STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF GREENWOOD	3021 STELLA DRIVE, GREENWOOD, , 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00429658. Complaint IN00429658 - No deficiencies related to the allegations are cited. Survey dates: March 4, 5, and 6, 2024 Facility number: 012938 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 8, 2024.	R 0000		
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the	R 0042	R042 – Residents' Rights – Noncompliance The facility failed to ensure the	04/19/2024

	most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review the facility failed to ensure the previous survey results and corresponding plan of correction data were readily accessible for 1 of 3 days of the survey. Findings include: On 3/4/24 from 10:00 a.m. until 10:25 a.m., observed a credenza located in the front lobby. One drawer of the credenza contained a binder titled Indiana State Department of Health Surveys. A review of the binder lacked any reports after 9/9/22. On 3/6/24 at 11:33 a.m., the Administrator provided a list of surveys completed after 9/9/22. The list included, but was not limit to the following surveys: - 1/10/23 for a complaint investigation. - 4/19/23 for an annual survey - 9/5/23 for a complaint investigation. - 9/21/23 for a complaint investigation. On 3/4/24 at 10:10 a.m., the		previous survey results and corresponding plan of correction data were not readily accessible for 1 of 3 days of the survey What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Survey binder was placed at main entrance and made readily available How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by this deficient practice What measures will be put into place or what systemic changes the facility will make to ensure that the deficient	

	Administrator indicated she had the new binder in her office. It should have been easily accessible for the residents and the public to view. The binder was usually kept in the front lobby area. On 3/6/24 at 9:52 a.m., the Corporate Nurse Consultant indicated the facility policy regarding the binder being easily accessible was not available. The facility was to follow the state regulations. Based on observation, interview, and record review the facility failed to ensure the previous survey results and corresponding plan of correction data were readily accessible for 1 of 3 days of the survey. Findings include: On 3/4/24 from 10:00 a.m. until 10:25 a.m., observed a credenza located in the front lobby. One drawer of the credenza contained a binder titled Indiana State Department of Health Surveys. A review of the binder lacked any reports after 9/9/22. On 3/6/24 at 11:33 a.m., the Administrator provided a list of surveys completed after 9/9/22. The list included, but was not limit to the following surveys:		practice does not recur Executive Director will be responsible for ensuring that the most recent annual survey is readily available Executive Director/Designee will be re-educated on having most recent state survey available for viewing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will monitor for binder placement on routine visits	

	- 1/10/23 for a complaint investigation. - 4/19/23 for an annual survey - 9/5/23 for a complaint investigation. - 9/21/23 for a complaint investigation. On 3/4/24 at 10:10 a.m., the Administrator indicated she had the new binder in her office. It should have been easily accessible for the residents and the public to view. The binder was usually kept in the front lobby area. On 3/6/24 at 9:52 a.m., the Corporate Nurse Consultant indicated the facility policy regarding the binder being easily accessible was not available. The facility was to follow the state regulations.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of	R 0092	R092 – Administration and Management-Noncompliance The facility failed to ensure monthly fire drills were conducted for 3 of 12 calendar months reviewed What corrective action(s) will be accomplished for those residents found to have	04/19/2024

	nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 3 of 12 calendar months reviewed. Findings include: On 3/4/24 at 11:45 a.m., the Maintenance Director provided documentation of the 2023 facility fire drills that were conducted. A review of the record indicated the following months lacked documentation that fire drills were conducted: - April 2023 - June 2023		been affected by the deficient practice: Fire drill binder has been updated How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by this deficient practice What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Director/Designee will be responsible for maintaining Fire Drill record to ensure all monthly fire drills have been completed	

	- July 2023 During an interview on 3/4/24 at 11:50 a.m., the Maintenance Director indicated the Fire drills were to be completed monthly alternating the shifts. The monthly fire drills for April, June, and July, 2023 were unavailable. On 3/6/24 at 10:56 a.m., the Corporate Clinical Nurse provided a policy titled Fire Drill Schedule, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "Fire drills shall be performed monthly. This includes each shift having one drill each quarter." Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 3 of 12 calendar months reviewed. Findings include: On 3/4/24 at 11:45 a.m., the Maintenance Director provided documentation of the 2023 facility fire drills that were conducted. A review of the record indicated the following months lacked documentation that fire drills were conducted: - April 2023 - June 2023		Executive Director/Designee will be re-educated in policy pertaining to Fire safety and frequency of drills Director/Designee will work with local Fire Department to provide bi-annual training for fie and disaster drills. Director/Designee will be instructed on proper procedure for successfully overseeing a Fire Drill in the absence of maintenance personnel. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will review Fire Drill records on a monthly basis.	

	- July 2023 During an interview on 3/4/24 at 11:50 a.m., the Maintenance Director indicated the Fire drills were to be completed monthly alternating the shifts. The monthly fire drills for April, June, and July, 2023 were unavailable. On 3/6/24 at 10:56 a.m., the Corporate Clinical Nurse provided a policy titled Fire Drill Schedule, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "Fire drills shall be performed monthly. This includes each shift having one drill each quarter."			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to maintain accurate personnel records and reference inquires for 2 of 5 employee records	R 0116	R116 – Personnel – Noncompliance The facility failed to maintain accurate personnel records and reference inquires for 2 of 5 employee records reviewed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	04/19/2024

	reviewed. (Activity and Dementia Care Director and CNA 5) Finding includes: On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions. The list included, but was not limited to: - The Activity and Dementia Care Director (ADCD) was hired on 10/2/23 and was currently employed at the facility. - Certified Nursing Assistant (CNA) 5 was hired on 2/15/24 and was currently employed at the facility. On 3/5/24 at 1:30 p.m., during review of employee records, the ADCD's and CNA 5's references were not provided with the rest of the requested employee records. During an interview on 3/5/24 at 1:35 a.m., the Administrator indicated that the facility was unable to locate the references for the ADCD and for CNA 5 and that both employees should have had the missing references with their employee files. On 3/6/24 at 10:30 a.m., the Corporate Nurse Consultant (CNC) provided a policy titled Personnel Files, dated as revised in September of 2016,		Activity Director is no longer employed with Bickford How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Director will audit all employee files to ensure they contain reference inquires 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/Designee will be responsible for ensuring that reference checks are completed for new employees prior to start of employment How the corrective action(s) will be monitored to ensure the	

	and indicated it was the current policy being used by the facility. A review of the policy indicated, "...Procedure: 1) All personnel files shall be kept in a secure file, and shall contain the following...b) Reference Checks..." Based on interview and record review, the facility failed to maintain accurate personnel records and reference inquires for 2 of 5 employee records reviewed. (Activity and Dementia Care Director and CNA 5) Finding includes: On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions. The list included, but was not limited to: - The Activity and Dementia Care Director (ADCD) was hired on 10/2/23 and was currently employed at the facility. - Certified Nursing Assistant (CNA) 5 was hired on 2/15/24 and was currently employed at the facility. On 3/5/24 at 1:30 p.m., during review of employee records, the ADCD's and CNA 5's references were not provided with the rest of the requested employee records. During an interview on 3/5/24 at		deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Healthy and Operations will audit next 6 new employee files to ensure reference checks have been completed Divisional Director of Health & Operations will audit employee charts on routine visits	

	1:35 a.m., the Administrator indicated that the facility was unable to locate the references for the ADCD and for CNA 5 and that both employees should have had the missing references with their employee files. On 3/6/24 at 10:30 a.m., the Corporate Nurse Consultant (CNC) provided a policy titled Personnel Files, dated as revised in September of 2016, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...Procedure: 1) All personnel files shall be kept in a secure file, and shall contain the following...b) Reference Checks..."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services	R 0117	R 117 – Personnel – Deficiency The facility failed to ensure all shifts had at least one staff member working who was CPR and First Aid certified for 5 of 21 shifts reviewed What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by	04/19/2024

	or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was CPR (Cardiopulmonary Resuscitation) and First Aid certified for 5 of 21 shifts reviewed. Finding includes: On 3/6/24 at 9:55 a.m., the Corporate Nurse Consultant provided a copy of the "as-worked" staff schedule from 2/25/24 through 3/2/24. A review of the document indicated the following:		this deficient practice How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Executive Director/Designee will complete an audit of all employee files to ensure compliance What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Divisional Director of Health & Operations will re-educate Executive Director and Health & Wellness Director on policy/procedure for the requirement to have one staff member with a current first aid certificate on each shift Health & Wellness director will schedule and ensure all staff members remain current with first aid and CPR.	

	The work schedule identified 3 shifts per day. The "first shift" hours were from 7:00 a.m. to 3:00 p.m.; "second shift" hours were from 3:00 p.m. to 11:00 p.m.; and "third shift" hours were from 11:00 p.m. to 7:00 a.m. The daily schedule identified each staff member who worked that shift and who was designated as the certified CPR staff member for that shift. The daily schedule identified each staff member who worked that shift and who was designated as the certified First Aid staff member for that shift. No certified CPR or First Aid staff members were identified as having worked during the following shifts: - 2/29/24 - third shift; no First Aid certified staff member on duty - 3/1/24 - second shift; no First Aid certified staff member on duty - 3/1/24 - third shift; no First Aid certified staff member on duty - 3/2/24 - third shift; no CPR certified staff member on duty - 3/2/24 - third shift; no First Aid certified staff member on duty During an interview on 3/5/24 at		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will audit employee files monthly x3 months and annually thereafter to ensure compliance.	

	1:55 p.m., the Administrator indicated the facility followed the State regulations regarding the certified CPR and First Aid staffing requirements. Each staff member was required to be CPR and First Aid certified. During an interview on 3/6/24 at 10:00 a.m., the Corporate Nurse Consultant indicated she was unable to provide verification that a certified CPR and First Aid staff person had worked for the shifts and dates listed above. On 3/4/24 at 1:45 p.m., the Administrator provided a copy of the Life Safety Training policy, dated July 2012, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff shall receive in-service and instruction on the life safety issues and procedures...it is the responsibility of each Bickford Family Member to have certification in CPR and First Aid within 30 days of employment and to maintain certification thereafter..." Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was CPR (Cardiopulmonary Resuscitation) and First Aid certified for 5 of 21 shifts reviewed.			

Finding includes:

On 3/6/24 at 9:55 a.m., the Corporate Nurse Consultant provided a copy of the "as-worked" staff schedule from 2/25/24 through 3/2/24. A review of the document indicated the following:

The work schedule identified 3 shifts per day. The "first shift" hours were from 7:00 a.m. to 3:00 p.m.; "second shift" hours were from 3:00 p.m. to 11:00 p.m.; and "third shift" hours were from 11:00 p.m. to 7:00 a.m.

The daily schedule identified each staff member who worked that shift and who was designated as the certified CPR staff member for that shift.

The daily schedule identified each staff member who worked that shift and who was designated as the certified First Aid staff member for that shift.

No certified CPR or First Aid staff members were identified as having worked during the following shifts:

- 2/29/24 - third shift; no First Aid certified staff member on duty

- 3/1/24 - second shift; no First Aid certified staff member on duty

- 3/1/24 - third shift; no First Aid certified staff member on duty

- 3/2/24 - third shift; no CPR certified staff member on duty

- 3/2/24 - third shift; no First Aid certified staff member on duty

During an interview on 3/5/24 at 1:55 p.m., the Administrator indicated the facility followed the State regulations regarding the certified CPR and First Aid staffing requirements. Each staff member was required to be CPR and First Aid certified.

During an interview on 3/6/24 at 10:00 a.m., the Corporate Nurse Consultant indicated she was unable to provide verification that a certified CPR and First Aid staff person had worked for the shifts and dates listed above.

On 3/4/24 at 1:45 p.m., the Administrator provided a copy of the Life Safety Training policy, dated July 2012, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff shall receive in-service and instruction on the life safety issues and procedures...it is the responsibility of each Bickford Family Member to have certification in CPR and First Aid within 30 days of employment and to maintain certification thereafter..."

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.	R 0121	R121 – Personnel – Noncompliance The facility failed to provide documentation for an employee's tuberculosis (TB) skin test for 1 of 5 employees reviewed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: TB tests given to those not in compliance How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Executive Director will audit all employee files to ensure TB tests are current and documentation is in file What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does	04/19/2024

	(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to provide documentation for an employee's tuberculosis (TB) skin test for 1 of 5 employees reviewed. (CNA 5) Finding includes: On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions. The list indicated CNA 5 was hired on 2/15/24 and CNA 5 was currently employed at the facility. On 3/5/24 at 1:30 p.m., during review of employee records, CNA 5's record lacked documentation of any tuberculin or TB skin tests (a test required for healthcare workers to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs).		not recur Executive Director & Health & Wellness Director will be responsible for ensuring that new employees will have TB documentation in employee file Executive Director & Healthy and Wellness Director will be re-educated on infection control, specifically TB regulation for all new hires and annually after. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will audit next 6 new employee files to ensure TB documentation is included. Divisional Director will audit for compliance on routine visits and at least annually.	

During an interview on 3/5/24 at 1:35 a.m., the Administrator indicated that the facility was unable to locate the TB documentation for CNA 5 and that the employee should have had the missing TB test documentation with their employee file.

On 3/6/24 at 8:55 a.m., the Corporate Nurse Consultant (CNC) provided a copy of the Tuberculosis Screening policy for employees, dated as revised in December 2015, and indicated it was the current policy in use by the facility. A review of the policy indicated, "Upon hire, all Bickford Family Members [employees] must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis."

Based on interview and record review, the facility failed to provide documentation for an employee's tuberculosis (TB) skin test for 1 of 5 employees reviewed. (CNA 5)

Finding includes:

On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions.

The list indicated CNA 5 was hired on 2/15/24 and CNA 5 was currently employed at the

	facility. On 3/5/24 at 1:30 p.m., during review of employee records, CNA 5's record lacked documentation of any tuberculin or TB skin tests (a test required for healthcare workers to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs). During an interview on 3/5/24 at 1:35 a.m., the Administrator indicated that the facility was unable to locate the TB documentation for CNA 5 and that the employee should have had the missing TB test documentation with their employee file. On 3/6/24 at 8:55 a.m., the Corporate Nurse Consultant (CNC) provided a copy of the Tuberculosis Screening policy for employees, dated as revised in December 2015, and indicated it was the current policy in use by the facility. A review of the policy indicated, "Upon hire, all Bickford Family Members [employees] must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis."			
R 0148	Sanitation and Safety Standards - Deficiency	R 0148	R148 – Sanitation and Safety	04/19/2024

	410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials, for 1 of 3 days during the survey. (Salon, Memory Care Secured Unit) Findings include: 1. During the initial facility tour		Standards – Deficiency The facility failed to ensure potentially hazardous material were kept secure and behind locked doors to prevent resident's access to the materials What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Salon door was immediately locked and potentially hazardous chemicals were placed behind locked door How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by this deficient practice What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does	

	on 3/4/24 at 10:25 a.m. the facility Salon, located near the main dining room and along the 400 hall, was observed. The entry door was opened and unlocked. Inside the Salon, next to the sink basin, a storage compartment was observed. The compartment had four unlocked drawers. Inside the third drawer was a 24-ounce plastic bottle of Peroxide Multi Surface Cleaner and Disinfectant (multi-purpose solution effective on a wide range of non-food contact surfaces and glass). The bottle contained a liquid substance and the bottle was approximately one fourth full of the liquid. "Keep out of reach..." was pre-printed on the manufacturer's label. No staff were visible in the area at that time. During an interview on 3/4/24 at 10:28 a.m., Certified Nursing Assistant (CNA) 2 indicated the Salon door was to be kept closed and locked while no staff were in the salon. During an interview on 3/4/24 at 10:30 a.m., the Administrator indicated the Salon door was to be kept closed and locked when no staff were present in the salon. During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse		not recur Executive Director will be responsible for ensuring that all potentially hazardous materials are behind locked doors Executive Director will be re-educated on Policy PP-50400 Hazardous Waste Executive Director/Designee will in-service all employees on the storing of hazardous waste. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will monitor compliance of storage of hazardous materials on routine visits.	

	Consultant indicated there were 16 self-mobile cognitive impaired residents, who resided on the 100, 200, 300, and 400 halls, who had access to the Salon. 2. During the initial facility tour on 3/4/24 at 10:30 to 10:34 a.m., the Memory Care Secured Unit was observed. On a table, located in the hall between Rooms 503 and 504, a 6.2-ounce can of Glade Room Spray Air Freshener was observed. The can of Glade was approximately one half full. "Keep out of reach..." was pre-printed on the manufacturer's label. During that same time, multiple residents were observed walking in the hall and had passed by the table which held the Glade Room Spray Air Freshener. No staff were visible in the area at that time. During an interview on 3/4/24 at 10:37 a.m., Qualified Medication Aide (QMA) 3 indicated the Glade Room Spray Air Freshener can should not have been left on the table or accessible to the residents. During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse Consultant indicated there were 14 self-mobile cognitive impaired residents who resided			

	in the Memory Care Unit. On 3/5/24 at 9:00 a.m., the Corporate Nurse Consultant provided a copy of the Hazardous Materials - Housekeeping / Laundry policy, dated July 2012, and indicated it was the current policy in use by the facility. A review of the policy, indicated "...all chemicals, poisons or combustible materials shall be stored and disposed of in accordance with the manufacturer's directions and all applicable regulations...all hazardous materials shall be properly labeled and stored in a locked storage area..." Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials, for 1 of 3 days during the survey. (Salon, Memory Care Secured Unit) Findings include: 1. During the initial facility tour on 3/4/24 at 10:25 a.m. the facility Salon, located near the main dining room and along the 400 hall, was observed. The entry door was opened and unlocked. Inside the Salon, next to the sink basin, a storage compartment was observed.			

The compartment had four unlocked drawers. Inside the third drawer was a 24-ounce plastic bottle of Peroxide Multi Surface Cleaner and Disinfectant (multi-purpose solution effective on a wide range of non-food contact surfaces and glass). The bottle contained a liquid substance and the bottle was approximately one fourth full of the liquid. "Keep out of reach..." was pre-printed on the manufacturer's label.

No staff were visible in the area at that time.

During an interview on 3/4/24 at 10:28 a.m., Certified Nursing Assistant (CNA) 2 indicated the Salon door was to be kept closed and locked while no staff were in the salon.

During an interview on 3/4/24 at 10:30 a.m., the Administrator indicated the Salon door was to be kept closed and locked when no staff were present in the salon.

During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse Consultant indicated there were 16 self-mobile cognitive impaired residents, who resided on the 100, 200, 300, and 400 halls, who had access to the Salon.

2. During the initial facility tour on 3/4/24 at 10:30 to 10:34

a.m., the Memory Care Secured Unit was observed. On a table, located in the hall between Rooms 503 and 504, a 6.2-ounce can of Glade Room Spray Air Freshener was observed. The can of Glade was approximately one half full. "Keep out of reach..." was pre-printed on the manufacturer's label.

During that same time, multiple residents were observed walking in the hall and had passed by the table which held the Glade Room Spray Air Freshener.

No staff were visible in the area at that time.

During an interview on 3/4/24 at 10:37 a.m., Qualified Medication Aide (QMA) 3 indicated the Glade Room Spray Air Freshener can should not have been left on the table or accessible to the residents.

During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse Consultant indicated there were 14 self-mobile cognitive impaired residents who resided in the Memory Care Unit.

On 3/5/24 at 9:00 a.m., the Corporate Nurse Consultant provided a copy of the Hazardous Materials - Housekeeping / Laundry policy, dated July 2012, and indicated it was the current policy in use by

	the facility. A review of the policy, indicated "...all chemicals, poisons or combustible materials shall be stored and disposed of in accordance with the manufacturer's directions and all applicable regulations...all hazardous materials shall be properly labeled and stored in a locked storage area..."			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility. (Resident 44, Resident 45) Findings include: On 3/4/24 at 9:45 a.m., the Administrator indicated 2 pets were housed in the facility.	R 0151	R151 – Sanitation & Safety Standards – Noncompliance The facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	04/19/2024

	1. On 3/4/24 at 10:30 a.m., observed a cat in Resident 44's room. Resident 44 indicated she was not sure if her pet had its immunizations or annual veterinarian exam. 2. On 3/4/24 at 11:00 a.m., observed a cat in Resident 45's room. Resident 45 indicated she was not sure if her pet had its immunizations or annual veterinarian exam. On 3/4/24 at 12:00 p.m., the Administrator indicated Resident 44 and Resident 45's pet records lacked veterinarian records including rabies vaccination and annual exams. On 3/4/24 at 11:55 a.m., the Administrator provided a policy titled Resident Services, dated February 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated "...3. In allowing residents to keep pets at Bickford, as indicated in the Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move-in and ongoing, the Resident must provide proof of current vaccination records." Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had		Vaccination records have been requested for 2 of 2 pets housed in the branch How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Executive Director/Designee will complete audit of all pets housed in the branch to ensure vaccination records are in file 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 will be responsible for ensuring that the annual vaccination records are kept up to date Executive Director/Designee will be re-educated on importance and safety of having up to date vaccination records for each branch housed pet	

	received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility. (Resident 44, Resident 45) Findings include: On 3/4/24 at 9:45 a.m., the Administrator indicated 2 pets were housed in the facility. 1. On 3/4/24 at 10:30 a.m., observed a cat in Resident 44's room. Resident 44 indicated she was not sure if her pet had its immunizations or annual veterinarian exam. 2. On 3/4/24 at 11:00 a.m., observed a cat in Resident 45's room. Resident 45 indicated she was not sure if her pet had its immunizations or annual veterinarian exam. On 3/4/24 at 12:00 p.m., the Administrator indicated Resident 44 and Resident 45's pet records lacked veterinarian records including rabies vaccination and annual exams. On 3/4/24 at 11:55 a.m., the Administrator provided a policy titled Resident Services, dated February 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated "...3. In allowing residents to keep pets at Bickford, as indicated in the		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Divisional Director of Health and Operations will review vaccination records for all newly accepted pets for the next 6 months to ensure compliance Divisional Director will audit for compliance on routine visits and at least annually.	

	Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move-in and ongoing, the Resident must provide proof of current vaccination records."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident	R 0217	R217 – Evaluation – Deficiency The facility failed to ensure service plans were signed and dated by the resident for 2 of 7 clinical record reviews (Resident 50 & 59) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Signatures have been requested for resident 50 & 59 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Health and Wellness	04/19/2024

upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident for 2 of 7 clinical record reviews. (Resident 50, Resident 39)

Findings include:

1. On 3/5/24 at 9:00 a.m., the clinical record of Resident 50 was reviewed. The diagnosis included, but was not limited to, debility.

A Mini Mental Status Examination, dated 10/9/23, indicated Resident 50 had no cognitive impairment.

A Significant Change Service Plan, dated 2/7/24, indicated services provided by the facility. The service plan lacked a signature and date from Resident 50.

Director/Designee will complete an audit of
all resident service plans to ensure all are signed

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 & Wellness Director will be responsible for ensuring that the most current service plan is signed by
resident or POA.

Executive Director/Designee will be re-educated the service plan
process which includes being signed by resident or POA.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be
put into place

	2. On 3/5/24 at 9:30 a.m., the clinical record of Resident 39 was reviewed. The diagnoses included, but were not limited to, constipation and anemia. A Mini Mental Status Examination, dated 9/8/23, indicated Resident 39 had no cognitive impairment. A service plan, dated 9/8/23, indicated services provided by the facility. The service plan lacked a signature and date from Resident 39. During an interview on 3/5/24 at 9:55 a.m., the Administrator indicated the service plans should have been signed by the residents. On 3/5/24 at 11:13 a.m., the Administrator provided a policy titled: Service Planning and Agreements, dated 11/2015, and indicated it was the current police being used by the facility. A review of the policy lacked documentation indicating the Service Plan required a date and signature. The Administrator indicated that the Resident and or family/POA are to sign completed Service Plans. Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident for 2 of 7 clinical record reviews. (Resident 50, Resident		Divisional Director of Health and Operations will review the service plan of the next 6 move ins to ensure it is complete with signature of resident and/or POA Divisional Director will audit for compliance on routine visits and at least annually.	

39)

Findings include:

1. On 3/5/24 at 9:00 a.m., the clinical record of Resident 50 was reviewed. The diagnosis included, but was not limited to, debility.

A Mini Mental Status Examination, dated 10/9/23, indicated Resident 50 had no cognitive impairment.

A Significant Change Service Plan, dated 2/7/24, indicated services provided by the facility. The service plan lacked a signature and date from Resident 50.

2. On 3/5/24 at 9:30 a.m., the clinical record of Resident 39 was reviewed. The diagnoses included, but were not limited to, constipation and anemia.

A Mini Mental Status Examination, dated 9/8/23, indicated Resident 39 had no cognitive impairment.

A service plan, dated 9/8/23, indicated services provided by the facility. The service plan lacked a signature and date from Resident 39.

	During an interview on 3/5/24 at 9:55 a.m., the Administrator indicated the service plans should have been signed by the residents. On 3/5/24 at 11:13 a.m., the Administrator provided a policy titled: Service Planning and Agreements, dated 11/2015, and indicated it was the current police being used by the facility. A review of the policy lacked documentation indicating the Service Plan required a date and signature. The Administrator indicated that the Resident and or family/POA are to sign completed Service Plans.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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