

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 01/03/2014
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NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE CROWN POINT, IN 46307
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R000000	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: January 2 and 3, 2014</p> <p>Facility number: 012940 Provider number: 012940 AIM: N/A</p> <p>Survey Team: Regina Sanders, RN, TC Caitlyn Doyle, RN</p> <p>Census bed type: Residential: 16 Total: 16</p> <p>Census Payor type: Other: 16 Total: 16</p> <p>Residential Sample: 5 Supplemental Sample: 1</p> <p>These Residential State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed January 3, 2014, by Janelyn Kulik, RN.</p>	R000000	Please accept this document as our Plan of Correction for the Survey completed 01-03-2014 at Bickford of Crown Point. The deficiencies noted have been corrected and the facility is in substantial compliance. No residents were negatively affected by these deficient practices. Sincerely, Anthony Ughetti, Director Bickford of Crown Point	

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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R000121	<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 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>			

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	<p>Based on record review and interview, the facility failed to ensure employees at the facility received a first and second step Mantoux (test for tuberculosis) at the time of employment, or within one month prior to employment, for 2 of 5 employees hired in the past four months. (LPN #3 and CNA #5)</p> <p>Findings include:</p> <p>Employee Records were reviewed on 01/03/14 at 9 a.m. The records indicated LPN #3's and CNA #5's start date at the facility was 09/30/13.</p> <p>The Employee Records indicated LPN #3 and CNA #5 had a Mantoux on 10/22/13.</p> <p>There was a lack of documentation to indicate LPN #3 and CNA #5 had a Mantoux prior to their start date or had a second step Mantoux administered by the facility one to three weeks after the first step Mantoux was given.</p> <p>During an interview on 01/03/14 at 10:25 a.m., the Executive Director indicated it was his and the RN Coordinator's responsibility to ensure the employee had their</p>	R000121	<p>R121:CORRECTIVE ACTION TAKEN: Director performed a review of all active personnel files to identify any employees who have not received a first and second step mantoux test at the time of employment. Any employees identified were administered the Mantoux test as required.POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR: Director and RN-Coordinator received in-service education from the Divisional Director of Resident Services regarding the requirements for Mantoux testing for employees. Director will record test administration on the initial orientation form.MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Director of Operations will perform audit of employee files, using the Bickford Family Member Personnel Core Check tool, to include Mantoux records and employment checklist, at least twice a year, on an ongoing basis, to ensure Mantoux tests are occurring as required. DATE OF COMPLIANCE: 1-14-2014.</p>	01/14/2014			

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R000148	<p>Mantoux's administered prior to starting work at the facility. He indicated he was calling the employees past employers to see if they had a Mantoux completed there.</p> <p>During the Exit Conference on 01/03/14 at 11:00 a.m., no further information had been provided by the facility.</p> <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to ensure the facility was free of hazards, which could adversely affect the health and welfare of the residents, related to</p>	R000148	R148:CORRECTIVE ACTION TAKEN: Bickford will maintain the Branch to be free of hazzards which may affect the health and welfare of the residents. -The Bleach spray, window cleaner,	01/08/2014			

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	<p>hot coffee pots left with heating element left on, in the Mary B. Unit (Memory Care Unit), which had the potential to affect 4 residents who resided on the Mary B. Unit, chemicals left in an unlocked cabinet in the Bistro, which had the potential to affect 9 residents, identified as confused of the 12 residents who resided in the facility outside of the Mary B. Unit, and a radio/CD player, which had an electrical cord, stored on the floor next to the resident's bath tub in the Spa.</p> <p>Findings include:</p> <p>During the environmental tour on 01/02/14 at 10:15 a.m. through 10:45 A.M., with the Director of Maintenance present, the following was observed:</p> <p>1. There was an unlocked cabinet in the Bistro, which resident's had access to, which contained a bottle of bleach spray, two bottles of window cleaner, and a can of furniture polish.</p> <p>During an interview at the time of the observation, the Director of Maintenance indicated he was unsure who is responsible for locking the cabinet where the</p>		<p>and furniture polish were removed from the Bistro cabinet. -The radio/CD player will be stored and used out of reach of the whirlpool in the Spa. -The coffee maker was removed from the Mary B's dining room.POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR: Director performed inservice training to staff regarding proper handling and storage of chemicals and general safety considerations in Assisted Living. MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Director will perform random environmental rounds at least monthly, on an ongoing basis, using the Basic Needs-Safety and Security Core Check, for a period of one year to observe and identify any unsafe conditions. Divisional Director of Operations will audit the Branch at least twice a year, using the Basic Needs-Safety and Security Core Check, on an ongoing basis. DATE OF COMPLIANCE: 1-8-14.</p>				

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	<p>chemicals were stored.</p> <p>2. There was a radio/CD player, with the electrical cord, unplugged stored on the floor, next to the bath tub in the Spa.</p> <p>3. There were two hot plates turned on, on the coffee maker and two pots of hot coffee sitting on the coffee maker on the counter in the serving area of the Mary B. Unit Dining Room. The area was accessible to the resident's of the unit.</p> <p>During an interview at the time of the observation, LPN #1 indicated there was not always staff in the area to ensure the residents did not touch the coffee pots or coffee.</p> <p>4. During an observation on 01/02/14 at 12:15 p.m., there was an unlocked cabinet in the Bistro, which contained a bottle of bleach spray, two bottles of window cleaner and a can of furniture polish.</p> <p>During an interview at the time of the observation, LPN #1 indicated there were nine residents in the area who were confused and had access to the chemicals.</p>						

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R000241	<p>An undated facility policy, received from the Executive Director on 01/03/14 at 8:30 a.m., titled "Housekeeping/Laundry", indicated, "...chemicals shall be under lock at all times when not attended..."</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure medications were administered as ordered by the residents' physicians for 1 of 5 residents reviewed for medication administration in a total sample of 5. (Resident #9)</p> <p>Findings include:</p> <p>Resident #9's record was reviewed on 01/02/14 at 10:55 a.m. The resident's diagnoses included, but were not limited to, dementia and osteoporoses.</p> <p>The Physician's Current Orders, dated 12/13, indicated the resident's Seroquel (anti-psychotic) 25 mg (milligrams) daily and vitamin B-12</p>	R000241	<p>R241:CORRECTIVE ACTION TAKEN: -RN Coordinator will ensure that medications are administered as ordered by the resident's physician.-RN Coordinator contacted Resident #9's physician and clarified the orders for Seroquel, Vitamin B12 and D3.-MAR was updated to reflect the current orders. POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected. Divisional Director of Resident Services performed a random review of resident orders and MAR's that indicated no other residents were affected. MEASURES TO ENSURE DOES NOT RECUR: -Divisional Director of Resident Services performed additional education to RN Coordinator on Documentation Policy,</p>	01/14/2014			

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	<p>2500 mcg (micrograms), two tablets daily had been discontinued and the vitamin D3 5000 IU (international units), one tablet every day had been changed to three times daily. The orders were signed by the resident's Physician on 12/13/13.</p> <p>A Physician's pharmacy prescription, indicated an order 12/18/13 for Seroquel 25 mg, twice a day.</p> <p>The December 2013 E-MAR (Electronic Medication Administration Record), dated 12/13, indicated the resident continued to receive the Seroquel from 12/13/13 through 12/18/13, after the medication had been discontinued from the resident's Physician.</p> <p>The December 2013 E-MAR indicated the resident continued to receive the vitamin B-12 daily and vitamin D3 daily from 12/13/13 through 12/31/13, after the vitamin B-12 had been discontinued and the vitamin D3 had been increased to three times daily by the resident's Physician.</p> <p>During a telephone interview on 01/02/14 at 11:30 a.m., the RN Coordinator indicated she was aware the medications had been</p>		<p>documentation of physician visits and new orders.-"FAXED" Stamps have been placed in the facility to provide better tracking of date and time of faxed orders to physicians and pharmacy.MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Divisional Director of Resident Services will perform an audit of physician orders and MAR's, using the Medication Management Core Check, at least twice a year on an ongoing basis to monitor that medications are being administered as ordered. DATE OF COMPLIANCE: 1-14-2014.</p>				

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R000242	<p>discontinued. She indicated the pharmacy had sent the vitamin B-12 to the facility but she had not put the medication in the medication cart. She indicated another Physician had ordered the resident's Seroquel and the family had not wanted the Seroquel discontinued and had called the other Physician about the order. She indicated the facility did not have a written order until the prescription came in on 12/18/13 to continue the Seroquel.</p> <p>During an interview on 01/02/14 at 11:40 a.m., LPN #1 indicated the resident had been receiving the vitamin B-12 daily, "up until a few days ago". LPN #1 indicated the resident had been receiving the vitamin D3 daily, not three times a week.</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on observation, interview and</p>	R000242	R242:CORRECTIVE ACTION TAKEN: -Residents will be	01/14/2014			

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	<p>record review, the facility failed to observe for effects of medication, related to monitoring a pulse for a resident on digoxin (heart medication) for 1 of 5 residents observed for medication administration. (Resident #11)</p> <p>Findings include:</p> <p>During an observation of a morning medication administration on 01/03/14 at 8:50 a.m., LPN #2 prepared and administered Resident #11's medication, which included digoxin 0.125 mg (milligram). LPN #2 did not monitor the resident's pulse prior to the administration of the digoxin.</p> <p>During an interview on 01/03/14 at 9 a.m., LPN #2 indicated she did not take the resident's pulse because there was no Physician's order to take the pulse.</p> <p>Resident #11's record was reviewed on 01/03/14 at 9:10 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and Alzheimer's Disease.</p> <p>The resident's current Physician's Orders, dated 12/13, indicated an order for digoxin 0.125 mg, one</p>		<p>observed for effects of medications with appropriate documentation of any undesirable effects, as well as notification of their physician.-Resident #11's MAR was updated to include a pulse reading prior to administration of Digoxin.POTENTIAL RESIDENTS AFFECTED: All residents receiving Digoxin have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR: Divisional Director of Resident Services re-educated nursing staff in proper monitoring of medication effects and to call for clarification of orders if customary parameters are not addressed. MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Divisional Director of Resident Services will perform an audit of Physician Orders and MAR's at least twice a year, using the Medication Management Core Check, on an ongoing basis to ensure that appropriate parameters are being noted. DATE OF COMPLIANCE: 1-14-2014.</p>				

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R000273	<p>tablet every day.</p> <p>The facility's medication manual, identified as current by LPN #2, titled, "The Pill Book 15th Edition", indicated, "...DIGOXIN...Check your pulse every day...contact your doctor if it drops below 60 beats per minute..."</p> <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. Based on observation and interview, the facility failed to ensure food storage was in accordance with the State and local sanitation and safe food handling standards, related to open and undated food and expired food for 2 of 2 food storage areas outside of the kitchen. (Bistro and Mary B's Unit)</p> <p>Findings include:</p> <p>During the environmental tour on 01/02/14 at 10:15 a.m. through 10:45 a.m. with the Director of Maintenance present the following was observed:</p> <p>There was an undated cheese tray</p>	R000273	<p>R273:CORRECTIVE ACTION TAKEN: The undated items in Mary B's refrigerator and the Bistro refrigerator were disposed of. Bickford will ensure that all food preparation and services are in accordance with sanitation and safe food handling standards.POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR: Director retrained staff in proper handling, storage, dating, and disposal of opened food items. MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Director will perform random environmental rounds at least monthly, using the Dining Services Core Check, for a period of one year to monitor that</p>	01/08/2014

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R000408	<p>and a carton of Half and Half Cream with an expiration date of 12/15/13 stored in the refrigerator and an opened/undated box of crackers in the cabinet in the Bistro.</p> <p>There was a carton of Fat Free Milk with an expiration date of 12/24/13 and opened/undated cheese and butter stored in the refrigerator of the Mary B. Unit.</p> <p>During an interview on 01/03/14 at 8:35 a.m., the Executive Director indicated the facility did not have a policy on storage of food and followed the Safe Server Guidelines for food storage. He indicated the expired and opened food had been removed from the areas.</p> <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 record review and interview, the facility failed to ensure a resident had a chest x-ray completed no more than six months prior to admission for 1 of 5 residents reviewed for chest x-rays in a total sample of 5. (Resident #15)</p>	R000408	<p>opened food items are properly dated and stored. Divisional Director of Operations will perform random environmental rounds, at least twice a year on an ongoing basis, using the Dining Services Core Check. DATE OF COMPLIANCE: 1-8-2014.</p> <p>R408:CORRECTIVE ACTION TAKEN: Resident #15 received a chest x-ray from his physician on 1-10-14. All resident charts were reviewed to ensure compliance with the regulation.POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR:</p>	01/14/2014

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	<p>Findings include:</p> <p>Resident #15's record was reviewed on 01/02/14 at 10:30 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p> <p>The resident was admitted into the facility on 12/10/13.</p> <p>The chest x-ray in the resident's record was dated 08/04/09. There was a lack of documentation to indicate a chest x-ray had been completed within six months of admission into the facility.</p> <p>During an interview on 01/03/14 at 8:40 a.m., the RN Director of Residential Services indicated, the facility was still waiting to see if the Physician's Office had a chest x-ray for the resident.</p> <p>During the Exit Conference on 01/03/14 at 11 a.m., no further information had been provided by the facility.</p>		<p>Divisional Director of Resident Services re-educated RN-Coordinator and Director regarding the regulations for pre-admission chest x-rays, including the use of the New Admission Checklist to monitor that records are in compliance. MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Divisional Director of Resident Services will perform an audit of resident records at least twice a year, using the Resident Chart Core Check, on an ongoing basis, to monitor compliance with the regulation. DATE OF COMPLIANCE: 1-14-2014.</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 01/03/2014	
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R000410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident had a documented two-step Mantoux (test for tuberculosis) completed upon admission into the facility for 1 of 5 residents reviewed for Mantoux's in a total sample of 5. (Resident #15) Findings include: Resident #15's record was reviewed on 01/02/14 at 10:30 a.m. The resident's diagnosis included, but was not limited to, hypertension.</p>	R000410	R410:CORRECTIVE ACTION TAKEN: Resident #15 was administered a 2nd step Mantoux test. All resident charts were reviewed to ensure compliance with this regulation.POTENTIAL RESIDENTS AFFECTED: All residents have the potential to be affected.MEASURES TO ENSURE DOES NOT RECUR: Divisional Director of Resident Services re-educated RN-Coordinator and Director regarding the regulations for Pre-Admission Mantoux testing, including the use of the New Admission Checklist to monitor that records are in	01/16/2014			

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	<p>The resident was admitted into the facility on 12/10/13.</p> <p>The resident had a Mantoux administered on 12/02/13 and read on 12/04/13.</p> <p>There was a lack of documentation to indicate the resident had a second step Mantoux completed one to three weeks after the first step.</p> <p>During an interview on 01/02/14 at 1 p.m., the RN Director of Residential Services indicated the facility was attempting to locate the second step Mantoux.</p> <p>An undated facility policy, received from the Executive Director on 01/03/14 at 8:30 a.m., titled, "Tuberculosis Screening-Resident", indicated, "...upon move-in, all Residents must undergo a two-step Mantoux...to ensure that they are not infected with tuberculosis, unless the Resident brings proof of a recent negative PPD (Mantoux) Test..."</p> <p>During the Exit Conference on 01/03/14 at 11 a.m., no further information had been provided by the facility.</p>		<p>compliance.MONITOR PERFORMANCE TO ENSURE COMPLIANCE AS FOLLOWS: Divisional Director of Resident Services will perform an audit of resident records at least twice a year, using the Resident Chart Core Check, on an ongoing basis to monitor compliance with the regulation. .DATE OF COMPLIANCE: 1-16-2014</p>				

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