STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDI	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING 00 COM			
			B. WING	B. WING 01/18/2024		
	ROVIDER OR SUPPLIE	R TAGE OPCO, LLC	30	REET ADDRESS, CITY, STATE, ZIP COD 37 W DIVISION RD ABASH, IN 46992	•	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PRO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG			TA	CROSS-REFERENCED TO THE APPR	CROSS-REFERENCED TO THE APPROPRIATE	
R 0000	TEGOESTI ON					DATE
Bldg. 00	This visit was for t	he Investigation of Complaint	R 0000			
	IN00426399. Complaint IN00426399 - State deficiencies related to the allegations are cited at R145, R185, and R356.		10000			
	Survey date: Janua	ry 18, 2024				
	Facility number: 00	03466				
	Residential Census	:: 19				
	These State Reside accordance with 41	ential Findings are cited in 10 IAC 16.2-5.				
	Quality review con	npleted January 25, 2024.				
R 0145	410 IAC 16.2-5-1	.5(b) afety Standards - Deficiency				
Bldg. 00	(b) The facility sh	all maintain equipment and				
		and operational condition				
	and in sufficient q the residents.	quantity to meet the needs of				
	Based on observati review, the facility	failed to implement continuous ss doors that were unable to be	R 0145	R145 – Sanitation and Sa Standards - Deficiency	fety	02/29/2024
		r damage from a fire for 19 of 19		The rule is not met as	S	
		to implement a system to		evidenced by the facility fa		
	monitor residents v	who utilized the wander guard		implement continuous mo	nitoring	
		s out of operation to prevent		of egress doors that were		
	resident elopement	for 6 of 19 residents.		to be locked due to water from a fire. Failed to impl	_	
	Findings include:			system to monitor residen utilized the wander guard	ts who	
		facility, on 1/18/24 at 8:59 a.m.,		when it was out of operati	-	
	the Administrator v	was in the dining area. She		prevent resident elopeme	nt.	
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE

Jamie Langhans

continued program participation.

Divisional Director of Health & Wellness

(X6) DATE 02/08/2024

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

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 1 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	COMPLETED	
			B. WIN	IG		01/18/	/2024	
			 	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			DIVISION RD			
WARASH	BICKFORD COTT	TAGE OPCOLLIC			6H, IN 46992			
		<u> </u>			71, 11 10002			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		been a fire in the electrical						
	room on Tuesday, 1/16/24 between 3:30 p.m. and				What corrective actions will be			
	4:00 p.m. They were completing 15-minute checks				accomplished for those reside			
	on the residents. They did not have Internet and				found to have been affected b	y the		
	they were watching the doors because they did				deficient practice?			
	not lock. The fire alarm, the call light system, the wander guard system, and the phones were not				6 of 6 residents could have			
					been affected but no negative			
	working. Staffing was currently herself, a nurse, a				impact occurred due to this de	enant		
	CNA, and a cook. There were six residents who had wander guards on (to prevent elopement).				practice.			
	The cook was making rounds in the facility with a				Equipment systems,	ااه		
		g every room and making sure			including wander guards and a egress doors have been teste			
	-	it doors. The Maintenance man			and are working properly.	u		
	had stayed all night doing a fire watch, then she				and are working property.			
	came in to take over.				How the facility will identify oth	ner		
	came in to take ove	1.			residents having the potential			
	During a tour of the	e facility, on 1/18/24 at 9:10			be affected by the same defici			
	_	it doors at the end of the 100,			practice and what corrective a			
	· ·	alls, at the front of the building,			will be taken	1011011		
		n a common area that led to an			The HWD will be respons	ible		
	enclosed gated area				for evaluating cognitive status			
	8				remaining 10 residents to ens			
	During an interviev	v with the Maintenance			they don't meet criteria for wa			
	_	/24 at 9:37 a.m., he indicated			guard system			
	there was a wander	guard system at each exit door						
	and they were curre	ently non-operational. He had			What measures will be put into	0		
		residents to make no one exited			place or what systemic chang			
	the building.				the facility will make to ensure	:		
					that the deficient practice does	s not		
	-	v with Cook 5, on 1/18/24 at			recur.			
		cated she walked the hallways						
	1	She went to everyone's room			The Executive Director ar			
		ir doors to make sure the			Health and Wellness Director			
	residents were in their rooms. If they were not in				be re-educated in the event of			
	their rooms, she would go see where they were.				another emergency, residents			
	The wander guard system normally beeped at the				have cognitive impairment, wh			
		ed, then it sent a message to the			requires the use of wander gu			
	· . ·	ne facility phone at the same			will be monitored one caregive	er to		
	time.				four residents in a safe area.			

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 2 of 11

PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/18/2024	
	PROVIDER OR SUPPLIER		3037 W	ADDRESS, CITY, STATE, ZIP COD V DIVISION RD SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	DATE
140	During an interview 10:26 a.m., she indi residents, and they residents in their rockeep the residents meeded when they checked call out to the staff. who had fallen on the shift. They found he skin tear to her arm. During an interview 10:35 a.m., she indicated light systems we would make sure not a couple of resident to the bathroom and reminders for meals tried to get out becausife. A review of a facility the Administrator, coindicated on 1/16/24 rounding was compared to the half-hour checks. To checks and she asked attention to the residents.	with QMA 9, on 1/18/24 at cated she kept an eye on the were doing checks on om and hosting activities to where they could see them. If a sasistance, they asked them on them or waited for them to There had been a resident the night of the fire on third er on the floor, and she had a	IAU	How the corrective actions wi monitored to ensure the defic practice will not recur, what q assurance program will be purplace Divisional Director of Heat Operations will audit that resid have been appropriately ident to use the wander guard system on routine visits monthly time three months.	Il be ient uality t into Ilth & dents tified em
	Director, on 1/18/2/ day of the fire, he w Administrator called fire department because off. When he called	at 11:30 a.m., he indicated the vas on his way home when the d him and asked him to call the ause the fire alarm was going the fire department, they aware and were en-route to			

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PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

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 01/18/2024	
	OF PROVIDER OR SUPPLIED		3037 V	ADDRESS, CITY, STATE, ZIP COD V DIVISION RD SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	home. Wednesday the fire watch. The every half hour and damage from puttir system destroyed the locks to prevent ex the wander guard sessystem was running yesterday, he thouge doors were secure. call that the system came back to the far During an interview p.m., he indicated the night of the fire. The walking the halls er would switch off de rooms of those who the other residents, peeked in on them. specific person doing ive a bell to one of RN 4 didn't remem The checks were he know if they needed A current facility p provided by the Ad a.m., indicated the Family Members we remain safe and in Bickford will main alarm/sprinkler sys a temporary malfur Bickford will incore event the vendor cal immediately, a fire	the fire on Tuesday, he went might he stayed all night to do nurses were doing rounds a monitoring doors. The water ag out the fire from the sprinkler he server for the magnetic at or entry to the building and system for the doors. The ag for approximately six hours the everything was good, the He went home, and then got a went down again, and he cility. It with RN 4, on 1/18/23 at 3:20 he came in at 11:00 p.m. the new were doing a fire watch and very 30 minutes. The staff bring rounds. Staff entered the conceded assistance, and for they unlocked the doors and Yesterday, 1/17/24, they had a night he checks. They tried to fithe residents and he declined. He had a significant with anything. The work of the watch, "ministrator on 1/18/24 at 11:10 following: "Policy: Bickford will ensure that all residents a protected environment. It tain a functioning fire tem at all times. In the event of action of those systems, porate a fire watch2. In the annot respond or repair watch will be initiated4. The tembers on fire watch duty will			

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 4 of 11

PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JILDING	00	COMPL 01/18/	ETED	
	ROVIDER OR SUPPLIER			3037 W	DDRESS, CITY, STATE, ZIP COD DIVISION RD H, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observing for smoke						
R 0185	410 IAC 16.2-5-1.6	to Complaint IN00426399. 6(i)(1-2)(A)(i-iii)(B-E ndards - Noncompliance					
Bldg. 00	(i) The facility shall areas approved by and given a fire cle marshal. The facilit (1) Have a floor at facility whose plan effective date of th below ground leve the floors are not rebelow ground leve (2) Provide each reupon request at the (A) A bed: (i) of appropriate seresident; (ii) with a clean and (iii) with comfortabe the temperature of (B) A bedside cabic surface and washad (C) A cushioned con (D) A bedside lamp (E) If the resident if over-the-bed table	or above grade level. A s were approved before the is rule may use rooms I for resident occupancy if more than three (3) feet I. esident the following items e time of admission: ize and height for the d comfortable mattress; le bedding appropriate to f the facility. inet or table with a hard able top. omfortable chair.					
	(4) Provide a meth may summon a sta (5) Equip each res swings into the roo the corridor or com	sident in a shared room. nod by which each resident aff person at any time. sident unit with a door that om and opens directly into nmon living area. sident in such a manner as					

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ION	(X3) DATE SURVEY COMPLETED 01/18/2024		-
		ROVIDER OR SUPPLIEI		30	REET ADDRESS, 037 W DIVISIO ABASH, IN 46				
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	II. PRE	FIX (EACH CROSS-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
	TAG	to require passag another resident. as a thoroughfare (7) Individual clos additions to facilit plans are submitte 1984, each reside storage that include feet wide and two an easily opened least eighteen (18 height to provide wheelchairs. Based on observatire view, the facility residents to alert stalight system was not residents. Findings include: At entrance to the fithe Administrator vindicated there had room on Tuesday, 4:00 p.m. They were on the residents. They were watching not lock. The fire a wander guard system working. Staffing to CNA, and a cook. had wander guards The cook was make clip board, checking no one is by the exthad stayed all night came in to take over	et space. For facilities and des for which construction ed for approval after July 1, ent room shall have clothing des a closet at least two (2) (2) feet deep, equipped with door and a closet rod at 3) inches long of adjustable access by residents in on, interview, and record failed to implement a means for aff for assistance while the call on-operational for 19 of 19 Sacility, on 1/18/24 at 8:59 a.m., was in the dining area. She been a fire in the electrical 1/16/24 between 3:30 p.m. and re completing 15-minute checks they did not have Internet and at the doors because they did tharm, the call light system, the m, and the phones were not was currently herself, a nurse, a There were six residents who on (to prevent elopement). In grounds in the facility with a greery room and making sure at doors. The Maintenance man at doing a fire watch, then she	R 0185	R185 - Noncol Th evident implemto alert the call non-op What call accom found tall deficient All affecte occurre How the resider be affe practic will be Ex will pur	- Physical Plant Standa mpliance le rule is not met as ced by the facility failed ent a means for reside staff for assistance who light system was perational. corrective actions will be plished for those reside to have been affected be not practice? residents could have be do but no negative impaired due to this deficience and what corrective actions will identify other than the potential could be and what corrective actions are facility will identify other than the country of the same deficited by the same deficite and what corrective actions are enough bells for esident to have one play	d to ents hile e ents been act by ther I to cient action nee	02/29/2024	

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 6 of 11

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
			B. W	ING		01/18/2	2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIE	₹			/ DIVISION RD		
WARASI	H BICKFORD COT	TAGE OPCOLLC			SH, IN 46992		
	1	<u> </u>	<u> </u>		T		
(X4) ID		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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	cated she walked the hallways			at bedside in the event that th	е	
	every 15 minutes. She went to everyone's room				call light system is		
	and knocked on their doors to make sure the				non-operational.		
	residents were in their rooms. If they were not in their rooms, she would go see where they were.				NA/hat magazines will be mut into	_	
	The wander guard system normally beeped at the				What measures will be put int		
	1				place or what systemic chang		
	exit door if activated, then it sent a message to the				the facility will make to ensure that the deficient practice doe		
	pagers and called the facility phone at the same time.				recur.	o HUL	
	time.				Executive Director will be		
	During an interview with QMA 9, on 1/18/24 at				responsible for ensuring each		
	10:26 a.m., she indicated she kept an eye on the				resident has access to a bell		
	residents, and they were doing checks on				placed at the bedside in the e	vent	
	residents, and they were doing enecks on residents in their room and hosting activities to				of a non-functional call light	VOIN	
		where they could see them. If			system.		
	_	d assistance, they asked them			-,		
		on them or waited for them to			How the corrective actions will	ll be	
		There had been a resident			monitored to ensure the defici		
	who had fallen on t	he night of the fire on third			practice will not recur, what qu	uality	
	shift. They found l	ner on the floor, and she had a			assurance program will be pu		
	skin tear to her arm	.			place		
					The Divisional Director of	:	
	During an interview	v with CNA 13, on 1/18/24 at			Health & Operations will audit	bell	
	10:35 a.m., she ind	icated yesterday they were			supply in the branch on routin	е	
		ur checks on the residents. The			visits for three months.		
		vere not working, and they			Divisional Director of Hea		
		o one needed help. There were			Operations will audit compliar	nce	
	_	ts that needed total assistance			at least annually, thereafter		
		d a lot of the residents needed					
		s. There was one resident who					
		ause he was looking for his					
	wife.						
	Duning and interm	crywith CNIA 21 am 1/19/24 -4					
	_	with CNA 21, on 1/18/24 at					
	_	cated after the fire the system					
	_	started 15 to 30 minute checks					
		ne resident had fallen the night					
		dent was knocking on the					
		and when they entered her					
	room, ner wneelcha	air was in the doorway to her				l	

State Form Event ID: DM8P11 Facility ID: 003466 If continuation sheet Page 7 of 11

PRINTED: 02/19/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUIT A. BUILDING 00 COMPLET B. WING 01/18/20				
	F PROVIDER OR SUPPLIEI		3037 W	ADDRESS, CITY, STATE, ZIP COD V DIVISION RD SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF bathroom, there was her room. The resident statements of the statement of the	STATEMENT OF DEFICIENCIE SEY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION as blood in front of the door to dent was on blood thinners, and ear on her arm. She was sent	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETIC	ON
	During an interview 3:11 p.m., she indice residents to see if the had two bells in the offered to the residents to see if the had two bells in the offered to the residents, he indicated he night of the fire. The walking the halls end would switch off dorsoms of those who the other residents, peeked in on them. specific person doing give a bell to one on RN 4 didn't remem the checks were he know if they needed have a.m., indicated the Family Members were remain safe and in Bickford will main alarm/sprinkler systatemporary malfur Bickford will incorn Bickford Family Member on beserving for smok Family Member on the residents.	with the DON, on 1/18/24 at cated they checked on the hey needed assistance. They a facility and they had been ents to use. with RN 4, on 1/18/23 at 3:20 he came in at 11:00 p.m. the ney were doing a fire watch and very 30 minutes. The staff oing rounds. Staff entered the oneeded assistance, and for they unlocked the doors and Yesterday, 1/17/24, they had a night echecks. They tried to f the residents and he declined. Beer anyone else using a bell. The own the residents would let them disassistance with anything. The watch, "and liministrator on 1/18/24 at 11:10 following: "Policy: Bickford will ensure that all residents a protected environment. The tain a functioning fire tem at all times. In the event of nection of those systems, prorate a fire watch4. The dembers on fire watch duty will bunds throughout the Branch are or fire smells. 5. The Bickford of fire watch will not perform				
	regular duty activities"					

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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 00 COMPLETED			
			B. WING		01/18/2024	
	PROVIDER OR SUPPLIER		3037	T ADDRESS, CITY, STATE, ZIP COD W DIVISION RD ASH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S DEAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1/18/24 at 12:49 p.r system policy would Watch policy.	y, with the Administrator, on m., she indicated the call light d probably fall under the Fire to Complaint IN00426399.				
R 0356	410 IAC 16.2-5-8.					
Bldg. 00	Clinical Records - (i) A current emer	Noncompliance gency information file shall				
be immediately accessible for each resident,						
	-	ncy, that contains the				
	_	s name, sex, room or				
	, ,	r, phone number, age, or				
	date of birth.					
	, ,	s hospital preference.				
	, ,	phone number of any				
	legally authorized	phone number of the				
	resident 's physic					
		telephone number of the				
	, ,	r other persons to be				
	•	vent of an emergency or				
	death.					
	(6) Information on	any known allergies.				
		(for identification of the				
	resident).					
	· , · · ·	ce directives, if available. on, interview, and record	D 0256		02/20/2024	
		failed to ensure the facility's	R 0356	R356 – Clinical Records -	02/29/2024	
	-	tion was accurate with current		Noncompliance		
		n for 5 of 19 residents.		Noncompliance		
				The rule is not met as		
	Findings include:			evidenced by the facility failed	d to	
	-			ensure the facility's emergence		
		acility, on 1/18/24 at 8:59 a.m.,		information was accurate with	ı	
		vas in the dining area. She		current resident information.		
		been a fire in the electrical				
	room on Tuesday, 1	/16/24 between 3:30 p.m. and		What corrective actions will be	e	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING	_	01/18/	/2024
		.		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			DIVISION RD		
WARASH	H BICKFORD COTT	TAGE OPCOLLIC			SH, IN 46992		
	·			WADAC	71, 114 40332		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		re completing 15-minute checks			accomplished for those reside		
		ney did not have Internet and			found to have been affected b	y the	
	they were watching the doors because they did				deficient practice?		
	not lock. The fire alarm, the call light system, the				Executive Director or Hea		
	wander guard system, and the phones were not working. Staffing was currently herself, a nurse, a				& Wellness Director will audit		
					emergency handbook for the	Ö	
		There were six residents who			residents surveyed to ensure		
	had wander guards on (to prevent elopement).				residents emergency informat	ion	
	The cook was making rounds in the facility with a clip board, checking every room and making sure				is updated.		
	no one is by the exit doors. The Maintenance man						
					How the facility will identify oth		
	had stayed all night doing a fire watch, then she came in to take over.				residents having the potential		
	came in to take over.				be affected by the same defici		
	On 1/18/24 at 11:12 a.m., the Administrator				practice and what corrective a	iction	
		y emergency binder. She			will be taken	141.	
					Executive Director or Hea		
	indicated the binder	r really needed updated.			& Wellness Director will audit	ıne	
	During a ravious of	the emergency binder with the			emergency handbook for all residents to ensure residents		
	_	t 2:38 p.m., she indicated				otod	
		g medications, when there was			emergency information is upd and correct.	aleu	
		e responsible for grabbing the			and correct.		
		mergency binder, which had			What measures will be put into	0	
	_	nation in it. They normally			place or what systemic chang		
		when the residents moved into			the facility will make to ensure		
	_	comparing the census sheet to			that the deficient practice does		
	-	ler there were five residents			recur.	. 1101	
		o the facility since October			Executive Director and		
		the census sheet, but not in the			Maintenance Coordinator will	be	
		ed this was a mistake and they			re-educated on the expectatio		
		the binder. She had worked			that emergency information is		
		ch and delegated tasks, but			accurate with current resident		
	had not delegated the				information.		
					Executive Director is		
	During an interview with RN 4, on 1/18/23 at 3:20				responsible for ensuring the		
	_	n the event of an emergency			emergency information is acc	urate	
	_	as to grab the emergency			with current resident informati		
		ontained the resident's					
		ion, and the computer. He was			How the corrective actions wil	l be	
	to assist with the ev	vacuation.			monitored to ensure the defici	ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE OPCO, LLC		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 3037 W DIVISION RD WABASH, IN 46992			ETED		
(X4) ID PREFIX TAG	A current facility por EVACUATION PR Administrator, on 1 the following: "4. List from the Emergyou to the scene as who require immed	OCEDURE," provided by the //18/24 at 11:10 a.m., indicated Pull the Emergency Evacuation gency Handbook and take with a reference as to residents		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) practice will not recur, what qu assurance program will be put place Divisional Director of Heal Operations will audit the emergency binder monthly for three months and then annual thereafter.	ality into Ith &	(X5) COMPLETION DATE

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