

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD WABASH, IN 46992
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: July 9, 2015</p> <p>Facility number: 003466 Provider number: 003466 AIM number: n/a</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Census payor type: Other: 33 Total: 33</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	Thank you to our survey team for their professionalism.	
R 0119 Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(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:</p> <p>(1) Instructions on the needs of the</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.

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	<p>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.</p> <p>This Residential Rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure new employees completed orientation to their positions for 3 of 10 employee records (Employee # 1, 8, & 9)</p> <p>Findings include:</p> <p>Review of Employee records began on</p>	R 0119	R 0119 - Personnel -- No residents were harmed by this deficient practice. 1. Divisional Director to provide re-education for Director on use of the New Bickford Family Member Packet on 7/20/15. 2. Personnel files for all current staff to be audited by Director using Personnel File Checklist. Audit to be complete by 7/24/15. 3. Any deficiencies discovered to be corrected by 7/30/15. 4. The completed Personnel File Checklist for the next five new hires to be reviewed	07/30/2015

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R 0120	<p>7/9/15 at 4:30 p.m.</p> <p>Employee #1's employment record did not indicate completion of an orientation to the facility or specific job description.</p> <p>Employee #8's employment record did not indicate completion of an orientation to the facility or specific job description.</p> <p>Employee #9's employment record did not indicate completion of an orientation to the facility or specific job description.</p> <p>A policy, "Orientation and Inservice", dated 5/2014, and received from the Administrator on 7/9/15 at 5:29 p.m., indicated the following:</p> <p>"...1) Bickford Family Member orientation is to be completed at the time of employment and the Orientation Checklist is to be signed and dated..."</p> <p>During an interview with the Administrator, on 7/9/15 at 5:27 p.m., he indicated all employee files should contain a copy of the employees' orientation checklists.</p>		<p>by the Divisional Director within three weeks of hire. 5. Divisional Director to review personnel files twice a year. 6. If any deficiencies noted on divisional audit, the next five files will again be reviewed within three weeks of hire. 7. Date of completion 7/30/15 and ongoing.</p>				
	410 IAC 16.2-5-1.4(e)(1-3)						

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Bldg. 00	<p>Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>This Residential Rule was not met as evidenced by:</p>	R 0120	R 0120 - Personnel -- No residents were harmed by this deficient practice. 1. Divisional Director to provide re-education	07/30/2015
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	<p>Based on interview and record review, the facility failed to ensure staff completion and documentation of required in-services for 7 of 10 employee files reviewed for completion of dementia, abuse, and resident's rights training. (Employees #2, 3, 4, 5, 6, 7, & 10)</p> <p>Findings include:</p> <p>Review of Employee records began on 7/9/15 at 4:30 p.m.</p> <p>Employee #2's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>Employee #3's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>Employee #4's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>Employee #5's employment record did not indicate completion of required initial training on resident's rights.</p> <p>Employee #6's employment record did</p>		<p>for the Director on mandatory in-service schedule on 7/20/15. 2. Personnel files for all current staff to be audited for any absent in-service records by 7/24/15. 3. Any missing in-services from January - June 2015 will be presented and documented by 7/30/15. 4. Monthly in-services beginning July 2015 to be presented and documented for all staff. 5. In-service content and sign-in sheets to be kept in a binder in the Director's office - individual tests to be kept in personnel files. 6. In-servicing to follow the in-service schedule for 2015 provided by the corporate office. 7. In-service records to be reviewed by Divisional Director twice a year. 8. Date of completion 7/30/15 and ongoing.</p>				

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R 0121 Bldg. 00	<p>not indicate completion of required initial training on resident's rights.</p> <p>Employee #7's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>Employee #10's employment record did not indicate completion of required annual training on dementia.</p> <p>A policy titled, "Dementia Training", dated 9/2012, and received from the Director of Nursing on 7/9/15 at 5:29 p.m., indicated the following:</p> <p>"...3) All Bickford Family Members...will receive a minimum of 6 hours of dementia-specific training prior to or within 90 days of employment...."</p> <p>During an interview with the Administrator, on 7/9/15 at 5:27 p.m., he indicated he was aware of the requirements for dementia, abuse, and resident's rights training.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a</p>			

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	<p>tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>This Residential Rule was not met as evidenced by:</p> <p>Based on record review and interview,</p>	R 0121	R 0121 - Personnel -- No residents were harmed by this deficient practice although the potential for harm existed. 1. Divisional Director to provide	07/30/2015			

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	<p>the facility failed to ensure tuberculin skin tests were completed for 2 of 10 employee records reviewed for tuberculin skin tests and pre-employment physicals were completed for 4 of 5 employee records reviewed for physicals. (Employee # 1, & 5; Employee # 1, 5, 6, & 9)</p> <p>Findings include:</p> <p>Review of Employee records began on 7/9/15 at 4:30 p.m.</p> <p>Employee #1's employment record did not indicate completion of a pre-employment physical nor a tuberculin test.</p> <p>Employee #5's employment record did not indicate completion of a pre-employment physical nor a tuberculin test.</p> <p>Employee #6's employment record did not indicate completion of a pre-employment physical.</p> <p>Employee #9's employment record did not indicate completion of a pre-employment physical.</p> <p>A policy titled, "Employment Physicals", dated 9/2012, and received from the</p>		<p>re-education for the Director and RNC on Mantoux testing policy and for Director on the requirement for pre-employment physicals for staff on 7/20/15. 2. All TB testing records for current staff to be audited for proper initial, and subsequent testing. Audit to be completed by 7/24/15. 3. TB testing to be performed for any staff not meeting the required standard of testing by 7/30/15. 4. Pre-employment physical exams to be done for employees #1, #5, # 6 and #9. 5. Personnel File Checklist for next five hires to be reviewed by Divisional Director within three weeks of hire. 6. TB testing records to be reviewed by Divisional Director twice a year. 7. Date of completion 7/30/15 and on-going.</p>				

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	<p>Director of Nursing on 7/9/15 at 5:29 p.m., indicated the following:</p> <p>"...1) Once a job offer has been made and accepted, a pre-employment physical will be scheduled..."</p> <p>"...2) Employment is contingent upon receiving a satisfactory physician's report...."</p> <p>A policy titled, "Tuberculosis Screening-Bickford Family Member", dated 9/2012, and received from the Administrator, on 7/9/15 at 5:27 p.m., indicated the following:</p> <p>"...1) Upon hire, all Bickford Family Members must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis..."</p> <p>"...Annual: 1) Bickford Family Members must undergo a one-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis..."</p> <p>During an interview with the Administrator, on 7/9/15 at 5:27 p.m., he indicated all employee files should contain a copy of the pre-employment physical and initial or annual tuberculin</p>			

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R 0154 Bldg. 00	<p>tests.</p> <p>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. This Residential Rule was not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. Of the facility's 16 residents, this deficient practice had the potential to impact 16 of 16 residents who were served food from the facility's kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Kitchen sanitation tour, accompanied by Dietary Aide #2 on 7/9/15 at 10:04 a.m., indicated the following: <ol style="list-style-type: none"> a. The front of the kitchen cabinets had an accumulation of dust, grime and white dried substance on them. b. The microwave had dried food particles, a brownish yellow in color grime splattered on the inside walls, door 	R 0154	<p>R 0154 - Sanitation and Safety Standards -- No residents were harmed by this deficient practice although the potential for harm existed. 1. Director to provide re-education for Kitchen Manager and all assistant Cooks on the Kitchen Rotational Cleaning Schedule - 2015 and the Dining Service Core Check (QA). Education to be completed by 7/24/15. 2. Dining Service Core Check to be completed by the Director and all deficiencies addressed by 7/30/15. 3. Director to review kitchen for general cleanliness every business day and maintain documentation for one month, beginning 7/20/15. Dining Services Core Check to be completed weekly for the following month and monthly thereafter. 4. Cleaning schedule to be posted in the kitchen and line items initialed as completed - Director to review this monthly and initial as well for next six months. 5. Divisional Director to audit kitchen/dry storage area twice a year. 6. If deficiencies noted on divisional audit - weekly</p>	07/30/2015

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	<p>and top. The outside of the microwave had dust and grime on it.</p> <p>c. The tops of the stainless steel refrigerator and freezer had an accumulation of dust and grime. The bottom of them had an accumulation of dust, debris, grime and dried food particles.</p> <p>d. The kitchen cabinets had dust, grime and debris on the inside of them. A kitchen cabinet which stored dried goods had a loose brown powdery substance that covered the second shelf from the bottom. The dietary aide indicated it smelled like brownie mix. A loose white powdery substance was observed on the third shelf from the bottom.</p> <p>e. The floor and cove base located in the kitchen food preparation area had an accumulation of dirt, dust and grime. There was grease splattered on the floor between the kitchen cabinets and the stove.</p> <p>f. A stainless steel center island with two shelves had dried food particles, debris, dust and grime on two of two shelves.</p> <p>g. A ready to use uncovered white mixer, located on the stainless steel center island, had dried white and cream colored</p>		checks to resume as per above schedule. 7. Date of completion 7/30/15 and on-going.				

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	<p>food particles and a white loose powdery substance on it.</p> <p>h. The inside of the two of two ovens had an accumulation of dried spills, food particles and debris. The top of the stove had an accumulation of dried food particles, grime and debris. The back and side splash guards and 11 of 11 knobs on the two ovens had an accumulation of grime which was sticky to touch. The drip pan located under the stove top had an accumulation of dried food particles and debris covering the aluminum foil. The dietary aide #2 indicated it was cleaned every two months.</p> <p>i. There was a total of four plastic containers with ready to use kitchen utensils in them which had an accumulation of dust, debris and food particles in the bottom of the containers which contained the following: a.) 9 ice cream scoops. b.) 3 plastic scoops, 1 metal scoop, 1 metal egg slicer, 1 metal apple slicer, 1 tomato corer, 1 plastic attachment for food processor, 1 plastic scraper, 1 metal measuring cup. c.) 1 pastry cutter, 1 vegetable masher, 3 graters, 1 barbeque brush. d.) 1 cheese slicer, 1 meat tenderizer, and 1 can opener.</p> <p>j. There was an accumulation of grey</p>			

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	<p>dust hanging on the blue gas line and pipes behind the stove. The Executive Director indicated he could visibly see the accumulation of dust on the gas line behind the stove from where he was standing.</p> <p>k. A large oval serving tray was observed between the stainless steel freezer and a kitchen cabinet resting on its side which touched the floor. The serving tray had food debris which was white and brown in color on it.</p> <p>l. An uncovered meat slicer had dried food particles on the slicer.</p> <p>m. A ready to use 12 inch frying pan was located on the bottom shelf of the stainless steel island and was stored upright. The inside of frying pan had dried food particles on it.</p> <p>n. The white metal racks inside the two door stainless steel refrigerator were rusted. The walls of the inside of the refrigerator had a brown grime and debris on the walls. The fan located on the inside top of refrigerator had an accumulation of brown dust hanging from it.</p> <p>o. An uncovered, unlabeled and undated plastic container of a white powder,</p>			

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	<p>identified as baking soda, was located on the top shelf of the two door stainless steel refrigerator. It was measured by LPN #11 to be 1 and 1/4 cup.</p> <p>p. An uncovered 3/4 block of butter was observed to on the top shelf of the two door stainless steel refrigerator.</p> <p>q. An unlabeled and undated 4 pound plastic container of green beans was located on the top shelf of the two door stainless steel refrigerator.</p> <p>r. One unsealed plastic bag of cheddar cheese was located on the top shelf of the two door stainless steel refrigerator. It was measured by LPN #11 to be 1 and 1/4 cup.</p> <p>s. Six slices of cheese were located on the top shelf of the two door stainless steel refrigerator and not in a sealed container.</p> <p>t. One unsealed plastic bag of Mozzarella cheese was located on the top shelf of the two door stainless steel refrigerator. It was measured by LPN #11 to be 4.25 pounds.</p> <p>u. An unlabeled and undated plastic red bowl of a yellow, thick substance was located in the two door stainless steel</p>			

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NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD WABASH, IN 46992
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	<p>refrigerator. The dietary aide #2 indicated she was unsure of what it was. The Executive Director indicated it was cake batter. It was measured by LPN #11 to be 2 and 1/2 pounds.</p> <p>v. A large plastic container covered with aluminum foil contained water and 13 large, raw and whole potatoes. The potatoes had black spots on them and there was a fool odor that came from the container once it was uncovered. The container of potatoes was located on the bottom shelf of the two door stainless steel refrigerator.</p> <p>w. The bottom shelf of the two door stainless steel refrigerator had a red and yellow liquid substance, food particles, grime and 1 dead fly located on it.</p> <p>x. Three unopened 5 pound plastic containers of cottage cheese with a best by date of 6/19/15. One opened 5 pound plastic container of cottage cheese with a best by date of 6/19/15. The cottage cheese was located in the 2 door stainless steel refrigerator.</p> <p>y. An unwrapped and cut 1/2 head of lettuce was located on a rusted shelf of the two door stainless steel refrigerator.</p> <p>z. A medium, clear, plastic container</p>			

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	<p>held 1 head of cabbage, 1 tomato, 1 green onion, 2 mushrooms, 3 radish slices which were black in color, 1 wilted cabbage leaf and a parsley bunch with grey, fluffy mold adhered to the container. All the above items in the plastic container were unwrapped.</p> <p>aa. An opened 3/4 of a 1 pound box of lasagna was located on the top shelf in the food storage room.</p> <p>bb. An opened 3/4 of a 2 pound bag of northern beans was located on the second shelf in the food storage room.</p> <p>cc. One box of quick barley, had a best by date of 4/29/15, was located in the food storage room.</p> <p>During an interview with the Dietary Manager on 7/9/15 at 3:58 p.m., he indicated there was a cleaning schedule posted for the kitchen. He further indicated he does not believe it was being followed. The Dietary Manager indicated there was no cleaning checklist in place prior to 7/9/15 and was just brought one by the Executive Director on 7/9/15.</p> <p>The Dietary Manager indicated the Registered Dietician has come in since he had started in April of 2015 and had told</p>			

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	<p>him areas which needed to be worked on but had left nothing in writing.</p> <p>2. A second kitchen observation tour with the Dietary Manager on 7/9/15 at 4:15 p.m., indicated the following:</p> <p>a. A large accumulation of black liquid grease and a pile of food debris piled to the top of the drip pan approximately 3 inches in height by 4 inches in length by 2 inches wide.</p> <p>During an interview with the Executive Director on 7/9/15 at 4:52 p.m., he indicated the Registered Dietitian did not provide him with a kitchen sanitation evaluation on her last visit on 5/19/15.</p> <p>A review of the cleaning schedule titled "CLEANING SCHEDULE" provided by the Executive Director on 7/9/15 at 3:30 p.m., indicated the following:</p> <p>a. "AFTER EACH USE: ...Can Opener, ...Mixers...Stove Top (Range), Dishes, Pots and Pans, ...Kitchen and Dining Room Floors</p> <p>b. DAILY: ...Floors (Kitchen, Dining Room), Exterior of Dishwasher and Other Appliances...</p>			

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	<p>c. WEEKLY: ...Refrigerator</p> <p>d. TWICE PER MONTH: Oven, Kitchen Cabinets and Drawers</p> <p>e. MONTHLY: ...Clean Behind, Under Major Appliances, Vacuum, Dust Back of Appliances, Drawers, Shelves, Refrigerator Condenser Pan, Refrigerator Condenser Coils...."</p> <p>There were no initials, dates or shifts scheduled to clean the particular items listed on the schedule.</p> <p>No general kitchen sanitation policy was provided by the Executive Director as of exit but on 7/9/15 at 2:45 p.m. He did provide a specific area and equipment policy which each began with the following:</p> <p>"POLICY</p> <p>All items of equipment are cleaned and sanitized in accordance with the guidelines established by the U.S. Department of Health and Human Services as stated in the 'Food Service Code Manual', 1997...."</p> <p>No further documentation was provided</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	upon exit on 7/9/15.				