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 10/14/2025

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

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A 000	Initial Comment Investigation of Complaint # 2519118 / IL197654 and # 2519151 / IL197658 - Substantiated Violations: Section 295.1070 a) d) Annual On-Site Review and Complaint Investigation Procedures Section 295.2050 a) b c) Incident and Accident Reporting Section 295.3000 a) Personnel Requirements, Qualifications and Training Section 295.4010 d) e) g) h) Service Plan Section 295.4040 a) c) Communicable Disease Policies Section 295.4060 h) 3) 6) Alzheimer's and Dementia Programs Section 295.6010 a) b) d) Abuse, Neglect, and Financial Exploitation Prevention and Reporting Section 295.7000 b)16) Resident Records	A 000		
A1070	Section 295.1070 Annual on-Site Review and Complaint Procedure This Regulation is not met as evidenced by: Type 3 Violation Section 295.1070 Annual On-Site Review and Complaint Investigation Procedures a) The Department will conduct an	A1070		

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A1070	Continued From page 1 annual unannounced on-site visit at each assisted living and shared housing establishment to determine compliance with the applicable licensure requirements and standards as set forth in the Act and this Part. Additional visits may be conducted without prior notice to the assisted living or shared housing establishment. (Section 110(a) of the Act) ... d) An establishment shall not restrict or hamper access by Department staff to the building, residents or designated records required to conduct routine or periodic review or investigations. A resident may limit access to their private dwelling space to reviewers, except if suspected violations exist that may pose a threat to the resident's or others' health, safety or well-being. A resident may also elect to limit access to themselves and their records, except as required as a condition of payment for publicly funded housing and/or services ... This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure the investigation was not hampered by the delay of requested records. This applies to 1 of 4 residents (R1) reviewed for this requirement but has the potential to affect all residents in the establishment. This failure creates a substantial probability of severe harm to a resident or residents, in that an adequate complaint investigation cannot be completed to determine the safety of residents, without the necessary documentation. The findings include:	A1070		

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A1070	Continued From page 2 On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated. Investigation days took place in-person on Wednesday 9/24/25, Monday 9/29/25, Tuesday 9/30/25, Thursday 10/2/25, and remote on Monday 10/6/25. On Wednesday, 9/30/25 at 4:08 PM, request was made for R1's Lorazepam orders from January-September 2025 and the follow-up report submitted to the Department for an investigation conducted for R1's Injury of Unknown Origin identified on 9/6/25. The documentation was asked to be provided on 10/1/25 when this surveyor would return to the establishment in the afternoon. On 10/1/25 at 1:37 PM, this surveyor emailed E1 (Executive Director) that this surveyor would not be at the establishment in the afternoon and to scan the requested documentation to this surveyor's email. There was no reply to the email. On 10/2/25 at 9:35 AM, E1 indicated, E8 (Regional Health and Wellness Director) would contact R1's doctor for the orders and see if E8 could find a follow-up report for the 9/6/25 investigation. On Thursday, 10/2/25 after an interview was conducted with E1 from 3:49 PM-4:46 PM, this surveyor made another request for R1's Lorazepam orders and the follow-up report for R1's 9/6/25 investigation, and additionally requested for care track charting for R1, in-services for mechanical lift training, and plumbing invoice for increasing washer water	A1070		

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A1070	Continued From page 3	A1070		

temperatures during the outbreak of scabies. This surveyor let E1 know to scan the documents to this surveyor's email.

There was no email communication from E1 or documentation provided, Friday 10/3/25 through Monday 10/6/25.

On Tuesday 10/7/25 at 8:35 AM, this surveyor emailed E1 to request R1's hospice records and to turn in any requested documentation by 10:00 AM, as the investigation was complete. There was no reply to this email.

On Wednesday 10/8/25 at 1:58 PM, this surveyor emailed E1 that the hospice notes were still not received. On Tuesday 10/8/25 at 5:15 PM, E1 emailed R1's hospice notes and indicated their fax machine was out of ink for a day and a half, and the pharmacy would not email the orders, so they would hopefully have ink in the following day and send them.

On Tuesday 10/8/25 at 7:09 PM, E1 emailed or noted on the documentation that was requested on 10/2/25. E1 noted they still needed to reach out to the pharmacy for R1's lorazepam orders.

On Thursday 10/9/25 at 12:59 PM, E1 emailed R1's lorazepam orders.

During phone exit with E1 and E8 on 10/14/25 at 1:30 PM, E1 confirmed delays and indicated E1 misunderstood the need to provide documentation when the surveyor was not at the establishment due to days off, and again explained the delay with the printer.

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A2050	Continued From page 4	A2050		
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. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023) This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure they notified or notified the Department within 24 hours of a	A2050		

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A2050	Continued From page 5	A2050		

serious incident or accident. This applies to 2 of 4 residents (R1, R3) reviewed for this requirement.

The findings include:

On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated.

There was no documentation to show the following serious incidents/accidents were not reported to the Department:

R3's Progress Note, dated 6/20/25 at 1:20 PM, showed R3 was found lying on her back next to bed. The note showed R3 had complaints of back pain to the left side mid/lower back and x-rays were ordered.

R3's Primary Care Progress Note, dated 6/27/25, written by Z6 (Nurse Practitioner), showed R3 had complaints of hip pain after a fall earlier in the month. The note showed three x-rays of the lumbar spine were taken and revealed a mild compression fracture in L1 vertebrae.

The following serious incidents/accidents were not reported to the Department within 24 hours of the occurrence:

R1's Incident and Accident Report, date/time 7/10/25 1:30 AM, showed "see attached" for narrative, but there was no attachment. The report showed x-rays were ordered for the left foot. R1's Progress Notes from 7/10/25 showed R1 had a fall that later resulted in pain, swelling, and non-bearing to the left foot, and x-rays

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A2050	Continued From page 6 showed a fracture. There was no confirmation with the report that it was submitted to the Department. The Department facility cases log was searched and showed a confirmation date/time of 7/16/25 at 9:45 AM. During interview on 9/29/25 at 4:27 PM, E1 (Executive Director) indicated, E2 (previous Health and Wellness Director) was responsible to submit reports to the Department, E1 indicated, E2's email could no longer be accessed, so E1 did not have access to confirmation pages.	A2050		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training 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) ... (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) This requirement was not met, as evidenced by:	A3000		

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A3000	Continued From page 7	A3000		

Based on interview and record review, the establishment failed to train staff in the use of mechanical lifts to ensure they had staff with adequate skills to meet the needs of those residents. This applies to 1 of 4 residents reviewed for this requirement (R1) and has the potential to affect any resident who uses a mechanical lift. This creates a substantial probability of harm to a resident or residents, and possibly contributed to R1's severe injuries.

The findings include:

On 9/24/25, an investigation of complaints # 2519151 / IL197658 and # 2519118 / IL197654.

There was no documentation to show the establishment trained staff in the use of mechanical lifts to ensure there was staff with the skills to meet the needs of residents who cannot transfer on their own.

R1's medical record showed R1 moved into the establishment on 6/24/24, was on hospice, and passed away on 9/11/25. R1 had multiple diagnoses, including Raynaud's syndrome, osteoarthritis, and Alzheimer's disease.

R1's Service Plan, dated 9/5/25, showed R1 used a mechanical lift (hoyer) for all transfers. The plan showed R1 was anxious with transfers and cares and required more than two staff assist at times.

R1's Progress Notes, dated 9/3/25-9/6/25, showed R1 had a large bruise to the left chest.

R1's Incident/Accident report, dated 9/6/25, showed R1 complained of pain, swelling, and

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A3000	Continued From page 8	A3000		

guarding to the left arm, and x-rays showed R1 had a spiral fracture to the left humerus.

R1's hospital records, from 9/7/25, showed R1 was evaluated for the spiral fracture and bruising to the left chest. R1's records confirmed R1 had a spiral fracture to the left humerus, but also showed R1 had two subacute right rib fractures and an acute left rib fracture.

R1's death certificate showed R1 passed away on 9/11/25, with Cause of Death as Lewy Body Dementia and Significant Conditions Contributing to Death as Left Humerus Fracture.

During interview with Z9 (Hospice Physician) on 9/29/25 at 11:27 AM, Z9 indicated, there was a correlation between R1's arm fracture and rapid decline and death. The spiral fracture was diagnosed on 9/6/25 and R1 passed away on 9/11/25.

During interviews, E5, E9, E11, E12, E15, E16, and E18 (all Caregivers) indicated, the establishment did not provided training on how to operate a mechanical lift, and did not provide training until after R1's arm injury and/or until the first week in October. They indicated, R1 was anxious during care and transfers and grabbed on to them or the bed rails. They indicated, they were not aware how the R1's injuries occurred.

During interviews with E3 and E17 (both Previous Nurses), E4 (Assistant Health and Wellness Director) E6, E13, E17, E19, and E20 (all Nurses), there were concerns that all caregivers were not required to be Certified Nursing Assistants may not have adequate training with the level of care required for residents at the establishment.

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A3000	Continued From page 9 During interview on 10/7/25 at 9:13 AM, Z11 (Hospice Nurse) indicated, training, specific to R1 was conducted on 9/10/25, after R1's care conference. Z11 indicated, the establishment set-up for them to provide training in the use of mechanical lifts, to be held last week, but it was canceled by the establishment, because they used a different provider for the training. During interview on 10/2/25 at 3:49 PM, E1 (Executive Director) indicated, caregivers were trained in the use of mechanical lifts. E1 was requested to provide any in-services/trainings for the use of mechanical lifts. E1 indicated, the training with R1 was conducted but not documented. As of 10/8/25 at 3:17 PM, the only documentation for training provided was dated 5/15/25 called Body Mechanics: Resident Safety and Fall Prevention and Dining Service and Food Safety. The content was reviewed, and it did not cover the use of mechanical lifts. On 10/14/25, E1 provided In-Service Documentation, dated 10/1/25, for operating hoyers. There was no documentation provided to show caregivers were trained in the use of mechanical lifts prior to 10/1/25. There was no establishment investigation into R1's bruising to the left chest, therefore, no determination was made how the broken ribs occurred. The establishment investigation for R1's spiral fracture to the left arm did not have a follow-up report, but E1 indicated, it could not be determined how the injuries occurred. This investigation could not determine how R1's injuries occurred but could not rule out improper use of mechanical lifts.	A3000		

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A4010	Continued From page 10	A4010		
A4010	Section 295.4010 Service Plan	A4010		

This Regulation is not met as evidenced by:
Type 2 Violation

Section 295.4010 Service Plan ...

d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)

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) ...

g) Service plans shall address:

1) The level of service the resident is receiving, including:

A) assistance with activities of daily living;

B) dietary needs, if the establishment provides therapeutic diets; and

C) special accommodations for the resident;

2) The amount, type, and frequency

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A4010	Continued From page 11 of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment ... This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure they developed and maintained a service plan that corresponds with the resident's needs. This applies to 2 of 4 residents (R3, R4) reviewed for this requirement. This creates a substantial probability of harm to a resident or residents, in that it cannot be determined if the establishment is meeting the needs and safety of the resident. The findings include: On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated. R3 - The establishment failed to provide services in the service plan:	A4010		

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A4010	Continued From page 12 R3's Service Plan, dated 9/10/25, showed, "The Care Team supports me in meeting my special care needs in order to improve my overall wellbeing." It is not clear if the previous service plan addressed the use of a back brace, but the current service plan showed, R3 has chronic back pain and wears a back brace for a compression fracture. R3's Progress Note, dated 7/10/25 at 7:40 PM, written by E3 (Previous Nurse), showed R3 was found lying on their back on the floor, screaming "my back". The note showed Z6 (Nurse Practitioner) questioned if R3 had on the back brace that Z6 ordered for a previous fall that resulted in a compression fracture of the spine. The note showed, E3 indicated R3 did not have it on and could not find any documentation that an order was entered for a brace. R3's radiology Patient Report, dated 6/20/25, showed R3 had a mild compression fracture in L1, with a written order, dated 6/26/25, by Z6, for a lumbar brace and CT of lumbar spine. There was no documentation found to show the order was followed through and the brace ordered. R3's Progress Note, dated 7/10/25 at 4:22 PM, written by E2 (Previous Health and Wellness Director), showed the 6/26/25 order carried out and the back brace was ordered online and would be applied when it arrived. R3's September 2025 Physician's Orders showed, showed "apply back brace every day and off at night", Origination Date 7/18/25. R3 - The establishment failed to review the service plan and update interventions for falls:	A4010		

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A4010	Continued From page 13 R3's Service plan, dated 9/10/25, showed R3 is at a level three for falls, with multiple interventions noted, but it cannot be determined that the service plan was reviewed with each fall and interventions updated. R3's Progress Notes showed a history of falls on 12/6/24, 12/19/24, 12/20/24, 5/1/25, 5/18/25, 6/20/25, 7/10/25, 7/21/25, 8/4/25, 9/8/25, and 9/10/25, that were not noted on the service plan. R4 - The establishment failed to review the service plan and update interventions for falls: R4's Service plan, dated 7/16/25, showed R3 is at a level three for falls and has a history of falls, with multiple interventions noted, but it cannot be determined that the service plan was reviewed with each fall and interventions updated. R4's Progress Notes showed R4 a history of falls on, 7/2/25, two on 7/4/25, 7/14/25, two on 7/23/25, 7/26/25, 8/1/25, two on 8/6/25, 8/14/25, 9/7/25, 9/12/25, and 9/19/25, that were not noted on the service plan. The establishment policy titles Fall Policy (10/2024) showed: ...Procedure: ...3) Post Fall Evaluation Form ...After reviewing the current fall, the (Health and Wellness Director) should review the resident's history of falls and identify any trends. Interventions identified are implemented, documented in the resident record and on the service plan ... The establishment policy titled Service Planning and Agreements (Revised 03/2025) showed: Policy: A service plan shall be developed and	A4010		

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A4010	Continued From page 14 maintained for each resident that corresponds with their individual needs, preferences and expected outcomes and is based on the resident's functional and cognitive abilities and their health service. On 10/2/25 at 3:49 PM, E1 (Executive Director) indicated, the resident should receive services provided in the service plan, and the establishment should follow their policies and state regulation.	A4010		
A4040	Section 295.4040 Communicable Disease Policies This Regulation is not met as evidenced by: Type 3 Violation Section 295.4040 Communicable Disease Policies a) The establishment shall meet the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) ... c) All illnesses required to be reported under the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693) shall be reported immediately to the local health department and to the Department. The establishment shall furnish all pertinent information relating to such occurrences. In addition, the establishment shall also inform the Department of all incidents of scabies and other skin infestations.	A4040		

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A4040	Continued From page 15	A4040		

This requirement was not met, as evidenced by:

Based on interview and record review, the establishment failed to report multiple residents and staff with unidentified rashes and itching where all staff and residents were treated for scabies. This applies to all residents that reside in, and all staff that work at, the establishment.

The findings include:

On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated.

There was no documentation found to show the establishment reported an outbreak of an unknown rash and itching on multiple residents and staff that were treated for scabies.

During interview with E17 (Previous Nurse) on 10/2/25 at 1:50 PM, E17 indicated, R1's hospice nurse and two of R1's family members tested positive for scabies.

During interview with Z10 (Nurse Practitioner) on 9/29/25 at 2:04 PM, Z10 indicated, there was a hospice nurse that provided care at the establishment that tested positive for scabies.

R1's Progress Note, dated 9/5/25 7:19 PM, showed Z2 (R1's Spouse) and other family members tested positive for scabies.

During interview on 10/2/25 at 3:49 PM, E1 (Executive Director) explained, multiple residents and staff developed an unidentified rash and

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A4040	Continued From page 16 itching. E1 indicated residents and staff were treated for scabies, though no confirmed cased in the community, as recommended by the local health department, due to possible contact with visitors with reported scabies.	A4040		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs ... h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: ... 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; ... 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	A4060		

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A4060	Continued From page 17 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; ... (Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure policies were in place to ensure continued safety for residents that require the use of mechanical lifts for transfers. This applies to 1 of 4 residents (R1) reviewed for this requirement but has the probability to affect all residents that use a mechanical lift. This failure creates a substantial probability of severe harm to a resident or residents, and possibly contributed to severe injuries to R1. The findings include: On 9/24/25, an investigation of complaints # 2519151 / IL197658 and # 2519118 / IL197654. There was no documentation to show the establishment developed and implemented policy for the use of mechanical lifts. R1's medical record showed R1 moved into the establishment on 6/24/24, was on hospice, and passed away on 9/11/25. R1 had multiple diagnoses, including osteoarthritis and Alzheimer's disease. R1's Service Plan, dated 9/5/25, showed R1 used	A4060		

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A4060	Continued From page 18 a hoyer (mechanical lift) for all transfers. R1's September 2025 Progress Notes showed R1 had a large bruise to the left chest and was later diagnosed with acute and subacute rib fractures. The notes showed R1 presented with severe left arm pain, with swelling and guarding of the arm, and was later diagnosed with a displaced spiral fracture to the left arm. There was no documentation to show how the injuries occurred, but the investigation showed the establishment had hospice provide hoyer training, specific to R1, after R1's injuries occurred. During this investigation, a list of residents who use mechanical lifts was requested. On 9/24/25 at 12:50 PM, E2 (Regional Health and Wellness Director) indicated, there was only one resident (R5) with a mechanical lift, however, interviews with staff showed R5, R6, R7, and R8 used a mechanical lift, either hoyer or sit-to-stand. During this investigation, hoyer (mechanical lift) policy was requested. On 9/24/25 at 12:50 PM, E1 (Executive Director) indicated, they did not have a separate policy for hoyers, and it would be covered under Service Planning and Agreements policy. The establishment policy titled Service Planning and Agreements (Revised: 03/2025) was reviewed and showed: Policy: A service plan shall be developed and maintained for each resident that corresponds with their individual needs, preferences and expected outcomes. The policy did not contain any language on the use of and safe practices for operating a mechanical lift.	A4060		

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A6010	Continued From page 19	A6010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

This Regulation is not met as evidenced by:
Type 2 Violation

Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting

a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:

1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.

2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following:

1) Dates, times, and description of the alleged abuse, neglect or financial exploitation;

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A6010	Continued From page 20 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future ... d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to follow their policy and state regulation when they did not notify the Department of allegations of abuse/neglect or injury of unknown origin, within 24 hours of the allegations/incident. They failed to ensure investigations were conducted or adequately conducted for abuse/neglect allegations. They failed to develop a written report of an	A6010		

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A6010	Continued From page 21	A6010		

investigation within 14 days and submit it to the Department within 24 hours after completion. This applies to 2 of 4 residents (R1, R3) and 1 of 4 employees (E22) reviewed for this requirement, but has the possibility to affect all residents that reside in the establishment. The failure to investigate or adequately investigate allegations creates a substantial probability of harm to a resident or residents and does not protect the residents' right to be free of abuse and neglect.

The findings include:

On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated.

R1

R1's Incident and Accident Report, dated 9/6/25 - time unknown, showed R1 had complaint of left arm pain, decreased range of motion, swelling, and guarded the arm. The report showed x-rays were taken and R1 was diagnosed with an acute displaced spiral fracture of the left humerus. The report showed an internal investigation was done.

The Department was not notified within 24 hours of the occurrence. The establishment could not provide documentation to show when the report was submitted to the Department. The Department Cases log was searched and showed a confirmation date/time of 9/8/25 at 10:37 AM.

There was no documentation to show the establishment completed a written report of investigation withing 14 days after the initial report and submitted it to the Department. In email

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A6010	Continued From page 22	A6010		

communication on 10/7/25 at 7:09 PM, E1 (Executive Director) indicate, she could not locate a follow-up report. The Department Cases log was reviewed and there was no documentation that a follow-up written report was submitted.

During interview on 9/29/25 at 4:27 PM, E1 indicated, E2 (previous Health and Wellness Director) submitted reports to the Department and E2's email could no longer be accessed to search for submissions.

R3

R3's Progress Note, dated 9/20/25 at 3:24 PM, showed E3 (Previous Nurse) heard R3 crying hysterically and went to see what was wrong. The note showed R3 reported E5 (Caregiver) was upset with R3 and twisted R3's arm. R3 reported pain to the left leg and left arm and grimaced with pain when both were touched. E3 assessed R3 and found R3's left leg inwardly rotated. The note showed E6 (Nurse) was asked to return with E3 and witness R3's statement and help with an assessment, which E6 confirmed. The note showed E3 notified E4 (Assistant Health and Wellness Director) and E1 (Executive Director).

There was no documentation an investigation of the allegation was conducted or reported to the Department. The establishment was asked to provide any abuse/neglect investigations conducted July-September 2025. During interview on 9/24/25 at 3:34 PM, E1 indicated she went to the establishment and assessed and interviewed with the hospice nurse and reviewed records and determined the allegation was not valid. E1 indicated, E3 and E6 was not interviewed. E1 indicated, the Department was not notified of the

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A6010	Continued From page 23 allegation. R4 R4's Progress Note, dated 9/7/25 at 11:56 AM, written by E3 (Previous Nurse), showed E9 (Caregiver) called E3 to R4's room around 6:20 AM, and E9 witnessed R4 set self on the floor. The note showed E3 assessed R4 and there were no visible injuries. The note showed E3 went back into R4's room around 8:30 AM and saw E9 (Caregiver) dressing R4 and noticed R4 had a bruise to the left eye with a knot. The note showed E9 did not know how the injury occurred, when questioned, and did not report the injury to E3. The note showed E9 notified E2 (Previous Health and Wellness Director - HWD) and E4 (Assistant HWD) about the matter. There was no investigation into an injury of unknown origin and no report of the allegation to the Department. During interview, on 9/29/25 at 1:17 pm, E9 indicated, E3 asked E9 to make a statement and E9 submitted a texted statement to E2, and E3 sent E9 home. E9 indicated, E9 was told E1 (Executive Director) would contact E9, but never did. E9 indicate, E9 returned to work the following day. On 9/29/25 at 4:27 PM, E1 indicated, E1 was not aware of the incident, or if investigation was not conducted, and would follow-up. On 9/30/25 at 10:55 AM, E1 indicated, E1 spoke with E9 and E9 indicated E9 was not sent home but left because E9 was upset that E3 said E9 did not report about the eye. E1 indicated, E1 was never told about the incident and E9 was not sent home or suspended, and there was never an investigation.	A6010		

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A6010	Continued From page 24 E22 During this investigation, employee records were reviewed for those disciplined July-September 2025. E22's (Previous Caregiver) Disciplinary/Counseling Report, dated 7/10/25, and attached statement showed, on the morning of 7/10/25, there was an unnamed resident that had a fall and was left on the floor during E22's shift, and E22 left the shift and did not report the resident was on the floor and did not chart the fall in the Electronic Health Record (EHR), as well as other allegations of tasks not completed. The report showed E22 was terminated. There was no documentation to show the establishment investigated the allegation or reported it to the Department. During interview on 9/29/25 at 4:27 PM, E1 indicated, an investigation was not conducted because E22 was terminated. During interview on 10/2/25 at 3:49 PM, E1 (Executive Director) indicated, if they determine something should be investigated or reported to the Department, they will do so. E1 agreed, the establishment should follow its policies and state regulation. The establishment policy titled Abuse and Neglect (Revised: 02/2025) showed: Policy: (The establishment) Executive Directors and other health care professionals who have reasonable cause to believe that a resident is being, or has been abused, neglected or exploited shall report the information immediately to the State licensure	A6010		

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A6010	Continued From page 25 authority and branch support.	A6010		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: Type 3 Violation Section 295.7000 Resident Records ... b) An establishment shall maintain a resident's record that contains at least the following: ... 16) Orders from a licensed health care provider for medication that is to be administered by the establishment. This requirement was not met, as evidenced by: Based on interview and record review, the establishment failed to ensure medication orders were maintained as part of the resident's record. This applies to 1 of 4 residents reviewed for this requirement. The findings include: On 9/24/25, an investigation of complaints # 2519151 / IL197658 and #2519118 / IL197654 was initiated. On Wednesday, 9/30/25 at 4:08 PM, request was made for R1's lorazepam orders from January-September 2025, as there was only one order, for 9/8/25, found in the Electronic Health	A7000		

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A7000	Continued From page 26 Record (EHR). On 10/2/25 at 9:35 AM, E1 (Executive Director) indicated, no other orders were found and E8 (Regional Health and Wellness Director) had to contact R1's doctor for the orders.	A7000		