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	08/19/2022

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00387647. Complaint IN00387647 - Substantiated. State deficiencies related to the allegations were cited at R52, R116, R119 and R120. Survey date: August 19, 2022 Facility number: 004503 Residential: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 30, 2022.	R 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 10/11/22.**	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident, with Alzheimer's Disease, was kept free from physical and mental abuse during a shower, to ensure their abuse policy was followed for keeping the resident safe from the abuse perpetrators (QMA 1, CNAs 2 and 3), to ensure the resident was assessed for physical and mental trauma following the incident and failed to follow their abuse policy to ensure the alleged abuse incident was	R 0052	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that the 2567 plan of**	10/11/2022

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

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	accurately reported immediately to the Executive Director (ED) and the State Agency to prevent further potential abuse for 1 of 1 resident being reviewed for abuse (Resident B). Resident B received a 15 x 10 cm (centimeter) bruise to his left forearm and a 10 x 6.5 cm bruise to his right wrist and forearm area. Finding includes: During an interview, on 8/19/22 at 2:15 p.m., the ED indicated the alleged abuse incident on 8/7/22, involving Resident B, QMA 1 and CNAs 2 and 3, was not reported accurately immediately to the Director of Nursing (DON) or himself, which it should have been. QMA 1 called the DON on 8/7/22, to notify her of bruising observed on Resident B related to he had hit his arm during his shower. On 8/8/22, CNA 2 asked to speak with the ED and DON following the morning meeting. CNA 2 informed the ED and DON there was more to the story of the shower incident with Resident B. The ED then started his investigation. The next day (8/9/22), he called his Director to get further guidance and at that time, he was advised all three individuals who were involved with the incident needed to be suspended pending the investigation and to notify IDOH (Indiana Department of Health). On 8/10/22 (two days after the alleged abuse incident), the ED submitted a document to IDOH titled "Indiana State Department Health Survey Report System." The ED indicated after the investigation of the alleged abuse incident involving Resident B, QMA 1 was terminated. QMA 1 was terminated because she was the nursing staff member in charge when the alleged abuse incident occurred. She should have known better, than to ask CNAs 2 and 3 to help her force the resident into the		**correction be considered the letter of credible allegation and request a post certification review on or after 10/11/22.** **R0052** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. It is also the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility or other designee and to other officials in accordance with state law through established procedures. Resident Bs identified bruises have resolved. All direct care staff have been updated on his current status and level of assistance required for transfers and care. **How will you identify other residents having the potential to be affected the same deficient practice and what**	

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	shower. CNAs 2 and 3 were allowed to come back to work with stipulations they had to be re-educated on abuse, residents' rights and the Elder Justice act. Also, both CNAs were given a "Teachable Moment" for participating in giving Resident B a shower against his will and for not reporting the allegation to the ED or the DON. They both were given a final written warning which indicated the next offense would result in termination. Copies of the Teachable Moments and the Termination documents were requested at that time. The ED indicated he was not able to get the Termination document for QMA 1, but he was able to tell me she was terminated. On 8/19/22 at 2:45 p.m., Resident B was observed sitting in his apartment watching TV. He was not able to answer any questions regarding the incident which occurred on 8/7/22, as the resident was very confused and his speech was very hard to understand. He was disoriented to place and time. He had no idea what questions was being asked of him. The record for Resident B was reviewed on 8/19/22 at 3:00 p.m. Diagnoses included, but were not limited to, Alzheimer's Dementia with behavioral disturbance, osteoarthritis of the left knee, major depressive disorder, anxiety disorder and chronic kidney disease stage 3. A progress note, dated 8/8/22 at 8:30 a.m., indicated the DON assessed skin bruises on Resident B's forearms. His left forearm bruise measured 15 cm (centimeters) wide x 10 cm long. His right wrist/forearm bruise measured 10 cm wide x 6.5 cm long. This was the area under his wanderguard bracelet, which was cut off to prevent further skin injury.		**corrective action will be taken?** All residents are at risk to be affected by this finding. An all-staff in-service will be held on 09/16/2022. This in-service will include review of the facility policy and procedure titled, “Resident Abuse Prohibition; Reporting and Investigation; Resident Rights; and the Elder Justice Act”. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the Administrator and DON. The facility will immediately initiate a full investigation as well as ensure notification to the PCP, family, ISDH, and other agencies as outlined in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A comprehensive head to toe assessment is completed on admission, re-admission, and transfer/discharge and at least weekly by the Registered Nurse Coordinator. Any new findings such as skin tears, bruising, etc.…will be documented in the clinical record. In addition, residents who receive assistance with bathing and toileting care will be observed daily by the nursing staff and any new areas of concern noted will be reported to	

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	A progress note, dated 8/8/22 at 1:30 p.m., indicated the DON spoke to the daughter when she came into the facility to pick the resident up for a physician's appointment regarding the bruises on his forearm and agitation that had increased during his care. She discussed the wanderguard bracelet getting stuck when taking his shirt on and off and the daughter may need to purchase bigger sized shirts for him. A progress note, dated 8/9/22 at 11:50 a.m., indicated when the resident's NP (Nurse Practitioner) called to discuss another issue with the DON regarding Resident B, the DON informed her regarding his increased agitation with care and the bruises on his arms, which were found after his shower. QMA 1 indicated the resident swung his arm and hit it on the safety bar in the shower. The resident's record lacked documentation regarding the alleged abuse incident, which occurred on 8/7/22 between 7 p.m. and 8 p.m., the specifics of what happened, who was involved, the injuries which occurred during the shower, and there was no follow-up afterward to assess the resident's physical or mental state following the abusive incident. An investigation packet, titled "Interview Questions for State Reportable Incident which occurred on 8/7/2022," included, but were not limited to, interviews from the ED with QMA 1, CNA 2 and CNA 3, all three staff members statements of the incident, a timeline of events which occurred with all three staff members perspective and a summary of the incident with a follow-up of what was being completed, so the incident did not happen again. Interviews from all three staff members were		the Charge Nurse for further assessment. The facility will immediately initiate an internal investigation process to determine the probable cause and to ensure proper follow up. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The RNC or other designee will be responsible for completion of the quality assurance audit tool titled, “Abuse Prohibition and Investigation” and “Abuse” weekly x4 then monthly x3 and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the Executive Director who will submit to: Divisional Director of Operations, and the Divisional Director of Resident Services for review and follow up.	

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	reviewed and the following summary of the interviews indicated: (The same questions were asked from the ED to each of the three employees: QMA 1, CNA 2 and CNA 3). CNA 2's interview summary indicated, she entered Resident B's room to ask if he wanted to take a shower at 7:00 p.m., he refused. After asking him twice, she left and notified QMA 1 at 7:05 p.m., he had refused his shower. At 7:10 p.m., QMA 1 entered the resident's room in a demanding and aggressive manner telling the resident if he was going to hit a woman, then to hit her, but he was still going to take a shower. She was in Resident B's room for 20 minutes giving him a shower. He was fully clothed when he was forced into the shower. He was forced into the shower because he was resisting. QMA 1 and CNA 3 were both yelling at the resident while he was being showered. The resident appeared frightened and agitated prior to, during and after the shower. She did not report the incident immediately to the DON because she did not want to "face the wrath of (Name of QMA 1)." CNA 2 did not believe the incident was an intentional act of abuse, but she did believe Resident B was "stripped" of his dignity. CNA 3's interview summary indicated, she entered Resident B's room to ask if he wanted to a shower between 7:30 p.m. and 8:00 p.m., she notified QMA 1 right after she left the resident's room he had refused his shower. QMA 1 immediately went into the resident's room demanding he take a shower. The resident was fully clothed while he was in the shower. He was forced into the shower by QMA 1. CNAs 2 and 3 guided him into the shower while QMA 1 pushed him into the shower. All the staff members (QMA 1 and CNAs 2 and 3) helped at one point or another to get his shirt off			

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	him. She and QMA 1 yelled at the resident while showering him. QMA 1 yelled at him "We have to get you clean." CNA 3 yelled at him "We don't want to have to be in here anymore than you do." The resident appeared frightened and was agitated prior to, during and after the shower. She did not report the incident to the DON because QMA 1 called the DON after it happened. She and CNA 2 was just as scared as the resident was. They were scared if they did not help QMA 1, she would say they were being neglectful and they were already too deep into the situation and could not stop without ensuring the resident remained safe. She did not feel the incident started out as an intentional act of abuse, QMA 1 wanted to get the resident clean for his appointment the next morning, but the resident was "stripped" of his dignity. QMA 1's interview summary indicated, she was informed by CNAs 2 and 3 at approximately 8:00 p.m., Resident B refused his shower. She immediately proceeded to the resident's room to assist the two CNAs with his shower. She was in the resident's bathroom 10-15 minutes giving him his shower because things escalated very quickly. They tried to shower him quickly and de-escalate the situation the best they could and keep him safe. When asked if the resident was fully clothed when put in the shower, QMA 1 indicated "No." When asked if he was guided into the shower or forced, QMA 1 indicated the girls (CNAs 2 and 3) had his hands and guided him into the bathroom. Everything happened so fast she did not remember. QMA 1 indicated her role was she removed the clothing and she only was able to wash his bottom at that time. She was not aware anyone held down the resident's arms. When asked if she or anyone else was involved in yelling at the resident, she indicated she was not,			

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	but CNA 3 was. She indicated the resident was agitated, which was why the staff members were trying to get him sat down, so he could calm down. QMA 1 indicated the incident was reported to the DON at 8:13 p.m. An incident report was not filled out because she was told by the DON she did not need to do anything further. She did not feel the situation was an intentional act of abuse and she did not believe the resident was "stripped" of his dignity. The summary of the incident, which occurred on 8/7/22, included, but was not limited to, the following details: 1. QMA 1 and CNAs 2 and 3 were the parties involved in the incident, which occurred on 8/7/22 between 7 p.m. and 8 p.m. 2. QMA 1 called the DON at 8:13 p.m., to notify her of the bruises related to the resident hitting his arm during a shower. 3. The further alleged information regarding the incident was provided by CNA 2 on 8/8/22 at 10:45 a.m. 4. The ED reported the alleged incident to IDOH (Indiana Department of Health) on 8/10/22 at 2:40 p.m. 5. The ED documented the details of the incident as reported to him by the participants in a timeline. 6. On 8/7/22 at approximately 8:15 p.m., documented as told by QMA 1 in an interview by the ED. QMA 1 indicated she called the DON to report a bruise on the resident's arm caused by him hitting his arm in the shower. She asked the DON if she needed to fill out an incident report and the DON answered "No" she did not have to. QMA 1 did not realize she was going to be accused of something that was not "really an issue." 7. On 8/8/22 at 10:45 a.m., CNA 2 reported to the ED and DON there was more to the story of the			

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	incident in question, which occurred with Resident B on 8/7/22. 8. On 8/8/22 between 11:05 a.m. and 11:10 a.m., the ED began his investigation 9. On 8/8/22 at 11:15 a.m., the ED talked with the Life Enrichment Coordinator in regards to any staff member being rude to the residents and she indicated she had witnessed QMA 1 being very loud and bossy. 10. On 8/9/22 at 9:49 p.m., the ED reached out the his Director for further guidance. 11. On 8/9/22 between 10:14 and 10:16 p.m., the ED informed QMA 1 and CNAs 2 and 3 they were all three suspended pending an investigation. 12. On 8/10/22 at 2:40 p.m., the ED submitted an alleged incident to the IDOH. The typed DON's statement included, but was not limited to, the following details: The DON received a phone call on 8/7/22 at 8:10 p.m., from QMA 1. She reported Resident B was agitated and verbally upset after a shower the staff had given him. During the shower, QMA 1 noticed he had swung his left arm and hit it on the grab bar in the shower. There was a mark on his right arm, which looked like a bruise or similar to the area he had on his arm a few months ago under his wanderguard bracelet. The DON instructed QMA 1 to cut off the resident's wanderguard bracelet to prevent further skin issues and she would assess it on Monday morning. QMA 1 told the DON the resident remained very upset and she told QMA 1 to let him deescalate and try back later. At that time, QMA 1 sent the DON a picture of Resident B's arms, the DON requested QMA 1 document the measurements of the bruise on his right arm in the progress notes and she would take care of the skin assessment and anything else on Monday morning.			

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	A document, titled "Teachable Moment," dated 8/16/22, indicated CNA 2 was given a final written warning with the next offense resulting in termination for showering a resident against his will and she did not report the incident on 8/7/22 at approximately 8:00 p.m., to the ED or the DON. A document, titled "Teachable Moment," dated 8/16/22, indicated CNA 3 was given a final written warning with the next offense resulting in termination for showering a resident against his will and she did not report the incident on 8/7/22 at approximately 8:00 p.m., to the ED or the DON. The document for QMA 1's termination was not provided as of the time of the end of the exit conference on 8/19/22. During a phone interview, on 8/19/22 at 3:45 p.m., QMA 1 indicated she was terminated after an abuse allegation involving Resident B on 8/7/22 at approximately 8:00 p.m. On 8/7/22, CNAs 2 and 3 asked Resident B a couple of times to take his shower and he refused. When they notified her he refused his shower, she told the CNAs he had a very strong urine and feces odor on him, so he needed to get a shower. After the CNAs got the resident into the shower, they were attempting to get his sweatshirt off which was too small for him. He started to get aggravated and was fighting against the CNAs, who were concerned he was going to fall in the shower. CNAs 2 and 3 quickly got him undressed and QMA 1 washed the dried feces off his bottom, then he was removed from the shower and sat on the toilet to allow him his own space to calm down safely. QMA 1 indicated she did not "yell" at Resident B. CNA 3 was "yelling" at him. He was agitated during the entire shower, so we were trying to finish quickly, then let him have his personal space to calm down and			

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	keep him safe from falling in the shower. After his shower, QMA 1 noticed a red mark on Resident B's right arm, so she contacted the DON immediately to inform her of the reddened area. After discussing the area with the DON, they both agreed it was most likely caused from his wanderguard bracelet. While QMA 1 was talking on the phone with the DON, she observed a bruise on the resident's left arm, but she was not sure how he received the bruise. She also informed the DON at that time, his urine was foul smelling and very thick. QMA 1 indicated she did not tell CNAs 2 and 3 Resident B had to get a shower. She along with the two CNAs decided he needed a shower because he had feces on him and he smelled like urine. He had a Doctor's appointment the next day. She did not lay a hand on the resident to get him into the bathroom. The two CNAs got him into the bathroom. The only time she touched the resident was to wash his bottom. She washed the resident in the shower without clothes on. The CNAs had a hard time getting his sweatshirt off because it was too small which was most likely how his right arm got the red mark from the wanderguard. She could not remember if either CNA held the resident's hands down during the shower. During a phone interview, on 8/19/22 at 4:08 p.m., CNA 3 indicated she was suspended for five days for an abuse allegation involving Resident B, which occurred on 8/7/22 between 7:30 p.m. and 8:00 p.m. She was allowed to come back to work after being re-educated on abuse and resident rights and given a final written warning. On 8/7/22, CNAs 2 and 3 went into Resident B's room to attempt to shower him, but after trying to get him			

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	to shower and him refusing, they both went and informed QMA 1. QMA 1 asked who was going into his room with her, so both CNAs went back into his room with QMA 1. QMA 1 told the resident to come on he needed to take his shower, he told her "No" he was not taking a shower. Both QMA 1 and the resident went back and forth a few times, each time their voices got louder. Resident B got so angry he stepped toward QMA 1 with his fist balled up like he was going to hit her, but he never did. QMA 1 told the resident if he was going to hit her, then for him to just go ahead and get it over with. Then she told him to come get in the shower and that was when he screamed "No." QMA 1 grabbed his right upper arm, then he pulled back his left arm like he was going to swing at her, so CNA 2 grabbed his left arm and CNA 3 was holding his wrists with her palms facing up. Resident B was furious. QMA 1 told the resident he was going to the shower and started pushing him towards the shower by using her right shoulder to continuously nudge him with her body into his right shoulder/upper back area until she got him into the bathroom. Then she tried pulling his pants off, but he bowed his knees out, so she could not get them pulled down all the way. She got them pulled down to his knees and got his brief off. QMA 1 attempted to remove his sweatshirt. QMA 1 indicated she did not care if the sweatshirt came off or not, they would get his clothes off in the shower. QMA 1 started pushing Resident B into the shower by using her right shoulder to continuously nudge him with her body into his right shoulder/upper back area until she got him into the shower. After QMA 1 got Resident B into the shower, QMA 1 had a hold of the resident's right arm and			

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	full control of the shower head. She had the shower on with the resident in the shower, standing up, with his pants to his knees and his sweatshirt was still. QMA 1 attempted to take his sweatshirt off. The sweatshirt finally came off, but his pants and socks were still on and the whole time. The resident was yelling. QMA 1 sprayed him with water and washed the areas of his body she could with a wash cloth, then put soap on his head and rinsed him off. CNAs 2 and 3 started drying him off, got him to sit on the toilet and he had calmed down. The resident was letting the CNAs take his wet pants and socks off. When QMA 1 came back into the bathroom, the resident began to get agitated. He refused to allow QMA 1 to dry his back. The CNAs helped him get dressed and left his room. After they were finished with Resident B's shower, QMA 1 called the DON to report bruises, which were found on Resident B's arms. CNA 3 indicated she heard what QMA 1 reported to the DON regarding the shower incident and she did not tell her the truth. Resident B was forced into taking his shower. CNA 3 did not remember seeing any bruises on his arms previous to his shower, but everything which happened was so chaotic and quick. The resident was forced into the shower and QMA 1 yelled and screamed at him throughout the shower. The residents were not allowed to refuse their showers according to QMA 1. CNA 3 did not see herself as participating in an abusive situation by helping with Resident B's shower, she thought she was protecting the resident from QMA 1. She indicated she had not reported the abuse incident to the ED or DON the night the incident happened. During an interview, on 8/19/22 at 4:45 p.m., the ED indicated he had been watching QMA 1 for a			

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		A. BUILDING 00 B. WING	08/19/2022

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	couple of weeks because he did not like her attitude toward the staff all the time. He had not noticed any inappropriate interactions toward the residents, but she did not always have positive interactions with the staff. He did have a few conversations with her about her interactions with others, but there was nothing she did bad enough to write her up or terminate her for. During a phone interview, on 8/19/22 at 4:50 p.m., CNA 2 indicated she was suspended for five days during an abuse investigation involving Resident B, which occurred at approximately 7:10 p.m. She was allowed to come back to work after being re-educated on abuse and resident rights and given a final written warning. On 8/7/22, Resident B was scheduled to get a shower. She and CNA 3 asked Resident B if they could give him a shower and he refused and became angry when they asked him twice. They both went out to report his refusal of the shower to QMA 1. QMA 1 indicated he had to get a shower because he had an appointment the next day. QMA 1 told both CNAs to go with her and help her get him into the shower. QMA 1 told the resident he had to get a shower and he told her "No" he was not taking a shower. The resident screamed in QMA 1's face and balled up his fist, he cussed at her. QMA 1 began yelling at him, if he wanted to hit her, then to go ahead and get it over with, but he was still going to take his shower. Resident B lunged at QMA 1, so she grabbed him by his right arm to stop him from hitting her, then she grabbed his right hand and elbow and pulled him into the shower. He was dragging his feet on the floor trying to stop her from pulling him to the shower. QMA 1 indicated he was going to get a shower with his clothes on because he needed a shower. She indicated she was going to wash his			

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	private area due to him being soiled with feces. QMA 1 was on the left side of the resident with her right arm interlocked with his left elbow and the shower head in her left hand. His clothes were still on him. QMA 1 did get the resident's pants down to his knees and got his brief off. He was fighting her. QMA 1 washed the resident's private area and his hair. CNA 3 yelled at the resident in a pleading manner asking him to stop fighting with QMA 1. After QMA 1 left the bathroom, CNAs 2 and 3 were able to get the resident to calm down after getting out of the shower. He let them dry him off and they started to dress him. QMA 1 came back into the bathroom and the resident became angry and agitated instantly. QMA 1 took pictures of both his wrist/forearm areas because there was a red mark. Resident B was getting more agitated the longer QMA 1 was in the bathroom and he indicated to her she could get out of his bathroom after their "little scuffle" they had. CNA 2 did not see herself as participating in an abusive situation by helping with Resident B's shower, she thought she was protecting the resident from QMA 1. She indicated she had not immediately reported the incident but did report it the next day (8/8/22). A current policy, titled "Resident Bill of Rights (IN)," dated as revised 9/2014, provided by the ED on 8/19/22 at 3:18 p.m., indicated "...Residents have the right to exercise any or all of the enumerated rights without: (1) restraint...(5) threat of reprisal by facility. These rights shall not be abrogated or changed in any instance except that, when the resident has been adjudicated incompetent, the rights devolve to the resident's legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident's legal			

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	representative. d. Residents have the right to be treated with consideration, respect and recognition of their dignity and individuality...j. Residents have the right to the following...(4) Refuse any treatment or service, including medication...(u) Resident have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not require to treat the resident's medical symptoms. (v) Residents have the right to be free from...(2) physical abuse (3) mental abuse, (6) involuntary seclusion. (w) Residents have the right to be free from verbal abuse...." A current policy, titled "Resident Services," dated revised 04/2015, provided by the ED on 8/19/22 at 3:18 p.m., indicated "POLICY: Bickford Directors and other health care professionals who have reasonable cause to believe that a Resident is being, or has been, abused, neglected or exploited shall report the information immediately to the State licensure authority and Branch support...RESPONSIBILITY: Director/RN Coordinator/Bickford Family Members PROCEDURE:..7) The State licensure authority and State Ombudsman within 24 hours, whose phone numbers are posted in the Branch. The report must be made to local law enforcement agency at times when the state offices are no open. A report will be called to the State offices on their next working day by the Director. NOTE...The Director shall not employ individuals who they are aware have been found guilty of abusing, neglecting or mistreating residents by a court of law, or have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment or residents or misappropriation of their property...." This State finding relates to Complaint			

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	IN00387647.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure reference checks were completed for new employees for 5 of 5 employees being reviewed for employee files. (Life Enrichment Coordinator, QMA 9, NA (Nursing Assistant) 10, CNA 11 and CNA 12). Finding includes: The employee records were reviewed on 8/19/22 at 4:38 p.m., and the following was found: 1. Life Enrichment Coordinator (LEC) was hired on 7/11/2022. Her employee record lacked reference checks. 2. QMA 2 was hired on 7/19/22. Her employee record lacked reference checks. 3. NA 10 was hired on 7/19/22. Her employee record lacked reference checks. 4. CNA 11 was hired on 7/11/22. Her employee record lacked reference checks. 5. CNA 12 was hired on 5/16/22. Her employee record lacked reference checks.	R 0116	**R0116** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by this deficient practice. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** No other residents have the potential to be affected by this deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	10/11/2022

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	During an interview, on 8/19/22 at 4:45 p.m., the Executive Director (ED) indicated he was the person responsible for making sure the employee files were up to date, since there was no dedicated Human Resource staff member. There were no references available for the five new employees being reviewed because he had forgotten to get the references done during the hiring processes for LEC, QMA 9, NA 10, CNA 11 and CNA 12. A current policy, titled "Personnel," dated revised 04/2015, provided by the ED on 8/19/22 at 3:18 p.m., indicated, "POLICY: Bickford shall comply with Indiana regulations or guidelines regarding Bickford Family member dependent adult and child abuse checks...." This State finding relates to Complaint IN00387647.		Personnel files of current staff were audited by the Director to ensure there are completed Reference checks. The Director has delegated this task to the Administrative Assistant. All potential new candidates will have Reference Checks prior to extending an offer of employment **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Two personnel files will be audited monthly to keep current employee's files complete.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children;			

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	served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on interview and record review, the facility failed to ensure dementia training was completed for new employees for 5 of 5 employees being reviewed for employee files. (Life Enrichment Coordinator, QMA 9, NA (Nursing Assistant) 10, CNA 11 and CNA 12). Finding includes: The employee records were reviewed on 8/19/22 at 4:38 p.m., and the following was found: 1. Life Enrichment Coordinator (LEC) was hired on 7/11/2022. Her employee record lacked dementia training. 2. QMA 2 was hired on 7/19/22. Her employee record lacked dementia training.	R 0119	**R0119, R0120** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by this deficient practice. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** No other residents have the potential to be affected by this	10/11/2022

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	3. NA 10 was hired on 7/19/22. Her employee record lacked dementia training. 4. CNA 11 was hired on 7/11/22. Her employee record lacked dementia training. 5. CNA 12 was hired on 5/16/22. Her employee record lacked dementia training. During an interview, on 8/19/22 at 4:45 p.m., the Executive Director (ED) indicated he was the person responsible for making sure the employee files were up to date, since there was no dedicated Human Resource staff member. No dementia training had been completed by the survey date except CNA 12 and her dementia training was not accessible due to their Corporate office kept those files and he was not able to get the information at that time. A secure email address was given to the ED for him to forward the information on 8/22/22, when he received it from the Corporate office. No dementia training policy was provided by the end of the exit conference. On 8/22/22, by the end of the day at 11:59 p.m., there had been no email communication from the facility regarding the missing dementia training. This State finding relates to Complaint IN00387647.		deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All current staff have been retrained in regards to Resident Rights; Resident Abuse Prevention and Reporting; and The Elder Justice Act. Dementia training is ongoing. All staff are required to re-do Dementia training yearly. New staff will be trained in regard Resident Rights; Resident Abuse Prevention and Reporting; and The Elder Justice Act as part of their orientation and must be completed within 30 days after hire. Company-provided (Core-E) e-learning orientation module "Dementia Training" must also be completed prior to working in the facility. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Director will audit two	

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			personnel training completion trackers in Core-E monthly to ensure compliance.	
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 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.			

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	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure resident rights training was completed for new employees for 5 of 5 employees being reviewed for employee files. (Life Enrichment Coordinator, QMA 9, NA (Nursing Assistant) 10, CNA 11 and CNA 12). Finding includes: The employee records were reviewed on 8/19/22 at 4:38 p.m., and the following was found: 1. Life Enrichment Coordinator (LEC) was hired on 7/11/2022. Her employee record lacked resident rights training. 2. QMA 2 was hired on 7/19/22. Her employee record lacked resident rights training. 3. NA 10 was hired on 7/19/22. Her employee record lacked resident rights training. 4. CNA 11 was hired on 7/11/22. Her employee record lacked resident rights training. 5. CNA 12 was hired on 5/16/22. Her employee record lacked resident rights training. During an interview, on 8/19/22 at 4:45 p.m., the Executive Director (ED) indicated he was the person responsible for making sure the employee files were up to date, since there was no dedicated Human Resource staff member. No resident rights was accessible at that time due to their Corporate office kept those files and he was not able to get the information at that time. A secure email address was given to the ED for him to forward	R 0120	**R0119, R0120** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents have been affected by this deficient practice. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** No other residents have the potential to be affected by this deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All current staff have been retrained in regards to Resident Rights; Resident Abuse Prevention and Reporting; and The Elder Justice Act. Dementia training is ongoing. All staff are required to re-do Dementia training yearly. New staff will be trained in regard	10/11/2022

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	the information on 8/22/22, when he received it from the Corporate office. No residents rights training policy was provided by the end of the exit conference. On 8/22/22, by the end of the day at 11:59 p.m., there had been no email communication from the facility regarding the missing resident rights or dementia training. This State finding relates to Complaint IN00387647.		Resident Rights; Resident Abuse Prevention and Reporting; and The Elder Justice Act as part of their orientation and must be completed within 30 days after hire. Company-provided (Core-E) e-learning orientation module "Dementia Training" must also be completed prior to working in the facility. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Director will audit two personnel training completion trackers in Core-E monthly to ensure compliance.	