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	ASL510054	A. BUILDING: _____ B. WING _____	C 03/14/2025

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BICKFORD - BLOOMINGTON	14 HEARTLAND DR BLOOMINGTON, IL 61704

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A 000	Initial Comment Original Complaint # 2561779/IL187418 - Section 295.3000 b) and 295.4060 b) cited. Original Complaint #2562210/IL188048 - Section 295.6000 a)1)5)13) and 295.6010 a)b) cited. Original Complaint #2561840/IL187506. - No violation	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Section 295.3000 Personnel Requirements, Qualifications and Training b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. Type 3 Based on interview and record review, the establishment failed to have CPR certified staff on duty 24 hours a day. This has the potential to affect all 51 residents residing in the establishment. Findings include: The establishment's provided census sheet documents there are 51 residents presently residing in the establishment. E1 (Executive Director) provided a copy of all	A3000		

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A3000	Continued From page 1 CPR certified staff members. The establishment's schedules from January 2025 to March 11, 2025 were reviewed. Eight days were checked for staff working with CPR certification. Six of those eight days did not have CPR certified staff working on all shifts. On 2-5-25, 2-7, 2-11, 2-12-25, and 3-6-25, on the 10:00 pm to 6:00 am night shift, there was no one working with CPR certification. On 3-1-25, there was no one working the 2:00 pm to 10:00 pm evening shift with CPR certification. On 3-18-25 at 9:30 am, E1 (Executive Director) stated she did not have any more CPR cards to provide.	A3000		
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) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide	A4060		

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A4060	Continued From page 2 such services. (Section 150(b) of the Act) Type 3 violation Based on interview and record review, the establishment failed to provide staffing for the memory care unit as specified in their Special Care Disclosure. This has the potential to affect all 14 residents residing in the memory care unit. Findings include: The establishment's Special Care Disclosure for their memory care unit 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. The establishment's provided census sheet documents there are 51 total residents with 14 located on the memory care unit and 37 residents on the assisted living side. On 3-14-25 at 11:15 am, E5 (Caregiver Assistant) stated sometimes at night, there will work with one caregiver on the assisted living side and one on the memory care unit side of the building and no nurse on duty. They have multiple residents on the memory care unit who need assistance with incontinence during the night. If an issue arises, they will call the on call nurse. On 3-12-25 at 1:30 pm, E18 (CNA/Certified Nursing Assistant) stated she works all shifts. E18 stated there are times when there are only two staff working in the establishment which makes it unsafe for the memory care unit. The establishment's schedules from January 1, 2025 to March 11, 2025 were reviewed. On 2-5, 2-7, and 3-6-25, there were only two caregivers	A4060		

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A4060	Continued From page 3 present on the night shift with no nurse present. On 3-13-25 at 11:10 am, E2 (Health & Wellness Nurse) stated it is their intention to have a nurse on duty 24 hours a day, but stated there is not always a nurse on duty during the night shift. E2 stated they schedule more that two caregivers at night but sometimes there are call offs or other circumstances.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights 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: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Violation 1) Based on interview and record review, the facility failed to follow their policy regarding	A6000		

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A6000	Continued From page 4	A6000		

reporting of potential abuse, investigation, and immediate removal of the alleged abuser for one (R2) of three residents reviewed for abuse in a sample of three.

2) Based on interview and record review, the establishment failed to assist R1 with hygiene and care as specified in her service plan for one of three residents (R1) reviewed in a sample of three.

Findings include:

1) On 3-13-25 at 10:45 am, R2 stated awhile ago, a male caregiver (E4 Caregiver Assistant) took her to the bathroom at night time and when he was helping her back to bed, she slid off the bed onto the floor. R2 asked E4 to go get help to help her back up but he said no as the other worker was "way over the other end." E4 assisted her to bed by himself and against her wishes. R2 stated she believes maybe the next night, E4 entered her room and flicked her overhead light on and off repeatedly and just looked at her. R2 told him to stop then said she would scream if he didn't leave so he did. R2 felt uneasy and fearful after that thinking he was upset with her about the fall.

On 3-14-25 at 1:50 am, E2 (Health and Wellness Director) stated a staff member, he doesn't remember who, informed him of about R2's fall. E2 talked with E4 and E5 (Caregiver Assistants) who denied R2 falling about 2-22-25. E2 talked with R2 who stated she did slide off the bed when E4 was assisting her. E2 stated he was unaware of the flickering of R2's light. E2 stated that would be a form of intimidation and abuse.

On 3-18-25 at 5:00 am, E12 (Wellness Nurse)

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stated on the evening of 2-22-25, a caregiver reported to her that R2 was upset. E12 went and talked with R2 who stated she was scared saying "was that man coming back in ?" R2 told her E4 (Caregiver Assistant) had dropped her on the floor and would not get help to get her up. Unsure when that was. And then another time she called for help and he came and when she asked for a female to help her, he told her there was no one else. R2 did not get to the bathroom and was incontinent. Another time, E4 came to her room, stood in the doorway and kept flickering her light on and off rapidly, and just looked at her. R2 asked him to leave and then threatened to scream if he did not. E12 stated she immediately tried calling E2 and E7 about 8:00 pm with no answer. E12 also texted both with no answer. After 11:00 pm, E7 and E2 returned her call and she informed them what happened and said she considered that a form of abuse. E7 and E2 told her to write up her statement and put it under E2's door. E2 came in and asked E4 (Caregiver Assistant) to leave pending an investigation.

On 3-18-25 at 9:00 am, E7 (Assistant Director) stated she believes about 2-22-25, E12 (Wellness Nurse) reported that E4 was agitating R2 and asked him to leave the room. R2 was fearful of E4. E4 was removed from duty by E2 pending investigation. E7 stated E12 reported the incident to her as potential abuse.

The facility's investigation dated 2-24-25 document there was a complaint that E4 had dropped R2. There was no mention of E4 flickering the lights in R2's room on the Investigation Form. The investigation included a question to E4 about repeatedly turning R2's light on and off which E4 denied. The Investigation Form documents the State Department was not

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A6000	Continued From page 6 notified of the allegation. On 3-12-25 at 2:00 pm, E1 (Executive Director) stated she was not aware there was an allegation of abuse for R2. E1 stated she was unaware of E4 repeatedly flickering her lights on and off and intimidating R2, therefore she did not report the allegation to the State Agency. E1 stated she did not see E12's written statement nor was potential abuse reported to her. The establishment's 2-2025 Abuse and Neglect policy documents: "Any (employee) who has reasonable cause to believe that a Resident is being or has been, abused, neglected or exploited shall report the information immediately to the Executive Director or Health & Wellness Director. The alleged perpetrator (s) will be immediately suspended by the Branch. "When the Branch has a reasonable belief that a resident has been a victim of abuse, neglect, or financial exploitation, (The State Agency) will be notified within 24 hours after receiving the allegation. An internal investigation will be completed by the Branch and documented on the Investigation Report. A written report will be developed for the State within 14 days after the initial report, using the (State) report and sent to the (State) within 24 hours of completion." 2 On 3-14-25 at 11:00 am, Z1 (R1's family) stated on Sunday 3-9-25, when she came to visit R1 about 1:45 pm, R1 was still in bed asleep. R1 had not been gotten breakfast or lunch. When she went to change R1 and clean her up, she was soaked with urine through the bed linen and her night clothes down to the mattress. Z1 went	A6000		

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A6000	Continued From page 7 into the hallway and found E6 (Caregiver Assistant) who stated when he checked on her in the morning, she was still asleep. Then he was called over to the memory care unit to help them and he was the only one on duty on the Assisted Living side. Z1 stated R1 has been left in her wheelchair to sleep overnight on two occasions and has missed supper several times. On 3-13-25 at 12:15 pm, E7 (Assistant Director) stated on 3-9-25, about 6:30 am, she received a call from the establishment stating they had a call off. E7 went into work to cover as they only had E6, E3 (Wellness Nurse) and another caregiver on the memory care unit. About lunch time, she saw E6 enter R1's room. E6 stated to E7 that R1 did not want lunch. E7 stated E6 was responsible for getting R1 up and caring for her that day. R1's service plan dated 2-4-25 documents R1 is receiving hospice services depending on the assistance of staff for transfers, toileting, dressing, bathing and set up to eat. R1 "will need to be offered toileting every time you check on her. Make sure she is wearing a depends and they are dry." R1 "likes to wake up between 8 and 9 am". "The Care Team supports me with my dressing and helps me present in clean, well maintained/fitting appropriate clothing and footwear." "Assistance with morning grooming" and "assistance with dressing, including selection of clothes and hygiene and grooming."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by:	A6010		

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A6010	Continued From page 8 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; 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.	A6010		

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A6010	Continued From page 9 Violation Based on interview and record review, the establishment failed to report an allegation of abuse to the State Department for one of one residents (R2) reviewed for abuse in a sample of three. Findings include: On 3-13-25 at 10:45 am, R2 stated awhile ago, a male caregiver (E4 Caregiver Assistant) took her to the bathroom at night time and when he was helping her back to bed, she slid off the bed onto the floor. R2 asked E4 to go get help to help her back up but he said no as the other worker was "way over the other end." E4 proceeded to put R2 in bed against her wishes. R2 stated she believes the next night, E4 entered her room and flicked her overhead light on and off repeatedly and just looked at her. R2 told him to stop then said she would scream if he didn't leave so he did. R2 felt uneasy and fearful after that thinking he was upset with her about the fall. On 3-14-25 at 1:50 am, E2 (Health and Wellness Director) stated a staff member, he doesn't remember who or exactly when, informed him of about R2's fall. E2 talked with E4 and E5 (Caregiver Assistants) who denied R2 fell about 2-22-25. E2 stated he was unaware flickering lights or an abuse allegation. E2 stated that would be a form of intimidation and abuse. On 3-18-25 at 5:00 am, E12 (Wellness Nurse) stated on the evening of 2-22-25, R2 was scared saying "was that man coming back in ?" R2 told her E4 (Caregiver Assistant) had dropped her on the floor and would not get help to get her up. Unsure when that was. And then another time	A6010		

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A6010	Continued From page 10	A6010		

she called for help and E4 came and when she asked for a female to help her, he told her there was no one else. R2 did not get to the bathroom and was incontinent. Another time, E4 came to her room, stood in the doorway and kept flickering her light on and off rapidly, and just looked at her. R2 asked him to leave and then threatened to scream when he did not. E12 stated she believed this was a form of intimidation and mental abuse. E12 stated she immediately tried calling E2 and E7 about 8:00 pm several times and then texted them. She left a phone message stating she had an allegation of abuse. E2 and E7 returned her call shortly after 11:00 pm and she relayed the abuse allegation to them. E7 and E2 told her to write up her statement and put it under E2's door.

The facility's investigation dated 2-24-25 documents there was a complaint that E4 had dropped R2. There was no mention of E4 flickering the lights in R2's room on the Investigation Form and no mention of abuse. The investigation included a question to E4 about repeatedly turning R2's light on and off which E4 denied. The Investigation Form documents the State Department was not notified of the allegation. E12's written statement was not included in the investigation.

On 3-18-25 at 9:00 am, E7 (Assistant Director) stated she believes on 2-22-25, E12 (Wellness Nurse) reported that E4 was agitating R2 and asked him to leave the room. R2 was fearful of E4. E4 was removed from duty by E2 pending investigation. E7 stated E12 reported the incident as potential abuse.

On 3-12-25 at 2:00 pm, E1 (Executive Director) stated she was not aware there was an allegation

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A6010	Continued From page 11 of abuse for R2. E1 stated she was unaware of E4 repeatedly flickering her lights on and off and intimidating R2, therefore she did not report the allegation to the State Agency. E1 stated she did not see E12's written statement nor was potential abuse reported to her. The establishment's 2-2025 Abuse and Neglect policy documents: "When the Branch has a reasonable belief that a resident has been a victim of abuse, neglect, or financial exploitation, (The State Agency) will be notified within 24 hours after receiving the allegation. An internal investigation will be completed by the Branch and documented on the Investigation Report. A written report will be developed for the State within 14 days after the initial report, using the (State) report and sent to the (State) within 24 hours of completion."	A6010		