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	09/06/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00415717 and IN00416126. Complaint IN00415717 - No deficiencies related to the allegations are cited. Complaint IN00416126 - No deficiencies related to the allegations are cited. Survey dates: September 5 and 6, 2023 Facility number: 003466 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 13, 2023.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation, record review, and interview, the facility failed to ensure their survey results binder included the results (the 2567 report from the Indiana Department of Health) of their most recent surveys and any related plans of correction, for 1 of 1 state survey results binder reviewed. Findings include: During an observation, on 9/5/23 at 10:10 a.m., a table near the entrance to the facility had a frame sitting on top of it that included a sign to indicate	R 0042	R042 Residents' Rights - Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice Survey results binder has been updated with the most recent annual survey and any plan of correction	10/09/2023

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

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	annual survey results were located in the center drawer. In the center drawer was a binder titled "Bickford Cottage ISDH Survey Documents". The most recent survey in the binder was a PSR (Post-Survey Revisit) 2567, dated 6/16/21, from a State Residential Licensure Survey completed on 4/15/21. The binder did not include a State Residential Licensure Survey completed on 8/17/22, the plan of correction related to the survey, or the PSR completed in October 2022. During an interview, on 9/6/23 at 2:06 p.m., the Nurse Consultant indicated the binder included their most recent survey, completed in 2021. She was not aware a survey had been done after 2021.		Executive Director or Designee are responsible for ensuring that the survey binder is updated annually. 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 performed an audit on October 9, 2023 to ensure compliance. 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 or Designee will receive additional training by the Divisional Director of Operations on residents right to examine the results of the most recent annual survey and any plan of correction. 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 survey binder to ensure most recent survey results are available on routine branch visits, and at least annually. By what date the systemic	

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			changes will be completed by October 9, 2023.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, record review, and interview, the facility failed to protect residents' rights to be free from another resident's mental abuse and sexual abuse for 3 of 5 residents reviewed for abuse (Residents 24, 27, and 28) and failed to protect a resident's right to be free from neglect for adequate supervision to reduce the risk of falls for a resident with multiple falls for 1 of 5 residents reviewed for neglect (Resident 24). Findings include: 1. During an observation, on 9/5/23 at 11:04 a.m., Resident 24 was sitting in a wheelchair in between the dining room and lounge. He was muttering to himself. On 9/6/23 at 1:46 p.m., he was sitting in a wheelchair in his room. His clinical record was reviewed on 9/5/23 at 2:02 p.m. Diagnoses included neurocognitive disorder with Lewy Body dementia with behavior disturbance, violent behavior-aggression, and restlessness and agitation. Current physician orders included the following: a. Buspirone (anti-anxiety), 10 mg (milligram), one tablet three times a day for anxiety, the order date was 5/15/23. b. Clonazepam (benzodiazepine that can be used for anxiety) 0.5 mg, one tablet twice a day for	R 0052	R052 Residents' Rights - Offense What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 24 still resides at Bickford of Wabash; no further incidents have occurred. Resident 27 still resides at Bickford of Wabash Resident 28 still resides at Bickford of Wabash 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 Service plans of residents with high fall risk will be reviewed to ensure individualized fall interventions are in place. Service plans will be developed and implemented that include interventions for behavior disturbance, violent behavior-aggression, and restlessness and agitation, and wandering behaviors. What measures will be put into place or what systemic changes the facility will make to ensure	10/10/2023

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	restlessness and agitation, the order date was 5/15/23. c. Sertraline (anti-depressant) 25 mg, three tablets, for 75 mg total dose, every day for restlessness and agitation, the order date was 5/15/23. d. Seroquel (anti-psychotic) 50 mg, one and one-half tablets, for 75 mg total dose, twice a day for aggression, the order date was 6/27/23. e. Trazadone (anti-depressant) 100 mg, one tablet at bedtime for insomnia, the order date was 6/27/23. f. Depakote (mood stabilizer) 500 mg, one tablet twice a day, the order date was 8/28/23. This was a dosage increase from the previous order of 125 mg twice a day. A Cognitive Assessment, dated 5/15/23 at 11:00 a.m., indicated a GDS (Global Deterioration Scale) score at Stage 6 - severe cognitive decline. A Service Plan, dated 5/15/23 at 11:30 a.m., indicated with morning care he required extra assistance from staff if tired or unsteady. He required stand by assist with daily morning routines. He required extra assistance with evening care, encouraged to stay out of room and insight of staff until he was tired. For mobility he was independent with walker and used a wheelchair at times and needed reminders to use walker for safety. Required to be checked on four times during the night for safety, assisted to the bathroom to prevent him from trying to ambulate by himself, would wake up confused and required re-direction, often he was looking for his wife who had passed away. The social section indicated walking outside with physical assistance of staff		that the deficient practice does not recur. Executive Director/HWD to receive additional training by the Divisional Director of Health and Operations on the expectation that Service plans are developed and implemented to include individualized interventions to address behavior disturbance, violent behavior-aggression, and restlessness and agitation, and wandering behaviors. Re-training will also cover Abuse and Neglect Policy and fall risk with individualized interventions. To be completed by October 10, 2023 Executive Director and Director of Health & Wellness will be responsible for ensuring individualized service plan are developed and address the care needs of residents, include behavior disturbance, violent behavior-aggression, and restlessness, agitation, wandering behaviors, and high fall risk. Health & Wellness Director will conduct an in-service on interventions and supervision as identified on service plan for residents exhibiting behavior disturbance, violent behavior-aggression, and restlessness and agitation, and wandering behaviors, abuse and neglect policy for all caregivers by October 10, 2023. Residents with behavior disturbance, violent	

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	helped with agitation and burned off energy with confusion. The safety section indicated he was at risk for falls. He didn't like staff to place their foot in front of his walker and/or grab his walker from him, and staff were to walk with him and let him explore safely. Progress notes included the following: A progress note, dated 5/17/23 at 5:45 a.m., indicated the resident was up through-out the shift in the hallway without a walker, used handrails to balance, screamed loudly for his wife, continued to wander into other resident's rooms, he was difficult to re-direct, became agitated upon re-direction, required one-on-one supervision at that time for his safety and the safety of other residents, continued to exit seek, and he continued to disturb other residents while attempting to enter their rooms. A progress note, dated 5/17/23 and untimed, indicated he had approached a female resident (Resident 28) and tried to grab her by the waist. He shoved a staff member and grabbed their wrist and squeezed and twisted it. A staff member locked Resident 28's room door, and Resident 24 went to her room knocked and twisted door handle and shouted out his wife's name. A staff member approached him to re-direct him, and he slapped the staff member across the face and continued to knock on Resident 28's door shouting for his wife to come out for an extended period of time. A progress note, dated 5/17/23 and untimed, indicated he was standing in front of a dining room table with a walker, fell backwards, and landed on his back. He was transferred to a local hospital emergency room for treatment and		behavior-aggression, and restlessness and agitation, and wandering behaviors will be discussed with Divisional Team during weekly care calls to ensure proper assessment and intervention development. 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 and Operations will review service plans monthly for three months and then annually to ensure residents identified with behavior disturbance, violent behavior-aggression, and restlessness, agitation, wandering behaviors, and residents with high fall risk have appropriate interventions implemented in service plan. By what date the systemic changes will be completed by October 10, 2023.	

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	evaluation. A progress note, dated 5/17/23 at 11:00 p.m., indicated he had returned to the facility. He was argumentative, walking down the halls without a walker, and had gone into Resident 28's room. A progress note, dated 5/18/23 at 6:00 a.m., indicated he had been up through-out the night, had been noted to be in the doorway of multiple different resident rooms, attempted to open all doors and screamed for his wife, the resident was a safety concern, and he was not appropriate for assisted living level of care. A progress note, dated 5/18/23 and untimed, indicated the resident was in another resident's room using the bathroom. A progress note, dated 5/21/23 and untimed, indicated he walked in hallway without a walker, opened another resident's room door, tried going into room, he refused to let go of the door handle, the door was locked, and he turned around. A progress note, dated 5/24/23 at 9:30 a.m., indicated he was yelling in his room and staff were unable to open his door. A staff member went outside, climbed through his window, and the resident was on the floor in front of his door. Three staff members assisted him off the floor. No injuries were noted. A progress note, dated 5/27/23 at 12:00 p.m., indicated he was found on the floor. He had thought there were kids down there, and he was trying to help them. He had no injury noted. A progress note, dated 5/30/23 at 5:00 a.m., indicated he had been awake through-out the			

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	shift, was attempting to enter rooms of various residents, and calling out for his wife. A progress note, dated 5/30/23 at 2:00 p.m., indicated a new order for Seroquel 25 mg in the morning and 50 mg in the evening had been received. A progress note, dated 6/7/23 at 6:16 p.m., indicated as staff assisted the resident with toileting, he attempted to shove his walker at a staff member, and fell to the ground. No injury was noted. A progress note, dated 6/8/23 at 3:00 a.m., indicated he had been found on a toilet in an empty apartment. A progress note, dated 6/9/23 at 6:00 p.m., indicated the resident was in a female resident's room (Resident 27). A staff member attempted to re-direct him out of her room, and was struck in the shoulder with a closed fist. A progress note, dated 6/9/23 at 9:20 p.m., indicated as a staff member was providing evening care, the resident tried to strike the staff member with a closed fist, and he fell. No injury was noted. A progress note, dated 6/15/23 at 3:00 a.m., indicated he attempted to get into a female resident's room and got angry with a staff member because they would not unlock that resident's door. A progress note, dated 6/17/23 at 4:10 p.m., indicated Resident 24 took Resident 27's walker and would not give it back.			

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	A progress note, dated 7/8/23 at 3:05 p.m., indicated he was found in his room lying on his left side on the floor. No injury was noted. A progress note, dated 7/11/23 at 12:30 a.m., indicated Resident 27 had called for help. Resident 24 was in her room on the toilet, and had turned the television around, unplugged the television, and knocked over the table at the end of her bed. A progress note, dated 7/25/23 at 6:12 p.m., indicated he had been found lying on his back beside the kitchenette. He had sustained an abrasion to his left hand. A progress note, dated 7/30/23 at 7:30 p.m., indicated he had walked into Resident 28's room and tried to use the bathroom. A staff member assisted Resident 28 away from her bathroom and Resident 24 out of her room. A progress note, dated 8/1/23 at 8:00 a.m., indicated the resident went into another female resident's room and scared her. Staff members found him sitting in a chair in her room. A progress note, dated 8/2/23 at 1:30 a.m., indicated he had been found in his room sitting on the floor. No injury was noted. A progress note, dated 8/14/23 at 1:30 p.m., indicated he was very combative and tried to hit staff and other residents. A progress note, dated 8/14/23 at 4:10 p.m., indicated the resident was in Resident 27's room and kissed her. A progress note, dated 8/28/23 at 3:30 p.m.,			

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	indicated he had been found lying on floor. He was very agitated, hitting and kicking everyone near him. A new order to increase his Depakote to 500 mg twice a day was received. During an interview on 9/6/23 at 1:57 p.m., CNA 7 indicated Resident 24 got up on his own, and she tried to anticipate his needs, but he did whatever he wanted to do, and did not always accept assistance. The other residents in the facility were asked to lock their room doors to prevent him from entering their rooms and not all residents were okay with that intervention. During an interview on 9/6/23 at 3:45 p.m., the DON indicated a resident's service plan reflected their plan of care. Interventions for falls, wandering, and safety concerns were included in his service plan. The facility did encourage the other residents to lock their doors to prevent him from entering their rooms. 2. Resident 27's clinical record was reviewed on 9/6/23 at 11:16 a.m. Diagnoses included frail elderly, anxiety, and confusion. Current physician orders included the following: a. Sertraline 25 mg, one tablet every day for depression, the order date was 2/11/22. b. Buspirone 5 mg, one tablet twice a day for anxiety, the order date was 8/21/23. A note to a physician, with a response date of 8/17/23, indicated a request to change buspirone from once a day to twice a day because she was having behaviors with morning and evening care and behaviors had become more frequent several days a week. The order had been changed to			

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	twice a day. A progress note, dated 8/14/23 at 4:15 p.m., indicated Resident 24 had entered her room and kissed her. A progress note, dated 8/18/23 at 10:30 p.m., indicated she had been angry that shift, pushed her call pendent, and when staff responded she told them she didn't know what she needed. She continued to yell for help and got angry when staff didn't know what she needed. Review of a facility report incident, dated 8/17/23 at 9:28 a.m., indicated an event had occurred on 8/16/23 at 6:34 p.m. Resident 24 had kissed Resident 27 in her room. The preventative measures indicated Resident 24's service plan had been updated with interventions to assist him to and from dining room, redirecting him when wandering in hallway to open areas, and not allowing either resident alone together behind closed doors. 3. Resident 28's clinical record was reviewed on 9/6/23 at 10:35 a.m. Diagnoses included dementia. A Nurse Assessment, dated 4/26/23 at 11:00 a.m., indicated she had limited range of motion to her left shoulder. Current physician orders included sertraline (anti-depressant) 25 mg, one tablet every day for depression, the order date was 8/23/23. Review of a current facility policy, titled "Abuse and Neglect," with a revised date of 04-2015 and provided by the Nurse Consultant on 9/6/23 at 4:16 p.m., indicated "...NOTE: All Bickford Family Members are required to be knowledgeable of the			

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	policies and procedures regarding the prohibition of mistreatment, neglect, and abuse of residents and misappropriation of their property. Bickford Family Members must not use...involuntary seclusion...." 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to employ a licensed administrator. This deficient practice had the potential to affect 19 of 19 residents residing in the facility. Findings include: During an interview, on 9/5/23 at 9:47 a.m., the acting Administrator indicated she was new to the job. She had previously been the Activity Director. Employee records were reviewed on 9/6/23 at 9:40 a.m. The acting Administrator lacked an Administrator's license. During an interview, on 9/6/23 at 12:01 p.m., the Corporate Nurse Consultant indicated the Administrator had previously been the Activity Director. She was currently the Administrator of the facility and would be taking classes soon to get her administrator's license. The corporation often had temporary proctors to advise and utilize their administrator's license until a facility's current administrator obtained their license. She was uncertain who was the current proctor for the facility. During an interview, on 9/6/23 at 12:07 p.m., the Corporate Nurse Consultant indicated there was not a currently licensed administrator for the			
R 0088 Bldg. 00		R 0088	R088 Administration and Management - Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this alleged deficient practice. 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 No residents were harmed by this alleged deficient practice. 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 facility is actively recruiting for a licensed residential care facility administrator. Once a qualified candidate is secured the facility will complete the state form titled Administrator or Director of Nursing Change (State form 554444).	10/25/2023

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	facility. The facility had not had a licensed administrator for about two and a half months. A current, undated facility policy, provided by the acting Administrator on 9/6/23 at 4:28 p.m., titled "PP-10600-Director Requirements," indicated "Policy: Bickford shall employ an administrator/operator who has completed the training requirements pursuant to State Law ...."		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 applicants prior to interview to ensure Administrator license is current. By what date the systemic changes will be completed by October 25, 2023.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure fire drills were conducted quarterly each shift. This deficient practice had the potential to affect 19 of 19 residents residing in the facility. Finding includes: During an interview, on 9/5/23 at 10:46 a.m., the Maintenance Director indicated the facility's fire drills were in the facility's survey binder. The facility's fire drills, provided in the facility's survey binder by the acting Administrator on 9/5/23 at 10:36 a.m., were reviewed on 9/5/23 at 11:11 a.m. The facility lacked documentation of fire drills performed May 2023, June 2023, and August 2023. During an interview, on 9/6/23 at 3:58 p.m., the acting Administrator indicated she was uncertain where additional documentation of fire drills	R 0092	R092 Administration and Management - Noncompliance No residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Fire drill will be completed by October 25, 2023. 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 other delegated staff member will be responsible for running an effective fire drill on monthly basis.	10/25/2023

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(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
	would be located. The Maintenance Director was called by the acting Administrator and indicated the former Maintenance Director had been off work and some of the fire drills had been missed. If the fire drill documentation was not there, then it was not done. A current, undated policy, provided by the acting Administrator on 9/6/23 at 4:27 p.m., titled "Fire Drill Schedule," indicated "Fire drills shall be performed monthly. This includes each shift having one drill each quarter ...."		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on policy pertaining to Fire Safety and frequency of drills. Executive Director or other delegated staff member shall work with local Fire Department to provide bi-annual training for fire and disaster drills. 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 of Operations will review Fire Drill records on monthly basis. By what date the systemic changes will be completed by 10/25/23	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a first aid-certified staff member was scheduled onsite for 1 of 21 shifts reviewed. This deficient practice had the potential to affect 19 of 19 residents residing in the facility. (RN 51 & QMA 52) Finding includes:	R 0117	R117 Personnel - Deficiency What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice	10/25/2023

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	09/06/2023

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	The staffing schedule from 8/31/23 through 9/6/23, provided by the acting Administrator on 9/5/23 at 11:41 a.m., and first aid certifications, provided by the acting Administrator on 9/6/23 at 9:34 a.m., were reviewed on 9/6/23 at 10:52 a.m. RN 51 and QMA 52 were scheduled on third shift on 9/4/23. Both employees lacked a certification in first aid. During an interview, on 9/6/23 at 11:25 a.m., the Director of Nursing (DON) indicated on 9/4/23 the third shift did not have anyone in the building certified in first aid. A current, undated policy, provided by the Administrator on 9/6/23 at 4:27 p.m., titled "PP - 30800 - First Aid," indicated " ...Bickford Family members shall be responsible to maintain their certification in CPR and First Aid ...."		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 will complete an audit of all employee files to ensure compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on policy PP-30800 First Aid. 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 audit 6 new employee files to ensure compliance Divisional Director of Operations will continue to randomly audit employee files on routine visits. By what date the systemic changes will be completed by October 25, 2023.	
R 0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance			

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		A. BUILDING 00 B. WING	09/06/2023

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Bldg. 00	Based on interview and record review, the facility failed to ensure six hours of initial dementia training was completed for 1 of 3 new employees files reviewed (CNA 53). Finding includes: Employee files, provided by the Administrator on 9/6/23 at 9:34 a.m., were reviewed on 9/6/23 at 9:40 a.m. CNA 53 was hired 2/10/23. She completed 1.75 hours of initial dementia training. During an interview, on 9/6/23 at 2:30 p.m., the Director of Nursing (DON) indicated she was unable to provide additional dementia training for CNA 53. A current, undated policy, provided by the Corporate Nurse Consultant on 9/6/23 at 5:10 p.m., titled "PP - 21100 - Dementia Training," indicated " ... All Bickford Family Members, or the caregivers of the companies in contract with Bickford, will receive a minimum of 6 hours of dementia-specific training prior to or within 90 days of employment ...."	R 0120	R120 Personnel - Noncompliance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice 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 will complete an audit of all employee files to ensure that initial six hours of dementia training was completed with supporting documentation noted in the employee file What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate the Director regarding training requirements to meet the needs of cognitively impaired residents. Executive Director will ensure all direct care staff complete six hours of initial dementia training within 6 months of employment with supporting documentation noted in the employee file	10/25/2023

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			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 audit the next 5 employee hire files for compliance. Divisional Director of Operations will complete audit at least annually to monitor compliance. By what date the systemic changes will be completed by October 25, 2023.	