STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CROWN POINT	140 E 107TH AVENUE, CROWN POINT, , 46307

(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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00381025 completed on 7/14/22, which resulted in unrelated deficiencies cited. Unrelated deficiency - not corrected. Survey date: 9/8/22 Facility number: 012940 Residential Census: 58 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/13/22.	R 0000		
R 0087	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(b)(1-3) (b) The licensee shall provide the number of staff as required to carry	R 0087	R087 Administration and Management Noncompliance - Revised 2 residents were harmed by this	10/07/2022

out all the functions of the facility, including the

following:

(1) Initial orientation of all employees.

(2) A continuing inservice education and training program for all employees.

(3) Provision of supervision for all employees.

Based on record review and interview, the Administrator failed to ensure adequate provision of medical care was provided to residents, related to residents who had fallen being assessed by the QMAs and not by a Licensed Medical Person as well as no follow up assessment by licensed facility staff completed for 3 of 4 residents reviewed for provision of medical care. (Residents C, D & F)

Findings include:

1. Resident C's record was reviewed on 9/8/22 at 1:04 p.m. The diagnoses included, but were not limited to, dementia.

A facility fax notification to the Physician, dated 9/1/22 at 8:40 (no a.m./p.m. documented) indicated the resident was observed on the floor beside the bed. The range of motion (ROM) was normal, there were

deficient practice

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

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Resident
C still resides at Bickford of Crown Point

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Resident
D still resides at Bickford of Crown Point

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Resident
F expired on 9/8/22

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RNC/ACC
and Administrator are responsible for ensuring that QMAs are working within the Qualified Medication Aide Scope of Practice

How the facility will identify other residents having the
potential to be affected by the same deficient practice and

	no complaints of pain, and no bruising/skin tears were observed. The Unusual Occurrence Report, dated 9/1/22 at 8:40 p.m., indicated the fall was unwitnessed. The resident was observed on the floor beside the bed and was sitting against the closet door. She had indicated she turned over in bed and fell to the floor. There was no pain or discomfort voiced. The RNC (Resident Nurse Coordinator) was notified in person, no date or time documented. The QMA had attempted to help the resident off the floor and was not able to. The Fire Department was notified and came to the facility to assist the resident off of the floor. There were no directions from the RNC documented. The form was signed by QMA 1 and dated on 9/1/22. A facility fax notification to the Physician, dated 9/5/22 at 7:45 (no a.m. or p.m. documented) indicated the resident was observed on the floor by the wheelchair, "earlier". They were unable to determine if she was walking or sitting in her wheelchair, "by the way, she seems fine..." Vital signs and ROM was checked. She was assisted off the floor. There were no injuries at this time. The RNC was a made aware.		what corrective action will be taken . Administrator and RNC/ACC to audit the fall risk assessment of every resident to determine which residents are at a high risk for falls . RNC/ACC will complete a fall risk assessment on all new admissions prior to move in What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. . Administrator and RNC/ACC will receive additional training by the Divisional Director of Resident Services and be responsible for the development and implementation of service plans and to ensure individualized interventions are included for residents with high fall risk, Fall Policy, and post fall procedures	

	The Unusual Occurrence Report, dated 9/5/22 at 7:45 p.m., indicated the fall was unwitnessed. The resident stated she slid from the wheelchair and there was no pain present. The RNC was notified by phone, no time of the notification was documented. There were no directions given by the RNC documented. The Report was signed on 9/5/22 by QMA 2. The Nurses' Progress reports indicated there had not been a physical assessment completed by a Licensed Medical Professional after the falls of 9/1/22 and 9/5/22. During an interview on 9/8/22 at 1:28 p.m., the RNC indicated the QMA on 9/5/22 had not documented the directions she had given her. The QMAs were not to complete the the ROM and were only to document the movements the residents could do on their own. For the fall documentation on 9/1/22, the QMA had not indicated the Fire Department had assessed the resident prior to being assisted off the floor. 2. Resident D's record was reviewed on 9/8/22 at 1:40 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A fax notification to Resident D's		and documentation. . Administrator or RNC/ACC to ensure all current and new staff have reviewed and have been educated on Fall Policy and post fall procedures and documentation. . Administrator and RNC/ACC to re-educate all QMA’s on reporting falls to the facility’s licensed nurse for direction prior to moving resident and post fall documentation. 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 Resident Services will review the Unusual Occurrence Log weekly for six weeks, then monthly for 3 months to ensure individualized interventions were added to resident’s service	

	Physician, dated 9/2/22 at 6:45 a.m., indicated there had been an unwitnessed fall. The resident had been found sitting on the floor. There were no injuries. An undated Unusual Occurrence Report, indicated an unwitnessed fall. The resident was observed on the floor next to the bed. She had stated she had slid off the bed when she attempted to transfer herself to the bathroom. There was no documentation that indicated the RNC or the Administrator had been notified. The action taken was vital signs obtained, was assessed by the QMA, ROM completed, there were no complaints of pain or other injuries and the she was transferred safely to the chair. The Report was signed by QMA 3 and dated on 9/2/22. There was no physical assessment completed by a Licensed Medical Professional after the fall on 9/2/22 at 6:45 a.m. During an interview on 9/8/22 at 2 p.m., the RNC indicated the policy for a fall without injury was to observe the situation, leave the resident on the floor and the nurse was to be notified to get instructions. QMA 3 was an Agency QMA. 3. Resident F's record was		plan . Divisional Directors will continue to monitor on routine branch visits, and at least annually. By what date the systemic changes will be completed by October 7, 2022.	

reviewed on 9/8/22 at 3:05 p.m. The diagnoses included, but were not limited to, hypertension and coronary artery disease.

A Physician's Order, dated 8/30/22, indicated the resident had been admitted into Hospice care.

A Physician's Fax notification, dated 9/4/22 at 6:40 p.m., indicated the resident was observed on the floor beside the bed. There were no injuries.

The Unusual Occurrence Report, dated 9/4/22 at 6:40 p.m., indicated an unwitnessed fall. The resident was observed lying on her left side on the floor next to the bed. The RNC and Hospice was notified by phone at 7 p.m. There was no documentation of any directions given by the RNC. The description of actions taken indicated there was no complaint of pain, ROM was normal, she was instructed to stay in bed and call for help if needed. The resident stood up and was assisted to bed. The form was signed by CNA 1 and QMA 1 on 9/4/22.

The Hospice Nurse visited the resident on 9/5/22 at 12:38 p.m. There was no other physical assessment by a Licensed Medical Professional prior to the Hospice Nurse's visit.

During an interview on 9/8/22 at

4:02 p.m. the RNC acknowledged there was no physical assessment by a Licensed Medical Professional after the residents had fallen. She indicated the post fall audits for assessment and documentation had not been completed.

A facility policy, for falls, dated 7/2022, and received from the Administrator as current, indicated the CNA/QMA was to determine if emergency action was needed after a fall. If injury is observed, the resident was to be kept on the floor until the ambulance arrived. The resident was not to be moved. If there was no injury observed, the RNC was to be notified.

The QMA Basic Curriculum, dated 10/2003, Lesson 1, indicated QMAs were prohibited from performing an assessment of a resident's condition.

This deficiency was cited on 7/14/22. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the Administrator failed to ensure adequate provision of medical care was provided to residents, related to residents who had fallen being assessed by the QMAs and not by a Licensed Medical Person

as well as no follow up assessment by licensed facility staff completed for 3 of 4 residents reviewed for provision of medical care. (Residents C, D & F)

Findings include:

1. Resident C's record was reviewed on 9/8/22 at 1:04 p.m. The diagnoses included, but were not limited to, dementia.

A facility fax notification to the Physician, dated 9/1/22 at 8:40 (no a.m./p.m. documented) indicated the resident was observed on the floor beside the bed. The range of motion (ROM) was normal, there were no complaints of pain, and no bruising/skin tears were observed.

The Unusual Occurrence Report, dated 9/1/22 at 8:40 p.m., indicated the fall was unwitnessed. The resident was observed on the floor beside the bed and was sitting against the closet door. She had indicated she turned over in bed and fell to the floor. There was no pain or discomfort voiced. The RNC (Resident Nurse Coordinator) was notified in person, no date or time documented. The QMA had attempted to help the resident off the floor and was not able to. The Fire Department was notified and came to the facility to assist the

resident off of the floor. There were no directions from the RNC documented. The form was signed by QMA 1 and dated on 9/1/22.

A facility fax notification to the Physician, dated 9/5/22 at 7:45 (no a.m. or p.m. documented) indicated the resident was observed on the floor by the wheelchair, "earlier". They were unable to determine if she was walking or sitting in her wheelchair, "by the way, she seems fine..." Vital signs and ROM was checked. She was assisted off the floor. There were no injuries at this time. The RNC was a made aware.

The Unusual Occurrence Report, dated 9/5/22 at 7:45 p.m., indicated the fall was unwitnessed. The resident stated she slid from the wheelchair and there was no pain present. The RNC was notified by phone, no time of the notification was documented. There were no directions given by the RNC documented. The Report was signed on 9/5/22 by QMA 2.

The Nurses' Progress reports indicated there had not been a physical assessment completed by a Licensed Medical Professional after the falls of 9/1/22 and 9/5/22.

During an interview on 9/8/22 at

1:28 p.m., the RNC indicated the QMA on 9/5/22 had not documented the directions she had given her. The QMAs were not to complete the the ROM and were only to document the movements the residents could do on their own. For the fall documentation on 9/1/22, the QMA had not indicated the Fire Department had assessed the resident prior to being assisted off the floor.

2. Resident D's record was reviewed on 9/8/22 at 1:40 p.m. The diagnoses included, but were not limited to, diabetes mellitus.

A fax notification to Resident D's Physician, dated 9/2/22 at 6:45 a.m., indicated there had been an unwitnessed fall. The resident had been found sitting on the floor. There were no injuries.

An undated Unusual Occurrence Report, indicated an unwitnessed fall. The resident was observed on the floor next to the bed. She had stated she had slid off the bed when she attempted to transfer herself to the bathroom. There was no documentation that indicated the RNC or the Administrator had been notified. The action taken was vital signs obtained, was assessed by the QMA, ROM completed, there were no complaints of pain or other

injuries and the she was transferred safely to the chair. The Report was signed by QMA 3 and dated on 9/2/22.

There was no physical assessment completed by a Licensed Medical Professional after the fall on 9/2/22 at 6:45 a.m.

During an interview on 9/8/22 at 2 p.m., the RNC indicated the policy for a fall without injury was to observe the situation, leave the resident on the floor and the nurse was to be notified to get instructions. QMA 3 was an Agency QMA.

3. Resident F's record was reviewed on 9/8/22 at 3:05 p.m. The diagnoses included, but were not limited to, hypertension and coronary artery disease.

A Physician's Order, dated 8/30/22, indicated the resident had been admitted into Hospice care.

A Physician's Fax notification, dated 9/4/22 at 6:40 p.m., indicated the resident was observed on the floor beside the bed. There were no injuries.

The Unusual Occurrence Report, dated 9/4/22 at 6:40 p.m., indicated an unwitnessed fall. The resident was observed lying on her left side on the floor next to the bed. The RNC and Hospice was notified by phone

	at 7 p.m. There was no documentation of any directions given by the RNC. The description of actions taken indicated there was no complaint of pain, ROM was normal, she was instructed to stay in bed and call for help if needed. The resident stood up and was assisted to bed. The form was signed by CNA 1 and QMA 1 on 9/4/22. The Hospice Nurse visited the resident on 9/5/22 at 12:38 p.m. There was no other physical assessment by a Licensed Medical Professional prior to the Hospice Nurse's visit. During an interview on 9/8/22 at 4:02 p.m. the RNC acknowledged there was no physical assessment by a Licensed Medical Professional after the residents had fallen. She indicated the post fall audits for assessment and documentation had not been completed.			

	A facility policy, for falls, dated 7/2022, and received from the Administrator as current, indicated the CNA/QMA was to determine if emergency action was needed after a fall. If injury is observed, the resident was to be kept on the floor until the ambulance arrived. The resident was not to be moved. If there was no injury observed, the RNC was to be notified. The QMA Basic Curriculum, dated 10/2003, Lesson 1, indicated QMAs were prohibited from performing an assessment of a resident's condition. This deficiency was cited on 7/14/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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