STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105934	A. BUILDING: _____ B. WING _____	C 05/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF AURORA	7 SOUTH ORCHARD ROAD AURORA, IL 60506

(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 Facility Reported Incident IL 201460. 295.6000 a) 13)	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 record review and interviews, the establishment neglected to provide the service planned supervision during ambulation for one of three sampled residents. (R1) This failure resulted in a fall in which caused a subarachnoid hemorrhage. This failure has the substantial probability to cause severe harm to a resident or residents. Findings include: R1's Service Plan notes that R1 was admitted to the establishment on 2/17/25 and has Diagnosis including Parkinson's Disease. Service Plan	A6000		

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A6000	Continued From page 1	A6000		

notes that R1 is a high fall risk. R1 requires one assist and caregiver to "Hold onto the gait belt when (R1) is up."

R1's fall report dated 4/21/26 reads, "Writer (E3 Nurse) called to resident's room (R1), Resident observed laying on the floor face down on her left side near recliner chair. Resident (R1) breathing and conscious but no response when asked if she was okay. Per BFM (Caregiver) resident was walking to her recliner chair from the bathroom when she fell, she had just finished her shower. Writer called 911. Resident began to speak, resident stated she didn't remember falling. Resident wearing slippers and fully dressed. Resident walker was near resident, gait belt not on. Resident assessed. No physical signs of a head injury. Resident had no complaints of pain or discomfort. Resident complained of dizziness. ROM WNL (range of motion within normal limits). No apparent injury noted. BP (blood pressure) 168/96, P (pulse) 65, T (temperature) 97.7 (degrees Fahrenheit), R (respirations) 18. Resident sent to ER for evaluation and treatment. .... Updated after ER visit - Subarachnoid Hemorrhage."

On 5/2/26 at 10:15 A.M., R1 stated that she remembers the day of 4/21/26 but does not remember the actual fall itself. R1 stated that after her shower, she was walking out of the bathroom with E4 (Caregiver). R1 stated that E4 told her to stay standing there while E4 went over to her bed to pull down the covers and get the bed ready. R1 stated that apparently was when R1 fell. R1 stated that E4 probably should not have left her standing alone, but E4 is her favorite caregiver.

On 5/2/26 at 11:08 A.M., E2 (Health and

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A6000	Continued From page 2 Wellness Director) stated that R1 is not supposed to be left standing or ambulating without hands on assistance, with staff holding on to gait belt. E2 stated that the caregiver (E4) left R1 in standing alone while she went to pull down the bed covers. R1 fell at this time. R1 went to the hospital, where she was noted to have a small brain bleed. E2 stated that E4 did receive a written disciplinary action. Establishment Disciplinary / Counseling Report for E4 reads, "At 8 pm after shower for Res. (R1), Resident was ambulating with her walker without a gait belt. Her (R1) service plan includes a gait belt with all ambulation. Caregiver (E4) should have hands on resident using the gait belt for resident safety and to lower her risk of falling. Failing to follow the service plan can result in resident injury, even death."	A6000		