| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00429658.<br><br>Complaint IN00429658 - No deficiencies related to the allegations are cited.<br><br>Survey dates: March 4, 5, and 6, 2024<br><br>Facility number: 012938<br><br>Residential Census: 37<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed March 8, 2024. | R 0000 | | |
| R 0042<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(p)<br>Residents' Rights - Noncompliance<br><br>Based on observation, interview, and record review the facility failed to ensure the previous survey results and corresponding plan of correction data were readily accessible for 1 of 3 days of the survey.<br><br>Findings include:<br><br>On 3/4/24 from 10:00 a.m. until 10:25 a.m., observed a credenza located in the front lobby. One drawer of the credenza contained a binder titled Indiana State Department of Health Surveys. A review of the binder lacked any reports after 9/9/22. | R 0042 | R042 – Residents' Rights – Noncompliance<br>The facility failed to ensure the previous survey results and corresponding plan of correction data were not readily accessible for 1 of 3 days of the survey<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Survey binder was placed at main entrance and made readily available<br>How will the facility identify | 04/19/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 3/6/24 at 11:33 a.m., the Administrator provided a list of surveys completed after 9/9/22. The list included, but was not limit to the following surveys:<br><br>- 1/10/23 for a complaint investigation.<br>- 4/19/23 for an annual survey<br>- 9/5/23 for a complaint investigation.<br>- 9/21/23 for a complaint investigation.<br><br>On 3/4/24 at 10:10 a.m., the Administrator indicated she had the new binder in her office. It should have been easily accessible for the residents and the public to view. The binder was usually kept in the front lobby area.<br><br>On 3/6/24 at 9:52 a.m., the Corporate Nurse Consultant indicated the facility policy regarding the binder being easily accessible was not available. The facility was to follow the state regulations. | | other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>No residents were affected by this deficient practice<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director will be responsible for ensuring that the most recent annual survey is readily available<br>Executive Director/Designee will be re-educated on having most recent state survey available for viewing.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will monitor for binder placement on routine visits | |
| R 0092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 3 of 12 calendar months reviewed.<br><br>Findings include:<br><br>On 3/4/24 at 11:45 a.m., the Maintenance Director provided documentation of the 2023 facility fire drills that were conducted. A review of the record | R 0092 | R092 – Administration and Management-Noncompliance<br>The facility failed to ensure monthly fire drills were conducted for 3 of 12 calendar months reviewed<br>What corrective action(s) will be accomplished for those residents found to have been | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated the following months lacked documentation that fire drills were conducted:<br><br>- April 2023<br>- June 2023<br>- July 2023<br><br>During an interview on 3/4/24 at 11:50 a.m., the Maintenance Director indicated the Fire drills were to be completed monthly alternating the shifts. The monthly fire drills for April, June, and July, 2023 were unavailable.<br><br>On 3/6/24 at 10:56 a.m., the Corporate Clinical Nurse provided a policy titled Fire Drill Schedule, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "Fire drills shall be performed monthly. This includes each shift having one drill each quarter." | | affected by the deficient practice:<br>Fire drill binder has been updated<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>No residents were affected by this deficient practice<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Director/Designee will be responsible for maintaining Fire Drill record to ensure all monthly fire drills have been completed<br>Executive Director/Designee will be re-educated in policy pertaining to Fire safety and frequency of drills<br>Director/Designee will work with local Fire Department to provide bi-annual training for fie and disaster drills.<br>Director/Designee will be instructed on proper procedure for successfully overseeing a Fire Drill in the absence of maintenance personnel.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will review Fire Drill records on a monthly basis. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0116<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(a)<br>Personnel - Noncompliance<br><br>Based on interview and record review, the facility failed to maintain accurate personnel records and reference inquires for 2 of 5 employee records reviewed. (Activity and Dementia Care Director and CNA 5)<br><br>Finding includes:<br><br>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 to:<br><br>- The Activity and Dementia Care Director (ADCD) was hired on 10/2/23 and was currently employed at the facility.<br><br>- Certified Nursing Assistant (CNA) 5 was hired on 2/15/24 and was currently employed at the facility.<br><br>On 3/5/24 at 1:30 p.m., during review of employee records, the ADCD's and CNA 5's references were not provided with the rest of the requested employee records.<br><br>During an interview on 3/5/24 at 1:35 a.m., the Administrator indicated that the facility was unable to locate the references for the ADCD and for CNA 5 and that both employees should have had the missing references with their employee files.<br><br>On 3/6/24 at 10:30 a.m., the Corporate Nurse Consultant (CNC) provided a policy titled Personnel Files, dated as revised in September of | R 0116 | R116 – Personnel – Noncompliance<br>The facility failed to maintain accurate personnel records and reference inquires for 2 of 5 employee records reviewed.<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Activity Director is no longer employed with Bickford<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>Director will audit all employee files to ensure they contain reference inquires<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director/Designee will be responsible for ensuring that reference checks are completed for new employees prior to start of employment<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2016, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...Procedure: 1) All personnel files shall be kept in a secure file, and shall contain the following...b) Reference Checks..." | | Divisional Director of Healthy and Operations will audit next 6 new employee files to ensure reference checks have been completed<br>Divisional Director of Health & Operations will audit employee charts on routine visits | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br><br>Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was CPR (Cardiopulmonary Resuscitation) and First Aid certified for 5 of 21 shifts reviewed.<br><br>Finding includes:<br><br>On 3/6/24 at 9:55 a.m., the Corporate Nurse Consultant provided a copy of the "as-worked" staff schedule from 2/25/24 through 3/2/24. A review of the document indicated the following:<br><br>The work schedule identified 3 shifts per day. The "first shift" hours were from 7:00 a.m. to 3:00 p.m.; "second shift" hours were from 3:00 p.m. to 11:00 p.m.; and "third shift" hours were from 11:00 p.m. to 7:00 a.m.<br><br>The daily schedule identified each staff member who worked that shift and who was designated as the certified CPR staff member for that shift.<br><br>The daily schedule identified each staff member who worked that shift and who was designated as the certified First Aid staff member for that shift. | R 0117 | R 117 – Personnel – Deficiency<br>The facility failed to ensure all shifts had at least one staff member working who was CPR and First Aid certified for 5 of 21 shifts reviewed<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>No residents were affected by this deficient practice<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>Executive Director/Designee will complete an audit of all employee files to ensure compliance<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Divisional Director of Health & Operations will re-educate Executive Director and Health & | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | No certified CPR or First Aid staff members were identified as having worked during the following shifts:<br><br>- 2/29/24 - third shift; no First Aid certified staff member on duty<br>- 3/1/24 - second shift; no First Aid certified staff member on duty<br>- 3/1/24 - third shift; no First Aid certified staff member on duty<br>- 3/2/24 - third shift; no CPR certified staff member on duty<br>- 3/2/24 - third shift; no First Aid certified staff member on duty<br><br>During an interview on 3/5/24 at 1:55 p.m., the Administrator indicated the facility followed the State regulations regarding the certified CPR and First Aid staffing requirements. Each staff member was required to be CPR and First Aid certified.<br><br>During an interview on 3/6/24 at 10:00 a.m., the Corporate Nurse Consultant indicated she was unable to provide verification that a certified CPR and First Aid staff person had worked for the shifts and dates listed above.<br><br>On 3/4/24 at 1:45 p.m., the Administrator provided a copy of the Life Safety Training policy, dated July 2012, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff shall receive in-service and instruction on the life safety issues and procedures...it is the responsibility of each Bickford Family Member to have certification in CPR and First Aid within 30 days of employment and to maintain certification thereafter..." | | Wellness Director on policy/procedure for the requirement to have one staff member with a current first aid certificate on each shift<br>Health & Wellness director will schedule and ensure all staff members remain current with first aid and CPR.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will audit employee files monthly x3 months and annually thereafter to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0121<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br><br>Based on interview and record review, the facility failed to provide documentation for an employee's tuberculosis (TB) skin test for 1 of 5 employees reviewed. (CNA 5)<br><br>Finding includes:<br><br>On 3/4/24 at 2:00 p.m., the Administrator provided a list of current employees with date of hire and positions.<br><br>The list indicated CNA 5 was hired on 2/15/24 and CNA 5 was currently employed at the facility.<br><br>On 3/5/24 at 1:30 p.m., during review of employee records, CNA 5's record lacked documentation of any tuberculin or TB skin tests (a test required for healthcare workers to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs).<br><br>During an interview on 3/5/24 at 1:35 a.m., the Administrator indicated that the facility was unable to locate the TB documentation for CNA 5 and that the employee should have had the missing TB test documentation with their employee file.<br><br>On 3/6/24 at 8:55 a.m., the Corporate Nurse Consultant (CNC) provided a copy of the Tuberculosis Screening policy for employees, dated as revised in December 2015, and indicated it was the current policy in use by the facility. A review of the policy indicated, "Upon hire, all Bickford Family Members [employees] must undergo a two-step Mantoux Purified Protein | R 0121 | R121 – Personnel – Noncompliance<br>The facility failed to provide documentation for an employee's tuberculosis (TB) skin test for 1 of 5 employees reviewed.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>TB tests given to those not in compliance<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>Executive Director will audit all employee files to ensure TB tests are current and documentation is in file<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director & Health & Wellness Director will be responsible for ensuring that new employees will have TB documentation in employee file<br>Executive Director & Healthy and Wellness Director will be re-educated on infection control, specifically TB regulation for all new hires and annually after.<br>How the corrective action(s) | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Derivative (PPD) testing to ensure that they are not infected with tuberculosis." | | will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will audit next 6 new employee files to ensure TB documentation is included.<br>Divisional Director will audit for compliance on routine visits and at least annually. | |
| R 0148<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(e)(1-4)<br>Sanitation and Safety Standards - Deficiency<br><br>Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials, for 1 of 3 days during the survey. (Salon, Memory Care Secured Unit)<br><br>Findings include:<br><br>1. During the initial facility tour on 3/4/24 at 10:25 a.m. the facility Salon, located near the main dining room and along the 400 hall, was observed. The entry door was opened and unlocked. Inside the Salon, next to the sink basin, a storage compartment was observed. The compartment had four unlocked drawers. Inside the third drawer was a 24-ounce plastic bottle of Peroxide Multi Surface Cleaner and Disinfectant (multi-purpose solution effective on a wide range of non-food contact surfaces and glass). The bottle contained a liquid substance and the bottle was approximately one fourth full of the liquid. "Keep out of reach..." was pre-printed on the manufacturer's label. | R 0148 | R148 – Sanitation and Safety Standards – Deficiency<br>The facility failed to ensure potentially hazardous material were kept secure and behind locked doors to prevent resident's access to the materials<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Salon door was immediately locked and potentially hazardous chemicals were placed behind locked door<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>No residents were affected by this deficient practice<br>What measures will be put into place or what systemic | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | No staff were visible in the area at that time.<br><br>During an interview on 3/4/24 at 10:28 a.m., Certified Nursing Assistant (CNA) 2 indicated the Salon door was to be kept closed and locked while no staff were in the salon.<br><br>During an interview on 3/4/24 at 10:30 a.m., the Administrator indicated the Salon door was to be kept closed and locked when no staff were present in the salon.<br><br>During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse Consultant indicated there were 16 self-mobile cognitive impaired residents, who resided on the 100, 200, 300, and 400 halls, who had access to the Salon.<br><br>2. During the initial facility tour on 3/4/24 at 10:30 to 10:34 a.m., the Memory Care Secured Unit was observed. On a table, located in the hall between Rooms 503 and 504, a 6.2-ounce can of Glade Room Spray Air Freshener was observed. The can of Glade was approximately one half full. "Keep out of reach..." was pre-printed on the manufacturer's label.<br><br>During that same time, multiple residents were observed walking in the hall and had passed by the table which held the Glade Room Spray Air Freshener.<br><br>No staff were visible in the area at that time.<br><br>During an interview on 3/4/24 at 10:37 a.m., Qualified Medication Aide (QMA) 3 indicated the Glade Room Spray Air Freshener can should not have been left on the table or accessible to the residents. | | changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director will be responsible for ensuring that all potentially hazardous materials are behind locked doors<br>Executive Director will be re-educated on Policy PP-50400 Hazardous Waste<br>Executive Director/Designee will in-service all employees on the storing of hazardous waste.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will monitor compliance of storage of hazardous materials on routine visits. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | During an interview on 3/6/24 at 9:15 a.m., the Corporate Nurse Consultant indicated there were 14 self-mobile cognitive impaired residents who resided in the Memory Care Unit.<br><br>On 3/5/24 at 9:00 a.m., the Corporate Nurse Consultant provided a copy of the Hazardous Materials - Housekeeping / Laundry policy, dated July 2012, and indicated it was the current policy in use by the facility. A review of the policy, indicated "...all chemicals, poisons or combustible materials shall be stored and disposed of in accordance with the manufacturer's directions and all applicable regulations...all hazardous materials shall be properly labeled and stored in a locked storage area..." | | | |
| R 0151<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(h)<br>Sanitation & Safety Standards<br>-Noncompliance<br>Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility. (Resident 44, Resident 45)<br><br>Findings include:<br><br>On 3/4/24 at 9:45 a.m., the Administrator indicated 2 pets were housed in the facility.<br><br>1. On 3/4/24 at 10:30 a.m., observed a cat in Resident 44's room. Resident 44 indicated she was not sure if her pet had its immunizations or annual veterinarian exam.<br><br>2. On 3/4/24 at 11:00 a.m., observed a cat in | R 0151 | R151 – Sanitation & Safety Standards – Noncompliance<br>The facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 2 residents who housed pets in the facility<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Vaccination records have been requested for 2 of 2 pets housed in the branch | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident 45's room. Resident 45 indicated she was not sure if her pet had its immunizations or annual veterinarian exam.<br><br>On 3/4/24 at 12:00 p.m., the Administrator indicated Resident 44 and Resident 45's pet records lacked veterinarian records including rabies vaccination and annual exams.<br><br>On 3/4/24 at 11:55 a.m., the Administrator provided a policy titled Resident Services, dated February 2018, and indicated it was the current policy being used by the facility. A review of the policy indicated "...3. In allowing residents to keep pets at Bickford, as indicated in the Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move-in and ongoing, the Resident must provide proof of current vaccination records." | | How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>Executive Director/Designee will complete audit of all pets housed in the branch to ensure vaccination records are in file<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director will be responsible for ensuring that the annual vaccination records are kept up to date<br>Executive Director/Designee will be re-educated on importance and safety of having up to date vaccination records for each branch housed pet<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and Operations will review vaccination records for all newly accepted pets for the next 6 months to ensure compliance<br>Divisional Director will audit for compliance on routine visits and at least annually. | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident for 2 of 7 clinical record reviews. (Resident 50, Resident 39)<br><br>Findings include:<br><br>1. On 3/5/24 at 9:00 a.m., the clinical record of Resident 50 was reviewed. The diagnosis included, but was not limited to, debility.<br><br>A Mini Mental Status Examination, dated 10/9/23, indicated Resident 50 had no cognitive impairment.<br><br>A Significant Change Service Plan, dated 2/7/24, indicated services provided by the facility. The service plan lacked a signature and date from Resident 50.<br><br>2. On 3/5/24 at 9:30 a.m., the clinical record of Resident 39 was reviewed. The diagnoses included, but were not limited to, constipation and anemia.<br><br>A Mini Mental Status Examination, dated 9/8/23, indicated Resident 39 had no cognitive impairment.<br><br>A service plan, dated 9/8/23, indicated services provided by the facility. The service plan lacked a signature and date from Resident 39.<br><br>During an interview on 3/5/24 at 9:55 a.m., the Administrator indicated the service plans should have been signed by the residents.<br><br>On 3/5/24 at 11:13 a.m., the Administrator provided a policy titled: Service Planning and Agreements, dated 11/2015, and indicated it was | R 0217 | R217 – Evaluation – Deficiency<br>The facility failed to ensure service plans were signed and dated by the resident for 2 of 7 clinical record reviews (Resident 50 & 59)<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Signatures have been requested for resident 50 & 59<br>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>Health and Wellness Director/Designee will complete an audit of all resident service plans to ensure all are signed<br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur<br>Executive Director and Health & Wellness Director will be responsible for ensuring that the most current service plan is signed by resident or POA.<br>Executive Director/Designee will be re-educated the service plan process which includes being signed by resident or POA.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Divisional Director of Health and | 04/19/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BICKFORD OF GREENWOOD | 3021 STELLA DRIVE<br>GREENWOOD, IN 46143 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the current police being used by the facility. A review of the policy lacked documentation indicating the Service Plan required a date and signature. The Administrator indicated that the Resident and or family/POA are to sign completed Service Plans. | | Operations will review the service plan of the next 6 move ins to ensure it is complete with signature of resident and/or POA<br>Divisional Director will audit for compliance on routine visits and at least annually. | |