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	11/17/2020

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00340642, IN00340080 and IN00336369. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00340642- Substantiated. State Residential Findings related to the allegations are cited at R0052, R0117 and R0214. Complaint IN00340080-Substantiated. State Residential Findings related to the allegations are cited at R0052, R0117 and R0214. Complaint IN00336369-Substantiated. State Residential Findings related to the allegations are cited at R0052. Survey date: November 17, 2020 Facility number: 004503 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 25, 2020.	R 0000	This plan of correction is submitted as required under the State Department of Health Law. The submission of this plan does not constitute and admission on the part of Bickford of Lafayette as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency. Any and all changes are to considered subsequent remedial measures to satisfy the surveyors findings and recommendations to improve the quality of life for all Bickford residents.	
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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(6) involuntary seclusion. Based on observation and interview, the facility failed to ensure residents were free from neglect, related to a resident with dementia who eloped twice outside the facility for an undetermined amount of time for 1 of 3 residents reviewed for neglect (Resident B) and to ensure the doors and pager system were in working order for 1 of 6 outside doors reviewed (hall 100 door). This deficient practice resulted in Resident B being discovered outside the facility on two separate occasions during the evening shift. Findings include: The record for Resident B was reviewed on 11/17/2020 at 3:03 p.m. The diagnoses included, but were not limited to, Lewy Body dementia, anxiety disorder and chronic obstructive pulmonary disease. 1. An incident report, dated 8/31/2020 at 9:10 p.m., indicated the resident was found outside the facility by a tenant at an apartment complex. The facility received a call from the police department. A progress note, dated 9/1/2020, indicated the resident had eloped from the facility on 8/31/2020 at approximately 9:10 p.m. The resident was found at [name of apartment building]. The progress note did not include how long the resident had been gone from the building. 2. An incident report, dated 11/1/2020 at 8:03 p.m., indicated the resident was found outside the facility. The incident report, on 11/1/2020, did not indicate where the resident was found.	R 0052	R052 The facility 100 hall door was repaired on 11/18, since the date of repair, this door is checked daily and remains in working order. Please see the attached service ticket regarding door repair. Daily wander guard door checks were implemented on December 11, 2020 these checks include using a test wander guard band, and a staff member walking to each exit door and activating the exit door to ensure the alarm goes to the pager that all caregiving staff are required to carry on their person during their entire shift. These daily door checks will remain as daily checks up to January 11, 2021, after January 11, 2021 these checks will remain on going three times a week up to March 12, 2021. After March 12, 2021 these checks will remain as weekly checks. Daily pager checks implemented to be completed no later than 8:30am every day, whereas a designated Bickford staff member reviews the pages (alerts) from the previous 24 hours, ensures these pages (alerts) are correct for the given time frame and responded to appropriately. Daily pager checks	12/10/2020

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	A progress note, dated 11/1/2020, indicated "around 7:45 p.m.," the pager showed an alert of the 300 door exit being breached. The staff responded to the alarm and went outside and did not observe Resident B. Staff went inside to check the building while another staff was outside to check the premises. The police department called the facility to inform them the resident was located at the [name of apartment building]. The progress note did not include how long the resident had been gone from the building. 3. During an ongoing observation, on 11/17/2020 starting at 1:37 p.m., with the Branch Director, the 100 hall door was able to be opened after 15 seconds and the door breach did not show on the staff pager system. The only message on the pager system was "lost communication." She was aware the door alarm and pager system on the 100 hall had not been working correctly since 11/13/2020 and had put in a work order. The system was supposed to be repaired on 11/17/2020 and the part was not in yet. During an interview, on 11/17/2020 at 3:50 p.m., an anonymous staff indicated Resident B had eloped from the facility twice. The staff did not know how long Resident B had been gone from the facility, the pagers did not go off and the resident was located at [name of apartment building]. The staff had assisted the resident to bed prior to him being located at the apartment building. During an interview, on 11/17/2020 at 5:30 p.m., the Branch Director indicated during Resident B's elopement on 8/31/2020, the report did not indicate which door the resident exited and did not indicate how long the resident was missing.		were started on December 11, 2020 these checks will remain on a daily schedule with no stop date intended. Daily Quantum (JNL) security system checks, these daily system checks were implemented on December 11, 2020 these checks will remain on a daily schedule with no stop date intended. This is a printed status report for the previous 24 hours that will correlate with our paging system. This report will be printed daily and placed on our Plan of Correction Binder until further notice. Daily Exit door checks these checks are typically completed as part of our weekly scheduled preventative maintenance program. These Exit door weekly PM's will remain weekly PM checks, as errors or system failure needs arise, the Branch Director, Nurse Coordinator will alert Bickford Senior Management along with JNL or Quantum Service provider for immediate service repair.	

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	She was not sure how Resident B was able to get out of the building on 11/1/2020 and the report did not indicate which door the resident walked through to get outside and did not include how long the resident had been gone from the facility. The staff on duty had given conflicting information on when the resident got out of the building and when they notified the Resident Care Coordinator of the missing resident. She indicated the 100 hall door was currently not secure since the staff would not be alerted by their pagers if the door was opened by a resident. A current policy, titled "Missing Resident," revised on 4/2014 and received from the Branch Director on 11/17/2020 at 5:49 p.m., indicated "...Upon becoming aware of a missing resident, immediately summon the assistance of the other employees on duty...One employee shall immediately search the entire inside of the building including all apartments...While one employee is checking the inside of the building, another employee shall simultaneously check the immediate outside vicinity of the building, including courtyard, carports, parking lot and the building property...Do not leave the building unattended more than one [1] minute...Call the Director immediately for further instructions...If the resident was not found during the search, the police must also be notified immediately about the missing resident...." This State finding relates to Complaints IN00340642, IN00340080 and IN00336369.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the			

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	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to provide enough staff to monitor a resident with dementia to prevent elopements for 1 of 3 residents reviewed for neglect (Resident B) and to supervise a wandering resident in the dining room (Resident B). Findings include: During an ongoing dining observation, on 11/17/2020 at 12:47 p.m., Resident B was observed to take a walker away from Resident E, then take Resident E's plate of food and give it to Resident G. Resident G was eating the food from Resident E's plate and the staff had to be notified. Resident B was also touching Resident H's arm after he had been observed placing his hands down his pants while she was trying to eat.	R 0117	R 117 Staffing Branch Director uses a master schedule, but we also use “daily staffing sheets” which is a summary of all departments within the branch working and what hours scheduled for that day. Effective November 22, 2020 the Branch Director will maintain not only the master schedule but each daily schedule sheet that shows the actual worked schedule and the hours of those and the actual hours they worked. It will also note the calls offs and those who were canceled for that day. This daily schedule sheets will remain	11/22/2020

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	The record for Resident B was reviewed on 11/17/2020 at 3:03 p.m. The diagnoses included, but were not limited to, Lewy Body dementia, anxiety disorder and chronic obstructive pulmonary disease. A progress note, dated 9/1/2020, indicated the resident had eloped from the facility on 8/31/2020 at approximately 9:10 p.m. The resident was found at [name of apartment building]. A progress note, dated 11/1/2020, indicated "around 7:45 p.m.," the pager showed an alert of the 300 door exit being breached. The staff responded to the alarm and went outside and did not observe Resident B. Staff went inside to check the building while another staff was outside to check the premises. The police department called the facility to inform them the resident was located at the [name of apartment building]. During an interview, on 11/17/2020 at 3:50 p.m., an anonymous staff indicated there was not enough staff in the building during the evening shift to watch all the residents. Several of the residents required the assistance of two staff to get them to bed while the other staff on duty was passing medications. The staff on duty did not realize Resident B had eloped from the building and their pagers did not indicate there had been a door breach. At times, it would take three staff to get Resident B to bed since he was combative during care. During an interview, on 11/17/2020 at 5:30 p.m., the Branch Director indicated staffing on some of the evening shifts only included two CNAs and other times there were three CNAs. At times, the management staff would work to cover the third		ongoing with no stop date in place. In addition, these daily schedule sheets will match the current payroll period. 1:1 resident assistance if needed will be mandated by Nurse Coordinator, Nurse Coordinator will instruct in person or via phone as to who will be assigned to remain with a resident when the need arises, the Nurse Coordinator will note on the daily schedule sheets who was/is assigned for 1:1 resident duties, the duration of the time the resident is to be on or remain 1:1 will also be determined by Nurse Coordinator. The Nurse Coordinator will document in the residents chart, progress notes the event that warranted the 1:1 assistance and time the 1:1 assistance was/is scheduled.	

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	CNA position although this was not shown on the "as worked" staffing schedule. She did not know for sure which door the resident had exited the building on 8/31/2020 and did not know how the long the resident was out of the building before he was located. The staff on duty on 11/1/2020 had given conflicting information on when the resident got out of the building and when they notified the Resident Care Coordinator of the missing resident. Resident B had never touched any of the other residents inappropriately although he did get in "their social bubble." Some of the residents were uncomfortable with this since he would often touch their shoulders. The facility did not provide a staffing policy upon exit. This State finding relates to Complaints IN00340642 and IN00340080.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to update a service plan for a resident with dementia who had eloped twice from the facility and who had wandering and intrusive behaviors toward other residents for 1 of 3 residents reviewed for neglect (Resident B). Finding includes:	R 0214	R214 Service Plan A role-playing in-service was held on 12/10, 12/11, and 12/12 for all staff to be reminded on how to approach and redirect a resident appropriately. This in-service will remain on going until all staff complete the role-playing	12/14/2020

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	During an ongoing dining observation, on 11/17/2020 at 12:47 p.m., Resident B was observed to take a walker away from Resident E, then take Resident E's plate of food and give it to Resident G. Resident G was eating the food from Resident E's plate and the staff had to be notified. Resident B was also touching Resident H's arm after he had been observed placing his hands down his pants while she was trying to eat. During an observation, on 11/17/2020 at 12:56 p.m. in the dining room, Cook 2 told Resident B not to touch the ladies then walked away from him. During the observation, on 11/17/2020 at 12:58 p.m., while Resident B was standing at Resident H's table she asked "what is wrong with him?" During an observation, on 11/17/2020 at 12:59 p.m., Resident B had been close to Residents K and J while they were sitting together on the sofa. An unidentified female staff stated "you can't touch the ladies." During an interview, on 11/17/2020 at 2:10 p.m., Resident D indicated Resident B needed to "be watched." The record for Resident B was reviewed on 11/17/2020 at 3:03 p.m. The diagnoses included, but were not limited to, Lewy Body dementia, anxiety disorder and chronic obstructive pulmonary disease. A progress note, dated 9/1/2020, indicated the resident had eloped from the facility on 8/31/2020 at approximately 9:10 p.m. The resident was found at [name of apartment building]. A progress note, dated 11/1/2020, indicated		in-service. Expected dates for all staff to have completed this role-playing in-service is 12/21/2020. A service plan conference was held for resident who was missing their current service plan, POA attended the service plan conference. Moving forward all service plans will be reviewed and signed by POA, a copy will be given to POA, a copy will be placed in our Service Plan binder for all staff to review. The master service plan will be kept in a locked safe location to ensure that all service plans are up to date with POA signature. This system will remain on going with no stop date.	

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	"around 7:45 p.m.," the pager showed an alert of the 300 door exit being breached. The staff responded to the alarm and went outside and did not observe Resident B. Staff went inside to check the building while another staff was outside to check the premises. The police department called the facility to inform them the resident was located at the [name of apartment building]. During an interview, on 11/17/2020 at 5:30 p.m., the Branch Director indicated Resident B had never touched any of the other residents inappropriately although he did get in "their social bubble." Some of the residents were uncomfortable with this since he would often touch their shoulders. She indicated the resident did not have a behavior plan. There was no formal meeting and no documentation on the service plan of how to keep the resident from eloping after the first or second time he had eloped or how to manage his behaviors with other residents. She and the Resident Care Coordinator did talk to the resident's family about the elopements. A current policy, titled "Assessments," revised on 8/2020 and received from the Branch Director on 11/17/2020 at 6:10 p.m., indicated "...The assessment process shall be completed prior to accepting the potential resident to determine if they meet the criteria for assisted living residency...Once residents move in, assessments are reviewed within 30 days of move-in, every 180 days and as needed due to significant changes. This assessment shall include the determination of each resident's functional and cognitive abilities and health status...An Assessment/Service Plan shall be completed to identify the following...Services to be provided...Supplemental services...Any applicable Managed Risk Agreement[s]...When the Resident			

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	needs personal care or health-related care, the Service Plan shall be updated within 30 days of move in, in consultation with a multidisciplinary team. This team will review every 180 days, each time there is a change of condition and at least annually...." This State finding relates to Complaints IN00340642 and IN00340080.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to implement infection control policies related to COVID-19 and implement the use of appropriate personal protective equipment (PPE) to prevent transmission of infections. This deficient practice had the potential to spread infections, including COVID-19, to 26 of 26 residents who resided in the facility. Finding includes: During ongoing observations, on 11/17/2020 at 12:47 p.m., the facility staff were noted to have on cloth face masks and no eye protection or face shields.	R 0407	R 407 Infection Control Our surveyor shared we are to be wearing not only the blue surgical masks but also a face shield and or goggles or both. The day following our survey November 18, 2020 all staff were instructed and were required to wear only the blue surgical masks, these masks are always available to all staff to ensure	11/18/2020

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	a. Cook 2 was wearing a piece of fabric around her neck which was pulled up to cover her mouth and nose and did not have on goggles or a face shield. She was in the dining room assisting residents during lunch. b. Agency CNA (certified nursing assistant) 3 was wearing a black cloth face mask and did not have on goggles or a face shield. She was in the television room close to several residents. c. CNA 4 was wearing a cloth face mask which was over her mouth but not covering her nose. d. CNA 5 was wearing a cloth face mask and was sitting between two female residents while assisting one female resident to eat. She was not wearing goggles or a face shield. During an interview, on 11/17/2020 at 1:20 p.m., CNA 4 indicated she was aware the face mask should be covering her nose although this made it difficult for her to breathe. During an interview, on 11/17/2020 at 5:30 p.m., the Branch Director indicated there was not a facility policy to include the type of face masks staff should be wearing and there was no policy about wearing goggles or face shields. The staff who were wearing cloth face masks had a skin sensitivity to surgical masks although there were no physician notes on file to indicate they had a skin sensitivity. A current policy, titled "Universal Precautions," revised on 09/2016 and received from the Branch Director on 11/17/2020 at 1:30 p.m., indicated "... [name of facility] family members shall follow procedures to prevent the spread of infection in accordance with CDC Guidelines and OSHA Standards...shall be instructed in universal precautions for infection control at orientation and on an annual basis...."		ongoing compliance with the CDC recommendations. On December 7, 2020 face shields and googles were made available and required for all staff to wear at all times during their shift at Bickford. At no time is a staff member allowed to remove these items from their daily required PPE. Information and education was given to all staff during an all staff in-service held on Monday December 14, 2020.	

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	A document from the Indiana State Department of Health, titled "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," dated as last updated 10/19/20, indicated " ...Direct care providers should wear a surgical mask for the duration of their shift...To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident in all levels of care in all long-term care facilities and assisted living...."			