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	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 IN00351203. Complaint IN00351203 - Substantiated. State deficiencies related to the allegations are cited at R0052 and R0118. Survey date: May 12, 2021. Facility number: 004503 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 14, 2021.	R 0000	This plan of correction is submitted as required under the Indiana 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 as admission that the findings constitute a deficiency. Any and all charges are to be considered subsequent remedial measures to satisfy the surveyors findings and recommendation to improve the quality of life for all the 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 (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from neglect, related to a resident who required two staff members for transfers, was transferred by one Home Health Aide (HHA) in Training. The resident was lowered to the floor during the transfer, which resulted in a fractured right hip	R 0052	**Revision for R 52** **Plan of Correction:** **The insufficiencies will be corrected as follows:** · Facility Nurse Coordinator to perform a fall risk assessment on all residents to determine current	07/08/2021

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

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	and femur, for 1 of 3 residents reviewed neglect. (Resident B and HHA in Training 3) Finding includes: An Indiana Department of Health Reportable Incident, dated 4/8/21, indicated on 4/7/21, Resident B was transferred from the wheelchair by a HHA in training. The resident crossed her legs during the transfer, the HHA in Training 3 was unable to finish the transfer, and lowered the resident to the floor. The resident had facial signs of pain and an x-ray of the right hip was ordered by the Nurse Practitioner. Resident B's record was reviewed on 5/12/21 at 9:48 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A Service Assessment, dated 2/16/21, indicated she required assistance of two staff members for transfers. A Service Plan, dated 2/17/21, indicated two staff members were needed for transfers. A Nurse's Progress Note, dated 4/7/21 at 2:50 p.m., indicated during a transfer, the resident crossed her legs and the staff assisted the resident to the floor. The resident complained of pain to the right leg and hip area and had facial grimacing. The Nurse Practitioner was notified and an order for an x-ray of the right hip and femur was received. A Nurse's Progress Note, dated 4/7/21 at 8:45 p.m., indicated the x-ray results were obtained with a result of a fractured right femur and hip. An order was received to transfer the resident to the Hospital.		fall risk utilizing Fall risk Assessment tool by 6-23-21. · Facility Nurse Coordinator will evaluate every resident to determine current transfer needs by 6-11-21. · Facility Nurse Coordinator will observe care team to ensure they demonstrate proper transfer technique by 6-11-21. · Resident Service Summary will be updated with all resident's current transfer status by 6-23.21. All staff will receive in-service and education on 6.24.21 as where to locate the Resident Service Summary and how to read and understand the Resident Service Summary. · All personnel will receive in-service and education on 6.24.21 of each residents Service Plan and where to locate each resident's specific transfer needs which will be documented in their Service Summary. **The following measures will be taken to ensure the problem does not recur:** · Facility Nurse Coordinator will identify residents that are high fall risk by performing a fall risk assessment utilizing the Fall Risk Assessment tool by 6.23.21 and putting interventions in service plan accordingly. Fall risk assessments will be completed with every new move in, routine, and change of condition	

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	The x-ray reports, dated 4/7/21, indicated an acute right hip fracture and a fractured femur. During an interview, on 5/12/21 at 10:42 a.m., HHA 1 indicated the resident required two staff members for transfers. She crossed her legs and at times would become combative, both made it difficult for the resident to be transferred by one staff. During an interview, on 5/12/21 at 10:45 a.m., the Director of Nursing (DON) indicated the resident was a two staff member assistance for transfers. The Service Plan indicated two staff members were required to transfer her. The HHA in Training 3 should not have been working by herself and should not have attempted the transfer of the resident without another staff member present. During an interview, on 5/12/21 at 10:49 a.m., RN 2 indicated the resident required two staff members to assist with transfers. Her legs would cross which made the transfers difficult for one person. She could also become combative. During an interview, on 5/12/21 at 12:59 p.m., HHA 1 indicated the HHA in Training 3 had not requested her assistance with the transfer. This Residential tag relates to Complaint IN00351203.		assessment. · Facility Administrator and Nurse Coordinator will conduct staff meeting on 6-24-21 to provide transfer technique education for all caregivers. Education to include transfer demonstration and a written pretest and post-test. Along with location and understanding of facilities Resident Service Summary and each resident's individual service plan. · Return demonstration of safe transfer techniques to be conducted with all caregivers by Nurse Coordinator by 7-7-21 with skills check-off to be placed in employee file. **The program will monitor performance to ensure compliance as follows:** · Facility Nurse Coordinator or designee will perform observation of resident transfer 3 times a day starting 6-11-21 through 6-30-21, daily from 7-1-21 through 7-30-21, and random checks thereafter to ensure safe transfer technique is utilized. Randon will be at a minimum of weekly completed by Nurse Coordinator and or designee, a record of employee name and resident transferred will be documented on an in-service record, and maintained in the employees file and facilities	

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			· Divisional Director of Resident Services will audit resident incidents at least bi-weekly and as needed along with facility Nurse Coordinator and Administrator to ensure interventions are in place and communicated to staff. · Facility Nurse Coordinator will provide transfer assistance training for all new employees during onboarding prior to working independently. Training will include safe transfer technique demonstration by Nurse Coordinator, return demonstration, and documented routine in-service training to be placed in personnel HR record. Continued corrective action will be all caregivers will receive monthly training at minimum and will be supervised by licensed RN's and LPN's and will not work independently until they have successfully completed a return demonstration independently. **Date of compliance 7.8.2021**	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees			

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	in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure an Employee who provided more than limited assistance with activities of daily living (ADL's) was certified as a Nurse Aide (CNA) or a Home Health Aide (HHA), related to a HHA in Training providing care to a dependent resident without assistance of another staff member. The resident fell during during the care, which resulted in a fractured right hip and femur, for 1 of 3 residents reviewed for care and 1 of 1 HHA in Training reviewed for certification. (Resident B and HHA in Training 3) Finding includes: Resident B's record was reviewed on 5/12/21 at 9:48 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A Service Assessment, dated 2/16/21, indicated she required assistance of two staff members for transfers and was total care for ADL's. A Service Plan, dated 2/17/21, indicated two staff members were needed for transfers. A Nurse's Progress Note, dated 4/7/21 at 2:50 p.m., indicated the resident was lowered to the floor by a staff member and complained of right leg and hip pain after being lowered to the floor. The Nurse Practitioner was notified and an order for an x-ray of the right hip and femur was received. A Nurse's Progress Note, dated 4/7/21 at 8:45 p.m., indicated the x-ray results were obtained with a result of a fractured right femur and hip.	R 0118	**Revision for R118** **Plan of Correction:** **The insufficiencies will be corrected as follows:** · The home health employee in training was immediately removed from hands on care. She currently is enrolled in the next Certified Nurse Aide training program. Effective immediately an audit was conducted to make sure all employees will be certified prior to hire, and certification of all nursing personnel files were audited to ensure appropriate compliance. · Upon completion of their certification these two caregivers will be placed on our caregiving schedule. Expected date of completion and certification 8.2.2021 **The following measures will be taken to ensure the problem does not recur:** · Facility Director will complete all future new hire recruitment, scheduling, and supervision. Facility Director will facilitate all new hire training and ensure complete before employee performs resident care. · Facility Director will ensure all new hire and current caregiving personnel are certified as A Home Health Aide, Nurse Aide,	06/10/2021

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	An order was received to transfer the resident to the Hospital. During an interview, on 5/12/21 at 10:45 a.m., the Director of Nursing (DON) indicated the HHA in Training 3 should not have been working by herself and should not have attempted the transfer of the resident without another staff member present. During an interview, on 5/12/21 at 12:59 p.m., HHA 1 indicated the HHA in Training 3 had not requested her assistance with the transfer. During an interview, on 5/12/21 at 1:40 p.m., HHA in Training 3 indicated the resident lost her balance and started to fall sideways during the transfer, her and the resident's legs became intertwined, and they ended up on the floor. She was unaware she was to be working with another staff member as she had completed her training in February. She had not taken her certification to be a HHA. During an interview, on 5/12/21 at 1:57 p.m., the DON indicated the HHA in Training 3 had not finished the clinical training. She had not been checked off on all the required clinical curriculum. A Nurse from the Corporation had started the HHA Training and the Nurse was no longer employed with the Corporation. Orientation, job description, and information about not working without another employee should have been discussed in the HHA Training. The training had began on 1/29/21. The DON was unable to locate the classroom and clinical training for the HHA in Training 3. During an interview, on 5/12/21 at 2:03 p.m., the DON indicated she had been looking for the		Qualified Medication Aide, Licensed Nurse or Registered Nurse prior to performing resident care. · Facility Director will obtain all caregiving personnel's certification through the Indiana Professional Licensing Board prior to hire. **The program will monitor performance to ensure compliance as follows:** · Facility Director will perform all new hire and onboarding processes including confirmation of certification for all caregiving staff prior to placing them on the branch schedule. · Facility Director will ensure no caregiver is providing hands on care without proper certification. · Facility Director will maintain a current licensing book containing all caregiver's certifications and license for all caregiving staff, available for Divisional Director of Resident Services or Divisional Director of Operations to review. · Divisional Director of Operations will perform yearly audit of Employee files to ensure all required documentation present. · The system and monitoring process will remain ongoing with no end date.	

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	training information for over a week and was unable to locate the information on the classroom or the clinical training for HHA in Training 3. This Residential tag relates to Complaint IN00351203.		**Date deficiencies corrected by: 6.10.2021**	