

## Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ASL510059</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/13/2025</b> |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BICKFORD - MOLINE COTTAGE</b> |                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3650 41ST ST<br/>MOLINE, IL 61265</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                | Initial Comment<br><br>Annual Licensure Survey.<br><br>For this survey, the establishment is in<br>compliance with Part 295 Assisted Living and<br>Shared Housing Establishment Administrative<br>Code and 210 ILCS 9/1 Assisted Living and<br>Shared Housing Act. | A 000                                                                                 |                                                                                                                          |                                                        |

Illinois Department of Public Health

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

TITLE

(X6) DATE