STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510062	A. BUILDING: _____ B. WING _____	C 06/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEORIA BICKFORD COTTAGE	2000 W WILLOW KNOLLS DR PEORIA, IL 61614

(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 investigation of complaint 2524963 / IL 193661 295.6000 a) 13) 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; VIOLATION Based on record review and interviews, the establishment failed to prevent neglect of one of three sampled residents. (R1) Findings include: R1's records note that R1 has resided at the establishment since 3/15/19. Current service plan dated 4/3/25, notes that R1 requires total staff assistance with repositioning and incontinent care. Service plan notes that R1 is to be turned, repositioned, and checked for incontinence at least every two hours.	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510062	A. BUILDING: _____ B. WING _____	C 06/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEORIA BICKFORD COTTAGE	2000 W WILLOW KNOLLS DR PEORIA, IL 61614

(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
A6000	Continued From page 1 On 6/8/25 at 11:30 A.M., Z1 (R1's Niece) stated that they have a camera in R1's room that is motion censored. Z1 stated that they had received a call on 5/23/25 by a nurse that informed them that R1 would be staying in bed for dinner due to his mechanical sling drying after being washed and that staff would feed him in bed. Z1 stated that when reviewing the video footage that evening she noted that R1 was provided incontinent care and repositioned in bed at 4:24 P.M.. R1 remained in that same position in bed when being fed by staff at 6:00 P.M.. Z1 stated that she continued to monitor the video system until 11:58 P.M. and no staff had been in all night to provide repositioning or incontinent care. Z1 stated she then called the facility and a caregiver answered and said that she would get in there right away and provide the care. Z1 stated that she noted that the caregiver did go right into R1's room and provided incontinent care and repositioning. This was over seven and a half hours with no care. Z1 stated that this was not the first time this has happened but she felt the need to call and complain to the staff so this lack of care does not continue. On 6/8/25 at 12:15 P.M., E1 (Executive Director) stated that R1's family did call the facility on 5/23/25 to let the staff know that R1 had not received any care for several hours that evening. E1 stated that they are aware of the situation and there is no excuse but they are making sure this does not happen again.	A6000		