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	08/21/2019

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: August 20 and 21, 2019 Facility number: 012940 Residential census: 59 These State Residential Findings were cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/26/19.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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: (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. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	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. (3) Inservice records shall be maintained and shall indicate the following: (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. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to ensure all annual inservices were completed for 1 of 5 employee records reviewed. (Employee 2) Finding includes: The employee inservices were reviewed on 8/21/19 at 2:05 p.m. The record for Employee 2 lacked documentation to indicate she received the mandatory 2018 annual inservices for infection control, safety, and preventing accidents. During an interview with the Executive Director, on 8/21/19 at 2:50 p.m., he indicated the employee was part time and she had not completed all the annual inservices.	R 0120	No residents were negatively affected by this deficient practice. All employee files will be audited to determine which employees are deficient in mandatory annual in-services. Director will receive in-service education on the policy for staff continuing education and documentation. Any staff member missing in-services for the last year will complete the appropriate self-study in-service training. Monthly education will be scheduled for the next year and staff education per the policy for mandatory attendance / completion on in-service.	09/27/2019

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			Divisional Director will monitor the completion of the monthly in-services for the next six months to ensure completion and appropriate documentation, including any need for "makeup" self study completion.	
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.			
	Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to a recipe. This had the potential to affect 2 residents who resided in the facility and received a pureed diet from the kitchen. (Kitchen) Finding includes: On 8/21/19 at 12:00 p.m., Assistant Cook 2 was observed preparing a pureed modified diet. She indicated the cauliflower with peppers was for 2 servings, then scooped out the already cooked cauliflower with peppers and placed the vegetable mixture into the puree blender. Assistant Cook 2 then preceded to add a liquid into the blender, and indicated the liquid was chicken stock and it was approximately an ounce. The vegetable mixture was pureed to a pudding like consistency. The recipe titled, "Pureed Vegetables, " was provided by the Assistant Cook 2 on 8/21/19 at 1:28 p.m. The recipe indicated the serving size for	R 0270	No residents were harmed by this deficient practice although the potential for harm did exist. Training has been provided via video and specific recipe notebook has been prepared for all kitchen cooks to ensure modified diets are prepared properly according to the recipe. Director documented in-service training on this video. Director/Designee will observe and document outcomes of modified diet preparation 3 times per week for the next 4 weeks and then monthly for the next 3 months to ensure compliance. If concerns are found at any time, this cycle will be restarted. Divisional Director will audit for compliance annually.	09/27/2019

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	10 servings and the serving size was 1/2 cup. The ingredients were vegetables 40 ounces, water 1 cup and margarine 1/4 cup. "The Procedure: 1. Measure 1/2 cup drained vegetables, 4 tsp (teaspoons) of water/vegetable liquid, and 1 tsp margarine for each pureed serving needed. Using a food processor, add vegetables, margarine and half the liquid. Stop and scrap down sides. Add remaining liquid and blend until smooth. Heat to 165 degrees or higher for 15 seconds. Discard leftover product after meal service." Interview with Assistant Cook 2 on 8/21/19 1:18 p.m., indicated she was taught last year to not use water in a pureed food. She could not remember who had taught her not use water in a recipe. A policy title, "Instructions when making Puree recipes," was provided by the Administrator's Assistant on 8/21/19 at 2:22 p.m. This current policy indicated, "...Prepare the menu item according to the Regular recipe...."			
R 0273 Bldg. 00	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, record review and interview, the facility failed to ensure food was stored under safe and sanitary conditions related to expired foods and unlabeled foods. The facility also failed to maintain a sanitary and clean environment related dirty ice machine and stove vents, improperly sanitizing the food thermometer, lack of sanitization chemicals in the sanitizer buckets, and the High Temperature dishwasher's rinse cycle not hot enough. This had the	R 0273	No resident was negative affected by this deficient practice although potential harm did exist. An audit of all food storage items was immediately completed on 8/21/19 and all compromised food was discarded. Kitchen Manager/Designee will monitor all food storage areas for proper storage. Director will audit	09/27/2019

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	potential to affect the 59 residents who resided in the facility and were served food from the kitchen. (Kitchen) Findings include: 1. Upon initial tour with CNA 3 and the Dietary Aide 3 on 8/20/19 at 1:07 p.m., the following was observed in the kitchen: A. In the cooler the following foods were observed: - Identified as Parmesan cheese and Mozzarella cheese, not in their original containers, and without a label to indicate what was in the containers and undated - sliced yellow cheese in saran wrap, lacked a label - sliced yellow cheese, indicated by CNA 3 at that time was American cheese, with a use by date of 8/10 - 3 containers of salad dressings, identified by CNA 3 as Italian, Thousand Island and Ranch dressings, lacked labels - cooked rice with a use by label of 8/17 - Kidney Bean salad with a use by label of 8/18 B. In the dry storage area the following foods were observed: - Cereals not in their original containers and lacked a label, identified as Rice Krispies, Corn Flakes, Frosted Shredded Wheat and Raisin Bran - 3 sheets of uncovered cookies - Shell past, bow tie pasta, elbow pasta, spaghetti pasta, corn meal and black beans not in their original containers and lacked a label C. In the "Left Over" Cooler, the following foods and juices were observed: - pasta dish with a use by date of 8/18		weekly for one month and then monthly for the next three months. This monitoring cycle will start over if improper storage or labeling is found. All staff will be trained on the proper storage/labeling of food items to ensure the protocols are being followed. Food "temping" will be monitored by Director/Designee at one meal daily for one month. Kitchen Manager/Designee to monitor temp logs weekly. Director to monitor monthly for three months. Ice machine was emptied, cleaned and sanitized on 8/21/19. Future cleaning will be completed per rotational cleaning. Hood vents were cleaned by Maintenance. Director will verify schedule with third party vendor for routine inspection/cleaning. Sanitizing solution will be refreshed/tested three times daily throughout the food service hours. Kitchen Manager/Designee will audit this log weekly. Director will perform random spot checks weekly for one month. Dishwasher temperatures will be logged per protocol by Kitchen staff. Kitchen Manager will be informed of any failure to achieve proper temperatures. Third party vendor will be called for inspection/service as needed to maintain proper temperatures. Kitchen Manager will monitor logs weekly. Director will audit logs	

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	- 2 bowls of green jello, unlabeled. Interview at that time with CNA 3, she was unable to indicate when green jello was served last. - a container of possible beef mixture. Interview with CNA 3 at that time, she was unable to identify what the beef mixture was and when it was served last. - 6 juices, not in their original containers, unlabeled and undated, were identified as 2 bottles of cranberry juice, apple juice, orange juice, lemon aide and grape juice. D. Inside the ice machine vent, there was a dark substance. When touched, it had a slimy feel and the substance was black in color. Interview with the Dietary Aide 3 at that time, indicated the ice machine was thoroughly cleaned 4 months ago and the vent was to be soaked every 6 months. E. The vents above the stove had a black discoloration and other debris on them. Interview with the Dietary Aide 3 at that time, indicated the vents were last cleaned 4/29/19 and they were to be cleaned every 6 months. A policy titled, " Food Storage-Labeling and Dating," was provided by the Executive Director on 8/20/19 at 3:30 p.m. This current policy indicated, "Policy: It is the policy for the Food Service Department to wrap, cover, label, date and store all foods in a safe, appropriate manner...Procedure: 1. All cooked foods, pre-packaged open container, protein-based salad and desserts are labeled, dated and securely covered....2. All dates are to be written on the container and represent the date it was opened or prepared. All foods that are prepared a the branch must e discarded a the end of the third day. 2. During the temperature checks of the foods on		monthly for six months. Director will complete a dining service quality audit as it relates to Kitchen procedures/food handling by September 27th. To ensure compliance. This audit will continue to be done every other month and scores reported to the Divisional Director of Operations. Divisional Director of Operations will monitor compliance on routine site visits and a quality audit will be completed annually. Completion date September 27,2019	

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	8/21/19 at 11:55 a.m., the following was observed with Assistant Cook 2: She removed her food thermometer from its sleeve and checked the spaghetti noodles temperature, then swished the food thermometer in a water with soap bucket, then swished the thermometer into a plain water bucket and then swished the thermometer in the sanitization bucket. She then proceeded to check the rest of the foods: spaghetti sauce, cauliflower with peppers, zucchini and baked chicken and cleaned the thermometer the same manner after each food was checked; swished the thermometer into the soapy water, plain water and sanitization buckets. The sanitization bucket in which the food thermometer was being cleaned was checked with a paper test strip on 8/21/19 at 12:00 p.m. The test strip read zero, indicating a lack of sanitization chemical in the bucket. Interview with Assistant Cook 2 at that time, indicated this sanitization bucket had Quat (quaternary sanitizer) and was prepared before breakfast and she usually changed it after lunch service. Interview with Maintenance Coordinator on 8/21/19 at 1:55 p.m., indicated the Quat paper test strips the Kitchen staff had used to test the sanitation buckets were expired. One container of strips expired in 2013 and one in 2018. A policy titled,"Thermometer Cleaning Procedure," was provided by the Administrative Assistant on 8/21/19 at 2:22 p.m. This current policy indicated, "...Procedure:...How to... Sanitize: sanitize by placing in Mikriklene solution for 1 minute...." A policy titled, "Sanitizer Solution Log," was provided by the Executive Director on 8/21/19 at			

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	2:44 p.m. This current policy indicated, "...Procedure: 1. All Sanitizer solution must be tested each time it is changed to ensure proper Part per million and maximum effectiveness of sanitizer...4. Utilize Eco Lab Quat Sanitizer 146. Titration reading is to be between 150 PPM (parts per million) and 400 PPM...." 3. On 8/21/19 at 1:10 p.m., the High Temperature dishwasher was observed in use. The rinse cycle indicated 174 degrees Fahrenheit. CNA 4 pushed the completed dish cycle of dishes out to the dishwasher and indicated the dishes were ready to be used. Interview with CNA 4 at that time, indicated the dishwasher was a High Temperature dishwasher and the rinse cycle should be between 175-180 degrees Fahrenheit. The "Dishmachine Temperature Log" for August 2019 indicated, on 8/18 the final rinse was 170.3 and on 8/20 the final rinse was 174.2. The following days on the log lacked the wash and final rinse temperatures of all three shifts: 8/1, 8/2, 8/3, 8/4, 8/6, 8/7, 8/8, 8/11, 8/13, 8/14, 8/17, 8/18, and 8/19. A policy titled, " Dish Washing-Cleaning," was provided by the Administrator's Assistance on 8/21/19 at 2:57 p.m. This current policy indicated, "...Procedure:1...The machine is ready when the wash temperature gauge on top of the machine read a minimum of 140 degrees Fahrenheit. Watch this gauge during the last 12 seconds of the wash cycle when it should go to 180 degrees Fahrenheit...."			
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:			

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	(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 sixty (60) days.			
	Based on record review and interview, the facility failed to ensure a pharmacy drug regimen review was completed every 60 days for 5 of 7 residents reviewed for pharmaceutical services. (Residents 2, 3, 8, 5, and 7) Findings include: 1. The record for Resident 2 was reviewed on 8/20/19 at 1:50 p.m. The last pharmacy review was 3/18/19. The record lacked documentation of additional 60-day reviews. 2. The record for Resident 3 was reviewed on 8/21/19 at 1:15 p.m. The last pharmacy review was 3/18/19. The record lacked documentation of additional 60-day reviews. 3. The closed record for Resident 8 was reviewed on 8/21/19 at 9:40 a.m. The last pharmacy review was on 3/18/19. The record lacked documentation of additional 60-day reviews. A letter from ValuMed Pharmacy, dated 8/21/19 and provided by the DON on 8/21/19 at 3:00 p.m., indicated the pharmacy reviews were to be done	R 0298	R 298 Pharmaceutical Services No residents were negatively affected by this deficiency although the potential for harm did exist. RN-C and Pharmacy Manager will be in-serviced on requirement for pharmacy consultant review every 60 days. A new consulting pharmacist has been hired to ensure timely consultant visits. All current charts will be audited by September 27, 2019. Moving forward, charts will be audited by the Pharmacist every 60 days. Results of audit to be communicated to the RNC for appropriate follow up.	09/27/2019

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	by the consulting pharmacist every 60 days. 4. Resident 5's record was reviewed on 8/21/19 at 9:02 a.m. Diagnoses included, but were not limited to dementia and hypertension (high blood pressure). The record lacked any Pharmacy review since the resident was admitted on 5/6/19. Interview with the RC Coordinator Assistant on 8/21/19 at 11:36 a.m., indicated there had not been a Pharmacist to review the resident's medications since March 2019. 5. Resident 7's record was reviewed on 8/21/19 at 8:48 a.m. Diagnoses included, but were not limited to dementia and diabetes mellitus. The Pharmacy review of Resident 7's medication, was last completed on 3/18/19. Interview with the RC Coordinator Assistant on 8/21/19 at 11:36 a.m., indicated there had not been a Pharmacist to review the resident's medications since March 2019.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.			
	Based on observation, interview and record review, the facility failed to ensure medications were properly labeled related to Over the Counter medications for 1 of 2 medications carts observed. (Assisted Living Medication Cart).	R 0302	No residents were harmed by this deficient practice although potential for harm did exist. RN-C/designee will complete an	09/27/2019

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	Finding includes: During the observation of medications in the Assisted Living cart with LPN 6 on 8/20/19 at 3:01 p.m., the following OTC (Over the Counter) medications were not properly labeled with the resident's name, the Physician who ordered the medication, the dose, and the frequency of the medication: - ICAPS (supplement), Room 205 was written in marker on the bottle's lid. - Melatonin 10 mg (milligrams), Room 213 was written in marker on the bottle's lid. - Vitamin B-12, Room 309 was written in marker on the bottle's lid. - Vitamin D3 50 mcg (micrograms), Room 309 was written in marker on the bottle's lid. - acetaminophen 325 mg, Room 309 was written in marker on the bottle's lid. Interview with LPN 6 at that time, indicated OTC medications should have the resident's name, doctor, dosage and how to take the medication. The policy titled, " Medication Storage," was provided by the Executive Director on 8/20/19 at 3:30 p.m. This current policy stated, "...Procedure...9. The medications shall be labeled and maintained in compliance with label instructions, as well as state and federal laws."		audit of both medication carts to ensure there are no OTC medications without complete identifying information including resident name, physician's name, expiration date, name of drug and strength of drug. Completion date 9/27/2019. RN-C to review 410IAC 16.2-5-6(c)(6) and conduct an in-service with all med passers to ensure knowledge of OTC medication labeling policy. RNC/designee will audit medication carts weekly indefinitely to ensure all OTC medications are properly labeled. Divisional Director to review audits weekly and audit medication carts on routine site visits.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:			

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	(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were monitored, completed and organized related to lack of a follow up for a laboratory result for 1 of 7 records reviewed for clinical records. (Resident 7) Finding includes: Resident 7's record was reviewed on 8/21/19 at 8:48 a.m. Diagnoses included, but were not limited to dementia and diabetes mellitus. A laboratory blood test, dated 4/26/19, indicated Vitamin D 25 had a result of 26.88. This value indicated a vitamin D insufficiency, per the reference range of below 30. On the completed laboratory test, there was a hand written note which read, "OTC (Over The Counter) Vitamin D, 3,000 units daily, X 4 weeks and recheck in 4 weeks". The record lacked an indication the resident was administered the Vitamin D 3,000 units daily. The record also lacked a repeat laboratory test for the Vitamin D level. Interview with the RN Coordinator on 8/21/19 at 2:00 p.m., indicated she was not aware of this hand written note, nor who wrote it, and it was possibly the Nurse Practitioner.	R 0349	No residents were harmed by the deficient practice although potential for harm did exist. Resident 7 no longer lives at branch. RNC/designee will audit all clinical records to ensure appropriate follow up completed on all orders, then weekly times 3 weeks and monthly until accurate 100% of the time for 3 consecutive months. Divisional to complete audit for compliance annually.	09/27/2019
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:			

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	08/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(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 record review and interview, the facility failed to ensure a system was in place to track patterns of infections throughout the facility. This had the potential to affect all residents residing in the facility. Finding includes: The policy titled, "Universal Precautions (Infection Control)", dated 9/2016, was reviewed on 8/20/19 at 3:35 p.m. The single paged policy lacked information regarding how to track patterns of infections within the facility. During an interview with the Registered Nurse Coordinator Assistant on 8/21/19 at 9:10 a.m., she indicated they only kept track of influenza. They did not monitor other respiratory infections or other contagious infections.	R 0407	No residents were negatively affected by this deficient practice. RN-C was in-serviced by Divisional Director of Resident Services on August 21, 2019 to use Bickford's Infectious Disease Log. All appropriate information as of 8/1/19 will be entered and log will be maintained going forward. RNC will monitor Infectious Disease Log to ensure all infectious diseases are being logged weekly for 3 months. RN-C will educate all nurses on tracking infectious diseases using the log. Completion 9/27/2019. Divisional Director will monitor use on routine site visits.	09/27/2019
R 0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			

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	08/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	(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 7 records reviewed. (Resident 2) Finding includes: 1. Resident 2's record was reviewed on 8/20/19 at 1:50 p.m. Diagnoses included, but were not limited to, dementia and pressure ulcers. The resident was admitted to the facility on 3/16/19. There was lack of documentation to indicate the resident had received a two step Mantoux test upon admission. Interview with the Administrative Assistant on	R 0410	No residents were negatively affected by this deficient practice, although potential for harm did exist. All resident charts will be audited to ensure that TB screenings are completed and consistent with policy. If any residents found to have incomplete testing, the appropriate testing will be completed. RNC will monitor all new admissions to ensure that 2-step TB has been administered for 3 months.	09/27/2019

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	08/21/2019

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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	8/20/19 at 3:55 p.m., indicated she was unable to find any second step TB testing documentation.		RN-C to review Policy # 72000 - Tuberculosis Screening Resident and provide an in-service for all nursing staff to ensure that TB screening process is begun on the day of admission. Policy #10400 Chart order will be used by RN as a checklist upon admission to ensure Mantoux testing is scheduled. TB screenings will be entered into the electronic Medication Administration Record to ensure that TB screenings will be completed consistently per policy. Divisional Director to review TB screening on routine site visits. Date of completion: 9/27/19	