STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510058	A. BUILDING: _____ B. WING _____	C 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - MACOMB COTTAGE	160 MAPLE AVE MACOMB, IL 61455

(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 Investigation of Facility Reported Incident date of 2-20-26, IL200638 295.6000 a) 1) 13) 295.6010 c) d)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation-Repeat 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; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the establishment failed to ensure a resident (R1) was free from physical abuse by an employee (E6). This failure creates a substantial probability of harm to a resident or residents.	A6000		

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A6000	Continued From page 1 Findings include: The establishment's investigation into R1's 2-20-26 incident documents (E6 LPN/Licensed Practical Nurse) was observed to grab (R1's) wrist and pry (R1's) fingers open with (E6's) other hand. The investigation continues that E1 Executive Director came in on 2-22-26, suspended E6 by phone, obtained witness statements and recommended termination of E6. On 3-13-26 at 9:45 am, E1 stated on Saturday 2-21-26, E1 contacted E3 CNA/Certified Nursing Assistant regarding another matter. E3 then told E1 that the evening before (2/20/26) during dinner, E6 was passing medications when E6 grabbed R1's wrist roughly and pried R1's fingers open to get pills out of R1's hand. On 3-13-26 at 12:45 pm, E3 CNA stated, on 2-20-26 during supper, E6 was passing medications when she heard R1 yelling "he's hurting me, he's hurting me." E3 approached and saw E6 behind R1 grabbing R1's left wrist tightly and prying open R1's hand. E3 stated she did not report the incident as she had previous issues with E6 and she was going to talk with E1 personally on Monday 2-23-26. On 3-17-26 at 10:10 am, E7 CNA stated on 2-20-26 during supper, E6 was giving medications to R1. R1 was resistive and was trying to put the medications in her pocket when E6 grabbed R1's wrist and said, "No, take them now." R1 then stood up with her fists over her head. E6 again grabbed R1's wrist. On 3-17-26 at 10:30 am, E5 Caregiver stated on 2-20-26, she was in the dining room during supper when she heard R1 yelling. E6 was	A6000		

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A6000	Continued From page 2 almost sitting on R1 holding R1's wrist tightly. R1's pills spilled. E6 then roughly grabbed R1's wrist again and was trying to pull R1's hand open. E5 did not report the incident until asked about it by E1 on 2-22-26. E6's Disciplinary/Counseling Report dated 3-3-26 documents E6 was terminated for the 2-20-26 abuse incident involving R1.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. 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. Based on interview and record review, the establishment failed to report an allegation of abuse immediately and failed to protect its residents by allowing an employee who allegedly abused a resident to continue working. This failure has a substantial probability of causing severe harm to a resident or residents.	A6010		

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A6010	Continued From page 3 Findings include: The establishment's Abuse and Neglect policy revised 2-2025 documents "Any (establishment 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 Branch Executive Director or Health & Wellness Director." The establishment's investigation into R1's 2-20-26 incident documents (E6 LPN/Licensed Practical Nurse) was observed to grab (R1) wrist and pry (R1's) fingers open with (E6's) other hand. The investigation continues that E1 Executive Director came in on 2-22-26, suspended E6 by phone, obtained witness statements and recommended termination of E6. E6's Disciplinary/Counseling Report dated 3-3-26 documents E6 was terminated for the 2-20-26 abuse incident involving R1 which was reported on 2-21-26. On 3-13-26 at 9:45 am, E1 stated on Saturday 2-21-26, E1 contacted E3 CNA/Certified Nursing Assistant regarding another matter. E3 then told E1 that the evening before (2/20/26) during dinner, E6 was passing medications when E6 grabbed R1's wrist roughly and pried R1's fingers open to get pills out of R1's hand. On 3-13-26 at 12:45 pm, E3 CNA stated on 2-20-26 during supper, E6 was passing medications when she heard R1 yelling "he's hurting me, he's hurting me." E3 approached and saw E6 behind R1 grabbing R1's left wrist tightly and prying open R1's hand. E3 stated she did not report the incident as she had previous issues	A6010		

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A6010	Continued From page 4	A6010		

with E6 and she was going to talk with E1 personally on Monday 2-23-26.

On 3-17-26 at 10:10 am, E7 CNA stated on 2-20-26 during supper, E6 was giving medications to R1. R1 was resistive and was trying to put the medications in her pocket when E6 grabbed R1's wrist and said, "No, take them now." R1 then stood up with her fists over her head. E6 again grabbed R1's wrist.

On 3-17-26 at 10:30 am, E5 Caregiver stated on 2-20-26, she was in the dining room during supper when she heard R1 yelling. E6 was almost sitting on R1 holding R1's wrist tightly. R1's pills spilled. E6 then roughly grabbed R1's wrist again and was trying to pull R1's hand open. E5 did not report the incident until asked about it by E1 on 2-22-26.

On 3-13-26 at 9:45 am, E1 stated staff did not report the incident immediately to her. E1 stated the incident happened on 2-20-26 during supper between 5:00 pm and 6:00 pm. E1 stated E3 worked the rest of her shift until 10:00 pm but has not worked in the establishment since that time.