

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
NAME OF PROVIDER OR SUPPLIER PEORIA BICKFORD COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint Investigation #2525336/IL194374 Section 295.6000 a)5)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: 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 Based on interview and record review, the establishment neglected to toilet/change a resident for an extended period of time for one (R1) of three residents reviewed for toileting in a sample of three. Findings include: On 6-16-25 at 11:30 am, Z1 (R1's family) stated	A6000		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
NAME OF PROVIDER OR SUPPLIER PEORIA BICKFORD COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 the following: On 5-20-25, Z1 stated there is a camera in R1's room and he could see that from 6:30 pm until after 11:00 pm, R1 was up and had not been checked on or put to bed. Z1 called the establishment and when no one answered, he went there and found R1 incontinent of BM (bowel movement) and not put to bed. On 5-28-25 at 11:15 am, Z1 saw on camera that R1 was wet. Z1 again called the establishment and when no one answered, he went to the establishment. R1 was found in the hallway looking for help. R1's shirt and pants were soaked with urine and beginning to dry. R1's incontinence brief was soaked and feces filled. On June 9, 2025, when Z1 visited R1 late afternoon, R1 was found to have hard balled feces stuck to his bottom area when changed. R1 stated it hurt when being changed and cleaned. On 6-16-25 at 1:05 pm, E1 (Executive Director) she looked into the above incidents. E2 stated on 5-20-25, the caregiver assigned to R1 (caregiver no longer works at establishment), stated she did not go into R1's room, only checked on him from the doorway which is not visible on camera. E2 stated the for 5-28-25 incident, the E3 (CNA/Certified Nursing Assistant) assigned to R1 stated she toileted R1 at 9:45 am. Before lunch, R1 was visiting with another caregiver so E3 did not toilet him. For the 6-9-25 incident, E2 stated that incident occurred on Sunday 6-8-25. E2 stated R1 was refusing to be toileted that day. On 6-16-25 at 2:15 pm, E5 (Executive Director of sister Assisted Living next door) stated on 5-28-25 before lunch, she saw R1's clothing soaked with urine. E1 asked E3 when R1 was last toileted and E3 told her about 9:45 am.	A6000		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
NAME OF PROVIDER OR SUPPLIER PEORIA BICKFORD COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 2 On 6-17-25 at 10:00 am, E3 (CNA) stated on 5-28-25, R1 was already up for the day on her shift. R1 was not cooperative that day. About 9:30 am, she got R1 to the bathroom but could not get him changed as he was uncooperative. E3 stated she then showered another resident and then went on break shortly before lunch. E3 stated she did not toilet/change R1 that morning. R1's 3-26-25 service plan documents R1 resides on the dementia unit and has problems with cognition. R1's service plan documents R1 is incontinent at times. The caregivers are to assist R1 with toileting during AM and PM cares, before and after meals, and as needed. The service plan also states caregivers will assist R1 in changing if soiled.	A6000		