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	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAFAYETTE BICKFORD COTTAGE LLC	3633 REGAL VALLEY DR LAFAYETTE, IN 47901

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00399057. Complaint IN00399057 - Unsubstantiated due to lack of evidence. Survey dates: Febraury 13, 14, and 15, 2023. Facility number: 004503 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 22, 2023.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Wafford	Executive Director	03/02/2023

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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	between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to attempt to hold fire drills in conjunction with the local fire department and failed to hold fire drills for 6 months. This deficient practice had the potential to affect 23 of 23 residents residing in the facility. Findings include: During a record review of the facility fire drills on 2/14/2023 at 11:10 a.m., the facility failed to hold fire drills for 6 months. (June 2022 and September 2022 through and including January 2023) During a record review of the facility fire drills on 2/14/2023 at 11:15 a.m., the facility failed to contact the local fire department twice in a 12-month period. During an interview, on 2/14/2023 at 11:19 a.m., the Maintenance Coordinator indicated there were no records of fire drills for June 2022 and September 2022 through and including January 2023. A fire drill should have been conducted each month. The fire department had been contacted but he did not document the calls. He could not remember when the fire department had been contacted in the past 12 months. During an interview, on 2/14/2023 at 11:30 a.m., the Director indicated he had no other fire drill	R 0092	R092 – Administration and Management – Noncompliance · 0 residents were affected by this practice, but it had the potential to affect 23 of 23 residents. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Fire drill was completed 2/28/23 and documented. 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 · Twelve (12) fire drills will be held every year. A record of all training and drills will be documented with the names and signatures of the personnel present. Fire drills will be held in conjunction with the local fire department at least every six (6) months. What measures will be put into place or what systemic changes	03/25/2023

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	documentation for June 2022 and September 2022 through and including January 2023. A fire drill should have been conducted monthly. There had been no interaction with the local fire department throughout the year. A facility policy, titled "Fire drill Schedule," not dated and received from the Director of Nursing on 2/15/2023 at 4:30 p.m., indicated "...Fire Drills shall be performed MONTHLY...."		the facility will make to ensure that the deficient practice does not recur. · Director will be re-educated in policy pertaining to Fire Safety and frequency of drills. · Director or other delegated staff member shall be responsible for maintaining Fire Drill record to ensure all monthly fire drills have been completed. · Director or other delegated staff member shall work with local Fire Department to provide bi-annual training for fire and disaster drill. 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 Operations will review Fire Drill records monthly. By what date the systemic changes will be completed by March 25, 2023.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of			

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	the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure the staff on duty met the requirements of first aid training certification for 3 of 14 shifts reviewed for first aid. Finding includes: A record review, on 2/14/2023 at 1:20 p.m., of the employee work schedule dated 2/5/2023 through and including 2/9/2023, indicated the facility had 3 out of 14 shifts without a first aid certified staff member in the facility. During an interview, on 2/14/2023 at 1:35 p.m., the Director of Nursing (DON) indicated first aid trained certified staff members were not on duty at the facility for the 3 shifts indicated on the staffing schedule reviewed for 2/5 through 2/9/2023. A facility policy, titled "Life Safety," dated as revised 4/2014 and received from the DON on 2/25/2023 at 4:30 p.m., indicated "...shall provide	R 0117	R117 – Personnel – Deficiency – First Aid Certification What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Schedule has been completed to ensure that a staff member with first aid training certification is present on each shift. 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 · Executive Director is responsible for ensuring that a first aid training certified staff member is present on each shift.	03/25/2023

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	First Aid to residents...Family Members and visitors...."		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 will be re-educated on state regulation to provide a minimum of (1) first aid certified staff members is to be on site at all times. 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 Operations will review schedule on routine visits to ensure first aid certified staff member is scheduled on each shift. By what date the systemic changes will be completed by March 25, 2023.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in			

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	accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to administer dementia education for 1 of 10 staff members reviewed for staff dementia training. (Staff Member 2) Finding includes: The staff record for Staff Member 2 was reviewed, on 2/15/2025 at 3:10 p.m., the employee dementia training was not in the employee file. During an interview, on 2/15/2023 at 4:10 p.m., the Director indicated Staff Member 2 did not have a dementia training record in her file.	R 0120	R120 – Personnel – Non-Noncompliance – Dementia Training What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Staff member 2 completed dementia training 2/28/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	03/25/2023

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			will be taken · Executive Director is responsible for ensuring that all staff members have completed dementia-specific training requirements. 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 will be re-educated on requirement for all staff members completing a minimum of six hours of dementia-specific training within six months and three hours annually thereafter. 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 Operations will review next 3 new hires to ensure dementia-specific training has been completed. · Divisional Director of Operations will review new hire records on routine visits to ensure dementia-specific training has been completed. By what date the systemic changes will be completed by March 25, 2023.	