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	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WABASH BICKFORD COTTAGE OPCO, LLC	3037 W DIVISION RD WABASH, IN 46992

(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 IN00426399. Complaint IN00426399 - State deficiencies related to the allegations are cited at R145, R185, and R356. Survey date: January 18, 2024 Facility number: 003466 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 25, 2024.	R 0000		
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview and record review, the facility failed to implement continuous monitoring of egress doors that were unable to be locked due to water damage from a fire for 19 of 19 residents and failed to implement a system to monitor residents who utilized the wander guard system when it was out of operation to prevent resident elopement for 6 of 19 residents. Findings include: At entrance to the facility, on 1/18/24 at 8:59 a.m., the Administrator was in the dining area. She	R 0145	R145 – Sanitation and Safety Standards - Deficiency The rule is not met as evidenced by the facility failed to implement continuous monitoring of egress doors that were unable to be locked due to water damage from a fire. Failed to implement a system to monitor residents who utilized the wander guard system when it was out of operation to prevent resident elopement.	02/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Langhans	Divisional Director of Health & Wellness	02/08/2024

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	indicated there had been a fire in the electrical room on Tuesday, 1/16/24 between 3:30 p.m. and 4:00 p.m. They were completing 15-minute checks on the residents. They did not have Internet and they were watching the doors because they did not lock. The fire alarm, the call light system, the wander guard system, and the phones were not working. Staffing was currently herself, a nurse, a CNA, and a cook. There were six residents who had wander guards on (to prevent elopement). The cook was making rounds in the facility with a clip board, checking every room and making sure no one is by the exit doors. The Maintenance man had stayed all night doing a fire watch, then she came in to take over. During a tour of the facility, on 1/18/24 at 9:10 a.m., there were exit doors at the end of the 100, 300, 400 and 500 halls, at the front of the building, in the kitchen and in a common area that led to an enclosed gated area. During an interview with the Maintenance Employee, on 1/18/24 at 9:37 a.m., he indicated there was a wander guard system at each exit door and they were currently non-operational. He had been watching the residents to make no one exited the building. During an interview with Cook 5, on 1/18/24 at 9:57 a.m., she indicated she walked the hallways every 15 minutes. She went to everyone's room and knocked on their doors to make sure the residents were in their rooms. If they were not in their rooms, she would go see where they were. The wander guard system normally beeped at the exit door if activated, then it sent a message to the pagers and called the facility phone at the same time.		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 6 of 6 residents could have been affected but no negative impact occurred due to this defiant practice. Equipment systems, including wander guards and all egress doors have been tested and are working properly. 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 The HWD will be responsible for evaluating cognitive status for remaining 10 residents to ensure they don't meet criteria for wander guard system What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Executive Director and Health and Wellness Director will be re-educated in the event of another emergency, residents who have cognitive impairment, which requires the use of wander guard, will be monitored one caregiver to four residents in a safe area.	

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	During an interview with QMA 9, on 1/18/24 at 10:26 a.m., she indicated she kept an eye on the residents, and they were doing checks on residents in their room and hosting activities to keep the residents where they could see them. If the residents needed assistance, they asked them when they checked on them or waited for them to call out to the staff. There had been a resident who had fallen on the night of the fire on third shift. They found her on the floor, and she had a skin tear to her arm. During an interview with CNA 13, on 1/18/24 at 10:35 a.m., she indicated yesterday they were completing half-hour checks on the residents. The call light systems were not working, and they would make sure no one needed help. There were a couple of residents that needed total assistance to the bathroom and a lot of the residents needed reminders for meals. There was one resident who tried to get out because he was looking for his wife. A review of a facility check off sheet, provided by the Administrator, on 1/18/24 at 11:01 a.m., indicated on 1/16/24, 1/17/24 and 1/18/24, rounding was completed every half hour. The Administrator indicated corporate sent her the regulations and the regulations indicated half-hour checks. They were just doing half-hour checks and she asked the staff to pay special attention to the residents with wander guards. During an interview with the Maintenance Director, on 1/18/24 at 11:30 a.m., he indicated the day of the fire, he was on his way home when the Administrator called him and asked him to call the fire department because the fire alarm was going off. When he called the fire department, they indicated they were aware and were en-route to		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 Health & Operations will audit that residents have been appropriately identified to use the wander guard system on routine visits monthly times three months.	

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	the facility. After the fire on Tuesday, he went home. Wednesday night he stayed all night to do the fire watch. The nurses were doing rounds every half hour and monitoring doors. The water damage from putting out the fire from the sprinkler system destroyed the server for the magnetic locks to prevent exit or entry to the building and the wander guard system for the doors. The system was running for approximately six hours yesterday, he thought everything was good, the doors were secure. He went home, and then got a call that the system went down again, and he came back to the facility. During an interview with RN 4, on 1/18/23 at 3:20 p.m., he indicated he came in at 11:00 p.m. the night of the fire. They were doing a fire watch and walking the halls every 30 minutes. The staff would switch off doing rounds. Staff entered the rooms of those who needed assistance, and for the other residents, they unlocked the doors and peeked in on them. Yesterday, 1/17/24, they had a specific person doing the checks. They tried to give a bell to one of the residents and he declined. RN 4 didn't remember anyone else using a bell. The checks were how the residents would let them know if they needed assistance with anything. A current facility policy, titled "Fire Watch," provided by the Administrator on 1/18/24 at 11:10 a.m., indicated the following: "...Policy: Bickford Family Members will ensure that all residents remain safe and in a protected environment. Bickford will maintain a functioning fire alarm/sprinkler system at all times. In the event of a temporary malfunction of those systems, Bickford will incorporate a fire watch...2. In the event the vendor cannot respond or repair immediately, a fire watch will be initiated...4. The Bickford Family Members on fire watch duty will			

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	make continuous rounds throughout the Branch observing for smoke or fire smells...." This citation relates to Complaint IN00426399.			
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as			

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	to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. Based on observation, interview, and record review, the facility failed to implement a means for residents to alert staff for assistance while the call light system was non-operational for 19 of 19 residents. Findings include: At entrance to the facility, on 1/18/24 at 8:59 a.m., the Administrator was in the dining area. She indicated there had been a fire in the electrical room on Tuesday, 1/16/24 between 3:30 p.m. and 4:00 p.m. They were completing 15-minute checks on the residents. They did not have Internet and they were watching the doors because they did not lock. The fire alarm, the call light system, the wander guard system, and the phones were not working. Staffing was currently herself, a nurse, a CNA, and a cook. There were six residents who had wander guards on (to prevent elopement). The cook was making rounds in the facility with a clip board, checking every room and making sure no one is by the exit doors. The Maintenance man had stayed all night doing a fire watch, then she came in to take over. During an interview with Cook 5, on 1/18/24 at	R 0185	R185 – Physical Plant Standards - Noncompliance The rule is not met as evidenced by the facility failed to implement a means for residents to alert staff for assistance while the call light system was non-operational. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents could have been affected but no negative impact occurred due to this deficiency 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/Designee will purchase enough bells for each resident to have one placed	02/29/2024

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	9:57 a.m., she indicated she walked the hallways every 15 minutes. She went to everyone's room and knocked on their doors to make sure the residents were in their rooms. If they were not in their rooms, she would go see where they were. The wander guard system normally beeped at the exit door if activated, then it sent a message to the pagers and called the facility phone at the same time. During an interview with QMA 9, on 1/18/24 at 10:26 a.m., she indicated she kept an eye on the residents, and they were doing checks on residents in their room and hosting activities to keep the residents where they could see them. If the residents needed assistance, they asked them when they checked on them or waited for them to call out to the staff. There had been a resident who had fallen on the night of the fire on third shift. They found her on the floor, and she had a skin tear to her arm. During an interview with CNA 13, on 1/18/24 at 10:35 a.m., she indicated yesterday they were completing half-hour checks on the residents. The call light systems were not working, and they would make sure no one needed help. There were a couple of residents that needed total assistance to the bathroom and a lot of the residents needed reminders for meals. There was one resident who tried to get out because he was looking for his wife. During an interview with CNA 21, on 1/18/24 at 2:54 p.m., she indicated after the fire the system was down and they started 15 to 30 minute checks on the residents. One resident had fallen the night of the fire. The resident was knocking on the inside of her door and when they entered her room, her wheelchair was in the doorway to her		at bedside in the event that the call light system is non-operational. 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 responsible for ensuring each resident has access to a bell placed at the bedside in the event of a non-functional call light system. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place The Divisional Director of Health & Operations will audit bell supply in the branch on routine visits for three months. Divisional Director of Health & Operations will audit compliance at least annually, thereafter	

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	bathroom, there was blood in front of the door to her room. The resident was on blood thinners, and she had a big skin tear on her arm. She was sent to the hospital and came back with steri strips. During an interview with the DON, on 1/18/24 at 3:11 p.m., she indicated they checked on the residents to see if they needed assistance. They had two bells in the facility and they had been offered to the residents to use. During an interview with RN 4, on 1/18/23 at 3:20 p.m., he indicated he came in at 11:00 p.m. the night of the fire. They were doing a fire watch and walking the halls every 30 minutes. The staff would switch off doing rounds. Staff entered the rooms of those who needed assistance, and for the other residents, they unlocked the doors and peeked in on them. Yesterday, 1/17/24, they had a specific person doing the checks. They tried to give a bell to one of the residents and he declined. RN 4 didn't remember anyone else using a bell. The checks were how the residents would let them know if they needed assistance with anything. A current facility policy, titled "Fire Watch," and provided by the Administrator on 1/18/24 at 11:10 a.m., indicated the following: "...Policy: Bickford Family Members will ensure that all residents remain safe and in a protected environment. Bickford will maintain a functioning fire alarm/sprinkler system at all times. In the event of a temporary malfunction of those systems, Bickford will incorporate a fire watch...4. The Bickford Family Members on fire watch duty will make continuous rounds throughout the Branch observing for smoke or fire smells. 5. The Bickford Family Member on fire watch will not perform regular duty activities...."			

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	During an interview, with the Administrator, on 1/18/24 at 12:49 p.m., she indicated the call light system policy would probably fall under the Fire Watch policy. This citation relates to Complaint IN00426399.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on observation, interview, and record review, the facility failed to ensure the facility's emergency information was accurate with current resident information for 5 of 19 residents. Findings include: At entrance to the facility, on 1/18/24 at 8:59 a.m., the Administrator was in the dining area. She indicated there had been a fire in the electrical room on Tuesday, 1/16/24 between 3:30 p.m. and	R 0356	R356 – Clinical Records - Noncompliance The rule is not met as evidenced by the facility failed to ensure the facility's emergency information was accurate with current resident information. What corrective actions will be	02/29/2024

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	4:00 p.m. They were completing 15-minute checks on the residents. They did not have Internet and they were watching the doors because they did not lock. The fire alarm, the call light system, the wander guard system, and the phones were not working. Staffing was currently herself, a nurse, a CNA, and a cook. There were six residents who had wander guards on (to prevent elopement). The cook was making rounds in the facility with a clip board, checking every room and making sure no one is by the exit doors. The Maintenance man had stayed all night doing a fire watch, then she came in to take over. On 1/18/24 at 11:12 a.m., the Administrator provided the facility emergency binder. She indicated the binder really needed updated. During a review of the emergency binder with the DON, on 1/18/24 at 2:38 p.m., she indicated whoever was giving medications, when there was an emergency, were responsible for grabbing the computer and the emergency binder, which had the resident's information in it. They normally updated the binder when the residents moved into the facility. While comparing the census sheet to the emergency binder there were five residents who had admitted to the facility since October 2023 who were on the census sheet, but not in the binder. She indicated this was a mistake and they should had been in the binder. She had worked the med cart so much and delegated tasks, but had not delegated the binder. During an interview with RN 4, on 1/18/23 at 3:20 p.m., he indicated in the event of an emergency his responsibility was to grab the emergency handbook, which contained the resident's important information, and the computer. He was to assist with the evacuation.		accomplished for those residents found to have been affected by the deficient practice? Executive Director or Health & Wellness Director will audit the emergency handbook for the 6 residents surveyed to ensure residents emergency information is updated. 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 or Health & Wellness Director will audit the emergency handbook for all residents to ensure residents emergency information is updated and correct. 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 Maintenance Coordinator will be re-educated on the expectation that emergency information is accurate with current resident information. Executive Director is responsible for ensuring the emergency information is accurate with current resident information. How the corrective actions will be monitored to ensure the deficient	

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	A current facility policy, titled "FIRE EVACUATION PROCEDURE," provided by the Administrator, on 1/18/24 at 11:10 a.m., indicated the following: "...4. Pull the Emergency Evacuation List from the Emergency Handbook and take with you to the scene as a reference as to residents who require immediate assistance...." This citation relates to Complaint IN00426399.		practice will not recur, what quality assurance program will be put into place Divisional Director of Health & Operations will audit the emergency binder monthly for three months and then annually thereafter.	