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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF GREENWOOD	3021 STELLA DRIVE GREENWOOD, IN 46143

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00438988. Complaint IN00438988 - State deficiencies related to the allegations are cited at R0052 and R0090. Survey date: August 9, 2024 Facility number: 012938 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 13, 2024.	R 0000	!--[endif]--="">1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; !--[endif]--="">2. 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; !--[endif]--="">3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and !--[endif]--="">5. By what date the systemic changes will be completed.	
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 interview and record review, the facility failed to ensure cognitively-impaired residents who resided on the Memory Care Unit (MCU) were free from staff-to-resident abuse in the	R 0052	1. The employee was suspended and subsequently terminated. 2. Other residents were not affected, the staff member was	09/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Madison	Executive Director	08/31/2024

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	presence of other staff. The facility failed to ensure LPN 1, QMA 2, CNA 1, and CNA 2 immediately reported the allegations of abuse to the Administrator for 2 of 3 residents reviewed for abuse. (Resident C, Resident B) This deficient practice resulted in Resident B and Resident C being physically abused and intimidated by QMA 1. This deficient practice resulted in the facility not immediately implementing interventions to prevent further staff-to-resident abuse perpetrated by QMA 1 between 7/12/24 and 7/15/24 and had the potential to affect 13 of 13 residents who resided on the MCU. Findings include: 1. During an interview on 8/9/24 at 9:50 a.m., CNA 1 indicated about a month ago she witnessed QMA 1 yell "what are you going to do about it, what are you going to do" at Resident C and act like she wanted to fight him. On 8/9/24 at 9:30 a.m., the Administrator provided a facility investigation into an allegation abuse. A witness statement, dated 7/17/24, indicated LPN 1 witnessed QMA 1 tell Resident C it was time for bed. Resident C said no. QMA 1 told Resident C she wasn't going to play with him. When Resident C walked away, QMA 1 followed behind him and told Resident C she said it was time for bed she wasn't going to tell him again and then yanked a little toy of some sort out of Resident C's hand. Resident C put his finger in QMA 1's face and screamed at her to leave him alone. Then QMA 1 screamed in Resident C's face and told him "let's go now, get your ass to your room now." QMA 1 grabbed Resident C's right elbow and walked him to his room. QMA 1 said she doesn't baby residents because residents need discipline.		terminated 3. Executive Director and Health and Wellness Director will be re-educated on Bickford's policy of resident's rights as well as the Indiana Resident Bill of Rights, which includes the right to be free of abuse and neglect and how to report any suspected abuse to the Executive Director with all current staff. The Executive Director is responsible for ensuring all new staff are educated on Resident Rights upon hire. 4. The Divisional Director of Health and Wellness will observe care being performed by Bickford staff during routine visits every 90 days. The Divisional Director of Operations will audit in-service completion annually and with routine visits. 5. Changes will be completed by 9/20/24	

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	The clinical record for Resident C was reviewed on 8/9/24 at 10:30 a.m. The diagnoses included, but were not limited to, hypothyroidism, dementia, and edema. During an interview on 8/9/24 at 10:37 a.m., the Administrator indicated she was never made aware of the LPN 1's allegation of that QMA 1 yelled and grabbed Resident C. The staff could not remember a date nor shift when it occurred. The Administrator told LPN 1 that she should have notified the Administrator immediately in person or by phone. 2. During an interview on 8/9/24 at 9:50 a.m., CNA 1 indicated she was working on the secured memory care unit, on 7/12/24 at approximately 5:00 p.m., when she witnessed QMA 1 push Resident B from behind and yell at her. CNA 1 told QMA 1 to leave Resident B alone. QMA 1 told CNA 1 that CNA 1 was "babying" the residents. During an interview on 8/9/24 at 10:14 a.m., CNA 2 indicated, on 7/12/24 at approximately 5:00 p.m., QMA 1 was being rough with Resident B. QMA 1 grabbed Resident B's arm and forced her to sit down. Once Resident B was seated in the chair, QMA 1 dragged the chair backwards through the dining room so Resident B would have to eat by herself because Resident B was "being bad." CNA 1 told QMA 1 to stop. QMA 1 continued to work the rest of that shift because it was not reported right away. CNA 2 indicated she should have notified the Administrator immediately. The clinical record of Resident B was reviewed on 8/9/24 at 8:37 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and depression.			

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	A Mini Mental Status Examination, dated 7/29/24, indicated Resident B was severely cognitively impaired. On 8/9/24 at 9:30 a.m., the Administrator provided the facility investigation into the allegation abuse of Resident B. The investigation included, but was not limited to: A witness statement, dated 7/17/24, indicated on 7/12/24, CNA 1 saw QMA 1 grab Resident B and talked loudly at Resident B, so it sounded like QMA 1 was arguing with Resident B. A witness statement, dated 7/17/24, indicated approximately a week ago, QMA 2 witnessed QMA 1 assisting Resident B with a shower. QMA 1 was pouring water in Resident B's face with a 24-ounce cup. QMA 2 asked if she could assist with anything, but QMA 1 told her no. QMA 1 proceeded to pour another cup of water on Resident B's face as Resident B cried and tried to stand up. A witness statement, dated 7/17/24, indicated on 7/12/24, CNA 2 witnessed QMA 1 being abusive to Resident B. QMA 1 grabbed Resident B's arm, yelled sit down, and made Resident B sit down with force. Once Resident B was seated, QMA 1 dragged Resident B's chair through the dining room so Resident B would have to eat alone because she was "being bad." CNA 1 intervened and told QMA 1 to step back. QMA 1 told CNA 1 and CNA 2 that they babied the residents. A Disciplinary/Counseling Report, dated 7/29/24, indicated QMA 1 was terminated for resident abuse. During an interview on 8/9/24 at 10:37 a.m., the Administrator indicated CNA 2 wrote a note			

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	alleging QMA 1 abused a resident. CNA 2 stuck the note under the Administrator's office door after the Administrator had left work for the weekend on 7/12/24. On 7/15/24, the Administrator found the note and suspended QMA 1. QMA 1 worked the rest of her shift, on 7/12/24 and the entire shift on 7/14/24. On 8/9/24 at 9:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse and Neglect, dated 4/2015, and indicated this was the current policy used by the facility. A review of the policy indicated staff must not abuse the residents. Any staff who has reasonable cause to believe that a resident has been abused shall report the information immediately. This citation relates to Complaint IN00438988.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall			

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	be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to notify the State department of health when an allegation of resident abuse was made against staff for 1 of 3 residents reviewed for abuse. (Resident C) Finding included: During an interview on 8/9/24 at 9:50 a.m., CNA 1 indicated about a month ago she witnessed QMA 1 yell "what are you going to do about it, what are	R 0090	1. The employee was suspended and subsequently terminated. The executive director will meet with each staff member who did not report the resident rights violation timely to go over timely reporting. 2. All current staff will be in service to review timely reporting. 3. All new staff will be trained on how to report resident rights violations prior to working the floor	09/20/2024

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	you going to do" at Resident C and act like she wanted to fight him. On 8/9/24 at 9:30 a.m., the Administrator provided the facility investigation into an allegation of abuse. A witness statement, dated 7/17/24, indicated LPN 1 witnessed QMA 1 tell Resident C it was time for bed. Resident C said no. QMA 1 told Resident C she wasn't going to play with him. When Resident C walked away, QMA 1 followed behind him and told Resident C she said it was time for bed she wasn't going to tell him again and then yanked a little toy of some sort out of Resident C's hand. Resident C put his finger in QMA 1's face and screamed at her to leave him alone. Then, QMA 1 screamed in Resident C's face and told him "let's go now, get your a** to you room now." QMA 1 grabbed Resident C's right elbow and walked him to his room. During an interview on 8/9/24 at 10:37 a.m., the Administrator indicated she was never made aware of the allegation of QMA 1 yelling and grabbing Resident C until 7/17/24. The staff could not remember a date nor shift when it occurred. The Administrator told LPN 1 that she should have notified the Administrator immediately in person or by phone. On 8/9/24 at 9:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse and Neglect, dated 4/2015, and indicated this was the current policy used by the facility. A review of the policy indicated any staff who has reasonable cause to believe that a resident has been abused shall report the information immediately. This citation relates to Complaint IN00438988.		and current staff will receive refresher classes annually. The executive director's cell phone number will be posted on the communication board to ensure all staff can reach her immediately. 4. The Executive Director will annual audit for resident rights in-service and the Health and Wellness director will observe care to ensure compliance every 90 days. 5. Changes will be complete by 9/20/24	