STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510055	A. BUILDING: _____ B. WING _____	C 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BOURBONNAIS HOUSE	100 JONES DR BOURBONNAIS, IL 60914

(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 Investigations Facility Reported Incident/IL188109-No Violations Facility Reported Incident/IL188727-No Violations Facility Reported Incident/IL200640 - 295.6000a)13) and 295.6010a)b)c) cited.	A 000		
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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; TYPE 1 VIOLATION Based on observation, interview, and record review the establishment failed to protect their residents from abuse and neglect for one resident (R3) of three residents reviewed for abuse in a sample of four. This failure has the potential to affect all 51 residents residing in the establishment and creates a substantial probability of severe harm to resident or residents. Findings include: The establishment's Resident Bill of Rights policy,	A6000		

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A6000	Continued From page 1	A6000		

revised 1/2014, documents "While residing in a health care facility, each Resident, Guardian, Power of Attorney, and Durable Power of Attorney for health Care Decisions has certain rights protected by the state. This document will outline and explain these rights." "Freedom from Abuse and Restraints - you will be free form physical, sexual, or mental abuse, corporal punishment and involuntary seclusion." And "File complaints about Abuse, Neglect, or Misappropriation of Property - You have the right to file a complaint with the state agency that inspects (named establishment), if you feel you have been abused or neglected or if you believe our property has been stolen."

The establishment's initial State reportable, dated 3/4/26, documents "On 3/4/26, ED (E1 Executive Director) and HWD (E2 Health & Wellness Director) were notified of possible verbal abuse allegation towards staff (Z1 former caregiver) against resident (R3). Date of occurrence: 3/3/26."

R3's clinical record documents R3 is non-ambulatory and requires staff assistance with dressing, transferring, mobility, and toileting.

On 3/25/26, at 2:45pm, R3 sat in a recliner in his apartment. R3 stated the following: A caregiver (Z1 former caregiver) was helping me get ready for bed. (Z1) was obnoxious and very demanding. (Z1) jerked this (call pendant) out of my hands and took control of it. (Z1) had it in her possession for a while. "I was very much upset. It was very disturbing."

The establishment's interview notes for witness E4 Caregiver, dated 3/4/26, documents E4 stated "The caregiver (Z1 former Caregiver) was

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A6000	Continued From page 2	A6000		

cussing and yelling at (R3). (R3) asked to go to the bathroom and (Z1) said 'no, you have to pee yourself."

On 3/26/26, at 8:50am, E4 Caregiver confirmed E4's interview statements. E4 stated that E4 believed this to be abuse and neglect of refusing a resident to use the bathroom.

The establishment's interview notes for witness E3 Caregiver, dated 3/4/26, documents E3 stated "(Z1) walks into the room. (Z1) is hostile and you can see she's mad. (Z1) immediately cussing (R3) out and yelling, refusing to take (R3) to the bathroom. (R3) transferred himself then (Z1) helped. (R3) had to change himself. (Z1) told (R3) that he had to sleep in his bed wet since (R3) did it to himself.'"

On 3/26/26, at 9:15am, E3 Caregiver confirmed E3's interview statements. E3 stated that (Z1) felt (R3's) bed that was wet and said (R3) could lay in it and all the things (R3) did. (Z1) got (R3) back into the wet bed and left the room.

On 3/25/26 at 3:04pm, E2 Health & Wellness Director stated the following: We substantiated it as verbal abuse by (Z1 former Caregiver) towards (R3). (Z1) was terminated.

The establishment's Disciplinary/Counseling Report, dated 3/6/26, documents Z1 former Caregiver was terminated on 3/5/26 for Company Policy Violation and Resident Abuse.

The establishment's Resident Roster, dated 3/4/26, documents there were 51 residents residing in the establishment.

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A6010	Continued From page 3	A6010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

This Regulation is not met as evidenced by:
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:

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.

TYPE 1 VIOLATION

Based on observation, interview, and record review the establishment failed to report an allegation of abuse and neglect to Management immediately for one (R3) of three residents reviewed for abuse in a sample of four. The establishment then failed to remove the perpetrator from direct contact with the residents. This failure has the potential to affect all 51 residents residing in the establishment and creates a substantial probability of severe harm to resident or residents.

Findings include:

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A6010	Continued From page 4 The establishment's Abuse, Neglect, and Financial Exploitation, Preventing and Reporting policy, revised 02/2025, documents "Policy: (Named establishment) does not tolerate abuse, neglect and/or exploitation of residents by anyone and will do all within its powers to prevent it from occurring." "Procedure: 1. Any (Named establishment) Family Member who has reasonable cause to belie e 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." "3. The alleged perpetrator(s) will be immediately suspended by the Branch." "Note: (Named establishment) Family Members must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion." The establishment's initial State reportable, dated 3/4/26, documents "On 3/4/26, ED (E1 Executive Director) and HWD (E2 Health & Wellness Director) were notified of possible verbal abuse allegation towards staff (Z1 former caregiver) against resident (R3). Date of occurrence: 3/3/26." On 3/25/26, at 2:45pm, R3 sat in a recliner in his apartment. R3 stated the following: A caregiver (Z1 former caregiver) was helping me get ready for bed. She was obnoxious and very demanding. She jerked this (call pendant) out of my hands and took control of it. She had it in her possession for a while. I was very much upset. It was very disturbing. The establishment's interview notes for R3, dated 3/4/26, documents R3 stated "On one occasion I was getting ready for bed. I requested to go to the bathroom, and this girl gave me a rough time."	A6010		

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A6010	Continued From page 5 On 3/26/26, at 8:41am, E4 Caregiver stated the following: (On 3/3/26) I went into (R3's) room to assist (Z1 former Caregiver) with (R3). (R3) was touching himself inappropriately and (Z1) started yelling and cussing at (R3). (Z1) escalated the situation; it was very heated. (R3) asked to go to the bathroom, and (Z1) refused to take (R3) and told (Z1) to wet himself and sit it in until overnight shift came in. (R3) tried to transfer himself into the wheelchair, but (Z1) kept holding the wheelchair back. (R3) ended up wetting himself so then she finally took (R3) to the bathroom. (Z1) held up (R3's) wet brief to (R3) and said, "Did you learn your lesson?" I felt that this was verbal abuse and neglect of refusing a resident to use the bathroom. I reported it the next night shift caregiver. Now I know I should report suspected abuse to (E2 Health & Wellness Director.) On 3/26/26, at 9:09am, E3 Caregiver stated the following: (E4 Caregiver, Z1 former Caregiver) and I went into (R3's) room around 9pm. (R3) was laying in bed saying he needs to use the bathroom. (Z1) started saying "no you are disgusting." Earlier (R3) was touching himself inappropriately. (R3) then said he wet the bed and needs the bed changed. (Z1) started cussing and using vulgar language. (R3) transferred himself into the wheelchair which forces (Z1) to take action. (Z1) took (R3) to the bathroom. (Z1) was vulgar and being inappropriate with (R3) while helping (R3) toilet. (R3) got his shirt off. (Z1) wheeled him back to the bedside, saying he is worthless. (R3) tried to undress and get clean clothes on. (Z1) helped then felt his bed that was wet and said (R3) could lay in it and all the things (R3) did. (Z1) got him back into the wet bed and left the room. I felt it was verbal abuse. I reported it to (E2 Health & Wellness Director/HWD) and	A6010		

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A6010	Continued From page 6 (E1 Executive Director/ED) the next morning. I should have reported it as soon as it happened. On 3/25/26 at 3:04pm, E2 Health & Wellness Director stated the following: We substantiated it as verbal abuse by (Z1 former Caregiver) towards (R3). (Z1) was terminated. We were notified the day after in the morning. It happened on 3/3/26 after dinner in the evening. (E3 Caregiver) reported it to myself and (E1 Executive Director.) (E3) should have reported it as soon as it happened. (Z1) completed her shift because we didn't know about it until the next day. (Z1) should have been sent home immediately - if we had known about it. The establishment's Timesheet record, printed on 3/25/26, documents Z1 former Caregiver worked on 3/3/26 from 3:04pm until 10:30pm. The establishment's Resident Roster, dated 3/3/26, documents there were 51 residents residing in the establishment.	A6010		