STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510067	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF TINLEY PARK	17301 80TH AVE TINLEY PARK, IL 60477

(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 FRI (Facility Reported Incident) -IL190943 (4/23/25) 295.3000 295.4010	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident. 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis. These Requirements were not met as evidenced by: Based on interview, and record review, the facility failed to adequately assess and monitor and document the neurological status of one resident who fell and sustained an orbital fracture and brain bleed after that resident was redmitted to the facility from the hospital. This failure affected 1 of 3 sampled residents (R1) reviewed for falls	A3000		

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A3000	Continued From page 1 with injuries. Findings include: R1 was admitted 7/14/23 with diagnoses including Dementia and Neurocognitive Disease. On 4/23/25 Progress Notes and Incident reports docuemnts staff found R1 laying prone on the hall floor. Another resident witnessed the fall and said R1 lost her balance and fell forward. The resident was conscious, talking and was bleeding from her left temporal area. After her transfer to the hospital she was found to have an orbital fracture and brain bleed. On 4/25/25 R1 was readmitted to the facility. R1's readmission note of 4/24/25 documents staff did document on the resident's left eye periorbital hematoma and 2 scabbed sores around the eye which were open to air. R1's record failed to document staff's assessment and or monitoring of the resident's neurological status during the readmission and afterwards. E4 (nurse) interviewed stated he'd not assessed the resident's neurological status after readmission. On 5/8/25 when asked about the care provided to R1 after she was readmitted on 4/24/25, E2, Wellness Director, replied stating the hospital said nothing could be done and the fracture would have to heal on it's own.	A3000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 2 This Regulation is not met as evidenced by: Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the 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) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). These Requirements are not met as evidenced by: Based on record review and interview the facility failed to revise a service plan to identify and address a resident's actual fall with injuries by failing to address care requirements for one resident who sustained an orbital fracture and a brain bleed. This failure affected one resident (R1) in the sample of 3 reviewed for falls. Findings include: R1 was admitted 7/14/23 with diagnoses	A4010		

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A4010	Continued From page 3 including Dementia and Neurocognitive Disease. The incident report and progress note documents R1's fall and transfer to the hospital. R1 fell on 4/23/25 and sustained a left orbital fracture and a brain bleed. R1 was readmitted to the facility on 5/24/25 with a left eye hematoma and scabbed sores on her face. R1's hospital discharge note dated 4/24/25 documented the resident had a fractured left maxillary sinus, fractured left orbital floor, and subarachnoid hemorrhage. Review of R1's service plan showed staff didn't identify R1's fractured orbital floor, her fractured maxillary sinus nor subarachnoid hemorrhage and didn't revise and implement interventions in an effort to address changes in R1's care needs. . On 5/8/25 at 4:00PM, E2, Wellness Director, admitted R1's service plan failed to identify and address the resident's fractures and changes in care needs.	A4010		