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	03/11/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00450622 and IN00453793. Complaint IN00450622 - No deficiencies related to the allegations are cited. Complaint IN00453793 - No deficiencies related to the allegations are cited. Survey dates: March 10 and 11, 2025 Facility number: 012938 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 13, 2025.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on observation, interview, and record review, the facility failed to notify the physician of changes in condition for 1 of 3 residents reviewed. (Resident 20) Findings included: On 3/10/25 at 9:33 a.m., the clinical record of Resident 20 was reviewed. The diagnoses included, but were not limited to, type 2 diabetes and benign prostatic hyperplasia (enlargement of the prostate gland that can cause urinary retention).	R 0036	**R036 Residents' Rights – Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 20 was sent to the ER admitted with UTI and treated; returned 3/11/25. No other residents were affected by the deficient practice but could have. ¿ How the facility will identify other	04/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Langhans	Administrator	03/31/2025

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	During an observation on 3/10/25 at 9:33 a.m., Resident 20's urinary catheter was observed to be half full of dark amber colored urine. During an observation on 3/10/25 at 11:33 a.m., Resident 20's urinary catheter was observed to be three quarters of the way full of dark amber colored urine. A strong foul smell of urine was noted in the residents room. A service plan, dated 10/3/24, indicted the following: - Medication Management - Full assistance with medication administration management, coordinate injections and glucometer checks (finger stick blood draw to determine blood glucose), observation and re-assessment - Coordination with outside agencies - Ongoing assistance with coordination with outside healthcare and home care providers. - Toileting - Facility staff to monitor for signs/symptoms of infection from back up of urinary catheter, dark colored urine and urine with a strong odor. Any of these should be reported to the licensed nurse so that that the MD can be notified. Physician orders, dated February 2025 with a start date of 9/27/2024 with no end date, indicated if blood glucose was greater than 400 mg/dL (milligrams per deciliter) notify the physician. A document titled "Administration History" for Resident 20, indicated on 2/27/25 Resident 20's blood glucose result was 489 mg/dL.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken¿ The HWD will review progress notes for any change of condition daily and report to the physician. ¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ Divisional Director of Health and Wellness will re-educate the Bickford staff on reporting changes in condition including but not limited to changes in urine or blood sugars outside parameters as indicated by the physician. The Health and Wellness Director is responsible for reporting change in condition to resident physicians. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ Divisional Director of Health and Wellness will review blood glucose checks and monitor EHR documentation weekly for a month and annually thereafter to ensure compliance	

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	The clinical record lacked documentation of physician notification of blood glucose result of 489 on 2/27/25. During an observation on 3/11/25 at 8:50 a.m., Resident 20's catheter was observed to be half full of dark amber colored urine. During an interview on 3/11/25 at 11:07 a.m., the Director of Nursing (DON) indicated the physician had not been notified of Resident 20's dark amber colored, foul smelling urine. The DON indicated the facility was unable to provide documentation of physician notification regarding the hyperglycemic (high blood sugar level) episode that occurred on 2/27/25. On 3/11/25 at 12:08 p.m., the Executive Director provided a policy titled Service Planning, dated May 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated "Policy: A service plan shall be developed and maintained for each resident that corresponds with their individual needs...4. Facility shall provide services according to the information contained in the service plan." On 3/11/25 at 12:08 p.m., the Executive Director provided a policy titled Diabetes Management, dated December 2021, and indicated it was the current policy being used by the facility. A review of the policy, indicated physician orders for blood glucose testing would include parameters which would provide instructions to licensed and/or certified caregivers on interventions required based on blood glucose results.			
R 0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 1 residents reviewed for elopement. A cognitively impaired resident exited the facility without staff knowledge. (Resident 26) Findings include: On 3/10/25 at 10:00 a.m., Executive Director provided a reportable incident from 2/25/25 between 6:25 p.m. and 6:35 p.m.. The reportable incident and accompanying documentation indicated the following: - Resident 26 had independently exited the facility through the 200 hall exit door which triggered the door alarm at 6:25 p.m. - The resident appeared to have used the sidewalk to walk from the 200 hall exit door area to the north side of the facility and then proceeded to walk to the front entrance door. - Once Resident 26 reached the front entrance, another resident's family member was exiting the facility. The family member assisted Resident 26 to gain entry into the facility at 6:35 p.m. - The 200 hall exit door alarm was triggered and the alarm sounded. However, the two staff members working at that time, CNA 4 and CNA 5, did not have their facility pagers on their person at the time of the elopement. Neither staff member heard the 200 hall exit door alarm sound. - Staff were unaware that Resident 26's wanderguard was not functioning properly at the	R 0052	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 26 still resides at Bickford of Greenwood; no further incidents have occurred Resident 26 Service Plan has been updated 2/26/25 with intervention to assist in preventing elopement. ¿ 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¿? ¿¿ Service plans of residents with exit seeking behaviors will be reviewed to ensure individualized interventions are in place. Completed by 4/30/25 Service plans will be developed and implemented that include interventions for residents with exit seeking behaviors. Completed by 4/30/25 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ Executive Director/Health & Wellness Director to receive additional training by the Divisional Director of Health and Wellness on the expectation that Service	04/30/2025

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	time of the elopement. Nurses notes, dated 2/27/25 at 9:01 a.m., indicated Resident 26 " ...went out an exit door and walked around the building to the front door. A family member helped him to get in the front door. Wander guard was not working and was replaced ..." On 3/10/25 at 11:10 a.m., Resident 26 was observed walking with a walker. On 3/10/25 at 11:15 a.m., Resident 26 was observed sitting in the recliner in his room. During an interview at that time, Resident 26 indicated that his spouse visited daily and he wanted to return home with her. On 3/10/25 at 11:30 a.m., Resident 26's clinical record was reviewed. The diagnosis included, but was not limited to, Alzheimer's disease. The Resident Assessment, dated 2/28/25, indicated Resident 26 was mildly cognitively impaired. On 3/10/25 at 12:40 p.m., Resident 26 was observed sitting in the dining room with his spouse by his side. During an interview at that time, Resident 26's spouse indicated she visited daily. Often as the spouse gets ready to leave the facility, Resident 26 followed her to the front door and must be redirected by staff so that he does not try to leave the building. On 3/11/25 at 11:00 a.m., during a facility tour with the Executive Director (ED) and Director of Nursing (DON), the 200 hall exit door area was observed. The 200 hall exit door was approximately 90 yards from the front entrance		plans are developed and implemented to include individualized interventions to address exit seeking behaviors. Re-training will also cover Abuse and Neglect Policy Executive Director and Director of Health & Wellness will be responsible for ensuring individualized service plan are developed and address the care needs of residents, including exit seeking behaviors. Health & Wellness Director will conduct an in-service on interventions and supervision as identified on service plan for residents exhibiting exit seeking behaviors and abuse and neglect policy for all caregivers. Residents with exit seeking behaviors will be discussed with Divisional Team during weekly care calls to ensure proper assessment and intervention development. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ Divisional Director of Health and Wellness will review service plans monthly for three months and then annually ensure residents identified with exit seeking behaviors have appropriate interventions implemented in service plan.	

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	area. The area outside of the 200 hall included a concrete side walk that followed the perimeter to the north side of the facility and around to the front entrance of the building. Just to the north of the sidewalk area was a side street and to the east (front side) of the building was a highly traveled four lane highway. During an interview at that time, the ED indicated all facility exit doors were to audibly alarm when opened unless the key code was first entered on the keypad. There were no exterior lights outside of the 200 hall exit door nor were there lights on the north side of the building. During an interview on 3/11/25 at 11:15 a.m., the DON indicated Resident 26's spouse visited daily. Often upon her departure from the facility, the resident followed her to the front entrance and would attempt to leave the facility with her which required staff to redirect the resident to prevent him from exiting the facility. The DON was unable to identify the start date of the wanderguard for Resident 26. The wanderguard was to be monitored during each shift to ensure it was in proper working order. The Medication/Treatment Administration Record lacked any record of the wanderguard or monitoring activities as having been implemented. Staff were unaware that Resident 26's wanderguard was not in working order at the time of the Resident 26's elopement on 2/25/25. During an interview on 3/11/25 at 11:40 a.m., the ED indicated CNA 4 and CNA 5 were working on 2/25/25 at the time of Resident 26's elopement. The staff members failed to have their facility pagers on their person which caused them to not know the 200 hall exit door alarm had sounded and that Resident 26 had exited the facility without supervision.			

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	During an interview on 3/11/25 at 11:45 a.m., CNA 3 indicated staff were to keep their facility pager on their person. The pagers were triggered when an exit door was opened without having first entered the key code on the keypad. The pager also alerted the staff to immediately check the door and monitor for any potential elopements. On 3/11/25 at 11:25 a.m., the DON provided a copy of the Resident Monitoring System Use and Maintenance policy, dated March 2020, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...Resident monitoring system will be inspected and maintained to ensure appropriate functioning at all times ..."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was First Aid certified for 1 of 21 shifts reviewed for First Aid certification coverage. (CNA 2) Finding includes: On 3/11/25 at 9:00 a.m., the Administrator provided a copy of the "as worked" staff schedule from 3/9/25 through 3/15/25. A review of the document indicated the following: - The work schedule identified one - eight-hour shift per day. The "third shift" hours were from 11:00 p.m. to 7:00 a.m. - The daily schedule identified each staff member who worked that particular shift and who was designated as the certified First Aid (training	R 0117	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice, but the potential for 40 residents could have been affected by the deficient practice. 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 Executive Director will complete an audit of all employee files to ensure compliance. Completed by 4/30/25.	04/30/2025

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	course that provides individuals with the knowledge and skills to respond to a medical emergency until more qualified help arrives) staff member for that shift. - CNA 2 was identified as having worked the third shift on 3/9/25 and was identified as the certified First Aid staff member for that particular shift. - No other certified First Aid certified staff members were identified as having worked during the third shift on 3/9/25. During an interview on 3/11/25 at 11:40 a.m., the Administrator indicated she was unable to provide verification that CNA 2 was First Aid certified. No other staff working the third shift on 3/9/25 were First Aid certified. During an interview on 3/11/25 at 12:07 p.m., the Executive Director provided a copy of Policies and Procedures, Certification and Licensure (IN) dated 1/2024, and indicated that this is the policy being followed by the facility, the policy indicated, "... 8) It is required that each Bickford family member is CPR and First Aid certified. Those not certified are required to meet this job requirement within 30 days of hire ..."		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on policy PP-30800 First Aid and CPR. The Executive Director is responsible for ensuring policy PP-30800 First Aid and CPR is followed. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place Divisional Director Operations will audit 6 new employee files and annually to ensure compliance	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure that annual health statements were documented for 7 of 7 residents reviewed. (Resident 3, Resident 18, Resident 20, Resident 26, Resident 43, Resident 44, Resident 45) Findings include:	R 0409	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ No residents were affected, however the potential for 40 residents could have been affected by the deficient practice.	04/30/2025

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	1. On 3/11/25 at 9:30 a.m., the clinical record for Resident 3 was reviewed. The diagnoses included, but were not limited to, dementia, diabetes, and hypertension (high blood pressure). Resident 3's clinical record lacked documentation of an annual health statement. 2. On 3/11/25 at 9:40 a.m., the clinical record for Resident 18 was reviewed. The diagnosis included, but was not limited to, depression. Resident 18's clinical record lacked documentation of an annual health statement. 3. On 3/11/25 at 9:50 a.m., the clinical record for Resident 20 was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and diabetes. Resident 20's clinical record lacked documentation of an annual health statement. 4. On 3/11/25 at 10:00 a.m., the clinical record for Resident 26 was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, history of colon cancer, and hypertension. Resident 26's clinical record lacked documentation of an annual health statement. 5. On 3/11/25 at 10:10 a.m., the clinical record for Resident 43 was reviewed. The diagnoses included, but were not limited to, dementia and kidney disease. Resident 43's clinical record lacked documentation of an annual health statement. 6. On 3/11/25 at 10:20 a.m., the clinical record for Resident 44 was reviewed. The diagnoses included, but were not limited to, dementia, kidney disease, and hypertension. Resident 44's clinical record lacked documentation of an annual health statement.		¿ ¿ 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¿ An audit of resident charts was completed on 4/10/25 to ensure compliance.¿¿¿ ¿¿ What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.¿ ¿ Divisional Director of Health & Wellness will provide reeducation to the Executive Director and Director of Health & Wellness on requirement for annual health statement that indicates resident is free of contagious disease.¿ Completed by 4/30/25. The Executive Director and Director of Health and Wellness will be responsible for ensuring residents have an annual health statement indicating they are free of contagious disease. ¿ How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.¿ Divisional Director of Health & Wellness will audit next 3 new admissions and annually	

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	7. On 3/11/25 at 10:30 a.m., the clinical record for Resident 45 was reviewed. The diagnoses included, but were not limited to, heart disease and hypertension. Resident 45's clinical record lacked documentation of an annual health statement. During an interview on 3/11/25 at 12:50 p.m., the DON (Director of Nursing) stated that the facility lacked a specific policy for annual health statements and the facility followed the state regulations.		thereafter to ensure compliance. ¿	