

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2023
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 IN00416173. Complaint IN00416173 - State deficiencies related to the allegations are cited at R0297. Survey date: September 5, 2023 Facility number: 012938 Residential Census: 32 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 11, 2023.	R 0000			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the	R 0297	R297 – Pharmaceutical Services - Noncompliance The rule is not met as evidenced by the facility	10/01/2023	

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following for that resident:

(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.

Based on interview and record review, the facility failed to ensure prescribed medications were available for a resident after transferring from another facility for 1 of 3 residents reviewed. (Resident B)

Findings include:

On 9/5/23 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, mood disorder, alcohol abuse alcohol dependence with alcohol-induced persisting dementia.

The Physician Orders, included but were not limited to:

- Clonazepam (an anti-anxiety) 0.05 mg (milligrams) 1 tablet by mouth, three times a day.

Resident B's MAR (Medication Administration Record) indicated from 8/24/23 through 8/29/23 Clonazepam was not administered.

On 9/5/23 at 11:40 a.m., the Wellness Director indicated on 8/24/23, Resident B was

failed to ensure prescribed medications were available for a resident after transferring from another facility for 1 of 3 residents reviewed.

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

All medications ordered by physician for Resident B have been received and are being administered as ordered by physician.

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

Health & Wellness Director will review new admission orders to ensure that pharmaceutical services are available to provide residents with prescribed medication prior to admission.

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transferred from a Skilled Nursing Facility to an assisted living facility. Resident B arrived from the other facility with all of his medications except for his insulin and his Clonazepam. The Wellness Director indicated the facility received its medications from their pharmacy based in Iowa, and all medication would arrive via UPS. She indicated she learned she needed to place the medication list into the computer to have it transfer to the MAR. The Wellness Director indicated the facility needed signed prescriptions from the physician, who even after multiple tries was unable to be reached to complete Resident B's orders.

On 9/5/23 at 1:57 p.m., the Director provided an Admission Agreement, revised 6/2023, and indicated it was the one currently in use by the facility. It indicated residents have a right to pick their own pharmacy if they chose not to use the facility pharmacy, however they or their family would be responsible to get the medications and deliver them to the facility. Resident B's guardian indicated she chose to use the facility pharmacy.

This State tag relates to Complaint IN00416173.

Based on interview and record review, the facility failed to ensure prescribed medications

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 and Health and Wellness Director will be re-educated on Medication Management Policy and Pharmaceutical Services to ensure pharmaceutical services are available to provide prescribed medications.

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 & Operations will review the next 3 admission charts to ensure that pharmaceutical services are available to provide residents with prescribed medications.

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were available for a resident after transferring from another facility for 1 of 3 residents reviewed. (Resident B)

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By what date the systemic changes will be completed by October 1, 2023.

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OMB NO. 0938-0391

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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