STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF CROWN POINT	140 E 107TH AVENUE CROWN POINT, IN 46307

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00381025. Complaint IN00381025 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: 7/14/22 Facility number: 012940 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/19/22.	R 0000		
R 0052 Bldg. 00	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. Based on record review and interview, the facility failed to ensure residents had the right to be free from neglect, related to Licensed Professionals not assessing residents after falls, for 2 of 2 residents reviewed for falls. (Residents D and C) Resident D's falls resulted in a fractured hip and Resident C's fall resulted in a lumbar spine vertebrae fracture.	R 0052	R052 Residents Rights - Offense 2 residents were harmed by this deficient practice What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident C expired 7/16/22	08/12/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: 1. Resident D's record was reviewed on 7/14/22 at 1:13 p.m. The diagnoses included, but were not limited to, dementia. A Nursing Progress Note, dated 7/8/22, no time documented, indicated the resident had gotten out of bed, was walking to the door and fell. She was found on the floor in her room at 3 a.m. The note was signed by CNA 1. An investigation of the fall, dated 7/8/22 at 3 a.m. and received from the Resident Care Coordinator (RCC), indicated at approximately 2:55 a.m. CNA 1 heard the resident yell for help. CNA 1 and Registry QMA 2 entered the room and the resident was lying on the floor by the bedroom door. There were no visible signs of injury, no complaints of pain, and the fall was unwitnessed. The Executive Director was notified at 3:30 a.m. and the RCC was notified at 3:33 a.m. A Nursing Progress note, dated 7/8/22 at 9 a.m., signed by QMA 3, indicated the resident was calling out for help and found on the floor at 6:45 a.m. by a CNA (CNA 4). There was complaints of left hip and knee pain and the resident was still complaining of pain currently and was unable to bear weight on the left leg at 9 a.m. She was transferred to the hospital by ambulance. The investigation of the fall, received from the RCC, dated 7/8/22, indicated the resident had been found on the floor between the bed and the night stand at 6:45 a.m. and had complained of hip and leg pain on the left side. At 8:30 a.m. she was still complaining of pain and was unable to bear weight on the left side. She was transferred to the hospital. The fall was unwitnessed, there was		· Resident D still resides at Bickford of Crown Point · ACC and Administrator are responsible for ensuring that fall investigations are completed with each fall and that a licensed nurse is notified for assessment of resident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Administrator and ACC will audit Fall Risk Assessments and service plans of current residents to identify those with high fall risk and ensure interventions are in place. · ACC and Administrator will review residents of new admissions to ensure that fall interventions are listed and followed by care staff. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · ACC will be responsible for ensuring post-fall assessments are completed with each fall · ACC will provide re-education to all care staff on ACC notification and guidance post falls · ACC to be re-educated on phone assessments post falls · Administrator and ACC will be re-educated on Life Safety	

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	pain, a minor skin injury, and a suspected fracture. The site of the injuries were left upper extremity, left lower extremity, left knee, and left hip. The description of the occurrence indicated the resident was yelling out for help. CNA 4 entered the room and found her on the floor between the bed and night stand table. She was complaining of pain on the left side going from the hip down to the leg. The Executive Director was notified of the fall at 8:45 a.m. by CNA 4 and the RCC was notified by QMA 3 at 9 a.m. on 7/8/22. CNA 4 and QMA 3 completed the investigation and the RCC and the Executive Director reviewed the investigation on 7/8/22. The Indiana Department of Health reported incident, dated 7/8/22 indicated there was a left femur fracture. During an interview on 7/14/22 at 9:17 a.m., CNA 4 indicated she had heard the resident calling out for help and found her on the floor in her room. QMA 5 was notified and came to the Memory Care Unit and assessed the resident. She was not assessed by a licensed nurse. There had been no nurse in the building yet, as the RCC did not arrive until 9 a.m. QMA 5 assessed her and she "seemed" alright, so she was assisted off the floor, dressed, and assisted to the front lounge. She laid on the couch and fell asleep. When breakfast was being served, she woke up and was in pain from her hip down her leg. QMA 3 and the Executive Director, who was in the building, were notified and she was transferred to the hospital. During an interview on 7/14/22 at 11:18 a.m., QMA 5 indicated Agency QMA 2 had been assigned to the Memory Care Unit that night and not been		Policy Incident and Accident Report, and the Fall Investigation Form · ACC re-educated all care staff on fall protocols, including the fall investigation form on 7/19/22 · Administrator and ACC will be re-educated on complete evaluation of resident post fall including signs and symptoms of pain, mobility, PRN medications as well as transfer to ER for evaluation. · ACC re-educated all care staff on observation of residents post fall on 7/19/22 How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place · Divisional Director of Resident Services will monitor the next 5 falls to ensure post-fall assessments have been completed. · Divisional Director of Resident Services will re-start monitoring if any deficiencies are found. · Divisional Administrator of Resident Services will review the next 3 new move in assessments for fall level risk and interventions. · Divisional Administrators will monitor compliance during routine visits By what date the systemic changes will be completed by August 12, 2022	

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	made aware of the fall earlier that morning on 7/8/22. QMA 5 was notified by CNA 4 of the resident's fall at approximately 6:50 a.m. and was told the resident was on the couch and "didn't look good". QMA 5 indicated the resident had not looked like she was in pain and a nurse should be in the building within 10 minutes and the Nurse could evaluate the resident. QMA 5 indicated when there has been a fall, the RCC or the Nurse on call is notified. They would have them complete an assessment, which included range of motion, then they would make the decision if the resident required to be transferred to the Hospital. The RCC or Nurse had the QMA's complete the assessment. If the resident was visibly hurt, they are transferred immediately to the hospital. During an interview on 7/14/22 at 12 p.m., the RCC indicated she received calls about falls from the staff and she gives directions to transfer the residents to the hospital to be evaluated. Agency QMA 2 had notified her early in the morning of the fall. She was informed the fall was unwitnessed. She had asked if the resident had been bleeding, complained of pain, and/or a outward rotation of the legs and Agency QMA 1 indicated there was no bleeding, complaint of pain and no outward rotations observed. The resident had attempted to get up off the floor and the staff assisted her off the floor. When the resident fell the second time, QMA 3 notified her and was informed she was on her way to the facility. She indicated she was notified approximately around 8:30 a.m. She had not been notified of the fall at the time of the fall at 6:45 a.m. During an interview on 7/14/22 at 1:34 p.m., QMA 3 indicated she had not arrived at the facility until 7:30 a.m. Agency QMA 2 and QMA 5 were not at the facility when she arrived and there was no			

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	nurse in the building when she arrived. At 8:30 a.m., CNA 4 had informed the Executive Director the resident was not bearing weight and was in pain. The Executive Director had given the order to send the resident to the Hospital. QMA 3 indicated she was not notified of the fall until 8:30 a.m. During an interview on 7/14/22 at 1:45 p.m., CNA 4 indicated Agency QMA 2 had exited the facility at 6:30 a.m. and the resident had been found on the floor at 6:40 a.m. QMA 5 was notified at the time of the fall. The resident was then dressed and walked with assistance to the couch in the lounge and she then fell asleep. When the resident awoke she was pale in color, was unable to bear weight, and continued to have pain. The Executive Director was in the facility, was notified, and directed staff to send the resident to the hospital. The RCC was not in the building at the time this fall occurred. 2. Resident C's record was reviewed on 7/14/22 at 12:42 p.m. The diagnoses included, but were not limited to diabetes mellitus and myasthenia gravis. A Progress Note, dated 6/28/22, no time documented and signed by QMA 5, indicated at 1:40 a.m. the resident was found on the floor. Vital signs were checked and the RCC was sent a text. The resident's son was called and a voicemail was left. The resident was able to ambulate to and from the bathroom after the fall. A Progress Note, dated 6/28/22, no time documented and signed by QMA 5, indicated the resident's family notified the facility at 4:30 a.m. and indicated the resident was in pain. The RCC was notified by telephone and "agreed" that the resident was to be sent to the hospital.			

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	The fax notification to the Physician, filled out by QMA 5, dated 6/28/22 at 1:41 a.m., indicated, "Resident pulled call light found on butt next to her bed complaining of hip pain." The investigation of the fall indicated the fall was unwitnessed and there were complaints of pain in the right hip. 911 had been notified of the need to transfer to the hospital at 4:25 a.m. The description of action taken, indicated vital signs were obtained, the resident was assisted off the floor, ambulated to the bathroom and back to bed with assistance. After the resident was back in bed, the pain worsened and she wanted to be sent out to the hospital. The investigation was signed by QMA 5 and reviewed by the Executive Director and RCC on 6/28/22 The hospital diagnosis, dated 6/28/22, indicated the resident had a closed lumbar 1, vertebral fracture. During an interview on 7/14/22 at 9:23 a.m., QMA 5 indicated the RCC had been texted after the fall on 6/28/22 and there was no call back from the RCC. The resident had some pain, though no more than usual. She was assisted off the floor and she ambulated. The range of motion was assessed while she was on the floor. The RCC then called the facility later and indicated since the resident was not in anymore pain than usual, she was to be monitored. When the resident complained of increased pain after she ambulated, she was transferred to the hospital. During an interview on 7/14/22 at 12 p.m. the RCC indicated the resident had slid from the bed. She was notified and when she called the facility back the resident remained on the floor and she was			

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	told the resident was "fine" and wanted off the floor. When she complained of pain later, they notified her and she gave orders for the resident to be transferred to the hospital. A facility policy for resident falls, dated 4/2014 and received from the RCC as current, indicated the first step to be taken after a fall was to determine if emergency action was required. If the resident had painful areas, they were to be encouraged to stay on the floor until the ambulance arrived. The resident was not to be moved. The QMA Basic Curriculum, dated 10/2003, Lesson 1, indicated QMA's were prohibited from performing an assessment of a resident's condition.			
R 0087 Bldg. 00	410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees. Based on record review and interview, the administrator failed to ensure adequate provision of medical care was provided to residents, related to residents who had fallen being assessed by the QMA's and not by a Licensed Medical Person, for 2 of 5 residents reviewed for provision of medical care. (Residents D and C). The residents' falls resulted in fractures and they were not treated with emergency care timely. The facility had no	R 0087	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident D expired 7/16/22 · Resident C still resides at Bickford of Crown Point · Nurse Coordinator and Administrator are responsible for ensuring that QMAs have	08/02/2022

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	policy and procedure for the QMA's to follow if there was a change in condition or a fall of a resident occurred. Findings include: Cross reference R052 for falls, assessments, and provision of medical care. During an interview on 7/14/22 at 1:10 p.m., the RCC indicated the facility had no policy and procedure to direct the QMA's on what to do if there was a fall or a change of condition of a resident when a nurse was not in the facility. She indicated they followed the State regulations.		Instructions to follow on what to do if there is a fall or change of condition when a nurse is not in the facility How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Administrator and Nurse Coordinator to audit service plans of all current residents to identify those with high fall risk and ensure interventions are listed · Nurse Coordinator to assess all new admissions for level of fall risk What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · Administrator and Nurse Coordinator will be re-educated on writing proper detailed service plans to ensure level of fall risk is included · Administrator to ensure all new staff has signed off on Life Safety Policy · Administrator and Nurse Coordinator will re-educate all care staff that resident is not to be moved post fall without nursing assessment completed · Director and Nurse Coordinator re-educated all staff on 7/19/22 on QMA's scope of practice to ensure compliance	

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			How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place · Divisional Director of Resident Services will review the next 3 falls to ensure procedure was followed · Divisional Directors will monitor at least annually for compliance By what date the systemic changes will be completed by August 2, 2022	