

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 10/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD WABASH, IN 46992
---	---

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This survey was for a State Residential Licensure Survey.</p> <p>Survey dates: October 1 and 2, 2014.</p> <p>Facility number: 003466 Provider number: 003466 AIM number: N/A</p> <p>Survey team: Jason Mench, RN</p> <p>Census bed type: Residential: 15 Total: 15</p> <p>Census payor type: Other: 15 Total: 15</p> <p>Sample: 7</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by Debora Barth, RN.</p>	R000000		
---------	---	---------	--	--

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 00 B. WING		X3) DATE SURVEY COMPLETED 10/02/2014	
NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD WABASH, IN 46992			
(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			
R000088	<p>410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance</p> <p>c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility.</p> <p>(d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator</p> <p>Based on observation and interview, the facility failed to have a licensed Administrator appointed to the facility. This deficient practice had the potential to affect 15 of 15 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the entrance conference with the Director of Nursing (DON) on 10/1/14 at 9:20 a.m., she indicated the facility did not currently have an Administrator. The previous Administrator had left on 9/3/14. The DON indicated her Divisional Director was taking over that role until a new Administrator could be hired.</p> <p>During a phone interview with the</p>	R000088	<p>In response to R 088</p> <ul style="list-style-type: none"> - No residents were negatively affected by this deficient practice although we realize the potential did exist. - Upon the resignation of the previous director, (we were informed on August 19th that her last day of employment would be September 2Nd) we immediately posted advertisements for the position. - We posted on our company web site and also on Career Builder and Indeed.com. - We are aggressively interviewing prospective candidates. - Continued oversight by Divisional Director of Operations to ensure day to day operations are complete - Expected completion of hire November 15th, 2014 	11/15/2014			

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 10/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WABASH BICKFORD COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3037 W DIVISION RD WABASH, IN 46992
---	---

(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>Divisional Director on 10/1/14 at 12:15 p.m., she indicated she was acting Administrator for the facility until they filled the position. She indicated she does not have an Administrator's license at this time.</p> <p>A policy titled "Policies and Procedures: Category: Administration", provided by the Divisional Director of Resident Services and dated July of 2012, indicated the following:</p> <p>"Policy: Bickford shall employ an administrator/operator who has completed the training requirements pursuant to State Law. The administrator/operator, hereafter referred to as Director, shall have the same statutory responsibility in ensuring the compliance of the branch with all rules and regulations..."</p>			