

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD - ROCKFORD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>960 N MULFORD RD</b> <b>ROCKFORD, IL 61107</b>
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A 000	<p>Initial Comment</p> <p>Investigation IL00197369, IL00197371, IL00197392, IL00197396, IL00197449 conducted on 9/15/2025-9/16/2025.</p> <p>IL00197369: Unsubstantiated</p> <p>IL00197371: Unsubstantiated</p> <p>IL00197392: Substantiated 295.2000 a) c) 3) 4) 5) 295.4000 a) b) c) 295.4010 d) 295.6000 a) 13)</p> <p>IL00197396: Substantiated 295.6010 a) 1)</p> <p>IL00197449: Substantiated</p>	A 000		
A2000	<p>Section 295.2000 Residency Requirements</p> <p>This Regulation is not met as evidenced by: Type 1 Violation</p> <p>Section 295.2000 Residency Requirements</p> <p>a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act)</p>	A2000		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A2000	<p>Continued From page 1</p> <p>c) A person shall not be accepted for residency if:</p> <p>3) The person requires total assistance with 2 or more activities of daily living</p> <p>4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living;</p> <p>5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect themselves, given the staffing and construction of the building;</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, record review, and interview, the establishment allowed a resident to remain in residence that required a level of service which the establishment is not licensed for. The establishment also let a resident remain in residence while requiring total assistance with 2 or more activities of daily living. The establishment also let a resident remain in residence that requires the assistance of more than one paid caregiver. These failures involve 2 of 4 residents reviewed for this requirement (R1 &amp; R13). These actions created a substantial probability of harm to a resident.</p> <p>Findings include:</p> <p>During observation on 9/15/2025 at 8:52 AM of R1's room camera video footage it was seen that</p>	A2000		

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A2000	<p>Continued From page 2</p> <p>on 9/20/2024 at 3:45 AM R1 crawled from their bed to their bathroom. It was seen that on 9/23/2024 at 5:00 AM R1 was yelling for help and crawled from their bed to their bathroom. It was seen that on 9/27/2024 at 3:59 AM R1 crawled from their bed to their bathroom.</p> <p>During observation on 9/15/2025 at 10:00 AM of R1's room camera video footage it was seen that on 9/28/2024 at 11:10 PM R1 yelled for help from their bed. Z1(R1's Family Member) can be heard from the camera reassuring R1 that the establishment is being called and that R1 will receive help soon. At 11:39 PM an employee came to help R1. It was seen that on 10/01/2024 at 4:36 AM R1 yells for help. An employee responds at 4:45 AM. It was seen that on 10/02/2024 at 8:33 PM R1 yells for help and crawls to the bathroom from their bed. At 8:45 PM two employees came to assist R1. It was seen that on 10/04/2024 at 1:48 AM R1 yells for help and crawls from their bed to their bathroom. R1 arrives back from the restroom with a caregiver at 2:32 AM. It was seen that on 10/04/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to assist R1.</p> <p>During observation on 9/15/2025 at 10:20 AM of R1's room camera video footage it was seen that on 10/4/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to help R1. At 8:01 PM R1 yells for help and is calmed by Z1. On 10/05/2024 at 5:25 AM R1 yells for help. At 5:50 AM R1 is seen still yelling for help. At 5:53 AM a caregiver arrives to help R1.</p> <p>During observation on 9/15/2025 at 10:40 AM of R1's room camera video footage it was seen that</p>	A2000		

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A2000	<p>Continued From page 3</p> <p>on 10/08/2024 at 1:00 AM R1 yells for help. Z1 can be heard reassuring R1 that the establishment has been notified. At 1:06 AM a caregiver arrives to help R1. At 3:41 AM R1 crawls to the bathroom. At 3:53 AM a caregiver arrives to help R1. At 6:35 AM R1 can be seen yelling for help. At 6:41 AM a caregiver arrives to help R1. On 10/10/2024 at 1:30 AM R1 can be seen crawling out of bed. Z1 contacts the establishment and a caregiver arrives to help R1. On 10/11/2025 at 12:23 AM R1 yells for help and caregivers respond. On 10/14/2025 at 1:56 AM R1 can be seen yelling for help. At 2:32 AM R1 continues to yell for help. Z1 calls the establishment and a caregiver arrives to help R1.</p> <p>During record review on 9/15/2025 at 8:30 AM it was found that the establishment is licensed for 65 assisted living units and zero Alzheimer's/memory care units.</p> <p>During record review on 9/15/2025 it was found that R1 was not being seen by hospice care.</p> <p>During record review on 9/15/2025 at 11:00 AM it was found that many emails were sent from the family to the establishment. The family expressed care concerns. The emails contain no recommendations from the establishment that the R1 be sent to a higher level of care.</p> <p>During record review on 9/15/2025 at 12:19 PM it was found that R1 had a cognitive assessment (MMSE) conducted on 7/11/2024. R1 scored 16/30- Severe Cognitive Impairment.</p> <p>During record review on 9/15/2025 at 12:28 PM it was found that R1 had a physician certification completed on 5/1/2024, however it was completed by a nurse practitioner and not a</p>	A2000		

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A2000	<p>Continued From page 4</p> <p>physician.</p> <p>During record review on 9/15/2025 at 12:31 PM it was found that R1 had a cognitive assessment (Global Deterioration Scale) completed on 7/11/2024. R1 scored a 5-Moderately Severe Cognitive Decline.</p> <p>During record review on 9/16/2025 at 9:30 AM R1's service plan, dated 10/01/2024, was reviewed. This service plan documents R1 as a maximum assist for bathing, dressing, transferring, cognition, and medication administration. The service plan also documents that R1 was exit seeking and had advanced dementia with speech, functional, and behavioral impairment.</p> <p>During record review on 9/16/2025 at 10:00 AM R1's earliest available service plan was reviewed. This service plan was dated 1/22/2024. This service plan documents R1 as a maximum assist for bathing, dressing, transferring, mobility, cognition, and medication management. Based on service plan dates and discharge date, the resident was in the establishment while having at least two activities of daily living requiring maximum assistance for at least 267 days.</p> <p>During record review on 9/16/2025 at 10:57 AM R1's progress notes for 2024 were reviewed. These notes contain no documentation of the facility recommending a higher level of care for R1 to the R1's family.</p> <p>During record review on 9/16/2025 at 2:37 PM a 9/10/2025 note was found in R13's record. This note states, "This nurse was called into resident's room because resident would not get off toilet. Did call daughter. Daughter was not able to coax</p>	A2000		

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A2000	<p>Continued From page 5</p> <p>resident off toilet. 3 CNA's needed to transfer resident to bed. Z12 was also notified. currently taking 12.5 mg seroquel."</p> <p>Another R13 note on 9/2/2025 stated, "Resident assisted from floor and into wheelchair with assistance of 3 staff members and gait belt."</p> <p>Another R13 note on 8/20/2025 stated, "Resident was placed in his recliner with this writer and 1 caregiver."</p> <p>Another R13 note on 8/22/2025 stated, "Resident had to be assisted by four staff members in order to get down to lunch. Resident took 30 minutes to get from recliner chair until wheelchair."</p> <p>During record review on 9/16/2025 at 2:51 PM R13's most recent service plan was reviewed. This service plan was dated 5/14/2025 and did not list R13 as being on hospice.</p> <p>During an interview with E7 (LPN) on 9/16/2025 at 11:38 AM they stated, "R1 had a call pendant but R1 could not remember to use it."</p> <p>During an interview with E7 on 9/16/2025 at 2:13PM they stated, "At first, they are they can push the button. After 2-3 months and they would have increased in confusion. Everyone is ok with one assist, but a couple times they might need 2 people assist. R13. R13 played football in the past. R13 needs assist at times but not always."</p>	A2000		
A4000	Section 295.4000 Physician/s Assessment	A4000		

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A4000	<p>Continued From page 6</p> <p>This Regulation is not met as evidenced by: Section 295.4000 Physician's Assessment</p> <p>a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.</p> <p>b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician.</p> <p>c) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition.</p> <p>Type 2 Violation</p> <p>This requirement was not met, as evidenced by:</p> <p>Based on record review, the establishment failed to ensure that physician's assessments were completed by a physician. This failure involves 1 of 1 resident reviewed for this requirement (R1). This failure creates a substantial probability of harm to a resident or residents.</p> <p>Findings include:</p> <p>During record review on 9/15/2025 at 12:28 PM it was found that R1 had a physician certification</p>	A4000		

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A4000	Continued From page 7  completed on 5/1/2024, however it was completed by a nurse practitioner and not a physician.	A4000		
A4010	Section 295.4010 Service Plan  This Regulation is not met as evidenced by: Section 295.4010 Service Plan  d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)  Type 1 Violation  This requirement was not met, as evidenced by:  Based on record review and observation, the establishment failed to ensure the service delivery contract was followed by not following the service plan. This failure involves 1 of 1 resident reviewed for this requirement (R1). This failure creates a substantial probability of severe harm to a resident or residents.  Findings include:  During record review on 9/16/2025 at 9:30 AM R1's service plan, dated 10/01/2024, was reviewed. This service plan documents R1 as a maximum assist for bathing, dressing, transferring, cognition, and medication	A4010		

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A4010	<p>Continued From page 8</p> <p>administration. The service plan also documents that R1 was exit seeking and had advanced dementia with speech, functional, and behavioral impairment.</p> <p>During record review on 9/16/2025 at 10:00 AM R1's earliest available service plan was reviewed. This service plan was dated 1/22/2024. This service plan documents R1 as a maximum assist for bathing, dressing, transferring, mobility, cognition, and medication management. Based on service plan dates and discharge date, the resident was in the establishment while having at least two activities of daily living requiring maximum assistance for at least 267 days.</p> <p>During record review on 9/15/2025 it was found that Z2 (R1's POA) reached out to the facility via email on 10/4/2024 with concerns about R1's service plan not being followed.</p> <p>During record review on 9/16/2025 at 9:30 AM it was found that R1's service plan, dated 10/01/2024, addressed every 2 hour safety checks for R1. The service plan also required R1 to be taken to the bathroom at 10:30 PM and 3:30 AM every night.</p> <p>R1's 7/11/2024 service plan addressed every 2 hour safety checks for R1 and a specified bathroom break at 12:30 AM nightly.</p> <p>R1's 3/26/2024 service plan addressed every 2 hour safety checks for R1 and a specified bathroom break at 12:30 AM nightly.</p> <p>During record review on 9/16/2025 at 12:00 PM it was found that Z1(R1's family) sent an email to Z3(Former, but at the time current, Executive Director) on 6/14/2024 stating, "The last two</p>	A4010		

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A4010	<p>Continued From page 9</p> <p>nights, it appears that nobody checked in on our mom or toileted her, despite her care plan indicating she should be checked every two hours."</p> <p>Z1 also sent emails to the establishment on 9/23/2024, 10/02/2024, 10/07/2024, and 10/14/2024 regarding concerned that R1's service plan was not being followed.</p> <p>During record review on 9/16/2025 at 1:05 PM Z1's spreadsheet notes were reviewed. This spreadsheet also contains video footage from R1's room. These notes document the following:</p> <ul style="list-style-type: none"> <li>9/19/2024- 7.5 hour no toileting</li> <li>9/20/2024- 5 hours 45 minutes no toileting</li> <li>9/21/2024- No toileting for over 10 hours</li> <li>9/22/2024- No toileting for 13 hours</li> <li>9/23/2024- No toileting for 9 hours</li> <li>9/24/2024- No toileting for 6.5 hours</li> <li>9/25/2024- No toileting for 6.5 hours</li> <li>9/26/2024- no toileting for 9 hours</li> <li>9/27/2024- no toileting for 6 hours</li> <li>9/30/2024- Toileted once Sunday night</li> <li>10/01/2024- No toileting for 9.5 hours</li> <li>10/02/2024- no toileting for 6 hours</li> <li>10/04/2024- no toileting for 6 hours and 20 minutes</li> <li>10/07/2024- no toileting at 10:30 PM</li> <li>10/08/2024- 3:30 AM toileting missed</li> <li>10/11/2024- No 10:30 PM toileting</li> <li>10/12/2024- toileted once</li> </ul> <p>During observation on 9/15/2025 at 8:52 AM of R1's room camera video footage it was seen that on 9/20/2024 at 3:45 AM R1 crawled from their bed to their bathroom. It was seen that on 9/23/2024 at 5:00 AM R1 was yelling for help and crawled from their bed to their bathroom. It was seen that on 9/27/2024 at 3:59 AM R1 crawled from their bed to their bathroom.</p>	A4010		

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A4010	<p>Continued From page 10</p> <p>During observation on 9/15/2025 at 10:00 AM of R1's room camera video footage it was seen that on 9/28/2024 at 11:10 PM R1 yelled for help from their bed. Z1 can be heard from the camera reassuring R1 that the establishment is being called and that R1 will receive help soon. At 11:39 PM an employee came to help R1. It was seen that on 10/01/2024 at 4:36 AM R1 yells for help. An employee responds at 4:45 AM. It was seen that on 10/02/2024 at 8:33 PM R1 yells for help and crawls to the bathroom from their bed. At 8:45 PM two employees came to assist R1. It was seen that on 10/04/2024 at 1:48 AM R1 yells for help and crawls from their bed to their bathroom. R1 arrives back from the restroom with a caregiver at 2:32 AM. It was seen that on 10/04/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to assist R1.</p> <p>During observation on 9/15/2025 at 10:20 AM of R1's room camera video footage it was seen that on 10/4/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to help R1. At 8:01 PM R1 yells for help and is calmed by Z1. On 10/05/2024 at 5:25 AM R1 yells for help. At 5:50 AM R1 is seen still yelling for help. At 5:53 AM a caregiver arrives to help R1.</p> <p>During observation on 9/15/2025 at 10:40 AM of R1's room camera video footage it was seen that on 10/08/2024 at 1:00 AM R1 yells for help. Z1 can be heard reassuring R1 that the establishment has been notified. At 1:06 AM a caregiver arrives to help R1. At 3:41 AM R1 crawls to the bathroom. At 3:53 AM a caregiver arrives to help R1. At 6:35 AM R1 can be seen yelling for help. At 6:41 AM a caregiver arrives to</p>	A4010		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510064</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD - ROCKFORD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>960 N MULFORD RD</b> <b>ROCKFORD, IL 61107</b>
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A4010	Continued From page 11  help R1. On 10/10/2024 at 1:30 AM R1 can be seen crawling out of bed. Z1 contacts the establishment and a caregiver arrives to help R1. On 10/11/2025 at 12:23 AM R1 yells for help and caregivers respond. On 10/14/2025 at 1:56 AM R1 can be seen yelling for help. At 2:32 AM R1 continues to yell for help. Z1 calls the establishment and a caregiver arrives to help R1.	A4010		
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  This requirement was not met, as evidenced by:  Based on observation and record review, the establishment failed to ensure a resident was free from neglect by failing to ensure that the residents service plan was followed. The establishment also failed to provide antibiotic treatment in a timely manner. These failures involved 1 of 4 residents reviewed for this	A6000		

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A6000	<p>Continued From page 12</p> <p>requirement (R1). These failures create a substantial probability of severe harm to a resident or residents.</p> <p>Findings include:</p> <p>On 9/6/2025 the Illinois Department of Public Health received a complaint about the establishment. The complaint stated, "Care logs and videos show that R1 was left for long stretches without toileting, sometimes forced to crawl to the bathroom, and that staff often failed to check on R1. Ultimately, the neglect led to an untreated urinary tract infections that went unaddressed for a week, despite the family's request for treatment, directly causing R1's Death. the failure to follow R1's toileting and hydration care plan directly contributed to the development and worsening of this infection."</p> <p>Section 295.200 Definitions defines neglect as: Neglect - a failure by the establishment to provide services, as outlined in the service delivery contract; a failure to notify the appropriate health care professional that an assessment is necessary in accordance with the service plan; a failure to modify a service plan, as appropriate, based on a new physician's assessment; or a failure to terminate the residency of an individual whose needs can no longer be met by the establishment, which failure results in an avoidable decline in function.</p> <p>During record review on 9/15/2025 the following timeline regarding R1's urinary tract infection was revealed: 10/11/2024- Z2(R1's POA) requests that a urine analysis be performed on R1 due to behavior changes. 10/14/2024- R1 is noted to have blood in their</p>	A6000		

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A6000	<p>Continued From page 13</p> <p>incontinence brief.</p> <p>10/15/2024- A urine sample is taken from R1.</p> <p>10/17/2024- R1's urine sample is resulted and reported. Positive for leukocytes, nitrites, and white blood cells. Positive for High E.Coli at &gt;39,000,000 copies/mL.</p> <p>10/18/2024- R1 started antibiotic treatment.</p> <p>10/19/2024- R1 was noted by staff to be weak and confused with urinary frequency. R1 admitted to the hospital with a diagnosis of a severe urinary tract infection.</p> <p>10/23/2024- R1 was discharged from the hospital to a skilled nursing facility.</p> <p>10/29/2024- R1 passes away. Death certificate lists cardiomyopathy, acute kidney injury, and urinary tract infection as causes of death.</p> <p>During record review on 9/15/2025 it was found that Z2 (R1's POA) reached out to the facility via email on 10/4/2024 with concerns about R1's service plan not being followed.</p> <p>During record review on 9/16/2025 at 9:30 AM it was found that R1's service plan, dated 10/01/2024, addressed every 2 hour safety checks for R1. The service plan also required R1 to be taken to the bathroom at 10:30 PM and 3:30 AM every night.</p> <p>R1's 7/11/2024 service plan addressed every 2 hour safety checks for R1 and a specified bathroom break at 12:30 AM nightly.</p> <p>R1's 3/26/2024 service plan addressed every 2 hour safety checks for R1 and a specified bathroom break at 12:30 AM nightly.</p> <p>During record review on 9/16/2025 at 12:00 PM it was found that Z1(R1's family) sent an email to E3(Former, but at the time current, Executive</p>	A6000		

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A6000	<p>Continued From page 14</p> <p>Director) on 6/14/2024 stating, "The last two nights, it appears that nobody checked in on our mom or toileted her, despite her care plan indicating she should be checked every two hours."</p> <p>Z1 also sent emails to the establishment on 9/23/2024, 10/02/2024, 10/07/2024, and 10/14/2024 regarding concerned that R1's service plan was not being followed.</p> <p>During record review on 9/16/2025 at 1:05 PM Z1's spreadsheet notes were reviewed. This spreadsheet also contains video footage from R1's room. These notes document the following:</p> <ul style="list-style-type: none"> <li>9/19/2024- 7.5 hour no toileting</li> <li>9/20/2024- 5 hours 45 minutes no toileting</li> <li>9/21/2024- No toileting for over 10 hours</li> <li>9/22/2024- No toileting for 13 hours</li> <li>9/23/2024- No toileting for 9 hours</li> <li>9/24/2024- No toileting for 6.5 hours</li> <li>9/25/2024- No toileting for 6.5 hours</li> <li>9/26/2024- no toileting for 9 hours</li> <li>9/27/2024- no toileting for 6 hours</li> <li>9/30/2024- Toileted once Sunday night</li> <li>10/01/2024- No toileting for 9.5 hours</li> <li>10/02/2024- no toileting for 6 hours</li> <li>10/04/2024- no toileting for 6 hours and 20 minutes</li> <li>10/07/2024- no toileting at 10:30 PM</li> <li>10/08/2024- 3:30 AM toileting missed</li> <li>10/11/2024- No 10:30 PM toileting</li> <li>10/12/2024- toileted once</li> </ul> <p>During observation on 9/15/2025 at 8:52 AM of R1's room camera video footage it was seen that on 9/20/2024 at 3:45 AM R1 crawled from their bed to their bathroom. It was seen that on 9/23/2024 at 5:00 AM R1 was yelling for help and crawled from their bed to their bathroom. It was</p>	A6000		

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A6000	<p>Continued From page 15</p> <p>seen that on 9/27/2024 at 3:59 AM R1 crawled from their bed to their bathroom.</p> <p>During observation on 9/15/2025 at 10:00 AM of R1's room camera video footage it was seen that on 9/28/2024 at 11:10 PM R1 yelled for help from their bed. Z1 can be heard from the camera reassuring R1 that the establishment is being called and that R1 will receive help soon. At 11:39 PM an employee came to help R1. It was seen that on 10/01/2024 at 4:36 AM R1 yells for help. An employee responds at 4:45 AM. It was seen that on 10/02/2024 at 8:33 PM R1 yells for help and crawls to the bathroom from their bed. At 8:45 PM two employees came to assist R1. It was seen that on 10/04/2024 at 1:48 AM R1 yells for help and crawls from their bed to their bathroom. R1 arrives back from the restroom with a caregiver at 2:32 AM. It was seen that on 10/04/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to assist R1.</p> <p>During observation on 9/15/2025 at 10:20 AM of R1's room camera video footage it was seen that on 10/4/2024 at 7:27 PM Z1 reminds R1 to push the call button on their wrist. At 7:32 PM a caregiver arrives to help R1. At 8:01 PM R1 yells for help and is calmed by Z1. On 10/05/2024 at 5:25 AM R1 yells for help. At 5:50 AM R1 is seen still yelling for help. At 5:53 AM a caregiver arrives to help R1.</p> <p>During observation on 9/15/2025 at 10:40 AM of R1's room camera video footage it was seen that on 10/08/2024 at 1:00 AM R1 yells for help. Z1 can be heard reassuring R1 that the establishment has been notified. At 1:06 AM a caregiver arrives to help R1. At 3:41 AM R1 crawls to the bathroom. At 3:53 AM a caregiver</p>	A6000		

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A6000	Continued From page 16  arrives to help R1. At 6:35 AM R1 can be seen yelling for help. At 6:41 AM a caregiver arrives to help R1. On 10/10/2024 at 1:30 AM R1 can be seen crawling out of bed. Z1 contacts the establishment and a caregiver arrives to help R1. On 10/11/2025 at 12:23 AM R1 yells for help and caregivers respond. On 10/14/2025 at 1:56 AM R1 can be seen yelling for help. At 2:32 AM R1 continues to yell for help. Z1 calls the establishment and a caregiver arrives to help R1.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr  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:  1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.  2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the	A6010		

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A6010	<p>Continued From page 17</p> <p>report.</p> <p>b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following:</p> <ol style="list-style-type: none"> <li>1) Dates, times, and description of the alleged abuse, neglect or financial exploitation;</li> <li>2) Description of any injury to the resident;</li> <li>3) Description of any change in the resident's physical, cognitive, functional, or emotional condition;</li> <li>4) Any actions taken by the licensee;</li> <li>5) A list of individuals and agencies interviewed or notified by the establishment;</li> <li>6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and</li> <li>7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future ...</li> </ol> <p>Type 1 Violation</p> <p>This requirement was not met, as evidenced by:</p> <p>Based on interview and record review, the establishment failed to investigate an injury of unknown origin upon notification that was determined to be multiple rib fractures.</p>	A6010		

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A6010	<p>Continued From page 18</p> <p>They failed to develop a written report that contained the required information, within 14 days after the initial report, and send it to the Department within 24 hours after it was completed for a resident.</p> <p>This applies to 2 of 10 (R4, R8) reviewed for this requirement. This failure creates a substantial probability of severe harm to a resident or residents, in that the establishment did not ensure injuries were not a result of abuse or neglect.</p> <p>The findings include:</p> <p>On 9/15/25, an investigation was initiated for complaints and facility reported incidents.</p> <p>Interviews and record reviewed showed no evidence that the establishment reported a serious incident to the Department, and conducted an investigation for an injury of unknown origin that resulted in a serious injury:</p> <p>R4's medical record showed R1 moved into the establishment on 6/24/24, was on hospice, passed away on 9/12/25, and had multiple diagnoses, including osteoarthritis, Raynaud's syndrome, and Alzheimer's disease.</p> <p>R4's Service Plan, dated 9/5/25, showed R4 had cognitive impairment, and required assist with Activities of Daily Living (ADLs), including total assist with transfers with mechanical lift, with the use of a sling.</p> <p>R4's Progress Notes showed E14 (LPN) was made aware, on 9/3/25, that R4 had purplish bruising to the left breast, left side of the body,</p>	A6010		

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A6010	<p>Continued From page 19</p> <p>and left upper arm area, of unknown origin, and E17 (Health and Wellness Director) would be notified. There was no documentation to show the establishment did an investigation to determine how the injuries occurred.</p> <p>R4's Progress Notes showed, on 9/6/25, E9 and E15 (both Caregivers) noticed bruising to R4's left side and immediately reported to the nurse.</p> <p>R4's September 2025 Hospice Notes showed report of left side abdominal pain that radiated around the back, on 9/2; report of a large bruise, on 9/3; a large deep purple bruise on the left chest that family did not know how it occurred, on 9/4; and report of a large dark purple bruise that expanded the whole left ribcage of the abdomen and breastbone, and guarding, discoloration, swelling, and pain to the left arm that staff did not know what occurred.</p> <p>R4's x-ray impressions, dated 9/6/25, showed osteopenia and spiral fracture to the left humerus.</p> <p>R4's Incident and Accident Report, date of occurrence 9/6/25, showed R4 had complaint of left arm pain, decrease in range of motion and swelling, and was unable to lift the arm. The report showed an x-ray of the arm was completed and R4 was diagnosed with a spiral fracture of the left humerus. The report did not mention the bruising to the left side.</p> <p>R4's After Visit Summary, dated 9/7/25, showed reason for visit as, arm injury. The summary showed diagnoses of humerus fracture and multiple rib fractures.</p> <p>During interview, on 9/16/25 at 2:42 PM, E1</p>	A6010		

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A6010	<p>Continued From page 20</p> <p>(Executive Director) confirmed the concern was not investigated but did not know why. E1 indicated, E17 (Health and Wellness Director) and E13 (Family Advisor) conducted investigations.</p> <p>During interview, on 9/16/25 at 2:53 PM, E13 indicated, E17 conducted the investigations, and she documented the staffs' answers to the questions asked. E13 indicated, she recalled the investigation on 9/6/25 related to R4's arm injury but did not recall any questions regarding the bruising to R4's side.</p> <p>The establishment failed to develop a written report within 14 days after the initial report and send it to the Department within 24 hours after it was complete:</p> <p>R8's medical record showed R8 moved into the establishment on 4/6/22 and has multiple diagnoses, including restlessness and agitation, dementia, and Alzheimer's disease.</p> <p>R8's Incident and Accident report, date/time of occurrence 5/10/25 at 9:10 AM, showed R8 presented with bruising around R8's right eye, with redness and swelling above the eyebrow, along with a slight abrasion.</p> <p>The establishment provided the completed investigation from 5/10/25.</p> <p>Establishment email, date/time 5/28/25 at 12:00 PM, to E17 (Health and Wellness Director), showed final report was due 5/24/25.</p> <p>Establishment email, date/time 5/28/25 at 4:03 PM, to the Department, showed, "Allegations of</p>	A6010		

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A6010	<p>Continued From page 21</p> <p>abuse were unsubstantiated. No evidence of abuse was reported by the resident or staff. Re-training was conducted with all staff on how to report unknown injuries or incidents.</p> <p>On 9/16/25, E1 indicated, the email communication provided was the follow-up report to the Department.</p>	A6010		