STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #4) reviewed for wandering, the facility failed to ensure the assessment accurately reflected the resident's status for behaviors and wander/elopement alarm at the time of the assessment. The findings include:Resident #4's diagnoses included vascular dementia with behavior disturbances, and depression. Elopement risk evaluation dated 11/11/2025 identified Resident #4 ambulated independently, was cognitively impaired with poor decision-making skills, and displayed behaviors that may indicate an attempt to leave the facility.^^ Resident Care Plan dated 11/11/2025 identified Resident #4 was at risk for wandering/elopement and had been observed near doors to the outside. Interventions directed staff to ensure a wander guard to the ankle, and to check placement and functioning every shift. Physician order dated 1/1/2026 directed a wander guard device to Resident #4's ankle, and to check placement and function every shift. The annual Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of six out of fifteen (6/15), indicating severe cognitive impairment. Resident #4 had no pacing or wandering behaviors and ambulated independently with supervision with a walker. Section E: Behavior was coded it indicate Resident #4 had delusions, and had no wandering behaviors. Section P: Restraints and Alarms was coded to identify no wander/elopement alarm was used. Interview with the DON on 3/3/2026 at 2:15 PM identified Resident #4's baseline behavior was to always wander up and down the hallways in the facility. The DON stated the MDS nurse will utilize, but was not limited to a resident's assessments, care plans, and progress notes, to ensure the resident's MDS was coded/completed accurately. The DON stated the MDS should accurately reflect a resident's care for all sections, including behaviors/wandering and wander/elopement alarm use. The DON stated Resident #4's MDS dated [DATE] did not accurately reflect Resident #1's behaviors. Although requested, the facility did not provide a policy regarding the accuracy of MDS assessments for surveyor review. Review of the Documentation Policy dated 11/2025 identified the facility will ensure nursing documentation is accurate, timely, complete, and reflective of the care provided.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies, and staff interviews, for two of five residents (Resident #1 and #2), reviewed for wandering behaviors, the facility failed to ensure elopement risk assessments were completed timely and a physician order for wander guard use was obtained timely for Resident #1, failed to replace Resident #2's wander guard device timely, and failed to ensure implementation of every 15-minute safety checks for Resident #2 after the resident's wander guard device malfunctioned and was not replaced on 2/27/2026. The findings include: Resident #1's diagnoses included dementia with behavior disturbances and depression. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) and was unable to complete the interview, indicating severe cognitive impairment. The MDS assessment indicated Resident #1 had no pacing or wandering behaviors and ambulated independently with supervision with a wheelchair. Section E: Behaviors, was coded to identify Resident #1 had delusions. Section E0600 identified Resident #1 did not intrude on the privacy or activity of others. Section E0900 identified Resident #1 had no wandering behaviors. Section P: Restraints and Alarms was coded to identify no wander/elopement alarm was used. The Resident Care Plan (RCP) dated 12/16/2025 identified Resident #1 roams into other resident's rooms. Interventions directed staff to ensure resident does not roam into rooms. ^^ Clinical record review identified Resident #1 had a wander guard in use during 2024 per nursing notes. Additional review failed to identify the date the wander guard (wander/elopement alarm) was initiated and the date it was discontinued, and failed to identify a physician order was in place that directed wander guard use. Record review failed to identify any elopement risk assessments were completed from the time of admission (during 9/2024) through 2/18/2026. Elopement risk evaluation dated 2/19/2026 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, had a history of wandering into unsafe areas, and displayed behaviors that may indicate an attempt to leave (the facility).^^ Interview and review of clinical documentation with the DON on 3/3/2026 at 2:15 PM identified elopement risk evaluations should be completed on admission, quarterly, and upon any readmission to the facility. The DON stated elopement risk evaluations should have been performed quarterly for Resident #1, stated they were not done, and was unable to explain why they were not completed timely. Further, the DON stated if a wander guard is in use, there should be physician orders that direct the use and it should be signed on the Medication Administration Record to reflect the device was in use, signed every shift that it was in place, and every day that it was functioning. Review of the Wandering Risk Assessment Policy dated 11/2025 directed in part, a wandering risk assessment will be utilized and completed on all residents to determine their risk level. Assessments will be done upon admission and quarterly. Although requested, a facility policy regarding physician orders for wander guard placement checks every shift was not provided for surveyor review. 2. Resident #2's diagnoses included dementia, transient ischemic attacks, and syncope. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating severe cognitive impairment, had no wandering behaviors, transferred with moderate assistance, used a wheelchair for mobility, had no impaired range of motion of the lower extremities, did not walk, and had a wander/elopement alarm daily. Elopement risk evaluation dated 12/30/2025 identified Resident #2 ambulated independently, was cognitively impaired with poor decision-making skills, and displayed behaviors that may indicate an attempt to leave.^^ Resident Care Plan dated 1/22/2026 identified Resident #2 was at risk for elopement. Interventions directed to check wander guard function and placement every shift and daily. Nursing note dated 2/27/2026 at 9:01 PM by LPN #3, identified the wander guard was in place but was not functioning and the supervisor was notified. Initiated every 15-minute checks in place. Nursing note dated 3/1/2026 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:27 AM by RN #4, identified wander guard #3349 replaced to the right ankle (two days after the wander guard was identified not functioning). Wander guard was checked and confirmed to be functioning. Interview with the Director of Nursing (DON) on 3/3/2026 at 2:15 PM identified that on 2/27/2026, Resident #2's wander guard device malfunctioned and the facility had no additional wander guard devices available to replace the device. The DON stated there may have been extra devices located in the former DON's office however, she did not have access to that office to verify if there were or were not any devices; the staff on the unit did not have access to any device to replace the wander guard. The DON stated, per facility policy, a malfunctioning wander guard device is to be replaced immediately to ensure continuous elopement protection and the staff should have had access to a replacement device. The DON stated Resident #2 was placed on every 15-minute safety checks until a replacement device could be obtained, and it was replaced on 3/1/2026 (two days after the device malfunctioned). Although requested, the DON was unable to provide documentation that the every 15-minute checks were performed on 2/27, 2/28 and 3/1/2026 until the new wander guard was applied. Interview and record review with the DON on 3/3/2026 at 2:15 PM identified the facility should have documented the every 15-minute checks and was unable to explain why there was no documentation. Review of the Wander-Guard Security System Policy dated 11/2025 directed in part, a wander guard security device will be placed on any resident that the care team decides is at risk for wandering away from the facility. The Policy further directed non-functional devices are to be replaced and the 11 PM to 7 AM nurse to check function daily. Although requested, a facility policy regarding physician orders for wander guard placement checks every shift was not provided for surveyor review. Wander-Guard Security System Policy dated 11/25 directed in part, non-functional devices are to be replaced. The Policy further directed the 11 PM to 7 AM nurse to check function daily. The facility Documentation Policy dated 11/25 directed in part, the facility will ensure nursing documentation is accurate, timely, complete, and reflective of the care provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews for facility egress review, the facility failed to ensure staff knew how to silence door alarms, failed to responded to door alarms timely, and failed to ensure exit doors were secured to prevent unauthorized exit. The findings include:Observation and interview on 3/3/2026 at 8:11 AM with RN #2 identified the facility staff were doing every 15-minute rounds on thirteen (13) facility egress doors on a rotating basis. Review of the schedule identified the rounds started with labeled on a map as Door #12, and then on the rotating basis it would take three (3) hours and fifteen (15) minutes to next check Door #12 again. Observation of Door #8 (near the hairdresser) identified the alarm sounded and RN #2 did not know how to silence the alarm. Continuous observation identified multiple staff walked by the alarming door. RN #2 asked NA #1 how to silence the alarm - NA #1 stated she does nothing with doors. RN #2 asked Housekeeper #1 what to do and Housekeeper #1 had no information. RN #2 then asked the Housekeeping Director, and the Housekeeping Director stated that the alarm was actually the alarm ringing for Door #10 (back door to the back parking lot). RN #2 asked Housekeeper #2 what to do, and Housekeeper #2 stated to enter the code in the keypad next to the door, and when that did not silence the alarm Housekeeper #2 stated he thought it was the back door by the kitchen (Door #10). The Housekeeping Director then again stated it was Door #10 alarming, and observation of Door #10 (back door to the back parking lot) with the Housekeeping Director identified Door #10 was not alarming. At 8:31 AM the door was still sounding an alarm, and RN 2 asked the Housekeeping Director who she should call. At 8:32 AM the Director of Nursing (DON) arrived and took the keys from RN #2 and went to the back door (Door #10) to silence the alarm. The DON was joined by [NAME] #1 who also stated the alarm was caused by the back door. [NAME] #1 took the keys and attempted to silence the back door (Door #10) alarm and stated the door was not alarming. The DON then stated, maybe it's not this door and [NAME] #1 and the DON walked back to Door #8 near the hairdresser and using the key, [NAME] #1 silenced the alarm at 8:37 AM. Observation and interview with RN #2 and the DON of the back door to the back parking lot, Door #10 on 3/3/2026 at 8:37 AM identified the door was secure and alarmed when the door was opened. The DON entered a code in the keypad next to the door to attempt to silence the alarm; the alarm continued to sound. Continuous observations identified the alarm continue to alarm without staff response. Staff were observed in the kitchen adjacent to the door hallway and did not respond to the alarm. At 8:44 AM, the Director of Maintenance arrived and silenced the alarm. interview with the Food Service Director and [NAME] #1 identified they did not respond to the alarming back door (Door #10) because they thought it was not the back door alarming. Interview identified staff should always respond to an alarming door to identify which door alarmed and if a resident had exited through the door. Observation and interview with the DON, Administrator and Food Service Director on 3/3/2026 at 11:31 AM identified the door near the nursing station leading to the basement and outside the side of the building, Door #12, had a keypad on the wall next to the door. The keypad light was red, and turned green after the code was entered and allowed opening of the door without any alarm sounding. After going through the door and closing the door, the light remained green and there was no way to re-arm the door from the top of the stairwell that led to the basement and to outside (without going down the stairs). On the stairwell side of the door, there was a button to push to unlock the door for entering the unit, but the button did not re-lock/re-arm the door. Re-entry from the stairwell into the unit side of the door identified the light was still green. The DON then re-entered the code in the keypad to relock/re-arm the door and the light turned red. When the light was red, the DON was able to open the door without difficulty and no alarm sounded. Subsequent to surveyor inquiry, the facility placed an employee on the door for constant observation until a new alarm was applied to the door. No facility policy was provided for surveyor review regarding securing egress doors.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on facility documentation, facility policies and interviews, the facility failed to ensure the provision and oversight of a Medical Director in accordance with federal requirements. The findings include: Interview and review of facility documentation with the Administrator and Director of Nursing (DON) on 3/3/2026 at 9:10 AM identified the facility had no current physicians that came to the facility. The DON stated the facility had one (1) physician, the Medical Director, the Medical Director was currently not available to come to the facility and was available only by phone. The DON stated that during 2025 there were two (2) physicians, but the second physician retired at an unidentified date last year, and was not replaced. All residents in the facility were patients of either the Medical Director who was not available to come to the facility, or Optum (a service with APRN coverage). The DON stated weekly Medical Director rounds on done every Thursday, and no physician did Medical Director rounds last week on 2/26/2026 and no one was scheduled for 3/5/2026; the last rounds were conducted on 2/19/2026 (12 days ago). Interview with the Administrator on 3/3/2026 at 9:40 AM identified the facility had no Medical Director available to come into the facility for weekly rounds. The Administrator stated after the second physician retired during 2025 on an unknown date, she called two (2) physicians to inquire about coverage and then she was waiting for the Medical Director to find a second physician to come to the facility. The Administrator stated she did not advertise or use a staffing agency to locate a second physician because she was relying on the Medical Director to do the search. Interview identified the facility failed to demonstrate that the designated Medical Director (MD #1) provided routine, ongoing oversight within the facility, including a presence in the building at least weekly. Facility record review failed to identify a current, executed contract outlining the responsibilities, availability, and coverage expectations of the Medical Director. Additionally, the facility was unable to provide documentation of a contingency agreement or alternate coverage plan to ensure Medical Director services were maintained in the event the appointed Medical Director was unavailable or failed to provide required services. Although requested, the facility was unable to provide a policy outlining the roles and responsibilities of the Medical Director, including expectations for facility involvement and oversight.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for five of five residents (Resident #1, #2, #3, #4, and #5), the facility failed to ensure a complete and accurate record to include wander guard devices for function and placement. The findings include:Resident #1's diagnoses included dementia with behavior disturbances and depression. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) and was unable to complete the interview, indicating severe cognitive impairment. The MDS assessment indicated Resident #1 had no pacing or wandering behaviors and ambulated independently with supervision with a wheelchair. Section E: Behaviors, was coded to identify Resident #1 had delusions. Section E0600 identified Resident #1 did not intrude on the privacy or activity of others. Section E0900 identified Resident #1 had no wandering behaviors. Section P: Restraints and Alarms was coded to identify no wander/elopement alarm was used. The Resident Care Plan (RCP) dated 12/16/2025 identified Resident #1 roams into other resident's rooms. Interventions directed staff to ensure resident does not roam into rooms. ^ Elopement risk evaluation dated 2/19/2026 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, had a history of wandering into unsafe areas, and displayed behaviors that may indicate an attempt to leave (the facility).^^ Physician order dated 2/17/2026 directed staff to check the placement and function of the wander guard every shift. Review of the MAR/TAR (Medication and Treatment Administration Record) for the month of February 2026 failed to document (the box to document was blank) that Resident #5's wander guard was checked for placement on 2/23/2026 (evening and night shift). 2. Resident #2's diagnoses included dementia, transient ischemic attacks, and syncope. The quarterly MDS assessment dated [DATE] identified Resident #2 had a BIMS score of six (6), indicating severe cognitive impairment, had no wandering behaviors, transferred with moderate assistance, used a wheelchair for mobility, had no impaired range of motion of the lower extremities, did not walk, and had a wander/elopement alarm daily. Elopement risk evaluation dated 12/30/2025 identified Resident #2 ambulated independently, was cognitively impaired with poor decision-making skills, and displayed behaviors that may indicate an attempt to leave.^^ The RCP dated 1/22/2026 identified Resident #2 was at risk for elopement. Interventions directed to check wander guard function and placement every shift and daily. Physician order dated 2/11/2026 directed staff to check the placement and function of the wander guard every shift. Review of the MAR/TAR from 2/13 through 2/28/2026 identified the staff failed to document Resident #5's wander guard was checked for placement (the box to document was blank) on 2/13 (day and evening shift), 2/14 (evening shift), 2/15 (evening shift), 2/23 (day and night shift), 2/24 (evening shift), and 2/26/2026 (night shift). 3. Resident #3's diagnoses included dementia with behavioral disturbances. The significant change in condition MDS assessment dated [DATE] identified Resident #3 had a BIMS score of eight out of fifteen (8/15), indicating severe cognitive impairment, had no wandering behaviors in the prior seven (7) days, ambulated independently, and had a wander/elopement alarm used daily. The RCP dated 1/20/2026 identified Resident #3 wanders (moves with no rational purpose, seemingly oblivious to needs or safety). Interventions directed use of a device that alarms when wanders and to check for proper functioning of device every 11 PM to 7 AM shift. Elopement risk evaluation dated 1/8/2026 identified Resident #3 ambulated independently, was cognitively impaired with poor decision-making skills, and displayed behaviors that may indicate an attempt to leave.^^ Physician order dated 1/22/2026 directed staff to check the placement of the wanderguard every shift. Review of the MAR/TAR for the month of February 2026 identified the staff failed to document Resident #3's wander guard was checked for placement (the box to document was blank) on 2/9 (day shift) and 2/22/2026 (day shift) . 4. Resident #4's diagnoses included vascular (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia with behavior disturbances, Alzheimer's disease, and depression. Elopement risk evaluation dated 11/11/2025 identified Resident #4 ambulated independently, was cognitively impaired with poor decision-making skills, and displayed behaviors that may indicate an attempt to leave (the facility).^^ The annual MDS assessment dated [DATE] identified Resident #4 had a BIMS score of six out of fifteen (6/15), indicating severe cognitive impairment, had no pacing or wandering behaviors, ambulated independently with supervision with a walker and had no wander/elopement alarm. The RCP dated 2/5/2026 identified Resident #4 had been observed near doors to the outside and was at risk for wandering/elopement. Interventions directed staff to ensure a wander guard to the ankle, and to check placement and functioning every shift. Physician order dated 2/9/2026 directed staff to check the placement of the wander guard every shift. Review of the MAR/TAR for the month of February 2026 identified the staff failed to document Resident #4's wander guard was checked for placement and function (the box to document was blank) on 2/2 (night shift), 2/9 (day shift), and 2/23/2026 (day and evening shift). 5. Resident #5's diagnoses included Alzheimer's disease and depression. The quarterly MDS assessment dated [DATE] identified Resident #5 had a BIMS score of ninety-nine (99) indicating Resident #5 was unable to complete the interview and had severe cognitive impairment for daily decision making, had wandering behaviors daily, ambulated independently with supervision, and had no wander/elopement alarm. The RCP dated 12/23/2025 identified Resident #5 wandered through out the hallway and into other rooms. Interventions directed to check wander guard every shift and as needed and redirect if found wandering in resident's rooms. Elopement risk evaluation dated 12/23/2025 identified Resident #5 ambulated independently, was cognitively impaired with poor decision-making skills and had a history of wandering into unsafe areas. Physician order dated 1/20/2026 directed staff to check the placement of the wander guard every shift. Review of the MAR/TAR from 2/13/2026 through 2/28/2026 identified the staff failed to document Resident #5's wander guard was checked for placement (the box to document was blank) on 2/13/2026 (day shift) and on 2/23/2026 (evening shift). Interview and review of clinical documentation with the DON on 3/3/2026 at 2:15 PM identified it was her expectation that nursing staff document all areas of provided care, and the staff should have documented on the MAR/TAR that the wander guard placement and function was checked. The DNS stated the documentation was missing, as listed above, for Residents #1, #2, #3, #4, and #5 and was unable to explain why it was not done. Review of a Documentation Policy dated 11/25 identified the facility will ensure nursing documentation is accurate, timely, complete, and reflective of the care provided to promote patient safety. All nursing staff are required to document patient care timely, and required documentation included treatments.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility documentation review, and interviews for facility review of QAPI, the facility failed to ensure quarterly Medical Staff meetings were held. The findings include:Interview and facility documentation review with the Administrator on 3/3/2026 at 9:40 AM identified the facility currently had a Medical Director that was unavailable to come into the facility since 2/19/2026. The Administrator stated the facility had one (1) additional physician that had retired at an unknown time in 2025 and had not been replaced. Interview and facility documentation review with the Administrator on 3/3/2026 at 2:37 PM identified she was unable to produce Medical Staff/QAPI meeting minutes and agendas for the prior 12 months. The Administrator stated the last Medical Staff/QAPI meeting was in September or October 2025, however she was unable to provide documentation that the meeting occurred. Further, the Administrator stated she had planned to have a Medical Staff/QAPI meeting last Thursday (2/26/2026), however they did not have a quorum to be able to meet. Although requested, no facility policy was provided for surveyor review.