

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2015
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NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE CROWN POINT, IN 46307
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: November 23, 2015</p> <p>Facility number: 012940 Provider number: 012940 AIM number: N/A</p> <p>Residential census: 44</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 14454 on December 2, 2015.</p>	R 0000		
R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure physician</p>	R 0241	No apparent negative effect to resident #6 by this deficient practice although potential for	12/18/2015

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

TITLE

(X6) DATE

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.

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	<p>orders were followed related to not holding and medications and giving medications as ordered. (Resident #6)</p> <p>Finding includes:</p> <p>The record for Resident #6 was reviewed on 11/23/15 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>A physician order, dated 10/30/15, indicated to hold the Hydrochlorothiazide (diuretic-medication that rids the body of water) 25 mg (milligrams) for three day and to give Lasix (diuretic-medication that rids the body of water) 20 mg for three days.</p> <p>Review of the October 2015, Medication Administration Record (MAR) indicated, the Lasix 20 mg and the Hydrochlorothiazide 25 mg had initials marked in the box dated 10/31/15, with a circle around the initials. The back page of the MAR indicated the 10/31/15 dose of Lasix was not given due to it not being in the facility. There was nothing written to indicated why the Hydrochlorothiazide was circled.</p> <p>Review of the November 2014 MAR indicated, the Lasix 20 mg had initials marked in the box of 11/1/15 and initials</p>		<p>harm did exist. RNC has documented medication errors with physician notification for the four errors discovered, with disciplinary process follow-through per protocol. Education provided for RNC by Divisional Director as to proper process to suspend medications on a temporary hold on the electronic MAR on 12-11-15. Bickford licensed staff to inform RNC of any new orders received, immediately, by phone if after hours. RNC to note, sign, date and time orders within twenty four hours (or next business day) to indicate that orders have been processed appropriately and electronic MAR updated. Divisional Director to audit charts for appropriate notations, per core check (QA audit) twice annually, and a random sampling on routine site visits. Re-education of all staff who administer medications on need for daily review of communication book and new orders, and Bickford's protocol to inform the RNC anytime an ordered medication is not available or there is a new discrepancy between written orders and electronic MAR by 12-18-15 Date completed 12-18-15 and on-going</p>				

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R 0356 Bldg. 00	<p>marked in the box dated 11/2/15 with the initial circled. The back page of the MAR indicated the Lasix was not in the facility on 11/2/15. The Hydrochlorothiazide 25 mg had initials marked in the boxes dated 11/1/15 and 11/2/15.</p> <p>During an interview on 11/23/15 at 3:00 p.m., the Registered Nurse Coordinator indicated she did not know why the Lasix would not have been given because the medication arrived at the facility on 10/31/15. She also indicated from what she could tell the Hydrochlorothiazide was give on 11/1/15 and 11/2/15 and should not have been.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p>			

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	<p>(6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to maintain a current emergency file for 1 of 5 residents whose records were reviewed. (Resident #5)</p> <p>Finding includes:</p> <p>Resident #5's record was reviewed on 11/23/15 at 2:25 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and hypothyroidism.</p> <p>Review of the facility's emergency binder lacked all information and a picture for Resident #5.</p> <p>Interview with the Administrator, on 11/23/15 at 2:40 p.m., indicated Resident #5 should have had information and a picture posted in the emergency binder upon admission.</p>	R 0356	<p>Although potential for harm did exist, no resident was negatively affected by this deficient practice. Director to audit Emergency Handbook to ensure demographic information and photo are in place for all current residents. Director and RNC were re-educated on state's standard to maintain demographic information and photo in the Emergency Binder on 12-11-15. Upon move in, Director to ensure that a copy of the Face Sheet is placed in the appropriate section of the Emergency Handbook. LEC to ensure photo is taken and copies given to RNC for proper distribution. RNC to write identifying information on photo and place in the Emergency Handbook. RNC to include checking the Emergency Handbook as part of the routine chart audit a week post move in. Date completed 12-23-15 and on-going</p>	12/23/2015
R 0408 Bldg. 00	<p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview,</p>	R 0408	<p>No residents were negatively affected by this deficient practice.</p>	12/18/2015

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	<p>the facility failed to ensure a resident had a chest X-ray completed no more than six months prior to admission for 1 of 7 residents reviewed. (Resident #8)</p> <p>Finding includes:</p> <p>Resident #8's closed record was reviewed on 11/23/15 at 12:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and hypothyroidism.</p> <p>The resident's closed record indicated he was admitted to the facility on 8/9/15. Chest X-ray results dated 11/19/14, were noted in the chart. There were no other chest X-ray results in the closed record.</p> <p>Interview with the RNC (Registered Nurse Coordinator), on 11/23/15 at 4:05 p.m., indicated there were no chest X-ray results available dated within 6 months prior to Resident #8's admission on 8/9/15.</p>		<p>Director and RNC were re-educated on the need to have CXR completed within six months of move in to facility on 12-11-15. RNC to audit all resident charts to ensure a qualifying CXR is in each record by 12-18-15. RNC to ensure that CXR results are obtained prior to move in. Divisional Director of Resident Services to review CXR results of the next five residents prior to move in to ensure they were completed within the 6 months prior to move in. Date of completion 12-18-15 and on-going</p>	