STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/19/2023

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. Survey dates: April 17, 18, and 19, 2023 Facility number: 012938 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 24, 2023.	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 05/30/2023**	
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:	R 0092	R092 Administration and Management - Noncompliance · 0 residents were harmed by this deficient practice.	05/30/2023

	(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 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 12 fire drills were conducted in the calendar year for 6 of 12 months reviewed. Finding includes:		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Fire drill was completed 5/4/23. 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 . Director or other delegated staff member will be responsible for running an effective fire drill on a monthly basis. 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 Operations will re-educate Director on policy	

	On 4/18/23 at 1:00 p.m., the Divisional Director of Operations (DDO) provided documentation of fire drills conducted for the past year; April 2022 through March 2023. A review of the records indicated fire drills were conducted on the following months: - July 2022 - August 2022 - September 2022 - October 2022 - November 2022 - January 2023 During an interview on 4/18/23 at 1:15 p.m., the DDO indicated that fire drills were to be conducted monthly and that documentation for some months were missing. During an interview on 4/19/23 at 9:45 a.m., the DDO indicated that no additional fire drill documentation for the missing months had been located. On 4/18/23 at 2:10 p.m., the DDO provided a copy Fire Drill Schedule policy, dated for April of 2016, and indicated it was the current policy in use by the facility. A review of the document indicated, "Fire drills shall be performed monthly ..."		pertaining to Fire Safety and frequency of drills. Date of completion May 30, 2023 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 of Operations will review Fire Drill records on a monthly basis. By what date the systemic changes will be completed by 5/30/23	

	Based on interview and record review, the facility failed to ensure 12 fire drills were conducted in the calendar year for 6 of 12 months reviewed. Finding includes: On 4/18/23 at 1:00 p.m., the Divisional Director of Operations (DDO) provided documentation of fire drills conducted for the past year; April 2022 through March 2023. A review of the records indicated fire drills were conducted on the following months: - July 2022 - August 2022 - September 2022 - October 2022 - November 2022 - January 2023 During an interview on 4/18/23 at 1:15 p.m., the DDO indicated that fire drills were to be conducted monthly and that documentation for some months were missing. During an interview on 4/19/23 at 9:45 a.m., the DDO indicated that no additional fire drill documentation for the missing months had been located. On 4/18/23 at 2:10 p.m., the			

	DDO provided a copy Fire Drill Schedule policy, dated for April of 2016, and indicated it was the current policy in use by the facility. A review of the document indicated, "Fire drills shall be performed monthly ..."			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy.	R 0123	R123 Personnel - Nonconformance · 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? . Personnel records for Maintenance Coordinator 2 and Wellness Nurse 3 have been created 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	05/30/2023

(10) Date and reason for separation.

Based on interview and record review, the facility failed to maintain current and accurate personnel records for 2 of 5 employee records reviewed. (Maintenance Coordinator 2, Wellness Nurse 3)

Findings include:

On 4/18/23 at 10:33 a.m., during employee record review, the Maintenance Coordinator (MC) 2's and Wellness Nurse (WN) 3's employee records were requested from the Divisional Director of Operations (DDO).

The DDO provided a list of current employees with date of hire and positions.

The list indicated MC 2 was hired 6/20/22 and WN 3 was hired 11/2/22. MC 2 and WN 3 were currently employed at the facility.

During an interview on 4/19/23 at 9:00 a.m., the DDO indicated the facility was unable to locate MC 2's and WN 3's employee records. The records should have been kept in a file and should have been readily available.

On 4/19/23 at 10:00 a.m., the facility was unable to provide

· Executive Director will audit all employee records by 5/30/23 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 Operations will re-educate Director on personnel records for all employees and contents of record. Date of completion May 30, 2023

How the corrective actions will be
monitored to ensure the deficient practice will not recur, what quality
assurance program will be put into place.

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Divisional of Operations will review employee record of
the next three new employees to ensure personnel records are complete.

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	the employee records by the end of the survey. On 4/18/23 at 2:10 p.m., the Wellness Director provided a policy titled Personnel, dated January 2023, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...Procedure: 1) When hired, a BFM personnel file is created. 2) All applicant files are retained. 3) BFM's can review personnel records upon request..." Based on interview and record review, the facility failed to maintain current and accurate personnel records for 2 of 5 employee records reviewed. (Maintenance Coordinator 2, Wellness Nurse 3) Findings include: On 4/18/23 at 10:33 a.m., during employee record review, the Maintenance Coordinator (MC) 2's and Wellness Nurse (WN) 3's employee records were requested from the Divisional Director of Operations (DDO). The DDO provided a list of current employees with date of hire and positions.		Divisional of Operations will randomly complete audits of employee records on routine branch visits. By what date the systemic changes will be completed by 5/30/23	

	The list indicated MC 2 was hired 6/20/22 and WN 3 was hired 11/2/22. MC 2 and WN 3 were currently employed at the facility. During an interview on 4/19/23 at 9:00 a.m., the DDO indicated the facility was unable to locate MC 2's and WN 3's employee records. The records should have been kept in a file and should have been readily available. On 4/19/23 at 10:00 a.m., the facility was unable to provide the employee records by the end of the survey. On 4/18/23 at 2:10 p.m., the Wellness Director provided a policy titled Personnel, dated January 2023, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...Procedure: 1) When hired, a BFM personnel file is created. 2) All applicant files are retained. 3) BFM's can review personnel records upon request..."				

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