STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/13/2022

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 Complaints IN00384662, IN00384916, and IN00384922. Complaint IN00384662 - Substantiated. No deficiencies related to allegations are cited. Complaint IN00384916 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00384922 - Substantiated. State deficiencies related to the allegations are cited at R52 and R90. Survey dates: July 12 and 13, 2022 Facility number: 012938 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July	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 08/01/2022.**	

	13, 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; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility neglected to provide supervision to prevent an elopement for 1 of 3 residents reviewed for elopement. This resulted in the resident exiting the facility, unsupervised, crossing a side street, and walking up to a random residential home. (Resident B) Finding includes: During an interview on 7/12/22 at 9:24 a.m., QMA 1 (Qualified Medication Aide) indicated Resident B admitted to the facility almost 2 weeks ago. The day after she admitted she was outside the building. Resident B was moved to secure unit that day after she was brought back	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 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	08/01/2022

	to the facility. The clinical record for Resident B was reviewed on 7/12/22 at 9:30 a.m. The diagnoses included, but were not limited to, acute metabolic encephalopathy, hypertension and dementia. A Mini Mental Status Exam, dated 6/29/22, indicated Resident B was severely cognitively impaired. A Service Plan, dated 6/29/22 at 3:00 p.m., indicated Behavior: Resident B's family has shared that while living at home Resident B had exited the home several times. Security has been discussed with Resident B's husband and her children. Resident B was to receive a wander guard on move in. This writer has discussed with Resident B's husband and family that wander guards alert staff and secure exit doors when resident is near doors. This writer has discussed assisted living and memory care programing with Resident B's husband. Family is aware and agrees that a move to memory care when apartment is available is ideal for Resident B... A hospital discharge summary, dated 7/1/22 at 12:25 p.m., indicated Resident B presented to the hospital with increasing		Monitoring System Policy. All BFM's will be educated on the policy, who has devices and how to check for function and placement. **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: 08/01/2022	

	confusion, increased wandering and increased agitation...Resident B's spouse was concerned about her safety and is considering options for facility placement...discharge diagnosis was acute metabolic encephalopathy presenting with worsening confusion and agitation/behaviors in the presence of worsening dementia. A progress note, dated 7/2/22, indicated Resident B exited the building without staff with her on 7/2/22 at approximately 8:00 a.m. A progress note, dated 7/5/22 (no time given), indicated one of the CNA's (Certified Nursing Aides) that was in the facility at that time (7/2/22) indicated they were made aware a resident had exited the building by a family living across the street from the facility. Resident B walked to a neighbor's house. The CNA escorted the resident back to the building. During an interview on 7/12/22 at 12:35 p.m., the Director of Nursing indicated everyone that worked that dayshift on 7/2/22 was from agency. She was on her way to the facility to work the floor as the nurse due to a call off. Resident B walked out the front door. She was wearing her wander guard, but she pushed on the door for 15			

	seconds and the doors opened. The alarm sounded but the aides were providing care in other resident rooms and were not able to get to the front door in time. A neighbor came to the building to let us know Resident B had walked to his house. Resident B remained with the neighbor's daughter, who is a nurse, while the man came to notify us. The aide went to Resident B, at the neighbor's house, and brought her back to the facility. There were no signs of any injury. We moved her to secure unit that day after a conversation with the family. On 7/12/22 at 8:30 a.m. The Director of Nursing provided a copy of a facility policy, titled "Missing Resident," dated 4/2014, and indicated this was the current policy used by the facility. A review of the policy indicated while one employee is checking the inside of the building another employee shall simultaneously check the immediate outside vicinity of the building, including courtyard, carports, parking lot and the building property... This State tag related to Complaint IN00384922. Based on interview and record review, the facility neglected to provide supervision to prevent an elopement for 1 of 3 residents reviewed for			

elopement. This resulted in the resident exiting the facility, unsupervised, crossing a side street, and walking up to a random residential home. (Resident B)

Finding includes:

During an interview on 7/12/22 at 9:24 a.m., QMA 1 (Qualified Medication Aide) indicated Resident B admitted to the facility almost 2 weeks ago. The day after she admitted she was outside the building. Resident B was moved to secure unit that day after she was brought back to the facility.

The clinical record for Resident B was reviewed on 7/12/22 at 9:30 a.m. The diagnoses included, but were not limited to, acute metabolic encephalopathy, hypertension and dementia.

A Mini Mental Status Exam, dated 6/29/22, indicated Resident B was severely cognitively impaired.

A Service Plan, dated 6/29/22 at 3:00 p.m., indicated Behavior: Resident B's family has shared that while living at home Resident B had exited the home several times. Security has been discussed with Resident B's husband and her children. Resident B was to receive a wander guard on move in. This writer has discussed with

	Resident B's husband and family that wander guards alert staff and secure exit doors when resident is near doors. This writer has discussed assisted living and memory care programing with Resident B's husband. Family is aware and agrees that a move to memory care when apartment is available is ideal for Resident B... A hospital discharge summary, dated 7/1/22 at 12:25 p.m., indicated Resident B presented to the hospital with increasing confusion, increased wandering and increased agitation...Resident B's spouse was concerned about her safety and is considering options for facility placement...discharge diagnosis was acute metabolic encephalopathy presenting with worsening confusion and agitation/behaviors in the presence of worsening dementia. A progress note, dated 7/2/22, indicated Resident B exited the building without staff with her on 7/2/22 at approximately 8:00 a.m. A progress note, dated 7/5/22 (no time given), indicated one of the CNA's (Certified Nursing Aides) that was in the facility at that time (7/2/22) indicated they were made aware a resident had exited the building by a			

	family living across the street from the facility. Resident B walked to a neighbor's house. The CNA escorted the resident back to the building. During an interview on 7/12/22 at 12:35 p.m., the Director of Nursing indicated everyone that worked that dayshift on 7/2/22 was from agency. She was on her way to the facility to work the floor as the nurse due to a call off. Resident B walked out the front door. She was wearing her wander guard, but she pushed on the door for 15 seconds and the doors opened. The alarm sounded but the aides were providing care in other resident rooms and were not able to get to the front door in time. A neighbor came to the building to let us know Resident B had walked to his house. Resident B remained with the neighbor's daughter, who is a nurse, while the man came to notify us. The aide went to Resident B, at the neighbor's house, and brought her back to the facility. There were no signs of any injury. We moved her to secure unit that day after a conversation with the family. On 7/12/22 at 8:30 a.m. The Director of Nursing provided a copy of a facility policy, titled "Missing Resident," dated 4/2014, and indicated this was the current policy used by the facility. A review of the policy			

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R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents.	R 0090	R0090 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.No residents were harmed by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Daily review by the RNC and Director of the unusual occurrencelogs and communication binder to ensure all unusual occurrences are reviewed and reported when appropriate.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**RNC re-educated on the Indiana State Department of Health Division of Long Term Care Residential Regulations 410	08/01/2022

	If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record		IAC 16.2-5-1.3 (g)(i1-6) R 0090 code for reporting Administration and Management Deficiency. Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice ofunusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. RNC re-educated on the Indiana Gateway and reporting within 24 hours of unusual occurrence. If the portal is down then RNC was educated that the Indiana state reportable form can printed and emailed to the Indiana State Department of Health @incidents@isdh.in.gov with initial and follow up reporting in the Indiana Gateway system once the system is back up and functional.	

review, the facility failed to report an elopement to the state survey agency for 1 of 1 elopements reviewed. (Resident B)

Finding includes:

During an interview on 7/12/22 at 9:24 a.m., QMA 1 (Qualified Medication Aide) indicated Resident B admitted to the facility almost 2 weeks ago. The day after she admitted she was outside the building.

The clinical record for Resident B was reviewed, on 7/12/22 at 9:30 a.m. The diagnoses included, but were not limited to, acute metabolic encephalopathy, hypertension, and dementia.

A Mini Mental Status Exam, dated 6/29/22, indicated Resident B was severely cognitively impaired.

A Service Plan, dated 6/29/22 at 3:00 p.m., indicated Behavior: Resident B's family has shared that while living at home Resident B had exited the home several times. Security has been discussed with Resident B's husband and her children. Resident B was to receive a wander guard on move in to facility. This writer has discussed with Resident B's husband and family that wander guards alert staff and secure exit doors when resident is near

How will the corrective action(s) be monitored to ensure the deficient practice will not recur. Unusual Occurrence Log updated with each occurrence and reviewed monthly by the divisional director of resident services.
Completion
Date: 08/01/2022

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A progress note, dated 7/5/22 (no time given), indicated one of the CNA's (Certified Nursing Aides) that was in the facility at that time (7/2/22) indicated they were made aware resident had exited the building by a family living across the street from the facility. Resident B walked to a neighbor's house. The CNA escorted the resident back to the building.

During an interview on 7/12/22 at 12:35 p.m., the Director of Nursing indicated everyone that worked that dayshift on 7/2/22 was from agency. She was on her way to the facility to work the floor as the nurse due to a call off. Resident B walked out the front door. She was wearing her wander guard, but she pushed on the door for 15 seconds and they opened. The alarm sounded but the aides were providing care in other resident rooms and were not able to get to the front door in time. A neighbor came to the building to let us know Resident B had walked to his house. Resident B remained with the neighbor's daughter, who is a nurse, while the man came to notify us. The aide went to Resident B, at the neighbor's house, and brought her back to the facility. There were no signs of any injury. We moved her to secure unit that day after a conversation with the family.

During an interview on 7/13/22 at 9:00 a.m., the Director of Nursing indicated she filled out a paper to report but did not report the elopement to the state survey agency.

On 7/13/22 at 11:30 a.m., the facility was unable to provide a policy regarding reporting an elopement to the state survey agency.

This State tag relates to Complaint IN00384922.

Based on interview and record review, the facility failed to report an elopement to the state survey agency for 1 of 1 elopements reviewed. (Resident B)

Finding includes:

During an interview on 7/12/22 at 9:24 a.m., QMA 1 (Qualified Medication Aide) indicated Resident B admitted to the facility almost 2 weeks ago. The day after she admitted she was outside the building.

The clinical record for Resident B was reviewed, on 7/12/22 at 9:30 a.m. The diagnoses included, but were not limited to, acute metabolic encephalopathy, hypertension, and dementia.

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indicated Resident B exited the building without staff with her on 7/2/22 at approximately 8:00 a.m.

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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