

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 10/17/2013
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NAME OF PROVIDER OR SUPPLIER LAFAYETTE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3633 REGAL VALLEY DR LAFAYETTE, IN 47901
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: October 15, 16 and 17, 2013</p> <p>Facility number : 004503 Provider number : 004503 AIM : N/A</p> <p>Survey team : Gloria Bond RN, TC Sandra Nolder RN</p> <p>Census bed type : Residential : 24 Total : 24</p> <p>Census payor type: Other : 24 Total : 24</p> <p>Sample : 8</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5</p> <p>Quality Review was completed by Tammy Alley RN on October 21, 2013.</p>	R000000	State Re-Licensure 10/17/13	

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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R000026	<p>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 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.</p> <p>Based on interview and record review the facility failed to have the Resident Rights Acknowledgement document signed on admission for 3 of 7 residents reviewed for residents rights acknowledgement. (Residents # 26, # 17, and # 7).</p> <p>Findings include:</p> <p>1. The record for Resident #26 was reviewed on 10/15/13 at 2:13 P.M. The resident was admitted to the facility on 4/9/2013. The Resident Rights Acknowledgement document</p>	R000026	No resident was negatively affected by the deficient practice. The Director has reviewed all Resident files to ensure all Residents have a signed copy of Resident Rights. Resident # 26, #17 and #7 -- Resident Rights documents' have all been signed. A check off sheet was implemented for completion of admission paperwork, including signed Resident Rights. The Divisional Director will audit new admission paperwork at least twice a year to ensure Resident Rights documents are signed. POC Completion Date: Nov. 2, 2013	11/02/2013

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	<p>was not found in the resident's record. A copy was requested from the Executive Director at this time.</p> <p>During an interview on 10/16/13 at 1:35 P.M., the Executive Director indicated she did not have the Resident Rights Acknowledgement document for this resident.</p> <p>2. The record for Resident #17 was reviewed on 10/15/13 at 1:07 P.M. The resident was admitted to the facility on 10/24/2008. The Resident Rights Acknowledgement document was not found in the resident's record. A copy was requested from the Executive Director at this time.</p> <p>During an interview on 10/16/2013 at 1:35 P.M., the Executive Directive indicated the resident had signed the Resident Rights Acknowledgement document yesterday after the document was requested.</p> <p>3. The review of Resident # 7's record was completed on 10/16/2013 at 11:00 A.M. The resident was admitted to the facility on 10/5/2012. The signed Resident Rights Acknowledgement document was not available.</p> <p>During the daily conference on 10/15/2013 at 3 P.M., a request was</p>						

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	made for the signed Resident Rights Acknowledgement for Resident #7. On 10/16/2013 at 4:35 P.M., the Executive Director indicated there was not a signed Resident Rights Acknowledgement document available for this resident.						

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review the facility failed to conduct a fire and disaster drill in conjunction with the fire department at least every 6 months. This had the potential to affect 24 of 24 residents in the facility.</p> <p>Findings include:</p> <p>During an interview with the Executive Director on 10/15/2013 at 10:45 A.M., she indicated she thought the last fire</p>	R000092	A fire and disaster drill, in conjunction with the local fire department, was conducted at Lafayette Bickford Assisted Living on October 21, 2013 at 3:00 PM. No resident was negatively affected by the deficient practice. The Director was re-educated on the fire and disaster drill schedule, including those in conjunction with the fire department, and the documentation of all training and drills with names and signature of personnel present. The	11/02/2013			

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	<p>drill in conjunction with the local fire department was done last year.</p> <p>Record review on 10/15/2013 at 11:00 A.M., of the last fire and disaster drill, indicated the last fire and disaster drill in conjunction with the local fire department was done 9/27/2012.</p>		<p>semi-annual fire and disaster drills have been added to the Preventative Maintenance and Inspection Schedule Program within Lafayette's computer tracking program.POC Date: Nov, 2, 2013</p>				

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R000217	<p>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:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview the facility failed to have the agreed upon service plans signed and dated by the residents for 2 out of 7 resident's reviewed for signed service plans. (Residents # 8 and # 26).</p>	R000217	Resident # 8 and # 26 - Service Plans have been signed. All records have been reviewed to ensure the Service Plans are signed. No resident was affected by the deficient practice. The Director and the RNC were re-educated on the process for proper documentation related to signing of Service Plans. The	11/02/2013			

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	<p>Findings include:</p> <p>1. Resident # 8's record was reviewed on 10/16/2013 at 11:00 A.M. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), hypothyroid, and gout. The resident's service plan dated 4/22/2013 lacked the resident / responsible party's signature.</p> <p>During an interview on 10/17/2013 at 11:30 A.M., with the Registered Nurse Coordinator (RNC), she indicated she was not sure why some of the service plans were not signed.</p> <p>2. The record for Resident #26 was reviewed on 10/15/13 at 2:13 P.M.</p> <p>The resident was admitted to the facility on 4/9/13. The admission service plan that was completed on 4/9/13 was not signed by the resident and/or her representative. The service plan that was completed 30 days later on 5/9/13 was not signed by the resident or her representative.</p> <p>During an interview on 10/16/13 at 10:30 A.M., the Registered Nurse Coordinator(RNC) indicated the service plans are completed upon admission, 30 days after admission,</p>		<p>Divisional Director of Resident Service will audit Service Plans for proper documentation including obtaining appropriate signature at least twice per year.</p>				

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	<p>then every 90 days thereafter.</p> <p>A policy titled "Service Planning and Agreements" dated 07/2012 was provided on 10/16/13 at 1:40 P.M., by the ED(Executive Director). The policy stated, "POLICY: A Service Plan shall be developed and maintained for each resident that corresponds with their individual needs and preferences... PROCEDURE: 1) Residents and/or their designated agents shall participate in the service planning process...."</p>				

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R000273	<p>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.</p> <p>Based on observation, interview and record review the facility failed to ensure food was properly labeled and dated, food was served under sanitary conditions and the trash disposal system was sanitary for 1 of 1 kitchens observed. This deficiency had the potential to affect 24 of 24 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During a kitchen tour on 10/15/13 at 10:40 A.M., with the Kitchen Manager, there was no trash can observed at the hand washing sink to allow staff to throw paper towels away after they washed their hands. The trash can in the dish room was observed with the lid lifted off the trash can and pushed to the side.</p> <p>During an interview on 10/15/13 at 10:40 A.M., the Kitchen Manager indicated the staff use a paper towel to lift the lid of the garbage can to throw away the paper towels after washing their hands or they will leave</p>	R000273	<p>1. No resident was negatively affected by the deficient practice. Trash cans with foot pedals were immediately purchased and placed by the hand washing sinks. Employees have been re-educated regarding hand washing and use of trash cans with foot pedals. Divisional Director of Operations will audit at least twice a year to ensure appropriate trash cans are at hand washing sinks. 2. No resident was negatively affected by the deficient practice. A review of the kitchen was completed to ensure all items were dated and labeled. The kitchen employees have received re-education on appropriate labeling, dating and storage of food. The Divisional of Operations will monitor at least twice a year to ensure compliance. 3 &amp; 4. No resident was affected by the deficient practice. All employees were re-educated on proper hand washing, glove usage and hairnet usage, including Cook # 1, Kitchen Manager, CNA # 1 and CNA # 3. The Director or Designee will monitor for compliance to ensure proper hand washing, glove usage and hairnet usage on a weekly basis.</p>	11/02/2013

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	<p>the lid off the garbage can slightly so the paper towels can be thrown away without touching the lid.</p> <p>2. The following foods were found unlabeled and undated:</p> <p>a. An unidentified item was observed in a bag dated 9/20, in the cabinet by the white refrigerator. The item lacked a label regarding the contents.</p> <p>During an interview, the Kitchen Manager indicated the item was bread that was suppose to be used for bread crumbs and she could not believe it was still in the cabinet.</p> <p>b. A sack with the contents labeled as "Soft Rye Bread" and dated 10/14 was observed in the cabinet by the white refrigerator with the sack open.</p> <p>During an interview, the Kitchen Manager indicated the bread sack should have been closed with a clip or a bread tie.</p> <p>c. An unidentified item was observed in a Ziploc bag in the cabinet by the white refrigerator without a label or a date.</p> <p>During an interview, the Kitchen Manager indicated the item was</p>		POC Date: Nov. 2, 2013				

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	<p>bread crumbs that should have been labeled and dated.</p> <p>A policy for labeling and dating food was requested on 10/15/13 at 12:25 P.M., from the Kitchen Manager. No policy was provided.</p> <p>A policy for labeling and dating food was requested on 10/16/13 at 4:45 P.M. from the Executive Director. No policy was provided.</p> <p>At the time of the exit conference on 10/17/13 at 12:50 P.M., the policy for labeling and dating food was not provided.</p> <p>3. Improper handwashing was demonstrated during the following instances:</p> <p>a. Cook #1 was observed placing frozen shrimp into the deep fryer without donning gloves or washing her hands before or after she touched the shrimp on 10/15/13 at the following times: 11:53 A.M., 12:00 P.M., and 12:14 P.M.</p> <p>b. The Kitchen Manager was observed walking into the prep area</p>						

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	<p>of the kitchen and placing a bottle of white cooking wine down on the metal preparation table without washing her hands.</p> <p>c. CNA #2 was observed touching the handle of the garbage can lid then opening the freezer door. She was observed going over to where the mushrooms were cooking on the stove and picking up the cooking utensil by the handle and stirring the mushrooms. She was observed not washing her hands during this time.</p> <p>4. CNA #3 was observed entering into the kitchen prep area without a hairnet on and without washing her hands to ask Cook #1 a question.</p> <p>During an interview on 10/15/13 at 12:25 P.M., the Kitchen Manager, indicated she expected staff to wear a hairnet when they were in the kitchen prep area where the food was being prepared.</p> <p>She indicated staff should wash their hands when they removed their gloves, when they went from one job to another job, when they left the kitchen area and came back into the</p>						

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	<p>kitchen, and when they used the restroom.</p> <p>She indicated staff should wear gloves when food is handled that was ready to eat or raw meat was handled.</p> <p>The policy titled, "When to Wash Hands" undated was provided on 10/17/13 at 10:00 A.M., by the Executive Director (ED). The policy stated, "Foodhandlers must wash their hands before they start work. They must also do it after the following activities... Handling raw meat, poultry, and seafood (before and after).. taking out garbage... Touching anything else that my contaminate hands, such as dirty equipment, work surfaces, or towels...."</p> <p>The policy titled, "When to Change Gloves" and undated was provided on 10/17/13 at 10:00 A.M., by the ED. The policy stated, "Foodhandlers must change gloves at all of these times... After handling raw meat, seafood, or poultry and before handling ready-to-eat food...."</p> <p>The policy titled, "Food Safety" dated 7/2012 stated, "...PROCEDURE: 1) Hair nets shall be worn which shall</p>						

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	completely cover all hair...."				

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R000300	<p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review the facility failed to dispose of expired medications and to label with the date the medication was opened for 1 of 1 medication carts observed for medication storage. This had the potential to affect 24 of 24 residents in the facility.</p> <p>Findings include:</p> <p>An observation of the medication labeling and storage was conducted on 10/16/2013 at 3:55 P.M. The following medications were found with an expired date and / or no open date still in the cart :</p> <ol style="list-style-type: none"> <li>1. The eye drop medication for glaucoma (high pressure inside the eye), Azopt 1% ophthalmic suspension, had an expiration date of 5/30/2013 and an open date of 11/17/2012. This expired medication was still in the cart.</li> <li>2. The triple antibiotic eye medication,</li> </ol>	R000300	No resident was negatively affected by the deficient practice. All medications were inspected, by the Divisional Director of Resident Services, to ensure medications were not expired and they were dated when opened. Re-education was provided to all staff responsible for administrating medications covering what to do when medications are expired and dated when opened. POC Date: Nov. 2, 2013	11/02/2013			

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 10/17/2013
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	<p>Neomycin-Polymyxin-Gramicidin dated 6/20/2013. This expired medication was still in the cart.</p> <p>3. The eye medication for glaucoma, Travatan Z, did not have an open date.</p> <p>4. The diabetic insulin, Novolog, with an open date of 8/31/2013 was still in the cart.</p> <p>During an interview on 10/17/2013 at 11: 45 A.M., with the Director / RN Coordinator, she indicated she checked the medications cart for dates and expiration dates often and was not sure how she missed the expired medications.</p> <p>Completion of record review for the facility's Medication expiration and medication disposal policy and procedure was completed on 10/17/2013 at 11:50 A.M. The facility's medication expiration policy and procedure dated 07-2012 indicated that expired medication shall be destroyed according to the facility's medication disposal policies. The facility's medication disposal policy indicated the facility shall follow the consultant pharmacist's policy for disposal of all drugs.</p>			

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R000408	<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 interview and record review the facility failed to ensure a chest X-ray was completed within 6 months on a resident prior to admission for 1 of 7 residents reviewed for chest X-rays prior to admission. (Resident #5)</p> <p>Findings include:</p> <p>The record for Resident #5 was reviewed on 10/16/13 at 9:26 A.M. Diagnoses included, but were not limited to dementia, diabetes, and osteoarthritis.</p> <p>The resident was admitted to the facility on 9/11/13. He had an order request for a chest X-ray faxed on 9/12/13 to the doctor. The doctor faxed back the physician order for the chest X-ray on 9/13/13. The physician order for the chest X-ray was written by the facility on 9/16/13. The admission chest X-ray was completed on 9/25/13.</p> <p>A doctors progress note on 9/9/13 indicated the last chest X-ray was done in 2011.</p>	R000408	<p>No resident was negatively affected by the deficient practice. All resident charts were reviewed to ensure compliance with the regulations regarding CXRs. Re-education was provided to the RNC and the Director regarding regulations related to CXRs. The re-education included use of New Admission Checklist to ensure all records are in order. The Divisional Director of Resident Services will audit the process at least twice a year. POC Date: Nov. 2, 2013</p>	11/02/2013			

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	<p>A request was made for the facility to provide a copy of a preadmission chest X-ray for this resident on 10/16/13 at 11:50 A.M. A copy of a chest X-ray dated 9/2/2011 was provided by the Registered Nurse Coordinator (RNC) on 10/16/13 at 12:50 P.M.</p> <p>During an interview on 10/17/13 at 12:15 P.M., the RNC indicated she thought the 9/2/2011 chest X-ray would be a sufficient preadmission chest X-ray for the resident since he was admitted from another facility.</p>						