STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/20/2024

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

(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 Bldg. 00	This visit was for the Investigation of Complaint IN00432249. Complaint IN00432249- No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: June 20, 2024 Facility number: 012940 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 21, 2024	R 0000		
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on record review and interview, the facility failed to ensure a resident's privacy was protected related to staff going through a resident's belongings without permission for 1 of 1 residents reviewed for misappropriation or property. (Resident B) Finding includes:	R 0055	POC – Bickford of Crown Point - Complaint # IN00432249 R092 – Resident Rights-Deficiency · 1 resident was affected by this practice	07/26/2024

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

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	Resident B's record was reviewed on 6/20/24 at 9:28 a.m. Diagnoses included, but were not limited to, vascular dementia and depression with anxiety. An Indiana Department of Health reportable incident, dated 6/11/24, indicated the resident's family had called and reported a potential theft. During an interview on 6/20/24 at 12:31 p.m., the Health and Wellness Director (HWD) indicated the resident's family had called the facility to report the potential theft of money from the resident's purse. The family had a video monitoring device in the room and had observed CNA 1 take money out of the resident's purse the previous night while the resident was in the shower. The family brought the video in and the HWD reviewed it. In the video, CNA 1 was observed entering the resident's room while the resident was in the shower. CNA 1 went through the resident's purse and removed some cash. She held the cash in her hand and flipped through it, as if she were counting it, flicking some bills to the floor in the process. She placed the money remaining in her hand back in to the resident's purse. She then picked up the cash from the floor and turned to exit the room. Prior to exiting the room, she had looked around and noticed the video monitoring device in the room. She looked out in to the hallway and then returned to the room. She went back to the resident's purse and appeared to place the money back in the purse. The resident and her family were unable to verify how much cash was in the resident's purse prior to the incident and the HWD was therefore unable to confirm if any money was actually taken by CNA 1. The HWD had interviewed CNA 1, and the CNA denied any knowledge of the incident and resigned from her position. The resident's		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · CNA 1 is no longer employed with Bickford How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Health and Wellness Director checked in with all residents to ensure they did not experience any theft. · No other residents have been affected by this deficiency - What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · Executive Director and Health and wellness Director will be re-educated in policy pertaining to Resident Rights, including protecting resident's privacy related to misappropriation of property by 7/12/24 · Health and Wellness Director will hold in-service for all employees and re-educate on Resident Rights related to misappropriation of property by 7/15/24 · How the corrective action(s) will be monitored to ensure the	

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	family had filed a police report and were pressing charges. The HWD had spoken with the police department and was informed CNA 1 was being charged with conversion and exploitation of an endangered adult.		deficient practice will not recur, i.e., what quality assurance program will be put into place? · Divisional Director of operations to review next 3 state reportable incidents related to residents rights. · Divisional Director of operations to review reportable incidents to ensure compliance on routine visits. · Executive Director/Health and Wellness Director/Health and Wellness Coordinator to conduct random observations of CNAs providing care in resident apartments 3x/week for 4 weeks, 1x/week for 4 weeks, then monthly for 4 months. · Administrative staff will conduct interviews with 5 randomly selected residents/family members to ensure concerns related to privacy and misappropriation have all been reported for investigation By what date the systemic changes will be completed by 7/26/24.	