STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510060	A. BUILDING: _____ B. WING _____	C 10/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - OSWEGO COTTAGE	3712 GROVE RD OSWEGO, IL 60543

(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 Complaint 2578794 / IL 197518. 295.6000 a) 13) 295.2050 a)	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 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. TYPE 3 VIOLATION Based on record review and interviews, the establishment failed to report an incident with injury to the Department for one of three sampled residents. (R1) Findings include: Establishment incident report dated 9/2/25 reads, "This nurse was alerted by Caregiver that resident (R1) had fallen out of the (Mechanical Lift) and was on the floor, this nurse found resident on the floor under the (Mechanical Lift)	A2050		

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A2050	Continued From page 1 on his right side of his face resting on the (Mechanical Lift) leg with blood noted underneath, this nurse placed her hand between residents face and (Mechanical Lift) leg for protection while (Mechanical Lift) was being moved out of the way, assistance from another nurse and caregiver arrived and resident was assisted to a sitting position on his buttocks for assessment, resident is able to move all 4 extremities without pain but states that his head and buttocks hurt and also Left knee with no obvious injuries noted to the buttock or knee, resident has a 1 1/2 laceration to upper back of head, Residents Daughter / POA (Z1) called with no answer and message left, 911 called for transport to (Hospital) ER. RNC notified, MD notified." Progress note dated 9/3/25 at 8:13 A.M. reads, "Resident (R1) arrived back to (Establishment) @0400. No c/o of pain or discomfort. Dried blood noted on laceration to upper back of head with three staples. Placed resident back in bed and product changed. Continues to MAE with not observable neuro deficits at this writing." On 10/11/25 at 11:02 A.M., E2 (Health and Wellness Director) stated that she did not report this to the Illinois Department of Public Health because she did not realize this was considered a reportable incident. E2 stated she will report these types of incidents in the future.	A2050		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights	A6000		

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A6000	Continued From page 2 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 and interviews, the establishment neglected to safely transfer one of three sampled residents using a mechanical lift. (R1) These failures resulted in R1 sustaining a one and a half inch laceration to his head, requiring three staples to close. This failure creates a substantial probability of severe harm to a resident or residents Findings include: R1's current Physician's Orders and Service Plan note that R1 resides on the Assisted Living side of the facility. Service Plan reads, "Transfer - Full assistance or bedridden - Assistance with transfers using mechanical devices. Mechanical lift. .....Hospice provides lift equipment and care staff will assist with transfers. Always use two or three person assist when using the (Mechanical Lift)." Establishment incident report dated 9/2/25 reads, "This nurse was alerted by Caregiver that resident (R1) had fallen out of the (Mechanical Lift) and was on the floor, this nurse found resident on the floor under the (Mechanical Lift) on his right side with his face resting on the	A6000		

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A6000	Continued From page 3	A6000		

(Mechanical Lift) leg with blood noted underneath, this nurse placed her hand between residents face and (Mechanical Lift) leg for protection while (Mechanical Lift) was being moved out of the way, assistance from another nurse and caregiver arrived and resident was assisted to a sitting position on his buttocks for assessment, resident is able to move all 4 extremities without pain but states that his head and buttocks hurt and also Left knee with no obvious injuries noted to the buttock or knee, resident has a 1 1/2 laceration to upper back of head, Residents Daughter / POA (Z1) called with no answer and message left, 911 called for transport to (Hospital) ER. RNC notified, MD notified."

On 10/10/25 at 1:19 P.M., Z1 stated that she has a camera in R1's room and she reviewed the camera footage at the time of R1's fall from the mechanical lift on 9/2/25. Z1 stated that only one caregiver was transferring R1 with the mechanical lift. Z1 said that the caregiver did not get one of the four straps hooked on correctly. Then when the caregiver was pushing the lift around the room, the strap fell off, and R1 flipped backwards and fell to the floor. Z1 said that R1 hit his head on the leg of the lift and received three staples at the hospital to close the laceration. Z1 stated that they are supposed to have two caregivers when using a mechanical lift. Z1 stated she then reviewed the last several months of video footage of transfers. Z1 said there was 38 times since 7/1/25 that R1 was transferred with only one caregiver using the mechanical lift.

On 10/11/25 at 11:02 A.M., E2 (Health and Wellness Director) stated that the incident on 9/2/25 where R1 fell out of the mechanical lift was caused by the caregiver not hooking up one of the four straps correctly. E2 stated that the

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A6000	Continued From page 4 caregiver also failed to have another caregiver with her to assist with the transfer. E2 stated this resulted in R1 being sent to the hospital and having three staples to close the laceration to the back of his head. E2 stated that this caregiver no longer works at the establishment.	A6000		