STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/30/2022

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 the Investigation of Complaint IN00376507. Complaint IN00376507 - Substantiated. State Residential Finding related to the allegations is cited at R52. Survey date: March 30, 2022 Facility number: 012938 Residential Census: 58 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 1, 2022.	R 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 4-22-2022.**	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**R0052** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were harmed by	04/22/2022

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility neglected to keep a resident safe for 1 of 1 residents reviewed for elopement. A cognitively impaired resident exited the building and was found outside away from the building and down a hill. (Resident C). Finding includes: On 3/30/22 at 10:25 a.m., during an initial tour of the facility, the Community Relations Director indicated that Resident C had exited the building on 3/27/22. She indicated that Resident C was confused, had vision difficulties, and utilized a walker for mobility. The Community Relations Director indicated that Resident C would be moved to the Memory Care Unit. On 3/30/22 at 10:48 a.m., Resident C's clinical record was reviewed. A Service Assessment, dated 12/1/21, indicated Resident C required multiple orientations to daily		this alleged deficient practice. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents MMSE & GDS scores were reviewed as well as following the trigger mechanisms identified in our Resident Monitoring System Policy. Those that were identified a monitoring device was placed. The residents service plan was updated to include the need for a monitoring device. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Residents will be assessed upon Move In and bi-annually and/or with any change of condition for the use of a resident monitoring device based on our Resident Monitoring System Policy. All BFM's will be educated on the policy, who has devices and how to check for function and placement.	

	routine, and would become confused and agitated. The Progress Notes, included, but were not limited to: 3/23/22 at 4:45 p.m., The nurse contacted physician to update physician on resident symptoms of hallucinations, unsteady gait, delusions, and inability to locate apartment. Apartment was in disarray. 3/26/22 (no time), Resident was extremely confused, wandering into other residents rooms. Resident was aggressive when staff attempted to redirect. Resident was not making any sense when speaking. Resident was hallucinating airplanes crashing in the sky. Resident walked the halls all day and has not stopped. Staff was concerned about her wellbeing. 3/27/22 at 10:30 a.m., Nurse alerted by aide that resident was not in her room or common area. Nurse, aides, and kitchen staff immediately checked all rooms in the facility. Resident was not in any of the rooms. The Director was notified and all staff did a perimeter check. Resident was found outside of the building. Emergency Services was called and resident was transferred to the hospital. 3/27/22 at 3:30 p.m., Resident returned from emergency room.		**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Resident monitoring devices are being checked for function and placement once daily and placement twice daily for 4 weeks. Then placement and function checks daily for 4 weeks and then placement and function checks weekly thereafter. RNC and/or designee to audit weekly and thereafter. During routine checks if the monitoring device is not found on the resident or is found to be not working, the RNC, Director and/or designee will be notified, and the resident will be placed on increased supervision until another monitoring device can be placed. Compliance Date: 04-22-2022	

No injuries noted. A wanderguard was placed to the left wrist.

3/30/22 at 6:00 a.m., This writer reapplied wanderguard to the right wrist. Wanderguard was noted to be on resident's table at the beginning of shift.

On 3/30/22 at 11:38 a.m., the Director indicated on 3/27/22 she received a phone call that staff could not find Resident C. She indicated that when she arrived the staff had looked throughout the facility. The Director indicated she had brought someone with her to the facility that morning and they found Resident C sitting behind the facility down a hill. At that time, the path the Director believed Resident C was observed. She indicated they believed Resident C exited the building through the front door, turned right, and walked around the side of the building. Almost to the back of the building a hill was observed. The hill was observed to be mildly steep. At the bottom of the hill a rockbed was present. The Director indicated that Resident C was found at the bottom of the hill at approximately 10:51 a.m. She indicated they believed Resident C slid down the hill on her backside and came to a stop at the rockbed. The Director indicated that all the doors to the facility are locked but on

weekends there are a lot of visitors. She further indicated some residents were moving out over the weekend.

On 3/30/22 at 12:03 p.m., CNA 1 indicated that she worked on the morning of 3/27/22. CNA 1 indicated she had served coffee to Resident C at 9:00 a.m. She indicated at 10:04 a.m., she received an alert for the front door alarm. CNA 1 then went to Resident C's room and Resident C's son was in the room but Resident C was not. She indicated she went to check on Resident C first because she had been upset the previous night and that morning. CNA 1 then went room to room to check for Resident C and notified the nurse. The nurse notified the kitchen staff and a silver alert (missing resident) code.

On 3/30/22 at 12:09 p.m., LPN 1 indicated she was working the morning of 3/27/22. LPN 1 indicated that 3/27/22 was the first date she had worked in the facility. She indicated that at approximately 8:30 a.m., she had begun her medication pass. During the medication pass, the CNA notified LPN 1 that Resident C was missing. They were looking for Resident C, called the Director, and checked the perimeter. After the Director arrived, Resident C was located down the hill by the Directors

friend. LPN 1 indicated she did not hear any alarms sounding that morning.

On 3/30/22 at 12:17 p.m., Resident C was observed to be sitting in the dining room eating the noon meal. On Resident C's right wrist, a wanderguard device was observed.

On 3/30/22 at 12:25 p.m., the historical weather forecast was reviewed. The low temperature was 24 degrees Fahrenheit and the high temperature was 36 degrees Fahrenheit.

On 3/30/22 at 12:30 p.m., the Missing Resident procedure, revised 4/2014, was reviewed. The procedure included, but was not limited to: Upon becoming aware of a missing resident, immediately summon the assistance of the other employees on duty. One employee shall immediately search the entire inside of the building including all apartments. Another employee shall simultaneously check the immediate outside vicinity of the building.

This State tag relates to Complaint IN00376507.

Based on observation, interview, and record review, the facility neglected to keep a resident safe for 1 of 1 residents reviewed for elopement. A cognitively impaired resident

exited the building and was found outside away from the building and down a hill. (Resident C).

Finding includes:

On 3/30/22 at 10:25 a.m., during an initial tour of the facility, the Community Relations Director indicated that Resident C had exited the building on 3/27/22. She indicated that Resident C was confused, had vision difficulties, and utilized a walker for mobility. The Community Relations Director indicated that Resident C would be moved to the Memory Care Unit.

On 3/30/22 at 10:48 a.m., Resident C's clinical record was reviewed. A Service Assessment, dated 12/1/21, indicated Resident C required multiple orientations to daily routine, and would become confused and agitated.

The Progress Notes, included, but were not limited to:

3/23/22 at 4:45 p.m., The nurse contacted physician to update physician on resident symptoms of hallucinations, unsteady gait, delusions, and inability to locate apartment. Apartment was in disarray.

3/26/22 (no time), Resident was extremely confused, wandering into other residents rooms.

Resident was aggressive when staff attempted to redirect. Resident was not making any sense when speaking. Resident was hallucinating airplanes crashing in the sky. Resident walked the halls all day and has not stopped. Staff was concerned about her wellbeing.

3/27/22 at 10:30 a.m., Nurse alerted by aide that resident was not in her room or common area. Nurse, aides, and kitchen staff immediately checked all rooms in the facility. Resident was not in any of the rooms. The Director was notified and all staff did a perimeter check. Resident was found outside of the building. Emergency Services was called and resident was transferred to the hospital.

3/27/22 at 3:30 p.m., Resident returned from emergency room. No injuries noted. A wanderguard was placed to the left wrist.

3/30/22 at 6:00 a.m., This writer reapplied wanderguard to the right wrist. Wanderguard was noted to be on resident's table at the beginning of shift.

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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