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	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF CROWN POINT	140 E 107TH AVENUE CROWN POINT, IN 46307

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: October 30 and 31, 2018 Facility number: 012940 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/5/18.	R 0000		
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to			

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	appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.			
	Based on record review and interview, the facility failed to ensure each resident who was discharged received, in writing, information regarding the ombudsman, State agency, and appeal process for 1 of 7 residents reviewed. (Resident 8) Finding includes: Resident 8's closed record was reviewed on	R 0045	No residents were negatively affected by this deficient practice. Resident 8 no longer resides at the facility. The Director/designee will be responsible for ensuring that	11/30/2018

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	10/31/18 at 8:59 a.m. Diagnoses included, but were not limited to, dementia, diabetes, and hypertension. A change of condition service plan, dated 8/1/18, indicated the resident and her family had refused transition to the memory care unit and were issued a 30 day discharge notice. The resident was discharged from the facility on 9/21/18. There was lack of evidence a notice of transfer or discharge form had been completed including the rights of the resident, information for the local Ombudsman, State Agency, and the appeal process. Interview with the RNC (RN Coordinator) on 10/31/18 at 11:18 a.m., indicated she was aware the notice of transfer or discharge form was to be completed if a resident went to the hospital but was unaware one needed to be completed upon discharge from the facility.		Residents, as well as other individuals as prescribed in regulation, will receive in writing the required information regarding their potential discharge/transfer, to include IN form #49669 and #4931. Divisional Director will provide training to Director on requirements as well as completion of IN forms #49669 and #4931 by 11/30/18. Director/designee will monitor weekly for 4 weeks the charts of any resident discharged to ensure necessary documentation is completed. Divisional Director will audit for compliance annually.	
R 0216 Bldg. 00	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.			

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	Based on record review and interview, the facility failed to ensure a medication self-administration evaluation was completed for 1 of 7 residents reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on 10/31/18 at 8:48 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's Disease, and type 2 diabetes mellitus. The resident was admitted to the facility on 2/2/18. The Resident Service Plan, dated 8/1/18, indicated the resident was to self administer his medications. Staff was to remind the resident to take his medications daily. The facility was responsible to administer the resident's eye drops and to complete his blood sugar checks every day. The resident was to administer all his other medications. The record lacked documentation a medication self-administration evaluation had been completed for the resident to ensure he could safely administer his own medications. Interview with the RN Coordinator on 10/31/18 at 9:58 a.m., indicated she could not find any documentation a medication self-administration evaluation had been completed for the resident.	R 0216	No residents were negatively affected by this deficient practice although the potential for harm did exist for all residents who self-administer medications. R-5 has had a medication self-administration evaluation on 11/12/18. The RNC/Back up RN will be responsible for completing a medication self-administration evaluation for all residents who self-administer medication at the same time as other evaluations are completed. RNC will audit all Resident Service Plans to ensure all residents who self-administer medication have a self-administration evaluation completed by 11/30/18. RNC/back-up RN will audit charts of all newly admitted residents within 7 days of admission to ensure compliance. Divisional will complete audit for compliance annually.	11/30/2018
R 0241 Bldg. 00	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			

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	the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure Physician's Orders were followed as written related to blood sugar testing, insulin administration, and blood pressure medication parameters for 2 of 7 residents reviewed. (Residents 3 and 8). Findings include: 1. Resident 3's record was reviewed on 10/30/18 at 1:57 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and dementia with behavioral disturbances. The Physician's Order Summary, dated 10/2018, indicated an order for metoprolol tartrate (a blood pressure medication) 12.5 mg (milligrams) twice daily, hold if SBP (systolic blood pressure) is less than 110. The Medication Administration Record (MAR), dated 10/2018, lacked documentation a blood pressure was checked prior to the metoprolol administration on the following dates and times: 10/25/18 7:00 p.m. 10/26/18 9:00 a.m. and 7:00 p.m. 10/27/18 9:00 a.m. and 7:00 p.m. 10/28/18 9:00 a.m. and 7:00 p.m. 10/29/18 9:00 a.m. and 7:00 p.m. 10/30/18 9:00 a.m. Interview with the RNC (RN Coordinator) on 10/31/18 at 9:58 a.m., indicated the nurses should have documented the blood pressure on the MAR.	R 0241	No resident was negatively affected by this deficient practice although the potential for harm did exist. Effective 11/11/18, R3's MAR has documentation that blood pressure was checked prior to metoprolol administration. R8 no longer resides at Bickford. The RNC will be responsible for re-delegating to LPNs/QMAs following physicians' orders, including required documentation of vital signs, blood sugars etc by 11/30/18. The RNC will audit all physician's orders/MARs to ensure that physician's orders are being followed and documented appropriately by 11/30/18. The RNC/Back-up RN will conduct medication audits weekly to ensure medications are administered and documented per MD order. Divisional will observe med pass annually.	11/30/2018

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	2. Resident 8's closed record was reviewed on 10/31/18 at 8:59 a.m. Diagnoses included, but were not limited to, dementia, diabetes, and hypertension. The resident was discharged from the facility on 9/21/18. The Physician's Order Summary, dated 9/2018, indicated an order to check blood sugar daily before breakfast and dinner and administer Humalog (insulin) 5 units twice daily if blood sugar was greater than 400. The MAR, dated 9/2018, indicated there were no blood sugar testing results documented for 9/12/18 at 4:00 p.m., 9/17/18 at 4:00 p.m., and 9/18/18 at 4:00 p.m. The blood sugar result was documented to be less than 400 and the insulin was recorded as administered on the following dates and times: 9/1/18 7:00 a.m. 9/2/18 7:00 a.m. 9/3/18 7:00 a.m. 9/6/18 7:00 a.m. and 4:00 p.m. 9/7/18 7:00 a.m. 9/8/18 7:00 a.m. 9/10/18 7:00 a.m. 9/12/18 7:00 a.m. 9/13/18 7:00 a.m. and 4:00 p.m. 9/18/18 7:00 a.m. 9/19/18 4:00 p.m. 9/20/18 7:00 a.m. and 4:00 p.m. Interview with the RNC (RN Coordinator) on 10/31/18 at 9:58 a.m., indicated the nurses should have documented the blood sugar results and also if the insulin was held or administered.			
R 0270	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency			

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Bldg. 00	(c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview the facility failed to ensure modified diets were prepared properly according to the recipe. This had the potential to affect 1 resident who resided in the facility and received a puree diet. Findings includes: During an observation on 10/30/18 at 11:45 a.m., the Kitchen Manager was observed preparing a puree modified diet. The Kitchen Manager took one scoop of the regular texture beef tips from a serving pan, put it in the blender, and turned on the blender for 10 seconds. She indicated the beef puree was too thick so she added a scoop of gravy from the regular texture beef tips serving pan to the blender and turned on the blender for 5 seconds. She poured the puree beef tips into a serving bowl and put the blender through the dishwasher. She then took a scoop of the regular texture garlic pasta from a serving pan and a spoonful of broth from a pot on the stove top and put it in the blender. She turned on the blender for 10 seconds. She then added an unmeasured amount of water to the blender and turned on the blender for 5 seconds. She poured the puree garlic pasta into a serving bowl and indicated it was "not all the way" blended. The puree garlic pasta was observed to be mostly puree consistency with small various size pieces of regular texture pasta in it. The	R 0270	No residents were harmed by this deficient practice although the potential for harm did exist. Corporate Director of Dining will provide retraining for the Kitchen Manager to ensure modified diets are prepared properly according to the recipe to be completed by 11/30/18. Director/designee will observe modified diet preparation 3 times per week for the next 4 weeks and then monthly to ensure compliance. If concerns are found at any time, this cycle will be restarted. Divisional Director will audit for compliance annually.	11/30/2018

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	Kitchen Manager covered both serving bowls with plastic wrap and prepared to start serving lunch. Interview with the Kitchen Manager on 10/30/18 at 12:00 p.m., indicated she did not have any puree recipes to follow. If the puree came out too thin, she would just add more regular texture food to the blender. She indicated the facility did not use thickener at all. On 10/31/18 at 9:30 a.m., the RNC (RN Coordinator) provided a recipe for pureed pasta. The recipe had measurements for each ingredient and the ingredients included instant thickener. The procedure indicated "...combine cooked noodles and white sauce in a food processor; process until smooth. Stir in thickener..."			
R 0273 Bldg. 00	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, interview, and record review, the facility failed to maintain proper food sanitation related to food thermometer handling. This had the potential to affect 42 residents that were served from the kitchen. Finding includes: During an observation on 10/30/18 at 11:45 a.m., the Kitchen Manager was observed taking the food temperatures prior to lunch service. She obtained a food thermometer and checked the temperature of the mixed vegetables, wiped the thermometer on a hand towel hanging on her side	R 0273	No resident was negatively affected by this deficient practice although the potential for harm did exist. Divisional Director of Dining will provide retraining for all cooks, including the Kitchen Manager, to ensure proper food sanitation related to food thermometer handling to be completed by 11/30/18. The Director/designed will observe	11/30/2018

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	from her belt loop, checked the temperature of the spinach, wiped the thermometer on the hand towel, checked the temperature of the garlic pasta, wiped the thermometer on the hand towel, checked the temperature of the beef tips, wiped the thermometer on the hand towel, set the thermometer on the counter, opened the oven, took out the tray of pork chops, checked the temperature of the pork chops, and wiped the thermometer on the hand towel. Interview with the RNC (RN Coordinator) on 10/30/18 at 12:21 p.m., indicated the Kitchen Manager should not have not been wiping the food thermometer on the hand towel in between foods. A facility policy titled, "Thermometer Cleaning Procedure," was provided by the RNC as current. The policy indicated "...wash, rinse, and sanitize thermometers after removing from holder and before taking any food product temperature...Thermometer must be washed, rinsed and sanitized between each food item if the temperature of the product is below 140 F..."		food temperature checks three a week for the next 4 weeks and than monthly. If concerns are found at any time, this cycle will be restarted. Director/designee will observe food temperature checks, prior to serving, as outlined in Bickford Policy Thermometer Cleaning Procedure.	
R 0408 Bldg. 00	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, the facility failed to ensure each resident had a chest X-ray completed no more than six months prior to admission for 1 of 7 residents reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on	R 0408	No resident was negatively affected by this deficient practice although the potential for harm did exist. R5 has a chest x-ray dated April 5, 2018 in clinical record. RNC will be responsible for	11/30/2018

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	10/31/18 at 8:48 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's Disease, and type 2 diabetes mellitus. The resident was admitted to the facility on 2/2/18. The record lacked documentation a chest X-ray had been completed no more than six months prior to admission to the facility. Interview with the RN Coordinator on 10/31/18 at 9:58 a.m., indicated she could not find any documentation a chest X-ray had been completed on the resident no more than six months prior to admission to the facility.		ensuring all residents have a chest x-ray completed within 6 months prior to admission. RNC will audit all resident's clinical records to ensure a chest x-ray was obtained within 6 months prior to admission by 11/30/18. RNC/back-up will audit charts of newly admitted residents charts prior to move in to ensure compliance. Divisional Director will audit annually for compliance.	