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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410515. Complaint IN00410515 - State deficiency related to the allegations is cited at R0052. Survey date: July 5, 2023 Facility number: 012940 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/6/23.	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 observation, record review, and interview, the facility failed to implement effective supervision of a resident with known exit-seeking behaviors to maintain the resident's safety related to two elopements from the facility for 1 of 2 residents reviewed for elopement. This resulted in the resident leaving the facility on 2 separate occasions in a busy traffic area, without the facility staff being aware until notified by family after being found wandering, once by the Police and once by a former neighbor approximately 2	R 0052	R052 – Resident Rights-offense· 1 residents was affected by this practice, but it had the potential to affect 4 of 4 residents with significant cognitive impairment identified as having a GDS of 4 or greater residing in assisted living. What corrective actions will be	07/17/2023

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

Jillian Sell | Executive Director | 08/15/2023

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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	miles away. (Resident B) Finding includes: On 7/5/23 at 2:48 p.m., Resident B was observed in her room in the Memory Care Unit watching television. The resident was confused and unable to answer questions appropriately. The resident did have a Wander Guard (elopement alert system) bracelet in place to her right ankle. Record review for Resident B was completed on 7/5/23 at 10:03 a.m. Diagnoses included, but were not limited to, dementia and depression. The resident was admitted to the facility on 3/2/22. The resident had multiple behaviors of exit-seeking in the facility prior to the elopements from the facility. The following are Progress Notes of when the resident was exit-seeking: - 3/5/22: exit-seeking, resident almost got out at he 100 exit hallway, called son and daughter but after 40 minutes the resident still would not calm down. - 3/26/22: resident has been exit-seeking. - 3/28/22: exit-seeking. - 4/10/22: exit-seeking. - 4/16/22: exit-seeking. - 8/21/22: resident agitated, exit-seeking. - 9/19/22: 180 day assessment, resident was very exit-seeking and required redirection throughout the day. - 10/26/22: exit-seeking - 11/1/22: gave resident lorazepam (anti-anxiety medication), she was anxious, earlier found the resident outside and she kept saying "I am going" - 2/11/23: elopement from facility - A late entry, dated 6/8/23, indicated the Administrator had spoken with the resident's son about her increased exit-seeking and the need for her to go to the Memory Care Unit. The son		accomplished for those residents found to have been affected by the deficient practice?· Resident moved to Memory care on 6/27/23· Daily Checks will be done to verify the residents wander guard is in place and documented on the residents MAR. · 3 Missing resident drills will be held within the next 6 months. A record of all training and drills will be documented with the names and signatures of the personnel present to ensure wander guard system is working properly and that staff is trained to handle the situation appropriately 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· An audit of all AL residents completed to ensure all residents with a GDS of 4 or greater have a wander guardWander guards will be check monthly to ensure they are in proper working order, alarming appropriately and record will be maintain by Maintenance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.· Executive Director and Health and wellness Director will be re-educated in policy pertaining to Missing Resident drills. · Director or other delegated staff member shall be	

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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	indicated his sister would be with the resident on Saturday and Sunday and when he came home from an out of town event he would come in to discuss the move to the Memory Care Unit but was refusing the move at that time. - 6/9/23: a lorazepam was give to the resident because she was exit-seeking. She was wandering and wanted to go home. - 6/10/23: elopement from facility A State Reportable Incident, dated 2/11/23 at 12:30 p.m., indicated the police notified the facility they had found the resident walking outside. The police notified the resident's POA (Power of Attorney) and drove the resident to her son's house. When the resident returned to the facility on 2/11/23, a Wander Guard was placed on the resident for safety. An investigation was initiated. A written interview from QMA 1, dated 2/11/23, indicated the last time she saw the resident was at 11:00 a.m. in the 400 Hallway. The resident asked the QMA if she was going out. The QMA reassured the resident no one was going out and that it was almost time for lunch. She asked the resident to go check on the resident's dog one more time and then it would be time for lunch. The resident walked towards her apartment. A written interview from CNA 1, dated 2/13/23, indicated the last time she observed the resident was after breakfast in the Living Room watching television. There was no documentation to indicate any door alarms were sounding when the resident exited the facility. There was no documentation to indicate if the resident was wearing the Wander Guard before she left the facility or of any increased monitoring after the elopement. A State Reportable Incident, dated 6/10/23 at 4:30		responsible for maintaining Missing Resident Drill record to ensure all 3 missing drills have been completed. 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 Health and Wellness will review residents at risk for elopement records monthly for 3 months. · The Health and Wellness Director will monitor checks in quick MAR to verify checks on the wander guard are completed weekly.Divisional Director of Operation will review Missing resident drill records monthly for the next 6 months. Divisional Director of Operations will review record of monthly wander guards proper working order every 6 months.	

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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	p.m., indicated the resident's POA notified the facility that the police had found the resident walking outside. The police notified the POA and drove the resident to the POA's neighbor's house. The POA's sister picked the resident up and brought her back to the branch. When the resident comes back to the facility she will be placed in the Memory Care Unit. The Administrator interviewed both CNA 2 and CNA 3 on 6/10/23. They both indicated they last saw the resident at lunch time. A Progress Note by QMA 2, dated as late entry on 6/27/23, indicated around 3:30 p.m., another QMA had asked if they had seen Resident B. QMA 2 indicated around 1:45 p.m., in the dining room. She had asked a CNA to take the resident to her room to put the dog away. The QMA indicated that the resident's daughter called and said her mom was by her old house with her former neighbor and was ok. There was no documentation to indicate any door alarms were sounding when the resident exited the facility. There was no documentation to indicate if the resident was wearing the Wander Guard before she left the facility or of any increased monitoring after the elopement. Interview with the Health and Wellness Director and the Assistant Health and Wellness Director on 7/5/23 at 11:56 a.m., indicated the resident had a Wander Guard. They were unsure when the resident started to wear one. The resident was known to have cut off the Wander Guard multiple times and they were alerted through the Wander Guard system in the front office. The system would beep until someone shut off the machine. They do not have any documentation of the times the resident had cut off the Wander Guard. They			

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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	do not document if a resident's Wander Guard is in place and functioning. The only verification was observing the residents to see if they were wearing them. They could not provide any documentation the resident had increased monitoring after exit-seeking, the elopements, or after cutting the Wander Guard off. There was no documentation provided that the family was told the resident was cutting off the Wander Guard. Interview with the Administrator on 7/5/23 at 12:16 p.m., indicated she was unsure if the resident had a Wander Guard in place before the first elopement in February. She physically put a Wander Guard on the resident when she was brought back to the facility that day. They put Wander Guards in place as a Nursing Measure. They do not document that the resident's Wander Guards are in place and functioning. During the first elopement from the facility in February, the police found the resident a block away from the facility. The resident had told the police to take her to her son's house. The resident's son then had called the facility and explained what happened. When she interviewed staff, no one knew the resident had left and no alarms were going off. The second time the resident had an elopement from the facility, the resident's daughter called the facility and said the resident showed up at the resident's former house. The resident use to live approximately 2 miles away from the facility. The residents old neighbor contacted the daughter. It was unclear if the resident walked to her former home or if the police picked her up and drove her to her former home. The Administrator had not asked for police reports from either elopement. During her investigation, she indicated no alarms went off when the resident left the facility. She could not provide any documentation the resident had any			

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	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	increased monitoring after the exit-seeking, the elopements, or when she had cut off the Wander Guard. Interview with the Maintenance Director on 7/5/23 at 3:00 p.m., indicated he checked the door alarms weekly. The Exit Door Inspection Checklist indicated the keypads, locks, release bars, and audible alarm sounds were inspected. There was no documentation the Wander Guard system was checked. He indicated he had checked the Wander Guard system periodically but could not provide any documentation of the last time it was checked. A facility policy titled, "Resident Monitoring Device, Panic Button" and received as current from the Assistant Director of Health and Wellness, indicated, "...A Resident shall use a Resident Monitoring Device, Panic Button if certain triggers are met..." "... c. Wandering (leaving residence or entering other's apartment)..." This state residential finding relates to Complaint IN00410515.			