STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG	_	03/06/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			TELLA DRIVE		
BICKFOF	RD OF GREENWO	OD		GREEN	IWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
Diag. 00			R 00	000			
	This visit was for a	State Residential Licensure	100	700			
	Survey. This visit	included the Investigation of					
	Complaint IN0042	<del>-</del>				ļ	
	Complaint INIO042	9658 - No deficiencies related to					
	the allegations are						
	the unegations are	oned.					
	Survey dates: Mar	ch 4, 5, and 6, 2024				ļ	
	Facility number: 012938						
	Residential Census	: 37					
	These State Reside accordance with 41	ntial Findings are cited in 10 IAC 16.2-5.					
	Quality review con	npleted March 8, 2024.					
R 0042	410 IAC 16.2-5-1	** /					
Bldg. 00	Residents' Rights	- Noncompliance					
Diag. 00	Based on observati	on, interview, and record	R 00	142	R042 – Residents' Rights –		04/19/2024
		failed to ensure the previous	1, 00	774	Noncompliance	ļ	07/17/2024
	•	corresponding plan of			The facility failed to ensure the	ا د	
	-	re readily accessible for 1 of 3			previous survey results and	<b>'</b>	
	days of the survey.				corresponding plan of correction	on	
	aays of the sarvey.				data were not readily accessib		
	Findings include:				for 1 of 3 days of the survey		
	On 3/4/24 from 10	:00 a.m. until 10:25 a.m.,			What corrective action(s)	vvIII	
		a located in the front lobby.			be accomplished for those residents found to have been	ļ	
		credenza contained a binder				co:	
		Department of Health Surveys.			affected by the deficient practi		
		nder lacked any reports after			Survey binder was placed at main entrance and made read		
	9/9/22.	ider facked any reports after			available	ııy	
	)) ) LL.				How will the facility identif	V	
					Tiest tim and identity identity	J	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		03/06/	2024
			_	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			TELLA DRIVE		
BICKEO	RD OF GREENWO	OD.			NWOOD, IN 46143		
DIOIN OI		<u> </u>		OILLI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		a.m., the Administrator			other residents having the		
	•	rveys completed after 9/9/22.			potential to be affected by the		
		ut was not limit to the			same deficient practice and w		
	following surveys:				corrective action will be taken:		
					No residents were affected b	эу	
		plaint investigation.			this deficient practice		
	- 4/19/23 for an ann				What measures will be pu	ıt	
	- 9/5/23 for a comp	_			into place or what systemic		
	- 9/21/23 for a com	plaint investigation.			changes the facility will make		
					ensure that the deficient pract	ice	
		a.m., the Administrator			does not recur		
		ne new binder in her office. It			Executive Director will be		
	should have been easily accessible for the				responsible for ensuring that t	ne	
	_	ablic to view. The binder was			most recent annual survey is		
	usually kept in the	front lobby area.			readily available		
					Executive Director/Designed		
		.m., the Corporate Nurse			be re-educated on having mos		
		d the facility policy regarding			recent state survey available f	or	
		sily accessible was not			viewing.		
		ity was to follow the state			How the corrective action		
	regulations.				will be monitored to ensure the		
					deficient practice will not recui	,	
					i.e., what quality assurance		
					program will be put into place		
					Divisional Director of Health		
					Operations will monitor for bin	der	
					placement on routine visits	ļ	
R 0092	410 100 16 2 5 1	2(i)(1.2)					
11 0032	410 IAC 16.2-5-1. Administration and						
Bldg. 00	Noncompliance	u Management -					
Diag. 00		and record review, the facility	R 00	002	R092 – Administration and		04/19/2024
		nthly fire drills were conducted	K U	192	Management-Noncompliance		04/19/2024
	for 3 of 12 calendar				The facility failed to ensure		
	151 5 51 12 calcildar	months fortewed.			monthly fire drills were conduc	rted	
	Findings include:				for 3 of 12 calendar months	ποα	
	1 manigo menae.				reviewed		
	On 3/4/24 at 11:45	a.m., the Maintenance Director			What corrective action(s)	will	
		ation of the 2023 facility fire			be accomplished for those	VV 111	
	_	ducted. A review of the record			residents found to have been		
	I amino man word com	and the first of the feeding	- 1		I residente tedita la nave peett		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED.
			B. WI	NG		03/06	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ZR.		l	STELLA DRIVE		
BICKFO	RD OF GREENWO	OOD			NWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	indicated the follow	wing months lacked			affected by the deficient practi	ce:	
	documentation that fire drills were conducted:				Fire drill binder has been		
					updated		
	- April 2023				How will the facility identif	·y	
	- June 2023				other residents having the		
	- July 2023				potential to be affected by the		
					same deficient practice and w	hat	
	During an intervie	w on 3/4/24 at 11:50 a.m., the			corrective action will be taken		
	Maintenance Direc	ctor indicated the Fire drills were			No residents were affected I	ру	
	to be completed m	onthly alternating the shifts.			this deficient practice		
	The monthly fire d	lrills for April, June, and July,			What measures will be pu	ıt	
	2023 were unavail	able.			into place or what systemic		
					changes the facility will make	to	
	On 3/6/24 at 10:56	a.m., the Corporate Clinical			ensure that the deficient pract	ice	
	Nurse provided a p	policy titled Fire Drill Schedule,			does not recur		
	undated, and indic	ated it was the current policy			Director/Designee will be		
	being used by the	facility. A review of the policy			responsible for maintaining Fi	re	
	indicated "Fire dri	lls shall be performed monthly.			Drill record to ensure all mont	hly	
	This includes each	shift having one drill each			fire drills have been completed		
	quarter."				Executive Director/Designed	e will	
					be re-educated in policy perta	-	
					to Fire safety and frequency o	f	
					drills		
					Director/Designee will work		
					local Fire Department to provi	de	
					bi-annual training for fie and		
					disaster drills.		
					Director/Designee will be		
					instructed on proper procedur		
					successfully overseeing a Fire		
					in the absence of maintenance	е	
					personnel.		
					How the corrective action		
					will be monitored to ensure the		
					deficient practice will not recui	Γ,	
					i.e., what quality assurance		
					program will be put into place		
					Divisional Director of Health		
					Operations will review Fire Dri	II	
1	1		1		records on a monthly basis		1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND LAN	or conduction	IDENTIFICATION NOWBER	B. WI			03/06/2024	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD TELLA DRIVE		
BICKFO	RD OF GREENWO	OD			NWOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	ON
R 0116	İ			1710		DATE	
KUIIU	410 IAC 16.2-5-1 Personnel - Nonc	` ,					
Bldg. 00	T CISOTHICI - INOHO	omphanoe					
Ū			R 0	0116 R116 – Personnel –		04/19/20	)24
	Based on interview	and record review, the facility			Noncompliance		
		accurate personnel records and			The facility failed to maintain		
	•	for 2 of 5 employee records			accurate personnel records ar	nd	
		and Dementia Care Director			reference inquires for 2 of 5		
	and CNA 5)				employee records reviewed.		
	Finding includes:				What corrective action(s)	will	
					be accomplished for those		
	On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions. The list included, but was not limited				residents found to have been		
					affected by the deficient practi	ce:	
					Activity Director is no longer		
	to:				employed with Bickford		
	- The Activity and	Dementia Care Director			How will the facility identif	·y	
	(ADCD) was hired	on 10/2/23 and was currently			other residents having the		
	employed at the fac	eility.			potential to be affected by the		
					same deficient practice and w		
		Assistant (CNA) 5 was hired			corrective action will be taken:		
		s currently employed at the			Director will audit all employ	ee	
	facility.				files to ensure they contain		
	0.015/04 . 1.00				reference inquires		
	-	o.m., during review of employee o's and CNA 5's references were			What measures will be pu	iτ	
	· ·	he rest of the requested			into place or what systemic	to	
	employee records.	he rest of the requested			changes the facility will make ensure that the deficient pract		
	employee records.				does not recur		
	During an interview	w on 3/5/24 at 1:35 a.m., the			Executive Director/Designed	≥ will	
	-	cated that the facility was			be responsible for ensuring the		
		e references for the ADCD and			reference checks are complete		
		both employees should have			for new employees prior to sta		
		erences with their employee			employment		
	files.				How the corrective action	(s)	
					will be monitored to ensure the	е	
		a.m., the Corporate Nurse			deficient practice will not recui	r,	
		provided a policy titled			i.e., what quality assurance		
	Personnel Files, da	ted as revised in September of			program will be put into place		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		03/06/	2024
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			TELLA DRIVE		
BICKFOR	RD OF GREENWO	OD			NWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		l it was the current policy being			Divisional Director of Health	-	
		. A review of the policy			and Operations will audit next	6	
		dure: 1) All personnel files shall			new employee files to ensure		
	_	file, and shall contain the			reference checks have been		
	followingb) Refer	rence Checks"			completed		
					Divisional Director of Health		
					Operations will audit employed	е	
					charts on routine visits		
R 0117	410 IAC 16.2-5-1.	4(b)					
	Personnel - Defici	• •					
Bldg. 00							
			R 0	117	R 117 – Personnel – Deficiend	су	04/19/2024
	Based on interview	and record review, the facility			The facility failed to ensure all		
	failed to ensure all	shifts had at least one staff			shifts had at least one staff		
	member working w	ho was CPR (Cardiopulmonary			member working who was CP	R	
	Resuscitation) and	First Aid certified for 5 of 21			and First Aid certified for 5 of 2	21	
	shifts reviewed.				shifts reviewed		
					What corrective action(s)	will	
	Finding includes:				be accomplished for those		
					residents found to have been		
		.m., the Corporate Nurse			affected by the deficient practi		
	_	d a copy of the "as-worked"			No residents were affected by	ру	
		2/25/24 through 3/2/24. A			this deficient practice		
	review of the docur	ment indicated the following:			How will the facility identif	У	
	Tel 1 1 1 1	:1 (:0 12 1:0 1			other residents having the		
		identified 3 shifts per day.			potential to be affected by the		
		thours were from 7:00 a.m. to 3:00			same deficient practice and w		
		' hours were from 3:00 p.m. to ird shift" hours were from 11:00			corrective action will be taken:		
	p.m. to 7:00 a.m.	na sint nouis were from 11:00			Executive Director/Designed		
	p.iii. 10 7.00 a.iii.				complete an audit of all emplo files to ensure compliance	yee	
	The daily schedule	identified each staff member			What measures will be pu	ıt	
	· ·	aift and who was designated as			into place or what systemic	••	
		taff member for that shift.			changes the facility will make	to	
					ensure that the deficient pract		
	The daily schedule	identified each staff member			does not recur		
		ift and who was designated as			Divisional Director of Health	&	
		id staff member for that shift.			Operations will re-educate		
					Executive Director and Health	&	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/06/2024	
	PROVIDER OR SUPPLIER		3021	ET ADDRESS, CITY, STATE, ZIP COD STELLA DRIVE ENWOOD, IN 46143	
BICKFOR  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN REGULATORY OF No certified CPR or identified as having shifts:  - 2/29/24 - third shi member on duty - 3/1/24 - second sh member on duty - 3/1/24 - third shift member on duty - 3/2/24 - third shift on duty - 3/2/24 - third shift member on duty	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION THIS First Aid staff members were worked during the following  ft; no First Aid certified staff ift; no First Aid certified staff ; no First Aid certified staff ; no CPR certified staff member ; no First Aid certified staff  or on 3/5/24 at 1:55 p.m., the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	taff t aid  for will aff with first  tion(s) te the ecur, e acce alth and
	State regulations regularized First Aid staffing regularized member was required certified.  During an interview Corporate Nurse Counable to provide wand First Aid staff pashifts and dates listed On 3/4/24 at 1:45 paa copy of the Life Sully 2012, and indicated, "staff sinstruction on the liproceduresit is the Bickford Family MCPR and First Aid was required."	a.m., the Administrator provided afety Training policy, dated cated it was the current policy. A review of the policy hall receive in-service and		files monthly x3 months ar annually thereafter to ensu compliance.	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
			B. W	NG		03/06/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			TELLA DRIVE		
BICKFOR	RD OF GREENWO	OD		GREENWOOD, IN 46143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
R 0121	410 IAC 16.2-5-1.						
	Personnel - Nonc	ompliance					
Bldg. 00							
			R 0	121	R121 – Personnel –		04/19/2024
		and record review, the facility			Noncompliance		
	_	cumentation for an employee's			The facility failed to provide		
		kin test for 1 of 5 employees			documentation for an employe		
	reviewed. (CNA 5)				tuberculosis (TB) skin test for	1 of	
					5 employees reviewed.		
	Finding includes:				What corrective action(s)	will	
	0.0/4/04 .0.00				be accomplished for those		
		.m., the Administrator provided			residents found to have been		
	a list of current employees with date of hire and				affected by the deficient practi		
	positions.				TB tests given to those not i	n	
		DIA 5 1: 1 2/15/24 1			compliance	,	
		NA 5 was hired on 2/15/24 and			How will the facility identif	y	
	CNA 5 was current	ly employed at the facility.			other residents having the		
	0:: 2/5/24 -4 1:20 ::	4			potential to be affected by the		
	_	.m., during review of employee ecord lacked documentation of			same deficient practice and w		
	· ·	B skin tests (a test required for			corrective action will be taken:		
	-	to assess for the presence of			Executive Director will audit		
		agious and potentially serious			employee files to ensure TB to are current and documentation		
	· ·	at mainly affects the lungs).			in file	11 15	
	bacterial disease the	at mainly affects the lungs).			What measures will be pu		
	During an interview	on 3/5/24 at 1:35 a.m., the			into place or what systemic	"	
		eated that the facility was			changes the facility will make	to	
		TB documentation for CNA 5			ensure that the deficient pract		
		ree should have had the			does not recur		
		cumentation with their			Executive Director & Health	& I	
	employee file.				Wellness Director will be		
	1 3				responsible for ensuring that r	new	
	On 3/6/24 at 8:55 a	.m., the Corporate Nurse			employees will have TB		
		provided a copy of the			documentation in employee fil	e	
		ning policy for employees,			Executive Director & Healthy		
		December 2015, and indicated			and Wellness Director will be	·	
		olicy in use by the facility. A			re-educated on infection contr	ol,	
	_	v indicated, "Upon hire, all			specifically TB regulation for a		
		embers [employees] must			new hires and annually after.		
	-	Mantoux Purified Protein			How the corrective action	(s)	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING _		03/06/	/2024
			I	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			TELLA DRIVE		
BICKFOR	RD OF GREENWO	OD			IWOOD, IN 46143		
			ı		T		975)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		S LSC IDENTIFYING INFORMATION esting to ensure that they are		TAG	will be monitored to ensure the		DATE
	not infected with tu	-					
	not infected with tu	berculosis.			deficient practice will not recui	,	
					i.e., what quality assurance program will be put into place		
					Divisional Director of Health	and	
					Operations will audit next 6 ne		
					employee files to ensure TB	·VV	
					documentation is included.		
					Divisional Director will audit	for	
					compliance on routine visits a		
					least annually.	ia at	
R 0148	410 IAC 16.2-5-1.	5(e)(1-4)					
	Sanitation and Sa	fety Standards - Deficiency					
Bldg. 00							
			R 0	148			04/19/2024
		on, interview, and record			R148 – Sanitation and Safety		
	_	failed to ensure potentially			Standards – Deficiency		
		s were kept secure and behind			The facility failed to ensure		
	_	vent resident's access to the			potentially hazardous material		
		days during the survey.			were kept secure and behind		
	(Salon, Memory Ca	re Secured Unit)			locked doors to prevent reside	nt's	
					access to the materials		
	Findings include:				What corrective action(s)	will	
		10.11			be accomplished for those		
	-	l facility tour on 3/4/24 at 10:25			residents found to have been		
	-	on, located near the main			affected by the deficient practi		
	-	ong the 400 hall, was observed.			Salon door was immediately		
	-	opened and unlocked. Inside			locked and potentially hazardo		
		ne sink basin, a storage			chemicals were placed behind	i	
	-	bserved. The compartment lrawers. Inside the third			locked door		
					How will the facility identif	У	
		nce plastic bottle of Peroxide ner and Disinfectant			other residents having the		
					potential to be affected by the		
		tion effective on a wide range			same deficient practice and w		
		surfaces and glass). The quid substance and the bottle			corrective action will be taken:		
		one fourth full of the liquid.			No residents were affected to	уy	
		_			this deficient practice	ı÷	
	manufacturer's labe	" was pre-printed on the			What measures will be pu	ıı	
	manuraciurer s iade	1.	1		into place or what systemic		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  03/06/2024	
	PROVIDER OR SUPPLIER		3021 S	ADDRESS, CITY, STATE, ZIP COD TELLA DRIVE NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	No staff were visible  During an interview Certified Nursing A Salon door was to be no staff were in the During an interview Administrator indice	e in the area at that time.  y on 3/4/24 at 10:28 a.m., assistant (CNA) 2 indicated the e kept closed and locked while salon.  y on 3/4/24 at 10:30 a.m., the ated the Salon door was to be ked when no staff were	TAG	changes the facility will make ensure that the deficient practices of the control	e to ctice  all als  400  ee will
	Corporate Nurse Co. 16 self-mobile cognresided on the 100, had access to the Sa. 2. During the initia to 10:34 a.m., the Mobserved. On a tab. Rooms 503 and 504 Room Spray Air Frean of Glade was approach to the self-model.	I facility tour on 3/4/24 at 10:30 demory Care Secured Unit was le, located in the hall between l, a 6.2-ounce can of Glade eshener was observed. The oproximately one half full" was pre-printed on the		How the corrective actio will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place Divisional Director of Healt Operations will monitor compliance of storage of hazardous materials on routivisits.	he ur, e h and
	observed walking in the table which held Freshener.  No staff were visible  During an interview  Qualified Medication  Glade Room Spray	me, multiple residents were in the hall and had passed by if the Glade Room Spray Air is e in the area at that time.  You on 3/4/24 at 10:37 a.m., on Aide (QMA) 3 indicated the Air Freshener can should not e table or accessible to the			

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COM		X3) DATE SURVEY COMPLETED 03/06/2024		
	ROVIDER OR SUPPLIER		3021 S	ADDRESS, CITY, STATE, ZIP COD TELLA DRIVE NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
R 0151 Bldg. 00	Corporate Nurse Co. 14 self-mobile cogn resided in the Memo On 3/5/24 at 9:00 a. Consultant provided Materials - Houseke July 2012, and indicin use by the facility indicated "all chematerials shall be st accordance with the and all applicable rematerials shall be plocked storage area. 410 IAC 16.2-5-1. Sanitation & Safet-Noncompliance Based on observation review, the facility resided in the facility resided in the facility vaccinations prior to veterinary examinat residents who house (Resident 44, Resident 44, Resident 44, Resident 44's room, was not sure if her pannual veterinarian	m., the Corporate Nurse I a copy of the Hazardous seping / Laundry policy, dated sated it was the current policy /. A review of the policy, micals, poisons or combustible ored and disposed of in manufacturer's directions sigulationsall hazardous roperly labeled and stored in a"  5(h) y Standards  on, interview, and record failed to ensure pets who y had received the rabies of its end date and that annual ions were completed for 2 of 2 and pets in the facility.  ent 45)  m., the Administrator indicated in the facility.  30 a.m., observed a cat in Resident 44 indicated she bet had its immunizations or	R 0151	R151 – Sanitation & Safety Standards – Noncompliance The facility failed to ensure pet who resided in the facility had received the rabies vaccination prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility  What corrective action(s) who is accomplished for those residents found to have been affected by the deficient practic Vaccination records have been requested for 2 of 2 pets house the branch	he vill ce:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/06/2024
	PROVIDER OR SUPPLIER		3021 S	ADDRESS, CITY, STATE, ZIP COD STELLA DRIVE NWOOD, IN 46143	
PREFIX TAG REGU Resident was not s annual ve On 3/4/2 indicated records la rabies va On 3/4/2 provided February policy be policy in keep pets Admissid with resp and in co move-in	SUMMARY (EACH DEFICIEN REGULATORY OF Resident 45's room was not sure if her annual veterinarian On 3/4/24 at 12:00 indicated Resident records lacked vete rabies vaccination a On 3/4/24 at 11:55 provided a policy ti February 2018, and policy being used b policy indicated " keep pets at Bickfo Admission Agreem with respect to sani and in compliance of	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Resident 45 indicated she pet had its immunizations or exam.  p.m., the Administrator 44 and Resident 45's pet rinarian records including and annual exams.  a.m., the Administrator tled Resident Services, dated indicated it was the current by the facility. A review of the 3. In allowing residents to rd, as indicated in the ent, pets shall be cared for tation issues, safety hazards with local codes. Prior to ng, the Resident must provide	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)  How will the facility id other residents having the potential to be affected by same deficient practice ar corrective action will be ta Executive Director/Designon provides and the branch to ensure vaccination records are in What measures will be into place or what system changes the facility will mensure that the deficient properties and the design provides and the complete and	DATE  COMPLETION DATE  Lentify  The Ind what Inken: Independent of the put Independent of t
R 0217	410 IAC 16.2-5-2( Evaluation - Defic			safety of having up to date vaccination records for ear branch housed pet  How the corrective ac will be monitored to ensur deficient practice will not ri.e., what quality assurance program will be put into ple Divisional Director of He Operations will review varecords for all newly accepts for the next 6 months ensure compliance  Divisional Director will a compliance on routine vis least annually.	ction(s) re the recur, ce lace ealth and ccination pted s to
Bldg. 00	valuation - Delic	ionoy			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLE	ETED
			B. W	ING		03/06/2	2024
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			TELLA DRIVE		
DICKEO	RD OF GREENWO	OD			NWOOD, IN 46143		
BICKFOR	RD OF GREENWO	ОБ		GREEN	NVOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record rev	view and interview, the facility	R 0	217	R217 – Evaluation – Deficiend	у	04/19/2024
		vice plans were signed and			The facility failed to ensure se	rvice	
	dated by the resider	nt for 2 of 7 clinical record			plans were signed and dated	by	
	reviews. (Resident	50, Resident 39)			the resident for 2 of 7 clinical		
					record reviews (Resident 50 8	59)	
	Findings include:				What corrective action(s)	will	
					be accomplished for those		
		0 a.m., the clinical record of			residents found to have been		
		viewed. The diagnosis			affected by the deficient pract	ce:	
	included, but was n	ot limited to, debility.			Signatures have been reque	ested	
					for resident 50 & 59		
	A Mini Mental Status Examination, dated 10/9/23,				How will the facility identit	·y	
	indicated Resident 50 had no cognitive				other residents having the		
	impairment.				potential to be affected by the		
					same deficient practice and w	hat	
	1	ge Service Plan, dated 2/7/24,			corrective action will be taken		
		provided by the facility. The			Health and Wellness		
	_	a signature and date from			Director/Designee will comple	te an	
	Resident 50.				audit of all resident service pla	ans	
					to ensure all are signed		
		0 a.m., the clinical record of			What measures will be pu	ıt	
		viewed. The diagnoses			into place or what systemic		
	included, but were	not limited to, constipation and			changes the facility will make	to	
	anemia.				ensure that the deficient pract	ice	
					does not recur		
		tus Examination, dated 9/8/23,			Executive Director and Heal	th &	
		39 had no cognitive			Wellness Director will be		
	impairment.				responsible for ensuring that t	he	
					most current service plan is		
	_	ed 9/8/23, indicated services			signed by resident or POA.		
		ility. The service plan lacked a			Executive Director/Designed		
	signature and date f	from Resident 39.			be re-educated the service pla	an	
					process which includes being		
	_	v on 3/5/24 at 9:55 a.m., the			signed by resident or POA.		
		cated the service plans should			How the corrective action	. ,	
	have been signed by	y the residents.			will be monitored to ensure the		
					deficient practice will not recu	r,	
		a.m., the Administrator			i.e., what quality assurance		
		tled: Service Planning and			program will be put into place		
	Agreements, dated	11/2015, and indicated it was			Divisional Director of Health	and	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
			B. WING		03/06/2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3021 STELLA DRIVE			
BICKFORD OF GREENWOOD			GREENWOOD, IN 46143			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG			DATE
	the current police being used by the facility. A			Operations will review the service		
	review of the policy lacked documentation indicating the Service Plan required a date and		plan of the next 6 move ins to ensure it is complete with			
	signature. The Administrator indicated that the Resident and or family/POA are to sign completed			signature of resident and/or POA Divisional Director will audit for		
	Service Plans.			compliance on routine visits and at least annually.		

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