PRINTED: 05/27/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>00</u>		00	COMPLETED			
			B. WI	B. WING			05/01/2025	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R			TELLA DRIVE			
BICKEOE		OD			IWOOD, IN 46143			
BICKFOR	RD OF GREENWO	ОВ		GREEN	1000D, IN 46143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I PREFIX (EACH CORRECTIVE A)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ACTION SHOULD BE		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0000								
Bldg. 00								
	This visit was for the	he Investigation of Complaint	R 0000					
	IN00458539.							
	This visit was in co	onjunction with a Post Survey						
	Revisit (PSR) to th	e State Residential Licensure						
	Survey completed	on March 11, 2025.						
	_	8539 - State deficiency related to						
	the allegations are	cited at R241.						
	Survey date: May	1, 2025						
	Facility number: 0	12938						
	5	40						
	Residential Census	:: 43						
	TILL CLAR DO LI	1 6 1 1 .						
	accordance with 41	tial finding is cited in						
	accordance with 41	10 IAC 16.2-3.						
	Ovality marriagy age	npleted May 6, 2025.						
	Quality leview con	inpleted May 0, 2023.						
R 0241	410 IAC 16.2-5-4	(e)(1)						
	Health Services -							
Bldg. 00	11001011 00111000	Chenes						
J			R 02	241	What corrective actions will be	<u>ڊ</u>	05/26/2025	
			1002	- 11	accomplished for those reside		03/20/2023	
	Based on interview	and record review the facility			found to have been affected by			
		at a resident received physician			deficient practice?	,		
		ions which resulted in resident			Resident B family has brou	uaht		
	-	zation for 1 of 2 residents			in prescription bottles for	3		
		cation administration. (Resident			medications to be administere	d by		
	B)				licensed nursing personnel or	-		
					qualified medication aids.			
	Finding includes:							
					How the facility will identify oth	ner		
		a.m., the clinical record of			residents having the potential	to		
	Resident B was rev	viewed. The diagnosis included,			be affected by the same defici	ent		
			1				1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
			B. WING			05/01/2025	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DIOKEOE		0.0	3021 STELLA DRIVE				
BICKFOR	RD OF GREENWO	OD		GREEN	IWOOD, IN 46143		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	PLAN OF CORRECTION (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	TAG DEFICIENCY)		DATE
	but was not limited to, major neurocognitive disorder.				practice and what corrective a	ction	
					will be taken		
	Physician orders, dated 4/30/25, include but were				All new residents will have	,	
					medication verification comple	ation completed	
	not limited to:	,			by the HWD or ED on day of	•	
				move-in.			
	- Donepezil 23 mg	(milligrams), one by mouth			HWD will conduct a med a	udit	
	daily, used to treat				of all AL residents to ensure		
		one tablet by mouth daily, used			medications are administered	as	
	to treat high blood	-			ordered by the physician with		
	- Desmopressin Spray 0.01%, 3 sprays in each				documentation noted in the e-	mar.	
	nostril every morning and evening (to treat central						
	1	a condition that causes the			What measures will be put into)	
	body to lose too mu			place or what systemic changes			
	- Warfarin 2.5 mg every Tuesday, Wednesday,			the facility will make to ensure			
	_	nd Sunday, to prevent blood		that the deficient practice does not			
	clots Warfarin 7.5 mg every Monday and Thursday, to prevent blood clots.				recur.		
					Executive Director/ Health and		
				Wellness Director/ Family			
	provent creat creats			Advocate will receive training on			
	The current census	tab in the Resident B's clinical			the move-in process and ensu		
record indicated Re		esident B was admitted to the			resident has everything neede	-	
		with family at his side with			move-in by the Divisional Dire		
	Residents B's medication in a pill organizer.		of Health and Wellness				
	A service plan, dated 4/22/25, indicated full						
					Education will be provided	d to	
assistance for medication administration management.					The Health and Wellness Dire		
					on the medication administration		
					policy by the Divisional Directo		
	A Progress Note, da	ated 5/1/25 at 9:40 a.m.,			Health and Wellness.		
		B was acting strange and was					
		normal. Resident B was sent			Training will be provided t	о .	
	to hospital for obse	rvation and admitted.			Nurses and QMA's on reportir		
	_				any medication not available	-	
	The clinical record lacked documentation related				immediately to HWD; training	will	
to Resident B not receiving medicat		eceiving medication.			be completed by the Health ar		
					Wellness Director.		
]		
During an interview on 5/1/25 at 11		v on 5/1/25 at 11:07 a.m., the ED			HWD will conduct weekly		
		ent B was admitted for a			med audit to ensure medication		
	I		I		1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2025				
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 3021 STELLA DRIVE GREENWOOD, IN 46143					
(X4) ID PREFIX TAG	short-term 2-mont filled pill organize medication. The fa medication bottles Facility staff informunable to administ original labeled comedication to Resifacility. The ED in contact the family about Resident B in ED indicated that Resident B did not prescribed medication to Resident B did not prescribed medication and 4/27/25. The staff observed a character B, so Resident B with department. Resident B with abnoton S/1/25 at 12:34 provided a policy Category: Medicated O4/25, and indicated being used by the indicated Bickford drugs are administrated Bickford drugs are administrated administered to the Resident's eMAR the drug"	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL AND LASC IDENTIFYING INFORMATION In stay. The family provided a re that contained Resident B's amily did not provide the actual for the pills in the pill organizer. In med the family that they were were medication that was not in its Intainer. The family administered ident B on 4/23/25 then left the Idicated that facility staff did not any further to express concern Into receiving medication. The It was a total of four days that It receive his physician Ition, on 4/24/25, 4/25/25, 4/26/25 ED indicated that on 4/27/25 Itange in condition for Resident It was sent to the emergency went B was admitted to the remail labs and dehydration. It p.m., the Executive Director titled Policy and Procedures ition and Nursing, dated revised and it was the current policy facility. A review of the policy I shall ensure that: "1) a) All were draw and the dose we Resident is recorded on the by the person who administers The family provided a rethat contains a provided a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) are administered per physicia orders and documented in the e-mar How the corrective actions will monitored to ensure the defici practice will not recur, what quassurance program will be puplace. Divisional Director of Heal Wellness will review next 3 move-ins to ensure medicatio are being administered and documented appropriately. Divisional Director of Heal Wellness will review med aud weekly for one month and at I monthly thereafter to ensure continued compliance. By what date the systemic changes will be completed by 5/26/25	n e de la			

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