STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/01/2026

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 Intake 469125. Intake 469125 - State deficiencies related to the allegations are cited at R243 and R357. Survey date: May 28, 29, and June 1, 2026 Facility number: 012938 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 5, 2026.	R 0000		
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s	R 0243	R 243 410 IAC 16.2-5-4(e)(3) Health Services – Deficiency. HWD reviewed and updated the MARs for Resident B and Resident C to ensure all	07/10/2026

	medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure documentation on the Medication Administration Record (MAR) was complete and accurate for 2 of 3 residents reviewed for medication administration. (Resident B, Resident C) Findings include: During an interview on 5/28/26 at 10:00 a.m., Visitor 1 indicated the staff hadn't ordered Resident B's acetaminophen suppositories (medication used to treat fever during end of life care) 650 mg (milligrams), and hyoscyamine (medication used to treat secretions during end of life care) 0.125 mg from the pharmacy on 3/5/26, when the hospice nurse ordered it. Visitor 1 requested for the staff to administer hyoscyamine and she was told the medication wasn't on the MAR so they had to get it from the pharmacy.		physician orders are accurately transcribed and medication administration is completely documented. HWD completed immediate physician orders review for both residents. 07/05/2026 DDHW re-educated the HWD on medication administration documentation protocols, including accurate MAR transcription and complete documentation of administration. HWD then re-educated all med-techs on these same protocols with a post-test competency validation. The Health & Wellness Director and Health & Wellness Coordinator will be reviewing Medication Variance Report for all residents, Complete Medication Cart audit for all the medication carts during which any missed items, or items in which exceptions are documented will be identified. The Health & Wellness Director and/or Health & Wellness Coordinator will address any identified issue per facility policies. The Divisional Director of Health & Wellness will be meeting with the branch leaders weekly to review medication administration compliance and audits performed. DDHW will audit all the residents' MARs weekly for 12 weeks to verify complete and accurate medication administration documentation, with findings reviewed at the Divisional	

	They administered hyoscyamine a few hours later after they received it from the pharmacy. The clinical record for Resident B was reviewed on 5/28/26 at 10:19 a.m. The diagnoses included, but were not limited to, dementia and anxiety. A Hospice physician's order form, dated 3/5/26 at 9:06 p.m., indicated the following: - Start on 3/5/26, acetaminophen 650 mg suppositories administer one suppository every 6 hours as needed for fever. - Start on 3/5/26, hyoscyamine 0.125 mg tablet administer one tablet sublingually every 4 hours as needed for increased secretions. The MAR, dated 3/1/26 at 12:00 a.m. through 3/31/26 at 11:59 p.m., lacked documentation of a physicians order for acetaminophen 650 mg suppositories and hyoscyamine 0.125 mg tablets. 2. The clinical record for Resident C was reviewed on 5/28/26 at 9:20 a.m. The diagnoses included, but were not limited to, hypertension and atrial fibrillation. The physician orders indicated:		Director of Health & Wellness review meeting. Completion date: 07/10/2026	

	- Started on 8/18/25, amantadine (medication used to treat Parkinson's disease) 100 mg capsule administer one capsule orally twice daily. The order was discontinued on 10/3/25. - Started on 8/18/25, atorvastatin (medication used to treat high cholesterol) 20 mg tablet administer one tablet orally every day. The order was discontinued on 10/3/25. - Started on 8/18/25, calcitonin spray (medication used to treat osteoporosis) 200 unit/actuation instill one spray in one nostril once daily. Alternate nostrils. The order was discontinued on 10/3/25. - Started on 8/20/25, cephalexin (medication used to treat infection) 500 mg capsule administer one capsule every 12 hours. The order was discontinued 9/9/25. - Started on 8/18/25, finasteride (medication used to treat benign prostatic hyperplasia) 5 mg tablet administer one tablet orally daily. The order was discontinued on 10/3/25. - Started on 8/18/25, hydralazine (medication used to treat hypertension) 50 mg tablet administer one tablet by mouth three times daily with food. The order was discontinued on			

	9/9/25. - Started on 8/18/25, Janumet (medication used to treat high blood sugar) 50 mg-1000 mg tablet administer one tablet by mouth twice daily. The order was discontinued on 10/3/25. - Started lacosamide (medication used to prevent seizures) 100 mg tablet administer one tablet orally twice daily. The order was discontinued on 10/3/25. - Started on 8/18/25, levothyroxine (medication to treat thyroid) 50 micrograms (mcg) tablet administer one tablet orally every day. The order was discontinued on 10/3/25. - Started on 8/18/25, losartan (medication used to treat high blood pressure) 100 mg tablet administer one tablet orally every day. The order was discontinued on 10/3/25. - Started on 8/18/25, metoprolol tartrate (medication used to treat hypertension) 25 mg tablet administer one tablet orally twice daily. The order was discontinued on 10/3/25. - Started on 8/18/25, Myrbetriq (medication used to treat overactive bladder) 50 mg tablet administer one tablet orally every day. The order was			

	discontinued on 10/3/25. The Medication Administration Record (MAR), dated 8/1/25 at 12:00 a.m. until 8/31/25 at 11:59 p.m., indicated the MAR was left blank, on 8/20/25 and 8/22/25 on day shift, for the following medications: - amantadine 100 mg capsule - atorvastatin 20 mg tablet - calcitonin spray 200 unit/actuation - cephalexin 500 mg capsule - finasteride 5 mg tablet - hydralazine 50 mg tablet - Janumet 50 mg-1000 mg tablet - lacosamide 100 mg tablet - levothyroxine 50 mcg tablet - losartan 100 mg tablet - metoprolol tartrate 25 mg tablet - Myrbetriq 50 mg tablet During an interview on 5/29/26 at 10:10 a.m., the Director of Nursing (DON) indicated there had been a problem with Resident B's insurance so hyoscyamine 0.125 mg was not added to his MAR. The facility			

	addressed the issue and administered it once the facility received it from the pharmacy. Resident C received all of his medications as ordered by the physician. The documentation on the MAR should have been completed. Resident C's hydralazine was discontinued on 9/9/25, by his physician and then restarted, on 9/22/25, when they re-evaluated him. On 5/29/26 at 12:05 p.m., the Regional Director of Nursing provided a copy of a facility policy, titled Medication Administration, dated 5/2026, and indicated this was the current policy used by the facility. A review of the policy indicated an accurate and up to date MAR would be maintained. This citation relates to Intake 469125.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications.	R 0357	R 357 410 IAC 16.2-5-8.1(j)(1-3) Clinical Records – Noncompliance HWD reviewed Resident B's clinical record and entered a late entry in the Electronic Health Record to document physician notification of the resident's death. 05/28/2026 DDHW re-educated the HWD on the Incident and Accident Report policy, specifically the requirement to notify the	07/21/2026

	(3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to document the physician had been notified after a resident died. (Resident B) Findings include: During an interview on 5/28/26 at 10:29 a.m., Visitor 1 indicated Resident B had been on hospice services and passed away on 3/13/26. She had been with Resident B when he passed away and hospice had been notified. The clinical record for Resident B was reviewed on 5/28/26 at 10:19 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and dementia. A progress note, dated 3/13/26 at 2:33 p.m., indicated Resident B's respirations had ceased on previous shift. Resident B's body had been released to the mortuary. During an interview on 5/29/26 at 10:10 a.m., the Director of Nursing (DON) indicated when Resident B died, the nurse should have documented the physician had been notified.		physician and document the notification in the Electronic Health Record following a resident's death. The HWD then re-educated all branch staff on these reporting and documentation requirements with post-test competency validation. The Executive Director will be reviewing residents charts daily and ensuring all notifications have been completed for every incident including deaths. Divisional Director of Health & Wellness and/or Divisional Director of Operations will be reviewing all residents' Notes/Incidents documentation weekly to verify that incidents are properly reported to all responsible parties applicable such as Powers of Attorney, Primary Care Providers, State (when applicable), and branch leaders. DDHW will audit deceased resident records monthly for 6 months to verify complete documentation of physician notification in the Electronic Health Record, reviewed at the Divisional H&W review meeting. Date of completion: 07/21/2026	

	On 5/29/26 at 12:05 p.m., the Regional Director of Nursing provided a copy of a facility policy, titled Documentation, dated 2/2025, and indicated this was the current policy used by the facility. A review of the policy indicated appropriate documentation was a necessary step for all care provided to the residents. This citation relates to Intake 469125.			

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 SIGNATURENicole Wechet	TITLEDDHW	(X6) DATE06/26/2026