

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 11/18/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Date of survey: 11/18/15</p> <p>Facility number: 003674 Provider number: 003674 AIM number: N/A</p> <p>Census bed type Residential: 19 Total: 19</p> <p>Census payor type: Other: 19 Total: 19</p> <p>Sample: 13</p> <p>This state finding is cited in accordance with IAC 16.2-5.</p> <p>Quality review completed November 24, 2015 by 29479.</p>	R 0000		
R 0273  Bldg. 00	<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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/18/2015	
NAME OF PROVIDER OR SUPPLIER  CRAWFORDSVILLE BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review the facility failed to ensure proper hand sanitation for 1 of 1 dining observation and sanitary food handling for 1 of 1 resident that required assistance with their meal. (Resident #7).</p> <p>Finding includes:</p> <p>During dining observations on 11/18/15 at 11:55 a.m., (Licensed Practical Nurse) LPN #1 was observed to rinse her hands with water and dry them without using soap. LPN #1 adjusted residents' clothing protectors, handled drinking glasses by the rim, and passed drinks and dinner rolls to the residents in the dining room. LPN #1 held and buttered Resident #7's dinner roll with her bare hands. Certified Nurse Aide (CNA) #2 passed bowls of fruit to the residents in the dining room. The Dietary Manager was heard asking CNA #2 if she washed her hands. The CNA was observed to wash her hands for less than 10 seconds and returned to serve the lunch meal to the residents in the dining room.</p> <p>On 11/18/15 at 1:40 p.m., the Administrator indicated staff should have washed their hands prior to passing food in the dining room and after contact with any resident or common object.</p>	R 0273	<p><b>Corrective Action Taken:</b></p> <p><b>Employees on duty were informed of lack of hand washing and appropriate handling of food. Correct procedures were reviewed. All staff will be in-serviced by 12/20/15 on proper hand washing and food handling in the dining room. Potential Residents Affected: No residents were affected. All residents had potential for harm due to noncompliance. Measures to ensure does not occur: New employees will be trained in proper hand washing and food handling in the dining room through policy review and new employee orientation. Monitor performance to ensure compliance: The Director, RNC and Kitchen Manager will observe and monitor staff's hand washing and handling of food in the dining room to ensure compliance with facility policy and state regulations every meal for 1 month and then monthly using QA (Core Check).</b></p>	12/20/2015			

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 11/18/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A policy, provided by the Administrator on 11/18/15 at 1:55 p.m., titled, "Preventing Contamination from Hands," dated March 2014 and identified as current, indicated, "Policy: Employees practice good handwashing techniques...Procedure: 1. Employees follow hand washing procedure at all times. Hands are to be washed between handing of a contaminated item and a clean item...."</p> <p>A policy, provided by the Administrator on 11/18/15 at 1:55 p.m., titled, "PP-60750-Handwashing," dated April 2014 and identified as current, indicated "Policy: Bickford Family Members shall follow hand washing policies. Procedure: 1. Bickford Family Members shall wash their hands: a. Between contact with different residents...h. Before and after assisting with any food service tasks...2. The following is the correct procedure to be followed for handwashing: a. Wet your hands with running water, b. Apply soap and lather well, c. Rub hands vigorously for at least 20 seconds...."</p>			