

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE CROWN POINT, IN 46307
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R000000	<p>This visit was for the Investigation of Complaint IN00154780.</p> <p>Complaint IN00154780- Substantiated. State Residential deficiency related to the allegation was cited at R0052 and R0090.</p> <p>Survey Dated: August 21, 2014</p> <p>Facility number: 012940 Provider number: 012940 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census by bed type: Residential: 25 Total: 25</p> <p>Census Payor type: Other: 25 Total: 25</p> <p>Residential Sample: 1</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 24, 2014, by Janelyn Kulik, RN.</p>	R000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from physical abuse, related to a family member grabbing a resident and pushing the resident onto a couch, which the resident received bruising to the upper arms. The facility failed to protect the resident after the incident had occurred and during the investigation, for 1 of 1 resident reviewed for abuse in a total sample of 1. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 08/21/14 at 1:22 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and chronic obstructive pulmonary disease.</p> <p>The Physician's Recapitulation Orders, dated 07/14, indicated the resident was receiving Eliquis (anticoagulant) 2.5</p>	R000052	<p><u>R 052—Residents Rights</u> Resident #B did have a negative effect. We believe this was an isolated incident, there is minimal potential for any further issues and no negative effect for other residents. Resident #B was the only resident who was interviewed as part of the invesigative process. Resident Rights will be discussed at the next Resident Council meeting which includes the right to feel safe and secure. If they do not , they will be instructed to see the RNC or Administrator. Service Plan care conferences will be scheduled every sixty days (for the next six months) with Resident #B and her family to increase communication and to monitor family dynamics. Director will audit all resident and personnel files to ensure that all involved parties have had basic education on Residents' Rights Residents' Rights will be discussed at the next Family Council Meeting Education will be provided on caregiver stress,</p>	09/30/2014

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	<p>milligrams twice daily.</p> <p>An assessment, dated 08/13/14, indicated the resident; placed clean depends under her mattress at night in case she had an incontinent episode, so she did not have to get up during the night to change her depends.</p> <p>A Global Deterioration Scale (cognition status), dated 03/17/14, indicated the resident scored a 4, resulting in moderate cognitive decline-"...decreased knowledge of current world events and recent events in own life...Frequently no deficits the following areas: a. orientation to time and person b. recognition of familiar persons and faces..."</p> <p>The resident's Progress Notes indicated: 08/09/14 at 11:30 a.m.- "...(CNA initials) caught writer and asked to enter resident's apartment as she was yelling to 'quit hurting me.' (Name) and resident arguing overuse of incontinence products & usage. Resident concerned that products didn't meet need, wanted additional liners and backup, daughter refused. Writer remained in room with resident and daughter until nurse arrived. Resident & daughter calmed. Resident states she was ok. Writer spoke with her regarding incontinence at which time she states she does not know when she needs to</p>		<p>specifically at next Dementia Support Group meeting · All families to have a resident diagnosed with dementia will be provided literature, with the monthly newsletter, about various topics related to the special challenges of dementia care for the next three months and then quarterly during 2015 · Director will send minutes of the Family Council and Dementia Support Group meetings to VP of Operations for next six months for monitoring of attendance and education provided/topics discussed POC date of completion 09.30.14 and on-going</p>	

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	<p>urinate...Resident states daughter grabbed upper right arm. Nurse to check for any signs of bruising/injury." The Resident's daughter remained in the building with the resident.</p> <p>08/09/14 at 11:50 a.m.-"Upon entering res (resident) room. (Executive Director) was c/ (with) resident & daughter (name). Res was quite shaken up and very nervous. Res was standing in her bathroom c/ director & rubbing her upper (arrow up) (r) (right) arm. Resident states to both myself & director that her daughter hurt her grabbing her arm & that her arm was hurting. Checked res (r) upper (arrow up) arm 0/ (no) s/s (signs/symptoms) of bruising or injury noted @ this time...daughter also trying dismiss mother's concern on her incontinency, explained to daughter it is our job/concern to address res concerns & provide assistance to her."</p> <p>08/10/14 at 9 a.m.- "f/u (follow-up) c/ res from yesterdays incident c/ daughter. Res states her (r) arm is sore 0/ problem c/ ROM (range of motion) 0/ bruising noted...checked (check mark) (l) (left) upper (arrow up) arm per res request noted x 3 small bruises. Res states daughter also grab (sic) her upper (arrow up) (l) arm at the same time she grab (sic) the (r) arm..."</p>			

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	<p>08/11/14 at 2:35 p.m.-"Bruising remains to her bil (bilateral) upper arms biceps/triceps area four dark blue bruises to left biceps/triceps area three bruises to right biceps/triceps area dark blue in color also resident states the bruises are from when her daughter pushed her to her love seat in her apt (apartment) when she was upset c/ her. RNC (RN Coordinator) is aware. Director is aware from 08/09/14 when it happened..."</p> <p>08/13/14 at 12:45 p.m.- (written by RNC) "...Resident also stated that Dtrs (daughter) has always been very strong, she also stated that she grabbed resident by both arms and was yelling at her. Writer asked if she hurt her and she said 'yes, she grabbed me'..." (unable to read the rest of the writing in the note, due to writing was illegible. The RN Divisional Director also was unable to read the rest of the writing and RNC not in building to clarify Progress Note).</p> <p>08/13/14 (no time documented) -"Condition of skin-5 small bruises noted to (l) upper arm & 2 small bruises noted to inside of (r) arm."</p> <p>An investigation dated 08/09/14 at 12:45 p.m. indicated, "To ensure the safety of the res & educated daughter her behavior</p>			

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	<p>towards res was unacceptable. Daughter seem to be remorse however seem to be dismissing us & wanted to get her mother out of apt where other family members were waiting."</p> <p>There was a lack of documentation to indicate the resident was kept safe from the family member during the investigation.</p> <p>During an interview on 08/21/14 at 11:30 a.m., CNA #1 indicated she had been walking past Resident #B's room (08/09/14) and heard the resident yell "stop your hurting my arms". CNA #1 indicated she informed the Executive Director and they went into the resident's room. She indicated the resident was upset and the resident's daughter said everything was ok. She indicated she had seen the daughter come back to visit the resident after the incident.</p> <p>During an interview on 08/21/14 at 12:32 p.m., Resident #B indicated her arm bruises had been caused by her daughter catching her when she was trying to pick items off the floor. She indicated her daughter was mad. Resident #B stated she was not starting to fall and her daughter grabbed her and pushed her back on the couch. She indicated her daughter did not want her over by the</p>						

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	<p>bed. She indicated this had never happened before and had not happened since the incident.</p> <p>During a telephone interview on 08/21/14 at 12:51 p.m., The RNC (RN Coordinator) indicated the Executive Director (ED) was in the building when the incident occurred and no staff had reported the incident to her (RNC). The RNC indicated the ED had reported the incident to her. She indicated the resident had said her daughter grabbed her arms because she was afraid she was going to fall and assisted her back into the chair. The RNC indicated she was told there were CNA's in the room at the time this occurred and the room was crowded. The RNC indicated she was not told who the CNA's were. She indicated the ED, "handled it".</p> <p>During an interview with the RN Divisional Director, on 08/21/14 at 1:12 p.m., she indicated it was reported to her as a non-issue. She indicated she was informed the RNC had spoke with the resident and the daughter and was told the resident was going to fall and the resident's daughter attempted to steady her.</p> <p>During a telephone interview on 08/21/14 at 2 p.m., the ED indicated she had not</p>			

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	<p>reported the incident because she did not feel this incident was abuse. She indicated the resident's daughter was removing the briefs from under the mattress and the resident was trying to go over to the bed to help the daughter pick up the briefs and the daughter was concerned about the resident's safety and had her hands on the residents arms trying to protect her from a fall and was trying to push the resident back. She indicated the resident was crying. The ED indicated the daughter was trying to protect the resident from harm and she did not feel it was abuse. The ED indicated she was not denying something occurred, but did not see it as anymore than the Resident's daughter trying to protect her mother.</p> <p>A facility policy, dated 07/12, received as current from the Director of Marketing, titled, "Abuse and Neglect", "...Bickford Family Members must not use verbal, mental, sexual or physical abuse..."</p> <p>This Residential Tag relates to complaint IN00154780.</p>			

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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent</p>			
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	<p>annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure an unusual occurrence, which directly threatened the safety of a resident was reported to the Indiana State Department of Health (ISDH), related to a potential abuse and an abuse allegation for 1 of 1 resident reviewed for abuse in a total sample of 1. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 08/21/14 at 1:22 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and chronic obstructive pulmonary disease.</p> <p>The Physician's Recapitulation Orders, dated 07/14, indicated the resident was receiving Eliquis (anticoagulant) 2.5 milligrams twice daily.</p>	R000090	<p><u>R 090. Administration and Management</u> Resident #B did have a negative effect. We believe this was an isolated incident, there is minimal potential for any further issues and no negative effect for other residents. · Specific education for Director by VP of Operations regarding the responsibility to evaluate and report issues · Director will report all incidents that threaten the welfare, safety or health of a resident to the Department within 24 hours of becoming aware · Director to audit personnel files to ensure required dementia training completed at hire and subsequent training on an annual basis · All staff will participate in an in-service on abuse prevention, identification and reporting · Specific education on identifying and treating caregiver/family stress to be provided by Divisional Director of Resident Services · Personnel files will be audited by VP for compliance with abuse and dementia training</p>	09/30/2014

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	<p>The resident's Progress Notes indicated: 08/09/14 at 11:30 a.m.- "... (CNA initials) caught writer and asked to enter resident's apartment as she was yelling to 'quit hurting me.' (Name) and resident arguing over use of incontinence products & usage. Resident concerned that products didn't meet need, wanted additional liners and backup, daughter refused. Writer remained in room with resident and daughter until nurse arrived. Resident & daughter calmed. Resident states she was ok. Writer spoke with her regarding incontinence at which time she states she does not know when she needs to urinate...Resident states daughter grabbed upper right arm. Nurse to check for any signs of bruising/injury." The Resident's daughter remained in the building with the resident.</p> <p>08/09/14 at 11:50 a.m.-"Upon entering res (resident) room. (Executive Director) was c/ (with) resident & daughter (name). Res was quite shaken up and very nervous. Res was standing in her bathroom c/ director & rubbing her upper (arrow up) (r) (right) arm. Resident states to both myself & director that her daughter hurt her grabbing her arm & that her arm was hurting. Checked res (r) upper (arrow up) arm 0/ (no) s/s (signs/symptoms) of bruising or injury noted @ this time...daughter also trying</p>		using core check process POC date of completion 09.30.14 and on-going				

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	<p>dismiss mother's concern on her incontinency, explained to daughter it is our job/concern to address res concerns & provide assistance to her."</p> <p>08/10/14 at 9 a.m.- "f/u (follow-up) c/ res from yesterdays incident c/ daughter. Res states her (r) arm is sore 0/ problem c/ ROM (range of motion) 0/ bruising noted...checked (check mark) (l) (left) upper (arrow up) arm per res request noted x 3 small bruises. res states daughter also grab (sic) her upper (arrow up) (l) arm at the same time she grab (sic) the (r) arm..."</p> <p>08/11/14 at 2:35 p.m.-"Bruising remains to her bil (bilateral) upper arms biceps/triceps area four dark blue bruises to left biceps/triceps area three bruises to right biceps/triceps area dark blue in color also resident states the bruises are from when her daughter pushed her to her love seat in her apt (apartment) when she was upset c/ her. RNC (RN Coordinator) is aware. Director is aware from 08/09/14 when it happened..."</p> <p>08/13/14 at 12:45 p.m.- (written by RNC) "...Resident also stated that Dtrs (daughter) has always been very strong, she also stated that she grabbed resident by both arms and was yelling at her. Writer asked if she hurt her and she said</p>			

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	<p>'yes, she grabbed me'...' (unable to read the rest of the writing in the note, due to writing was illegible. The RN Divisional Director also was unable to read the rest of the writing and RNC not in building to clarify Progress Note).</p> <p>08/13/14 (no time documented) -"Condition of skin-5 small bruises noted to (l) upper arm & 2 small bruises noted to inside of (r) arm."</p> <p>During an interview on 08/21/14 at 11:30 a.m., CNA #1 indicated she had been walking past Resident #B's room (08/09/14) and heard the resident yell "stop your hurting my arms". CNA #1 indicated she informed the Executive Director and they went into the resident's room. She indicated the resident was upset and the resident's daughter said everything was ok. She indicated she had seen the daughter come back to visit the resident after the incident.</p> <p>During a telephone interview on 08/21/14 at 12:30 p.m., the Local Ombudsman indicated she had not been notified by the facility of the occurrence.</p> <p>During an interview on 08/21/14 at 12:32 p.m., Resident #B indicated her arm bruises had been caused by her daughter catching her when she was trying to pick</p>						

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	<p>items off the floor. She indicated her daughter was mad. Resident #B stated she was not starting to fall and her daughter grabbed her and pushed her back on the couch. She indicated her daughter did not want her over by the bed. She indicated this had never happened before and had not happened since the incident.</p> <p>During a telephone interview on 08/21/14 at 12:51 p.m., The RNC (RN Coordinator) indicated the Executive Director (ED) was in the building when the incident occurred and no staff had reported the incident to her (RNC). The RNC indicated the ED had reported the incident to her. She indicated the resident had said her daughter grabbed her arms because she was afraid she was going to fall and assisted her back into the chair. The RNC indicated she was told there were CNA's in the room at the time this occurred and the room was crowded. The RNC indicated she was not told who the CNA's were. She indicated the ED, "handled it".</p> <p>During a telephone interview on 08/21/14 at 2 p.m., the ED indicated she had not reported the incident because she did not feel this incident was abuse. She indicated the resident's daughter was removing the briefs from under the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2014
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	<p>mattress and the resident was trying to go over to the bed to help the daughter pick up the briefs and the daughter was concerned about the resident's safety and had her hands on the residents arms trying to protect her from a fall and was trying to push the resident back. She indicated the resident was crying. The ED indicated the daughter was trying to protect the resident from harm and she did not feel it was abuse. The ED indicated she was not denying something occurred, but did not see it as anymore than the Resident's daughter trying to protect her mother.</p> <p>A facility policy, dated 07/12, received as current from the Director of Marketing, titled, "Abuse and Neglect", indicated, "...Reporting procedure will be to contact the State licensure authority and State Ombudsman within 24 hours...The report must be made to local law enforcement agency at times when the State offices are not open. A report will be called to the State offices on their next working day by the Director..."</p> <p>An Employee Manual, dated 05/12, received as current from the RN Divisional Director as current, indicated, "...Reporting Resident Abuse or Neglect...Once notified, the Director will conduct an internal investigation and</p>			

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	notify the appropriate agencies..." This Residential Tag relates to complaint IN00154780.				