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 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CARMEL	5829 EAST 116TH STREET CARMEL, IN 46033

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00175787. Complaint IN00175787 - Substantiated. State deficiencies related to the allegations are cited at R0053 and R0091. Survey Dates: June 24 & 25, 2015 Facility number: 013217 Provider number: 013217 AIM number: NA Census bed type: Residential: 26 Total: 26 Census payor type: Other: 26 Total: 26 Sample: 8 Supplemental Sample: 3 These State findings are cited in accordance with 410 IAC 16.2-5	R 0000		
R 0053	410 IAC 16.2-5-1.2(w)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview the facility failed to ensure residents were free from verbal abuse, in that when cognitively impaired residents appeared confused as to orientation, a facility staff member (Certified Nurse Aide #10), was verbally abusive to residents in front or other residents and facility staff members. This deficient practice had the potential to ffect 10 of 10 residents who resided on the Memory Care Unit. Findings include: A review of facility reportable incident's on 06-24-15 at 2:25 p.m., included documentation from Certified Nurse Aide (CNA), employee #11 which indicated a concern related to the actions of CNA employee #10. The documentation was provided to the Administrator on 05-26-15, related to the concerns she had from working with CNA #10 during the previous night shift. The documentation indicated the following: "On May 25th 2015 I was assigned to work the night shift CNA position with another CNA named [CNA #10] in the	R 0053	**In response to R 053-Resident Rights** The resident rights of resident E were violated. Potential for violation of the rights of the other residents in the memory care area. 1) Upon discovery of this violation, the investigation process was immediately started including suspension of caregiver, investigation and ultimate termination of C.N.A. #10. 2) Incident reported to ISDH with measures for prevention of reoccurrence as re- education of all staff on identification and reporting of any potentially abusive situation on 6/25 & 26/15. 3) Director to continue to provide abuse training upon hire and periodically throughout the year as per in-service schedule, and as needed. In-Services will be kept in the In-Service Binder in the Director's Office. 4) Resident safety – incident and accident in-service conducted for all staff on 6/25/15 by the Director 5) Abuse policy in-service conducted for all staff 6/26/15 by the Director	07/30/2015

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	Memory Care Unit/Assisted Living. During our shift (11:00 p.m.-7 a.m.), [name of CNA #10] spent most of her time sitting on the couch with her feet up, while watching TV. There was one resident that approached the living area around 5 a.m., right before I was to attend to residents on the Assisted Living side. He is generally confused on what to do when he is out of his room and where to go. The resident normally comes to the living area around the same time every day. Once the resident approached the living area, [name of CNA #10] became impatient with him and insisted on demanding that he sit down. She did not move off of the couch to assist him in sitting somewhere that he would be comfortable. She instead, raised her tone in a stern manner and told him to sit down several times. The resident asked 'What do I do ?' and she responded again with the same tone and said, 'It doesn't make a difference, pick one.' The resident is unable to make some decision's on his own without guidance and details about what he is to do. I am writing this letter to file a complaint about [name of CNA #10] behavior toward this resident, as well as her inability to properly care for memory care residents. There were also a few other comments made in front of residents and staff members about a residents personal hygiene, restroom		6) Specific in-service to cover the need / obligation to report any abusive situation to the Director conducted for all staff on 6/26/15 by the Director. 7) In-service on Resident Rights and Abuse with specific information on identification and prevention of caregiver stress to be conducted on 7/30/15 by the Director. 8) Director, RNC and LEC (Life enrichment coordinator) each to spend a minimum of fifteen minutes throughout their day in the memory care area to monitor staff / resident interactions. 9) Divisional Directors to monitor staff / resident interaction in the memory care area on routine site visits. 10) Special needs and concerns to continue to be addressed in daily staff meetings. Date of completion – 7/30/15 and ongoing	

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	issues and personal behaviors. Those things do not need to be discussed in front of other residents and not in a negative way. As a co-worker, it is very difficult to see someone behave in such a manner against the residents that we are suppose to treat with respect." Upon receipt of this letter, the facility administrative staff proceeded with their investigation and obtained statement's from the staff members who worked with CNA #10. The statements were written responses from staff members on 05-27-15 that questioned "Have you overheard or witnessed a BFM (Bickford Family Member) using an inappropriate tone to a resident that made you feel uncomfortable ?" Statement from Employee #11 - "I worked the night shift with [name of CNA #10] on 05-25-15 in Mary B. [secured memory care unit]. One of the residents approached her around 5:00 a.m. and asked her 'What do I do?' This resident is generally confused and unable to make most decisions on his own without guidance. She didn't move from the couch but instead in a stern and negative manner demanded that he sit down. He again asked 'What do I do ?'			

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	and again in a negative manner said, 'It doesn't make a difference, pick one.' There have also been instances that I witnessed on her making references to resident's hygienic care, restroom issues and behaviors loudly in front of other BFM's and residents." Statement from Employee #3 - "On numerous occasions I have witnessed [name of CNA #10] call resident's other names other than their own such as the "N" word." Statement from Employee #12 - "Yes I have witnessed [name of CNA #10] being mean to Resident "E." She yells at him and tells him to go back to his room in the early hours. He typically is up around this time as he gets confused. Instead of helping him back to bed, she will yell across the room at him." Statement from Employee #13 - "I have witnessed [name of CNA #10] speaking very rudely to numerous resident on the Memory Care. I don't think she should be allowed to work with Memory Care resident or anyone in that case." Statement from Employee #14 - "... she has been verbally inappropriate to [name of Resident "E"], [name of Resident "H"] and [name of Resident "M"]. She is rude			

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	and should not be working." Statement from Employee # 15 - "On one occasion, [name of CNA #10] said very loudly that a resident was 'nasty and gross.' This resident would occasionally touch herself but is in Mary B's and doesn't understand what she is doing. I would never want my loved one to be care for by [name of CNA #10]. She commented that a few other residents should not be in this facility but in nursing homes. She did like to put everyone in bed at the start of night shift if the [sic] were not already there and did not want to have them up dressed or showered before day shift arrived. She was unhappy with me that when one resident was up and dressed at 4:45 a.m., that after I returned with him to the room and brushed teeth, washed face and combed hair that I brought him into the common area because he 'would not be quiet.' I moved him and another resident to a different area, but she could have as easily moved to another area with her things - she had a purse, another bag and always a shawl which she kept on the sofa in front of the TV." A review of the facility policy on 06-24-15 at 1:00 p.m., titled "Resident Services - Abuse and Neglect," dated as revised 07-2010 indicated, "All Bickford			

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	Family Members are required to be knowledgeable of the policies and procedures regarding the prohibition of mistreatment, neglect, and abuse of residents and misappropriation of their property. Bickford Family Members must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion." During an interview on 06-24-15 at 2:00 p.m., the Administrator indicated she was unaware there were instances of verbal abuse by CNA #10 until she received the letter from CNA #11. "Once we started to interview the other staff members is when we realized what was going on. We suspended her while we investigated the allegation, and then eventually we terminated her." This State finding relates to Complaint IN00175787.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance			

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	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview the facility failed to ensure their abuse policy was implement and residents were free from verbal abuse, in that when facility staff members had knowledge of verbal abuse towards the residents on the secured Memory Care Unit by Certified Nurse Aide (CNA #10), the nursing staff failed to immediately report the incidents of abuse to the Administrator. In addition when CNA #11 determined the Administrator needed to be advised of the actions of CNA #10, she failed to immediately report her concerns during night shift and CNA #10 was allowed to continue to work with the cognitively impaired residents on the Memory Care Unit. This deficient practice had the potential to affect 10 of 10 residents who resided on the Memory Care Unit and involved 7 facility staff members (#10, #11, #3, #12, #13, #14 and #15).	R 0091	**In response to R 091-Administration and Management** The resident rights of resident E were violated with potential violation of rights of the other residents in the memory care area 1) Upon discovery of this violation the investigation process was immediately started including suspension of caregiver, investigation and ultimate termination of C.N.A. #10. 2) Incident reported to ISDH with measures for prevention of reoccurrence as re- education of all staff on identification and reporting of any potentially abusive situation on 6/25 & 26/15. 3) Director to continue to provide abuse training upon hire and periodically throughout the year as per in-service schedule, and as needed. In-Services will be kept in the In-Service Binder in the Director's Office.	08/30/2015

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	Findings include: A review of facility reportable incident's on 06-24-15 at 2:25 p.m., included documentation from Certified Nurse Aide (CNA), employee #11 which indicated a concern related to the actions of CNA employee #10. The documentation was provided to the Administrator on 05-26-15, related to the concerns she had from working with CNA #10 during the previous night shift. The documentation indicated the following: "On May 25th 2015 I was assigned to work the night shift CNA position with another CNA named [CNA #10] in the Memory Care Unit/Assisted Living. During our shift (11:00 p.m.-7 a.m.), [name of CNA #10] spent most of her time sitting on the couch with her feet up, while watching TV. There was one resident that approached the living area around 5 a.m., right before I was to attend to residents on the Assisted Living side. He is generally confused on what to do when he is out of his room and where to go. The resident normally comes to the living area around the same time every day. Once the resident approached the living area, [name of CNA #10] became impatient with him and insisted on demanding that he sit down. She did not		4) Resident safety – incident and accident in-service conducted for all staff on 6/25/15 by the Director 5) Abuse policy in-service conducted for all staff 6/26/15 by the Director 6) Specific in-service to cover the need / obligation to report any abusive situation to the Director conducted for all staff on 6/26/15 by the Director. 7) In-service on Resident Rights and Abuse with specific information on identification and prevention of caregiver stress to be conducted on 6/30/15 by the Director. 8) Director, RNC and LEC (Life enrichment coordinator) each to spend a minimum of fifteen minutes throughout their day in the memory care area to monitor staff / resident interactions. 9) Divisional Directors to monitor staff / resident interaction in the memory care area on routine site visits. 10) Special needs and concerns to continue to be addressed in daily staff meetings. 11) Abuse training to be conducted in August of 2015 as per annual in-service schedule (last provided 6/19/15)	

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	move off of the couch to assist him in sitting somewhere that he would be comfortable. She instead, raised her tone in a stern manner and told him to sit down several times. The resident asked 'What do I do ?' and she responded again with the same tone and said, 'It doesn't make a difference, pick one.' The resident is unable to make some decision's on his own without guidance and details about what he is to do. I am writing this letter to file a complaint about [name of CNA #10] behavior toward this resident, as well as her inability to properly care for memory care residents. There were also a few other comments made in front of residents and staff members about a resident's personal hygiene, restroom issues and personal behaviors. Those things do not need to be discussed in front of other residents and not in a negative way. As a co-worker, it is very difficult to see someone behave in such a manner against the residents that we are suppose to treat with respect." Upon receipt of this letter, the facility administrative staff proceeded with their investigation and obtained statement's from the staff members who worked with CNA #10. The statements were written responses		Date of completion – 8/30/15 and ongoing	

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	from staff members on 05-27-15 that questioned "Have you overheard or witnessed a BFM (Bickford Family Member) using an inappropriate tone to a resident that made you feel uncomfortable ?" Statement from CNA Employee #11 - "I worked the night shift with [name of CNA #10] on 05-25-15 in Mary B. [secured memory care unit]. One of the residents approached her around 5:00 a.m. and asked her 'What do I do?' This resident is generally confused and unable to make most decisions on his own without guidance. She didn't move from the couch but instead in a stern and negative manner demanded that he sit down. He again asked 'What do I do ?' and again in a negative manner said, 'It doesn't make a difference, pick one.' There have also been instances that I witnessed on her making references to resident's hygienic care, restroom issues and behaviors loudly in front of other BFM's and residents." Statement from CNA/Activities Employee #3 - "On numerous occasions I have witnessed [name of CNA #10] call resident's other names other than their own such as the 'N' word." Statement from CNA Employee #12 -			

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	"Yes I have witnessed [name of CNA #10] being mean to Resident "E." She yells at him and tells him to go back to his room in the early hours. He typically is up around this time as he gets confused. Instead of helping him back to bed, she will yell across the room at him." Statement from Licensed Nurse Employee #13 - "I have witnessed [name of CNA #10] speaking very rudely to numerous resident on the Memory Care. I don't think she should be allowed to work with Memory Care resident or anyone in that case." Statement from Licensed Nurse Employee #14 - "... she has been verbally inappropriate to [name of Resident "E"], [name of Resident "H"] and [name of Resident "M"]. She is rude and should not be working." Statement from Licensed Nurse Employee # 15 - "On one occasion, [name of CNA #10] said very loudly that a resident was 'nasty and gross.' This resident would occasionally touch herself but is in Mary B's and doesn't understand what she is doing. I would never want my loved one to be care for by [name of CNA #10]. She commented that a few other residents should not be in this			

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	facility but in nursing homes. She did like to put everyone in bed at the start of night shift if the [sic] were not already there and did not want to have them up dressed or showered before day shift arrived. She was unhappy with me that when one resident was up and dressed at 4:45 a.m., that after I returned with him to the room and brushed teeth, washed face and combed hair that I brought him into the common area because he 'would not be quiet.' I moved him and another resident to a different area, but she could have as easily moved to another area with her things - she had a purse, another bag and always a shawl which she kept on the sofa in front of the TV." A review of Employee Records on 06-25-15 at 11:00 a.m., indicated the above staff members signed the facility Abuse Policy as follows: CNA #10 - signed the Abuse policy on 10-20-14 and again on 02-19-15. CNA # 3 - signed the Abuse policy on 02-02-15. CNA #12 - signed the Abuse policy on 03-20-15. Licensed Nurse #13 - signed the Abuse policy on 03-08-15. Licensed Nurse #15 - signed the Abuse policy on 04-06-15.			

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	A review of the Job Description for the Licensed Nurses and Certified Nurse Aides included "Essential Duties and Responsibilities," and indicated "Reports problems and concerns to the Director." CNA #10 - signed the specific job description on 10-14-14. CNA # 3 - signed the specific job description on 02-02-15. CNA #12 - signed the specific job description on 03-20-15. Licensed Nurse #13 - signed the specific job description on 03-08-15. Licensed Nurse #15 - signed the specific job description on 04-06-15 During an interview on 06-25-15 at 1:00 p.m., the Interim Regional Nurse Consultant verified CNA #11 should have immediately notified "us" and then "we would have immediately suspended her [in regard to CNA #10]." A review of the "Timecard," for CNA #10, dated 05-25-15, indicated that even though CNA #11 was concerned about the actions of CNA #10, CNA #10 was allowed to complete her scheduled hours and "clocked out" at 7:01 a.m., the end of her shift. A review of a page from the Employee handbook on 06-25-15 at 10:45 a.m., and			

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	provided by the Administrator indicated on page 22 - "Reporting resident Abuse, Neglect or Exploitation - If a BFM [Bickford Family Member] is aware of potential resident abuse, they are to immediately notify their Director. Bickford does not tolerate resident abuse, neglect, or exploitation in any form: physical, emotional or financial." A review of the facility policy on 06-24-15 at 1:00 p.m., titled "Resident Services - Abuse and Neglect," dated as "revised" 07-2010 indicated the following: "Policy: Bickford Directors and other health care professional who have reasonable cause to believe that a Resident is being, or has been, abused, neglected or exploited shall report the information immediately to the State licensure authority and Branch Support. Any Bickford Family Member who has reasonable cause to believe that a Resident is being, or has been, abused, neglected or exploited shall report the information immediately to the Branch Director or RN [Registered Nurse] Coordinator." "NOTE: All Bickford Family Members are required to be knowledgeable of the policies and procedures regarding the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	prohibition of mistreatment, neglect, and abuse of residents and misappropriation of their property. Bickford Family Members must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion." On 06-25-15 at 10:45 a.m., the Administrator provided the current training tool used in "Resident Abuse," Inservice Education and dated as "revised 03-2014," indicated the following: "Topic: Resident Abuse." "Objectives: Learn to recognize the signs of abuse. Refresh you knowledge of company policy and expectations." "COMPANY POLICY ON ABUSE AND NEGLECT: Policy: BICKFORD Directors and other health care professionals such as RN's [Registered Nurses] who have reasonable cause to believe that a Resident is being, or has been, abused, neglected, or exploited shall report the information immediately to the State licensure/certification authority and The Management Company. Any staff member who has reasonable cause to believe that a Resident is being or has been abused, neglected or exploited shall report immediately to the residents Director or health care professional. All			

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	BICKFORD employees are required to be knowledgeable of the policy and procedures regarding the prohibition of mistreatment, neglect, and abuse of Residents and misappropriation of Resident property. BICKFORD employees must not use verbal, mental, sexual, physical abuse, corporal punishment, or involuntary seclusion." This State finding relates to Complaint IN00175787.			