STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CARMEL	5829 116TH STREET EAST CARMEL, IN 46033

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R000000	This visit was for an Initial State Residential Licensure Survey. Facility number :013217 Provider number : 013217 AIM number : N/A Survey Team : Michelle Hosteter, RN-TC Sandie Nolder, RN Gloria Bond, RN Census bed type: Residential : 19 Total : 19 Census payor type: Other : 19 Total : 19 Sample : 6 These state findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed by Tammy Alley RN on January 26, 2015.	R000000		
R000026	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.			
	Based on observation and interview, the facility failed to have the residents rights posted in an area accessible to residents for 19 of 19 residents living in the facility. Findings include: Upon entrance on 1/15/15 at 10 a.m., no residents rights were observed to be posted. On 1/16/15 at 11 a.m., the Branch Director indicated they had no residents right posted.	R000026	No residents were negatively affected by this deficient practice. Divisional Director to provide in-service education to Director and RNC on need to have resident rights information posted in the facility. Resident rights document has been posted in an accessible area to residents as of 2/15/15. Resident rights information placement to be audited twice a year indefinitely by Divisional Director.	02/19/2015
R000033	410 IAC 16.2-5-1.2(h)(1-2)			

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	Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.			
	Based on observation and interview, the facility failed to have the advocacy numbers of the ombudsmen, the State Department of Health, and others, posted in an area accessible to residents for 19 of 19 residents living in the facility. Findings include: Upon entrance on 1/15/15 at 10 a.m., no advocacy numbers were observed to be posted. On 1/16/15 at 11 a.m., the Branch Director indicated they had no advocacy numbers posted.	R000033	No residents were negatively affected by this deficient practice. Divisional Director to provide in-service education to Director and RNC on need to have advocacy numbers posted in an accessible area to residents. Advocacy contact information - including ISDH, office of secretary of family and social services, ombundsman , area council on aging, the local mental health center, and adult protective services has been posted in an area accessible to residents as of 2/16/15. Advocacy contact information placement to be audited twice a year indefinitely by Divisional Director.	02/19/2015

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R000095	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.			
	Based on observation and interview, the facility failed to have a Alzheimer's and Dementia Special Care Unit Disclosure Form, or to have a Director for the unit, for 5 of 5 residents residing on the locked dementia unit. Findings include:	R000095	No residents were negatively affected by this deficient practice. The RNC has been named as the Director for the Dementia Care Unit. Divisional Director has completed the Special Care Unit Disclosure Form and submitted it, with copy maintained in the facility director's office.	02/16/2015

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	On 1/15/15 at 10:10 a.m., a tour of the locked dementia unit was completed. An observation was made of three women and two men residing on the unit. There were 2 staff observed on the unit and identified themselves as an aid and a nurse. On 1/16/15 at 9:10 a.m., the Branch Director indicated they had no Director for the Dementia unit. He indicated he was not aware they needed a Dementia Special Care Unit Disclosure Form.			
R000116	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility had no policy or procedure in place for the background check screening , references or orientation newly hired employees for 3 of 10 employee files reviewed. (Employees # 6, 11 and 15) Findings include:	R000116	No residents were negatively affected by this deficient practice although potential for harm did exist. All employee files were audited using the Personnel File Checklist - Indiana form to confirm the presence of required hiring information to be in compliance with state regulations. Any information found to be	02/19/2015

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	On 1/16/15 at 9:30 a.m., the employee records were reviewed for the newly hired staff. There were drug screens and health screenings in place. However, there were no criminal background checks, no employee references, and no general or job specific orientation documentation found for Employee #'s 6, 11 and 15. On 1/16/15 at 12:10 p.m., the Branch Director indicated he was their human resource and business office person and he contacted the Corporate Human Resources with questions if he had them. He indicated the Corporate Human Resource Staff assisted with the onboarding process when they opened the new building and indicated to him the employee references were not needed. He indicated all of the staff job shadowed other staff at one of their sister facilities He indicated they had no documentation of the job shadowing that was completed as Corporate took care of that. A request was made for their policy and procedures for hiring. He indicated he had no policy and procedure other than contacting the Corporate Human Resource department.		missing, will be acquired and retained in personnel file.Director and RNC have been in-serviced on necessary documentation required for staff upon hire. Personnel File Checklist - Indiana to be used to ensure files are complete for all new hires. Divisional Director to audit personnel files of next five new hires within first month of hire date. Full audit of personnel files to be completed twice a year by Divisional Director using the BFM (Bickford Family Member) File Core Check.If outcome of core check finds issues, additional monitoring on new hires will be instituted, as per this POC (audit next five new hires within first month hire)	
R000119	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-			

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	Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility had no general or job specific training documentation for 3 of 10 new employees. (Employees # 6, 11 and 15) Findings include:	R000119	No residents were negatively affected by this deficient practice. All personnel files to be audited using the Initial Orientation check list to confirm the presence of required hiring information to be in compliance with state	02/19/2015

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	On 1/16/15 at 9:30 a.m., the employee records were reviewed for the newly hired staff. There were no general or job specific orientation documentation found for Employees #6, 11, and 15. On 1/16/15 at 12:10 p.m., the Administrator indicated he was their human resource and business office person and he contacted the Corporate Human Resources with questions if he had them. He indicated the Corporate Human Resource Staff assisted with the onboarding process when they opened the new building. He indicated all of the staff job shadowed other staff at one of their sister facilities. He indicated the facility had no documentation of the job shadowing that was done as Corporate took care of that.		regulations. Orientation protocol to be reviewed with Director and RNC. Director responsible to complete the orientation documentation utilizing the Initial Orientation checklist to ensure all necessary orientation has been completed Orientation that was provided upon facility opening will to be compiled and added to personnel files. Orientation of new hires since opening to be documented and to be maintained in personnel records, utilizing the Initial Orientation checklist. Divisional Director to audit the personnel files of the next five new hires within a month of hire date. Full audit to be completed twice a year by Divisional Director using the BFM Personnel Core Check. If audit (core check) reveals reocurrence of issue, the audit of next five new hires will be re-instituted.	
R000154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to keep the ovens in the kitchen in sanitary condition and maintained in good repair for 1 of 1 kitchen observations. This deficient practice had the potential to affect 19 of	R000154	No residents were negatively affected by this deficient practice although potential for harm did exist. Kitchen Manager has been in-serviced on the prescribed, written cleaning schedule by 2/17/15. Oven knobs	02/17/2015

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	19 residents currently residing in the building. Findings include: A kitchen sanitation tour was conducted on 1/15/2015 at 10 a.m., with the Kitchen Manager. A two oven stove was observed with 2 knobs missing above the right stove. The left stove had dark food residue on the bottom of the stove. During an interview with the Kitchen Manager at this time, she indicated the knobs had melted off a couple weeks ago. She was not there when this occurred, as a temporary agency was assisting some of the time. She did not know how this occurred. During a daily conference with the administrator on 1/15/2015 at 2:15 p.m., he indicated he was not aware of any broken or missing knobs to the stove in the kitchen. He would check on it. During an interview on 1/16/2015 at 10:30 a.m., the Kitchen Manager indicated she did not have a written cleaning schedule but she did clean the ovens every other weekend. As of exit on 1/16/2015 at 2:15 p.m., no other information relating to the stove		have been replaced, oven checked and no other damage noted. Director to review general cleanliness of kitchen and food storage areas on a daily basis Monday - Friday for the next two weeks. Director to audit the kitchen and food storage areas on a weekly basis for the next three months, then monthly indefinitely, using the Dining Service Observation Core Check document. Daily / monthly checks to be extended if deficiencies found. Monthly audits of the kitchen in regards to sanitation and safety to be done by Director (or designee). Full audit to be completed twice yearly by Divisional Director using the dining services core check documents. If audit reveals issues, the reviews/ audits will increase in frequency to the level outlined above.	

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	was provided.			
R000215	410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on interview and record review, the facility failed to ensure pre-admission evaluations were completed for 5 of 6 residents being reviewed for completion of pre-admission evaluations before admission to the facility. (Residents #2, #6, #7, #5 and #15) Findings include: 1. Resident #2's record was reviewed on 1/15/15 at 2:20 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, muscle weakness, abnormality of gait, hypertension, osteoarthritis and congestive heart failure. A pre-admission evaluation was not found in the resident's record. A "Resident Service Assessment" was dated 12/13/14 at 5:30 p.m.	R000215	No residents were negatively affected by this deficient practice. Divisional Director has provided in-service education for RNC on proper record keeping in regard to pre-admission assessment documentation. All charts have been audited for compliance with the service assessment regulation by 2/18/15. All residents admitted to facility since 1/16/15 have documented pre-admission assessments complete and retained in records.All resident assessments will be maintained in records. Divisional Director to review all new resident charts within a month of move in date for the next six months.Divisional Director to audit charts for compliance twice a year using Chart Core Check document.If semi-annual audit reveals issues, increased monitoring will be reinstituted for all new residents' charts.	02/18/2015

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	During an interview on 1/15/15 at 3:05 p.m., the RNC (Registered Nurse Coordinator) indicated the "Resident Service Assessment" dated 12/13/14 at 5:30 p.m., was Resident #2's initial admission evaluation. She indicated she had done a pre-admission evaluation with the out of state facility, where she was admitted from and the resident prior to her admission. The RNC indicated when Resident #2 was admitted to this facility she transferred the pre-admission information over to the initial admission assessment form, after asking the resident and family if the information had changed, since before her admission. The RNC indicated she had not saved the pre-admission evaluation form because she was not aware she needed to keep it in the resident's record. 2. Resident #6's record was reviewed on 1/15/15 at 2:40 p.m. Diagnoses included, but were not limited to, non-insulin dependent diabetes mellitus, Alzheimer's, and tremors. A pre-admission evaluation was not found in the resident's record. A "Resident Service Assessment" was dated 1/14/15 at 6:00 p.m. During an interview on 1/16/15 at 11:45			

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	a.m., the RNC indicated the "Resident Service Assessment" dated 1/14/15 at 6:00 p.m., was Resident #6's initial admission evaluation. She indicated she had completed a pre-admission evaluation for Resident #6 prior to his admission, but when he was admitted to the facility on 1/14/15 she copied all the information from the pre-admission evaluation over onto his admission assessment, after she asked the family if the information had changed, since before his admission. The RNC indicated she had not saved the pre-admission evaluation form because she was not aware she needed to keep it in his record. 3. Resident #7's record was reviewed on 1/15/15 at 2:45 p.m. Diagnoses included, but were not limited to, depressive disorder, anxiety state, anemia, hypertension and hypotension. A pre-admission evaluation was not found in the resident's record. A "Resident Service Assessment" was dated 1/13/15 at 2:30 p.m. During an interview on 1/16/15 at 11:45 a.m., the RNC indicated the "Resident Service Assessment" dated 1/13/15 at 2:30 p.m., was Resident #7's initial admission evaluation. She indicated she had completed a pre-admission			

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	evaluation on him prior to his admission, but she had copied all the pre-admission evaluation information over to his admission assessment, after checking with the resident and the family to make sure the information had not changed. The RNC indicated she was not aware she needed to save Resident #7's pre-admission evaluation in his record. 4. Resident #5's record was reviewed on 1/15/2015 at 1:05 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and hypothyroidism. The resident's record lacked a pre-admission evaluation. During an interview with the Registered Nurse Coordinator, on 1/16/2015 at 10:00 a.m., she indicated she did not keep this resident's pre-admission assessments. She just used the information to do the admission assessments. 5. Resident #15's record was reviewed on 1/15/2015 at 12:30 p.m. Diagnoses included, but were not limited to, vascular dementia, prostate cancer, and depression. The resident's record lacked a pre-admission evaluation. During an interview with the Registered Nurse Coordinator, on 1/16/2015 at 10:00 a.m., she indicated she did not			

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	keep this resident's pre-admission assessments. She just used the information to do the admission assessments so there were no pre-admission assessments available as part of the resident's chart.			
R000216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to do a self medication administration evaluations for 2 of 2 resident's reviewed for self medication administration assessments. (Resident #5 and #6). Findings include: 1. Resident #5's record was reviewed on 1/15/2015 at 1:05 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and	R000216	No residents were negatively affected by this deficient practice although the potential for harm did exist. All residents' charts have been audited to determine which residents are having medications administered by anyone other than staff. If resident is self- medicating or family is assisting with administration, a Self -Medication Assessment form will be completed by the RNC and in place. RNC to ensure that a physician order for self-medication is in place.	02/18/2015

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	hypothyroidism. During an interview on 1/15/2015 at 11:30 a.m., the Registered Nurse Coordinator had indicated this resident self administered her medications. The resident's record lacked a resident self medication administration assessment. On 1/16/2015 at 10:15 a.m., during an interview with the Registered Nurse Coordinator, she indicated she had done the assessment with this resident, but there was no form in the residents record to indicate this. She did not have a form available for when she did the assessment but now she has a specific form she was using. She was in the process of updating the records with the new form she has. 2. Resident #6's record was reviewed on 1/15/15 at 2:40 p.m. Diagnoses included, but were not limited to, non-insulin dependent diabetes mellitus, Alzheimer's, and tremors. A "Resident Service Assessment" dated 1/14/15 at 6:00 p.m., indicated "...16. Medication-choose the highest level that applies...Routine administration at med room...." During an interview on 1/16/15 at 11:45 a.m., the RNC (Registered Nurse		In-service education to be provided by Divisional Director for RNC as well as all licensed staff regarding the use and purpose of this tool. RNC to inform Divisional Director of any resident admitted with self-medication orders over the next six months. Divisional Director to review all new residents charts monthly for the next six months with full audit twice a year to ensure those self-medicating have assessments and physician order. If semi-annual audit reveals an issue, the new residents' charts will be reviewed monthly again for six months	

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	Coordinator) indicated Resident #6 self medicated, but he did not have a self medicate order or a self medicate assessment. She indicated he came with orders from out of state and the Physician had not ordered all of his medication, so his son wanted to continue to give him all his medications. She faxed the Physician the day he was admitted for clarification of orders, but she had not received those orders back yet. The RNC indicated the resident's son had set his pills up in a weekly pill box and came over in the a.m. and p.m., to remind him to take his pills. When his son was unable to come, the facility nurses reminded him to take his medications in the a.m. and p.m. She indicated she should have selected "Routine administration OR supervision-once per day" on the resident's service agreement since he required verbal cueing and reminding from the nurses.			
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and			

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	(D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to have the residents's Service Plans signed for 4 of 6 residents's Service Plans reviewed for signatures. (Resident #5, #15, #4 and #2). Findings include: 1. Resident #5's record was reviewed on 1/15/2015 at 1:05 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and hypothyroidism. Resident #5's record indicated the resident had a service plan done on admission. The record lacked the resident / legal representative signature.	R000217	No residents were negatively affected by this deficient practice. All service plan reviewed for need for signatures of Director, RNC, and resident / representative, and any missing signatures obtained.Director and RNC in-serviced on need to have the Service Plan reviewed and confirmed, in a timely manner after assessment, as evidenced by a signature. Service Plans for cognitively intact residents are to be completed, printed and signed upon completion of the assessment interview with resident. Service Plans, for residents that desire or require involvement of the resident's representative, are to be scheduled within a week of the assessment for review and	02/18/2015

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	2. Resident #15's record was reviewed on 1/15/2015 at 12:30 p.m. Diagnoses included, but were not limited to, vascular dementia, prostate cancer, and depression. The record lacked the resident / legal representative required signature on the service plan. On 1/16/2015 at 10:30 a.m., the Registered Nurse Coordinator indicated at the time of the service plan she was focused on just making sure the residents had service plans. 3. On 1/16/14 at 1:00 p.m., the record review for Resident #4 was completed. Diagnoses included, but were not limited to, dementia, weakness, late effects cerebrovascular disease and was on hospice. The resident had a document titled "Service Plan" dated 11/13/14. The signature page included a space for the Resident/Legal Representative to sign and the line was blank. On 1/15/15 at 2:20 p.m., the Branch Director indicated he had scheduled a time for the families to come in and sign the 30 day evaluations. He indicated there were no signed copies in the resident's record.4. Resident #2's record was reviewed on 1/15/15 at 2:20 p.m.		signing. If representative not available with in the week, a copy of the Service Plan will be sent for their signature. Director to audit Service Plan book monthly for the next six months for signatures on all Service Plans.Divisional Director to review the Service Plan book monthly for the next six months, with a full audit twice a year.	

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	Diagnoses included, but were not limited to, dementia without behavioral disturbances, muscle weakness, abnormality of gait, hypertension, osteoarthritis and congestive heart failure. A "Service Plan" dated 12/13/14 at 5:30 p.m., lacked a Resident/Legal Representative signature. During an interview on 1/15/15 at 3:05 p.m., the RNC (Registered Nurse Coordinator) indicated the "Service Plan" dated 12/13/14 at 5:30 p.m., was Resident #2's initial admission service plan. She indicated the "Service Plan" had not been signed by Resident #2 or her Legal Representative. She indicated the resident's Legal Representative had been in the facility to visit the resident, since 12/13/14 and could have signed the "Service Plan."			
R000241	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. Based on observation, interview and	R000241	No residents were negatively affected by this deficient practice	02/18/2015

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	record review, the facility failed to ensure a Physician order was followed during a medication pass for 1 of 5 residents observed during a medication pass. (Resident #2) Findings include: Resident #2's record was reviewed on 1/15/15 at 2:20 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, muscle weakness, abnormality of gait, hypertension, osteoarthritis and congestive heart failure. During a medication pass on 1/15/15 at 11:33 a.m., LPN #1 was observed administering Resident #2's medication, which included Lisinopril (a blood pressure medication), Diltiazem (a blood pressure medication) and Metoprolol (a heart medication used to treat high blood pressure) without taking her blood pressure (BP) before LPN #1 administered the medications. The Physicians order recapititulation (recap) dated January 2015, included, but were not limited to, the following orders: 12/13/14--Diltiazem Cap ER (Extended Release) 300 mg (milligrams) take one capsule by mouth daily at 12 p.m. 12/13/14--Lisinopril 2.5 mg take 1 tablet		although potential for harm did exist. All residents' medication records have been audited for any physician ordered parameters for administration. The Electronic Medication Record (EMAR - QuickMar) has been programmed to ensure the required vital signs are recorded at time of medication administration for all current residents with such orders. All staff licensed who administer medications have been in-serviced on need to follow specific ordered parameters, and inform RNC if EMAR does not require the information. Divisional Director to provide in-service education to RNC on how to customize the EMAR system to provide increased quality and record keeping. RNC to audit the EMAR system on a weekly basis and provide copies of these audits to the Divisional Director. Divisional Director to review the EMAR system on random visits with special attention to new residents, and with full audit twice a year.	

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	by mouth daily for hypertension. Hold if systolic blood pressure is less than 96. 12/13/14--Metoprolol ER take one tablet by mouth daily at 12 p.m. The Electronic Medication Record (EMAR) dated December 2014, indicated the following BP's were not found on the EMAR documentation for the following dates: 12/14/14, 12/16/14, 12/23/14, 12/24/14, 12/25/14, 12/26/14, 12/29/14, 12/30/14, and 12/31/14. The EMAR dated January 2015, indicated the following BP's were not found on the EMAR documentation for the following dates: 1/4/15, 1/6/15, 1/7/15, 1/10/15, 1/11/15, and 1/15/15. During an interview on 1/15/15 at 11:40 a.m., LPN #1 indicated she did not see the order for the BP to be taken before the Lisinopril was given. She indicated this was her first time working on the dayshift giving Resident #2 her medication. She indicated she usually worked the afternoon shift. During an interview on 1/15/15 at 2:00 p.m., the RNC (Registered Nurse Coordinator) indicated she expected LPN #1 to take Resident #2's BP before			

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	administering the Lisinopril to her. During an interview on 1/16/15 at 10:45 a.m., the RNC indicated if a BP was not documented on the EMAR, the nurse had not taken it for that date. She indicated there was no other place the nurses documented the BP when administering medications except on the EMAR under the Pass Notes.			
R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and record review the facility failed to notify a resident's Physician following a medication error for 1 of 6 residents reviewed for medication errors. (Resident #2) Findings include: Resident #2's record was reviewed on 1/15/15 at 2:20 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, muscle weakness, abnormality of gait, hypertension, osteoarthritis and congestive heart failure.	R000247	No residents were negatively affected by this deficient practice. Divisional Director to provide in-service education for the RNC on use of the Medication Audit and the Medication Error report forms, and need to inform physician of any medication error/ omission of prescribed treatment plan.Medication Audits and Error Report forms to be completed weekly by the RNC, documenting physician contact on any errors. Those reports to be submitted to Divisional Director for review weekly and determination that physician has bee informed.	02/18/2015

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	During a medication pass on 1/15/15 at 11:33 a.m., LPN #1 was observed administering Resident #2's medication, which included Lisinopril (a blood pressure medication), without taking her blood pressure (BP) before LPN #1 administered the medication. Resident #2's record lacked documentation the Physician had been notified her BP was not taken before her Lisinopril was given on 1/15/15 at 11:33 a.m. During an interview on 1/16/15 at 10:45 a.m., the RNC (Registered Nurse Coordinator) indicated she had not notified Resident #2's Physician regarding her BP not being taken prior to the administration of the Lisinopril on 1/15/15 at 11:33 a.m.			
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure foods were labeled and dated in both the refrigerator and freezer of the kitchen for 1 of 1 kitchen observations. This deficit	R000273	No residents were negatively affected by this deficient practice although potential for harm did exist. All food storage areas, especially cold storage had undated, improperly stored foods	02/18/2015

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	practice had the potential to affect 19 of the 19 residents currently residing in the building that were served food from the kitchen. Findings include: On 1/15/2015 at 9:50 a.m., a sanitation tour of the kitchen was conducted with the Kitchen Manager in attendance. There was a tray of small bowls with food in the refrigerator that were not labeled or dated. One of the freezers was observed with a piece of food wrapped with no label identifying the item and no date to indicate how long it had been there. The Kitchen Manager indicated at the time that it was a piece of meat but confirmed that it was not labeled. There was a package of what was identified as, " veal patties" next to some ice scream in the freezer. There was no date on the items. There was an uncovered and undated box of, " bread dough" in the freezer. An observation was made of a (name brand) chicken beef base with no date on it in another of the refrigerators. A piece of what the Kitchen Manager identified as, "pork" unlabeled and undated was observed on a shelf above containers of fruit in yet another refrigerator.		disposed of. Corporate Director of Dining Services has provided in-service education for kitchen staff on proper food storage and labeling using the Dietary Manual and Serv-Safe techniques. Food storage will be monitored by Director or designee daily, Monday through Friday for next two weeks, weekly for three months and then monthly using Core Check document. Divisional Director to monitor kitchen practices regarding storage, monthly for next six months, with full audit twice a year.	

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	During an interview, at that time, the Kitchen Manager indicated there was a new cook from a temporary agency that was not labeling and dating food items.			
R000275	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to ensure a resident had a Physician order for a diet for 1 of 6 residents being reviewed for having diet orders reviewed and revised by a Physician. (Resident #7) Findings include: Resident #7's record was reviewed on 1/15/15 at 2:45 p.m. Diagnoses included, but were not limited to, depressive disorder, anxiety state, anemia, hypertension and hypotension. Resident #7's record lacked a diet order. The resident's Physician orders were requested, however no Physician orders were provided. A "Facesheet" with a list of the resident's medications was provided as the resident's Physician order sheet.	R000275	No residents were negatively affected by this deficient practice. All charts audited for documentation of a diet order by the RNC. Resident #7's diet order has been clarified and is now properly documented. Divisional Director has provided in-service education to RNC with need to verify completeness of Physician Order Sheet prior to admission. Divisional Director will review Physician Resident Admission Order Sheets of all new residents for the next three months, with a complete audit twice a year to include checking for diet orders.	02/18/2015

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	During an interview on 1/16/15 at 12:52 p.m., the RNC (Registered Nurse Coordinator) indicated she had contacted the resident's Physician for order clarification on 1/13/14 when he was admitted, but as of 1/16/15 at 12:52 p.m., she had not heard back from the Physician's office about his orders. She indicated she had contacted Resident #7's Physician's office on 1/16/15 to get the orders clarified, but the nurse was out to lunch and she was not going to be able to get the orders clarified at that time. She indicated she did not have a diet order for the resident at that time, but the family had told her he was on a regular diet, so she had been feeding him a regular diet since admission.			
R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to get a free of communicable disease health statement upon admission for a resident for 1 of 6 residents reviewed for health statements.	R000409	No residents were negatively affected by this deficient practice. All charts audited for complete documentation of Physician Admission Order form. Resident #7 orders are now complete (as of 1/14/15) and include a signed	02/18/2015

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	(Resident #7) Findings include: Resident #7's record was reviewed on 1/15/15 at 2:45 p.m. Diagnoses included, but were not limited to, depressive disorder, anxiety state, anemia, hypertension and hypotension. Resident #7's record lacked a communicable disease health statement upon admission indicating the resident was free from communicable diseases such as; tuberculosis. The resident's Physician orders were requested, however no Physician orders were provided. During an interview on 1/16/15 at 12:52 p.m., the RNC (Registered Nurse Coordinator) indicated she had contacted the resident's Physician for order clarification on 1/13/14 when he was admitted, but as of 1/16/15 at 12:52 p.m., she had not heard back from the Physician's office about his orders. She indicated she had contacted Resident #7's Physician's office on 1/16/15 to get the orders clarified, but the nurse was out to lunch and she was not going to be able to get the orders clarified at that time. She indicated the resident's record did not		statement "I certify that the resident is free the of communicable disease, including active signs of TB". Divisional director has provided in-service education to RNC to verify completeness of physician orders prior to admission. Divisional Director to review all Physician's Admission Orders forms for next six months for complete/ signed physician orders including the above statement, with full audit twice a year. If this review reveals recurrent issues, the Divisional Director will review all Admission orders prior to resident move in.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CARMEL	5829 116TH STREET EAST CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	have a communicable disease health statement to indicate he was free from communicable diseases. She indicated she was working on obtaining that statement from the Physician with the clarified Physician orders.			