STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/23/2021

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 22 and 23, 2021. Facility number: 012940 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/24/21.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current first aid certificate scheduled for 8 of 21 shifts reviewed. Finding includes: Facility staffing schedules for 6/13/21 through 6/19/21 were reviewed on 6/23/21 at 9:15 a.m. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Day shifts on 6/15/21, 6/16/21, 6/17/21 and 6/19/21 Evening shifts on 6/14/21 and 6/19/21 Midnight shifts on 6/18/21 and 6/19/21 Interview with the Administrative Assistant on 6/23/21 at 10:40 a.m., indicated she was unaware there needed to be at least one staff member every shift with first aid certification. She was unable to provide any additional first aid certificates.	R 0117	No residents were harmed by this deficient practice however potential harm did All employee files will be audited to ensure current first aid certification is on file for staff members with first aid. Divisional Director of Resident Services will re-educate Administrator and Nurse Coordinator on policy/procedure for the requirement to have one staff member with a current first aid certificate on each shift. Nurse Coordinator will schedule and ensure all staff members remain current with first aid. Divisional Director will audit employee files monthly x3 months and annually to ensure compliancy Completion Date 7/26/21	07/26/2021
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the			

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	resident. Based on observation, record review, and interview, the facility failed to ensure a medication was accurately labeled and given per Physician's order for 1 of 5 residents observed during the medication pass observation. (Resident 9) Finding includes: On 6/22/21 at 11:05 a.m. LPN 1 was observed preparing Resident 9's medication. LPN 1 reviewed the Medication Administration Record (MAR) which indicated the resident should receive carbidopa/levodopa (Sinemet, a medication used to treat Parkinson's disease) 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg total. LPN 1 reviewed the medication card label which indicated carbidopa/levodopa 25/100 mg (milligrams) give 1.5 tabs to equal 27.5/150 mg. LPN 1 then administered 1.5 tabs of the medication to the resident. Record review for Resident 9 was completed on 6/22/21 at 3:15 p.m. The 6/2021 Physician's Order Summary indicated carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg by mouth three times daily. Interview with QMA 1 on 6/22/21 at 3:18 p.m. indicated LPN 1 had already gone home for the day. She reviewed the Physician's Order in the computer and compared it to the medication card. They both indicated carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg total. She indicated she would call the pharmacy to get clarification. Interview with the Assistant RNC (Registered Nurse Coordinator) on 6/23/21 at 11:10 a.m., indicated the correct order should have read	R 0247	No residents were harmed by this deficient practice although the potential for harm did exist. Resident was administered correct dose of medication. Labeling error by pharmacy. Divisional Director will re-educate Nurse Coordinator on verifying orders entered into eMar by pharmacy, including the correct dose. Nurse Coordinator will verify correct labelling on all incoming meds from pharmacy for 3 weeks. If any error is found, repeat audit will continue and be done weekly for three weeks until compliant. Divisional Director to audit 5 medication labels comparing to physician orders on routine visits x3 months for compliance, during branch visits. Completion date 7/26/21	07/26/2021

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	carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 37.5/150 mg total. They had clarified the order and updated the Physician's Order summary.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review, and interview, the facility failed to ensure a medication was accurately labeled and packaged per Physician's order for 1 of 5 residents observed during the medication pass observation. (Resident 9) Finding includes: On 6/22/21 at 11:05 a.m. LPN 1 was observed preparing Resident 9's medication. LPN 1 reviewed the Medication Administration Record (MAR) which indicated the resident should receive carbidopa/levodopa (Sinemet, a medication used to treat Parkinson's disease) 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg total. LPN 1 reviewed the medication card label which indicated carbidopa/levodopa 25/100 mg (milligrams) give 1.5 tabs to equal 27.5/150 mg. The medication card was observed to have 1.5 tabs prepackaged in each blister pack. LPN 1 then administered 1.5 tabs of the medication to the resident from the prepackaged medication pack. Record review for Resident 9 was completed on 6/22/21 at 3:15 p.m. The 6/2021 Physician's Order	R 0297	No residents were harmed by this deficient practice although the potential for harm did exist. Resident was administered correct dose of medication. Labeling error by pharmacy. Divisional Director will re-educate Nurse Coordinator on verifying orders entered into eMar by pharmacy, including the correct dose. Nurse Coordinator will verify correct labelling and packaging on all incoming meds from pharmacy for 3 weeks. If any error is found, repeat audit will continue and be done weekly for three weeks until compliant. Divisional Director will audit medication label and packaging audits completed weekly for 3 weeks by Nurse Coordinator to verify compliance, during branch visits.	07/26/2021

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	Summary indicated carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg by mouth three times daily. Interview with QMA 1 on 6/22/21 at 3:18 p.m. indicated LPN 1 had already gone home for the day. She reviewed the Physician's Order in the computer and compared it to the medication card. They both indicated carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg total. She indicated she would call the pharmacy to get clarification of the correct medication amount as compared to the packet label since the amounts did not match. Interview with the Assistant RNC (Registered Nurse Coordinator) on 6/23/21 at 11:10 a.m. indicated the correct order should have read carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 37.5/150 mg total. They had clarified the order and updated the Physician's Order summary.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every			

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	sixty (60) days. Based on record review and interview, the facility failed to ensure a pharmacist reviewed resident records every 60 days for irregularities for 7 of 7 records reviewed. (Residents 2, 3, 4, 5, 6, 7 and 8) Findings include: 1. Resident 2's closed record was reviewed on 6/22/21 at 9:45 a.m. The resident was admitted on 11/5/20, and discharged on 5/10/21. There was one pharmacy review completed on 3/19/21. 2. Resident 3's closed record was reviewed on 6/22/21 at 2:26 p.m. There was a pharmacy review on 10/16/20 and the next one was completed on 3/19/21. 3. Resident 4's record was reviewed on 6/22/21 at 11:50 a.m. There was a pharmacy review on 10/16/20 and the next one was completed on 3/19/21. 4. Resident 5's record was reviewed on 6/22/21 at 1:58 p.m. There was a pharmacy review on 10/16/20 and the next one was completed on 3/19/21. 5. Resident 6's record was reviewed on 6/23/21 at 10:23 a.m. There was a pharmacy review on 10/16/20 and the next one was completed on 3/19/21. 6. Resident 7's record was reviewed on 6/22/21 at 10:04 a.m. There was a pharmacy review on 10/16/20 and the next one was completed on 3/19/21. 7. Resident 8's record was reviewed on 6/23/21 at 8:30 a.m. There was a pharmacy review on	R 0298	No residents were harmed by this deficient practice, however, potential harm did exist. Divisional Director will re-educate nurse coordinator and pharmacy manager on policy/procedure for pharmacist reviews every 60 days. A pharmacist review has been completed on March 19, 2021 and May, 18, 2021 with written recommendations sent to the Nurse Coordinator for review and physician response. Physician responses will be forwarded to the pharmacy and any new orders completed per protocol. Divisional Director of Resident Services to audit resident clinical records every 60 days x2 and annually to ensure compliance. Completion date 7/26/21	07/26/2021

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	10/16/20 and the next one was completed on 5/18/21. Interview with Nurse Coordinator and Assistant Registered Nurse Coordinator, on 6/22/21 at 1:00 p.m., indicated the pharmacist wouldn't come into the building when the facility was having a COVID-19 outbreak. They were unable to say why the reviews weren't completed remotely.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to complete discharge and transfer paperwork for 1 of 2 closed records reviewed. (Resident 2) Finding includes: The closed record for Resident 2 was reviewed on 6/22/21 at 9:45 a.m. The resident was discharged to another facility on 5/10/21.	R 0354	No residents were harmed by this deficient practice although the potential for harm did exist. Nurse Coordinator will audit clinical charts of residents that have been transferred out of facility within the last 60 days to ensure a transfer document has been completed properly. Divisional Director of Resident Services will re-educate Nurse	07/26/2021

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	A Nursing Note, dated 5/10/21, indicated the resident had been picked up and the granddaughter would be by to pick up some belongings. There was no additional information regarding the discharge. Interview with the Nurse Coordinator on 6/22/21 at 1:00 p.m., indicated information had been faxed to the other facility and the POA (power of attorney) had signed the medication sheet to indicate they had picked up her medications. She indicated there was no additional paperwork completed.		Coordinator on policy/procedure for transferring a resident out of the facility. Divisional Director will audit resident transfers for the next 60 days to ensure the transfer document has been completed properly. Completion date 7/26/21	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a current emergency information file was complete and accurate for staff to review for 3 of 5 residents reviewed. (Residents 6, 7, and	R 0356	No residents were harmed by this deficient practice although the potential for harm did exist. Nurse Coordinator will audit all	07/26/2021

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	8) Findings include: The emergency file binder was reviewed on 6/22/21 at 1:35 p.m. 1. Resident 6 did not have allergies listed. 2. Resident 7 did not have a hospital preference or physician's name and phone number listed. 3. Resident 8 did not have allergies listed. Interview with the Nurse Coordinator and the Assistant Registered Nurse Coordinator on 6/22/21 at 2:00 p.m., indicated they were unaware of all the information that needed to be listed in the emergency file binder.		patient emergency file information to ensure all required information is completed. Divisional Director of Resident Services will re-educate Nurse Coordinator on emergency file information per state requirements. Divisional Director will audit emergency file information on routine visits for 60 days and then annually thereafter to ensure compliance. Completion date 7/26/21.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to staff and	R 0407	No residents were harmed by this deficient practice although the potential for harm did exist. All residents will be monitored daily for signs and symptoms of	07/26/2021

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	visitors self screening for symptoms of COVID-19 and not monitoring residents daily for signs and symptoms of COVID-19 for random Infection Control screening observations and 3 of 3 resident records reviewed. (Residents 5, 7, and 8) Findings include: 1. On 6/23/21 at 8:05 a.m. in the foyer of the facility, there was a kiosk for visitors to sign in and answer questions regarding signs and symptoms of COVID-19, and if they had been in contact with someone with COVID-19. There was a thermometer laying on the desk for visitors to take their own temperature and record it in the kiosk. Then a staff member would answer the door and ask if they had signed in before allowing them into the facility. No further active monitoring was completed. 2. Resident 5's record was reviewed on 6/22/21 at 1:58 p.m., the record did not have any daily monitoring for COVID-19 signs or symptoms. 3. Resident 7's record was reviewed on 6/22/21 at 10:04 a.m., the record did not have any daily monitoring for COVID-19 signs or symptoms. 4. Resident 8's record was reviewed on 6/23/21 at 8:30 a.m., the record did not have any daily monitoring for COVID-19 signs or symptoms. The Indiana Department of Health document, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure", updated 6/1/21, indicated, "Actively (in person) screen all healthcare personnel, visitors, vendors entering the facility for symptoms of COVID-19 and any history of being a close contact or exposed to COVID-19...." the document also		COVID-19 using Bets-E (Bickford's internal electronic COVID-19 tracking system). All healthcare personnel, visitors, and vendors entering the facility will be actively (in-person) temperature screened for COVID-19. Healthcare personnel, visitors, and vendors will use self-screening questionnaire for symptoms of COVID-19 and any history of being a close contact or exposed to COVID-19. Divisional Director of Resident Services will re-educate Administrator and Nurse Coordinator on the current Indiana Department of Health document, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," including sections indicating daily resident screening and healthcare, personnel, visitors and vendor screening. Divisional Directors will audit Bets-E to ensure compliance weekly x4 weeks, and routinely after.	

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	indicated, "...Assess resident's symptoms of COVID-19 infection upon admission to the facility and daily during this pandemic...." During an interview with LPN 1 on 6/23/21 at 1:15 p.m., she indicated residents' vital signs were checked monthly and they stopped monitoring for signs of COVID-19 after the last outbreak in February. She also indicated she screened herself and took her own temperature daily upon entering the facility. During an interview with the Administrative Assistant on 6/23/21 at 1:10 p.m., she indicated they used to take visitors and staff temperatures and kept a log, but had stopped due to Indiana lifting some COVID-19 restrictions on June 11. She later indicated the facility stopped daily resident COVID-19 monitoring on 2/24/21.			