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	03/09/2026

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 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 review, facility policy review, and interviews for two of two residents (Resident #1 and Resident #2) reviewed for abuse, the facility failed to ensure the clinical record was complete and accurate to include the name of the individual documenting in the electronic medical record, in accordance with facility policy. The findings include: Resident #1's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment and required assistance with ADLs. The Resident Care Plan (RCP) dated 1/6/2026 identified an alteration in self-care. Interventions directed to assist with ADLs. Nursing note dated 3/5/2026 at 6:53 AM identified Resident #1 received schedule pain medications. The note was signed 2LPN pool2 LPN (sic). Nursing note dated 3/6/2026 at 11:13 PM identified Resident #1 tolerated medications/fluids well. The note was signed 2LPN pool2 LPN (sic). Nursing note dated 3/7/2026 at 1:48 AM identified Resident #1 accepted medications, had no pain and was sleeping in naps. The note was signed poolnurse (sic) supervisor RN. Resident #2's diagnoses included bipolar, psychotic disorder and anxiety. The admission (MDS assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no/moderate/severe cognitive impairment, had delusions and rejected care four (4) to six (6) out of the prior seven (7) days. The Resident Care Plan (RCP) dated 12/3/2025 identified a care plan for accusatory behaviors. Interventions directed two (2) staff for all care. Facility reportable event dated 3/8/2026 at 1 to 1:30 PM, identified Resident #2 alleged verbal abuse by the 11 PM to 7 AM staff. Nursing note dated 3/8/2026 at 1:33 AM identified the assigned Nurse's Aide (NA) and the nursing supervisor offered Resident #2 care. Resident #2 was irritable, loud and yelled at staff to get out now and close my door. Additional review of the note identified the staff signature identified the author as poolnurse (sic) supervisor RN. Additional record review identified a nursing note dated 3/1/2026 at 2:46 PM was signed 2LPN pool2 LPN (sic). Interview, clinical record review, and facility documentation review with the Director of Nursing (DON) on 3/9/2026 at 2:21 PM identified the nursing notes were signed to identify the nurse was an agency (pool) nurse. The DON stated all agency nurses use the same login for access to the electronic medical record (EMR). The DON stated if she needs to identify who wrote a nursing note written by an agency staff, then she would need to check the facility schedule to identify who was working on the day and shift. The DON stated all agency RNs have one general login that is used by all the agency RNs and does not display the RN's name. Further, she stated all agency LPNs use one login, and all agency NAs also share one login. The DON stated she was aware the common login access for agency staff was a long-standing practice, and stated the notes should include the name of the person writing the note. Although review of the facility policy with the DON identified nursing notes should include the name and title of the individual, she was unable to explain why agency staff are not provided with individual login access for the EMR. Review of facility Charting and Documentation Policy dated 11/25, directed in part, documentation will include the name and title of the individual who provided care, and the signature and title of the individual documenting.

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