gesture, she knew what she was doing, and she has had suicide gestures before. R3 said they are cries for help, and she got plenty of attention with this one. R3 said R1 got a trip to the ER (emergency room) at the hospital, and within 24 hours she was transferred to a mental health hospital for about a

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A5000	Continued From page 9	A5000		

week and a half before she returned to the building, but she is no longer living in their apartment. R3 said the head of nursing came in and took all the pill bottles out of their apartment. R3 said the medications in their room were put aside for R1 to use periodically. R3 said the nurses were responsible to give her most of her medications other than her Xanax, which he was giving to R1 on an as needed basis, and another sedative medication R1 was to take before she went in to get pain injections. R3 said he used to have Tylenol, ibuprofen and aspirin in his apartment before the nurses came and took them. R3 said R1 has frontotemporal dementia, she is getting progressively more confused, and her short-term memory is pretty well "cashed." R3 said the agreement when they moved in was for the nurses to administer R1's medications.

On 10/6/26 at 11:39 AM, R1 said no one here gets a chance to do their own medications; the nurses give them to her. R1 said she took four antinausea pills at one time. R1 said they were in her apartment. R1 said she keeps some medications in her apartment but doesn't know what they are.

On 10/6/25 at 11:49 AM, E4, Certified Nursing Assistant (CNA), accompanied surveyor to R1's room. Hemorrhoid cream, hydrocortisone cream and eye relief wash were all noted in R1's bathroom.

On 10/6/25 at 1:47 PM, E2, Health and Wellness Director, said around 7:00 AM on 9/9/25, R3 came to her and told her that he saw R1 ingesting medications. E2 said R1 fully admitted that she took 10 prescription antinausea pills (Zofran). E2 said there shouldn't have been any medications in their (R1 and R2's) room. E2 said she

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immediately swept R1 and R2's room and found Xanax and valium both prescribed to R1. E2 said she also found over the counter medications in their room too (Gas X, stool softeners, and Tums). E2 said R1 was medicating R1 when he chose. E2 said R1 has a history of suicide attempts. After the medication ingestion, R1 went to the hospital and was later transferred to a behavioral health facility. E2 said R1 has a dementia diagnosis. E2 said neither R1 nor R3 are supposed to be self-administering their medications. E2 said there are only three residents in the establishment who are approved to self-administer their medications and they are the only ones allowed to keep medications in their rooms. The three residents do not include R1 or R3. E2 said R1 is now in a different unit and have updated her service plan to do frequent wellness checks to ensure all chemicals and care products are secure and not within her reach.

On 10/6/25 at 11:14 AM, E3, Licensed Practical Nurse (LPN), said if a resident self-administers their medications, it would be on their profile. If a resident self-administers medications, they keep the medications in their room. E3 said the majority of residents have their medications administered to them rather than doing their own. E3 said if residents are having their medications administered to them, they are not allowed to have medications in their room. E3 said if residents are paying them to administer their medications, they may not have the cognition to keep their medications; the concern is that they could overtake, undertake, or not take their medications at all, it's not safe.

On 10/6/25 at 11:55 AM, E5, Registered Nurse (RN), said no one with decreased cognition self-administers their medications; their mental

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capacity allows too much room for error. E5 said, "it would be totally unsafe for them." E5 said even over the counter medications stay locked up (in the med room) and the med room door is always locked for safety too.

R1's Progress notes dated 9/9/25 at 11:52 AM show R1's husband, R3, reported to E2, Health and Wellness Director, at 7:00 AM he observed R1 ingest 10 pills. R3 gave E2 an empty medication bottle. 911 was immediately called and R1 was transported to the hospital. R1 said she was depressed and can't stand it anymore. R1's Face Sheet (undated) printed and provided by the establishment on 10/7/25 shows R1's diagnoses include, but are not limited to major depressive disorder, and major cognitive disorder due to Alzheimer's. R1's most recent Service Plan provided by the facility shows R1 requires full assistance with medication administration management. The care team supports R1 in the Seven Rights of Medication Management including storing and receiving medications in a safe and timely manner.

The establishment's Medication Administration Policy (revised 4/25) shows administered medications shall be stored in the medication room and the establishment shall ensure that all drugs are administered by appropriate staff.