

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933
---	--

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This was for a State Residential Licensure Survey.</p> <p>Survey dates: October 29 and 30, 2014.</p> <p>Facility number: 003674 Provider number: 003674 AIM number: N/A</p> <p>Survey team: Laura Brashear, RN, TC Vicki Nearhoof, RN</p> <p>Census bed type: Residential: 25 Total: 25</p> <p>Census payor type: Private: 25 Total: 25</p> <p>Residential sample: 14</p> <p>These state findings are cited in accordance with IAC 16.2-5.</p> <p>Quality review completed 11/9/14 by Brenda Marshall, RN.</p>	R000000		
R000055	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as</p>			

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.

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 10/30/2014	
NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933			
(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			
	<p>individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:</p> <p>(1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy for a physical treatment for 1 of 2 residents reviewed. Resident #9</p> <p>Finding includes:</p> <p>On 10/30/14 at 11:50 a.m., LPN #1 was observed to administer a topical medication to Resident #9's knees. The resident was assisted from the dining room to a chair in a hallway outside of the medication room. The resident was seated, slacks pulled above the knees and knee high hose on. Resident #11 was seated next to the resident in the hallway. Both residents were in view of an adjacent hallway, and within view of the beauty shop where residents were present. LPN #1 applied a topical, prescription medication to both of Resident #9's knees.</p> <p>The Resident's clinical record was reviewed on 10/30/14 at 12:00 p.m.. A physician's order was noted for Voltaren 1% gel 1 gram to knees four times a day.</p>	R000055	<p>Corrective Action Taken: RN Coordinator reviewed all residents. An inservice was conducted with direct care staff to review residents' right to privacy and staff were instructed to ensure all treatments are performed in a private area away from public view. Potential Residents Affected: No resident was found to be negatively affected by noncompliance. Measures to ensure does not recur: All new employees will be provided residents rights documentation and trained for appropriate performance of treatments. An in-service on residents rights will be given annually. Monitor performance to ensure compliance: Director and RN Coordinator will observe and monitor treatments using QA (Core Check) monthly to ensure policy and state regulations are being followed.</p>	11/19/2014			

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933
---	--

(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
R000157	<p>The Administrator was interviewed on 10/30/14 at 3:00 p.m. The Administrator indicated Resident #9 had short term memory loss.</p> <p>The DON was interviewed on 10/30/14 at 3:00 p.m. and indicated the resident should have been afforded privacy during the treatment.</p> <p>A facility policy titled "Resident Bill of Rights" dated September 2014, included, but was not limited to, "(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: ... (3) Physical examinations and treatments."</p> <p>410 IAC 16.2-5-1.5(n) Sanitation and Safety Standards - Deficiency n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents' glucometers were stored in a manner to prevent cross contamination of items stored in the medication cart utilized for all 25 residents of the facility.</p> <p>Finding includes:</p>	R000157	<p>Corrective Action Taken: Upon surveyor's concern of resident glucometers, all resident glucometers were removed from medication cart and stored in individual resident apartments. RN Coordinator reviewed all residents. Potential Residents Affected: No resident was found to be negatively affected by noncompliance. Measures to</p>	11/19/2014

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 10/30/2014	
NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933			
(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			
	<p>On 10/30/14 at 11:30 a.m., LPN #1 was observed performing a blood glucose test for Resident #4. The nurse removed the resident's testing supplies in a black, zippered case stored in the third drawer of the medication cart, placed it into a plastic carrying tote, along with a bottle of medications, and went to the resident's room. The nylon case was placed on the counter top of the kitchen area in the resident's room. After the test strip was inserted into the meter the nurse placed the meter on the resident's dresser next to her bed. The nurse donned gloves, swabbed the resident's finger, performed the finger stick and placed a drop of blood onto the test strip. LPN #1 performed a second test as the first reading was 48. After completion of the test, the LPN returned the supplies to the nylon case while wearing the same gloves worn to perform the test. She zipped the case and returned it to the plastic tote. The nurse removed the gloves, picked up the tote, returned to the medication room and placed the nylon case in the bottom right hand drawer of the medication cart.</p> <p>On 10/30/14 at 2:35 p.m., with LPN #1 items in the third drawer of the cart were observed. The contents of the drawer included three nylon zippered cases containing glucose testing materials for</p>		<p>ensure does not recur: An in-service was conducted with staff to review cross contamination and policy on hand washing. Additionally, staff were informed that residents' personal glucometers are now stored in their apartments and going forward, this is to continue to be the protocol. Monitor performance to ensure compliance: RN Coordinator will perform weekly checks of the med cart to ensure no personal glucometers are stored there.</p>				

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933
---	--

(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
	<p>Residents #4, #7, and #17. Other items in the drawer were: a box of alcohol swabs, 20 insulin needles, 62 accucheck softelix lancets, 1 bag of safety lancets, house stock of glucose monitor test strips, one vial, accu-check meter testing solution, 15 fast click lancets and a sterile needle. The supplies were for use of all residents of the facility.</p> <p>Three residents of the facility had glucose monitoring meters that were stored in the same manner in the third drawer.</p> <p>Resident #17's clinical record was reviewed on 10/30/14 at 3:00 p.m. A physician's order was dated July 11, 2014 to Check blood sugars on Tuesday and Thursday at 10:00 a.m. and check fasting blood sugar on Tuesday and Thursday at 6:00 a.m. Resident #17's diagnosis included but was not limited to diabetes mellitus.</p> <p>Resident #7's clinical record was reviewed on 10/3/14 at 3:02 p.m., A physician's order dated October 20, 2012 was noted for "Check Blood Sugar Every Morning...Daily at 0630." The resident's diagnosis included but was not limited to, diabetes mellitus.</p> <p>Resident #4's clinical record was reviewed on 10/30/14 at 3:04 p.m. A</p>			

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 10/30/2014	
NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933			
(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			
	<p>physician's order included, but was not limited to: "Check Blood Sugar Four Times A Day Call MD if less than 60 or greater than 250...Daily at 0730, Daily at 11:30, Daily at 4:30, Daily at 2100." dated April 11, 2012.</p> <p>A facility policy titled "Preventing Contamination from Hands," dated 3/2014, included but was not limited to, "Procedure 1. Employees follow hand washing procedure at all times. Hands are to always be washed between the handling of a contaminated item and a clean item."</p> <p>Another facility policy titled "Bickford Family Members shall follow hand washing policies" dated April, 2014, included but was not limited to hands should be washed before and after performing treatments or procedures. After situations during which the spread of infection is likely to occur, especially those involving contact with mucous membranes, blood or body fluids.</p> <p>The Director of Nursing was interviewed on 10/30/14 at 12:05 p.m. The RN indicated there was a risk of contamination of items in the medication cart with the individual glucose meters that were not sealed in a protective clean covering.</p>						

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933
---	--

(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
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 prepared under sanitary conditions and failed to ensure adequate hand washing. This had the potential to affect 25 of 25 residents of the facility.</p> <p>Finding includes:</p> <p>On 10/29/14 at 11:20 a.m., the Dietary Manager (DM) was observed to wash her hands in the food preparation (prep) sink.</p> <p>On 10/29/14 at 11:55 a.m., the DM was slicing fresh strawberries and bananas without gloves at the food preparation sink. The DM turned on the faucet with her bare hands, rinsed a strawberry, turned off the faucet with bare hands and continued slicing the strawberries. The DM dropped a slice of banana onto the floor, picked it up, threw the slice into the garbage, and continued slicing the</p>	R000273	<p>Corrective Action Taken: Soap products were removed from food prep sink and sign posted to utilize sink for food prep only. An In-Service was conducted for the Kitchen Manager and staff to review the facility policies on food handling and hand washing. A review of the Retail Food Establishment Sanitation Requirements and Servsafe manual was also conducted to ensure that all kitchen staff is appropriately trained on proper hand washing protocol as well as safe food handling. Potential Residents Affected: No residents were negatively affected by noncompliance. Measures to ensure does not occur: Retail Food Establishment Sanitation and Servsafe manual will be kept in kitchen office for reference. Cooks will maintain Servsafe certification. New kitchen employees will be trained in proper food handling and hand washing. Monitor performance to ensure</p>	11/19/2014

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 10/30/2014	
NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933			
(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			
	<p>bananas.</p> <p>On 10/29/14 at 12:05 p.m., Dietary Aide (DA #2) washed her hands at the food preparation sink.</p> <p>On 10/29/14 at 2:45 p.m., DA #2 was observed coring fresh tomatoes at the food preparation sink with gloved hands. The DA #2 turned on the faucet with her gloved hands, rinsed the interior of the tomato, turned the faucet off with same gloves on, picked up another tomato to core it. The Aide repeated the procedure during the preparation.</p> <p>On 10/29/14 at 2:55 p.m., the DM indicated there was a hand washing sink but it was more convenient to wash hands at the food preparation sink.</p> <p>On 10/30/14 at 11:50 a.m., the Administrator provided a facility policy titled " Bickford Senior Living, POLICIES AND PROCEDURES, Dining Services Food Handling," revised July 2013, which included but not limited to: " ...All kitchen employees will follow Servsafe procedures for handling food products "</p> <p>On 10/30/14 at 11:50 a.m., the Administrator provided a facility policy titled, " Preventing Contamination from</p>		<p>compliance: The Director will observe and monitor kitchen staff's safe handling of food and hand washing to ensure compliance with facility policy and state regulations using QA (Core Check)monthly.</p>				

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 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933
---	--

(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
	<p>Hands," revised March, 2014, which included but not limited to: "</p> <p>...Employees follow hand washing procedure at all times. Hands are to always be washed between the handling of a contaminated item and a clean item. Hands are washed after washing fruit and vegetables. Ready-to-eat foods are handled with suitable utensils as deli tissue, spatula, tongs, single-use gloves or dispensing equipment "</p> <p>On 10/30/14 at 2:00 p.m., the Administrator provided documentation titled,</p> <p>" Servsafe Manager Book," which included but not limited to: " ...Where to Wash Hands: Hands must be washed in a sink designated for handwashing. NEVER wash hands in sinks designated for food prep, dishwashing, or utility services"</p>			