STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510059	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - MOLINE COTTAGE	3650 41ST ST MOLINE, IL 61265

(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 IL 198355. VIOLATION - 295.4060 h) 3) A)	A 000		
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 Based on record review and interviews, the establishment failed to have polices in place and implemented, resulting in one of one sampled memory care residents (R1) eloping from the establishment unsupervised. This failure had the substantial probability to cause severe harm to a resident. Findings include: R1's current service plan notes that R1 was admitted to the establishment as a memory care resident on 12/12/24. Service plan notes that R1	A4060		

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A4060	Continued From page 1	A4060		

has poor safety awareness, poor judgment and requires continuous assistance due disorientation and memory loss. Service plan notes that R1 is a high elopement risk, is constantly exit seeking and has a history of elopements.

R1's progress note on 10/30/25 titled, "Behavioral, Elopement, Medical Emergency, 911" reads, "Resident (R1) exited 100 hall without staff assistance. Resident (R1) had been exit seeking most of the shift. Resident (R1) eloped to a residential home. NOD (Nurse On Duty) called emergency services to help look for resident (R1). Resident (R1) brought back to facility via police car and two officers. Resident (R1) brought back inside. Resident (R1) covered in brush and burs from being outside. HWD (Health and Wellness Director) did skin assessment. POA (Power of Attorney) called and left a voicemail to call the facility fro an update on resident (R1)."

On 11/4/24 at 10:05 A.M., E2 (Health and Wellness Director) confirmed that on 10/30/25 at approximately 9:05 P.M., R1 eloped out the 100 hall exit door. E2 stated that staff did not get to the door fast enough to see R1 go out. E2 stated that the door alarms for 15 seconds before it will open. E2 stated that R1 apparently walked up through the woods and then tried to get in a neighbors house. Both the nurse on duty and the neighbor called the police. The police went to the house (Not even a 1/4 mile from facility), picked up R1 and returned R1 to the facility. E2 stated that when R1 was returned, he had leaves and burs on him as if he walked through the woods. E2 stated that R1 was gone for approximately 20 minutes.

On 11/5/25 at 10:45 A.M., E1 (Executive Director) stated that R1 has a history of elopement and

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A4060	Continued From page 2 that the facility was cited for R1 eloping back in 12/19/24. E1 stated that R1 is constantly attempting to exit the establishment. E1 stated that they have stressed the importance of staff responding immediately when the door alarms, due to R1's history and constant efforts to exit. E1 stated that the staff on this elopement failed to respond immediately and did not get to the door for two minutes after the alarm sounded. Establishment "Unwitnessed Door Alarm" policy notes that staff are to "Immediately" search inside and out when unwitnessed door alarm sounds.	A4060		