STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/23/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: April 22 and 23, 2026 Facility number: 012940 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 4/29/26.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:	R 0092	**R092 Administration and Management – Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	04/30/2026

	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure the fire department was invited to attend a fire drill every six months. This had the potential to affect all 55 residents residing in the facility. Finding includes: The fire drill log for the past twelve months was reviewed on 4/23/26 at 11:57 a.m. The logs included the date, time, and participants. There was no documentation the fire		• No residents were affected by the noncompliant practice, but 55 residents had the potential to be affected by this noncompliant practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken • The Divisional Director of Operations re-educated the Executive Director on the requirement to invite the fire department to attend a fire drill every six months. • The Executive Director will be responsible for inviting the fire department and documenting the invitation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. • Divisional Director of Operations will re-educate Executive Director on policy 410 IAC 16.2-5-1.3 completed by 4/30/26.	

	department had been invited to any of the drills. During an interview on 4/23/26 at 1:48 p.m., the Administrator indicated she could not provide any documentation the fire department was invited to attend a fire drill every six months.		• The Executive Director has created a calendar reminder every six months that will trigger the invitation to the fire department. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. • Executive director communicated with fire department on 4/30/26 and secured a fire drill on 5/20/26 with fire department participation. • Divisional Director of Operations will monitor this practice over the next 12 months.	
R 0272	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(e) (e) All food shall be served at a safe and appropriate temperature. Based on observation, record review, and interview, the facility failed to ensure foods were held at appropriate temperature prior to meal service. This had the potential to affect 2 of 2 residents who received a pureed diet at the facility.	R 0272	**R272 Food and Nutritional Services - Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • 0 residents were harmed by this deficient practice but had the potential to harm 2 residents. How the facility will identify other residents	04/30/2026

	Finding includes: On 4/22/26 at 11:58 a.m., AM Cook 1 was observed checking temperatures of the lunch meal. She checked the temperature of the food stored in large containers that was going to be served on the locked unit. She had checked the temperatures of all of the food, except for the four small serving dishes containing pureed food. At the time, AM Cook 1 indicated she had not previously checked the temperatures of any pureed food because there were no sections on her temperature log for pureed diets. She then checked the temperatures of the four serving dishes that contained pureed turkey and mashed potatoes. AM Cook 1 indicated all of the temperatures were out of range, with temperatures of 107, 102, 100.8, and 100 degrees Fahrenheit. AM Cook 1 sent the meal cart containing the pureed food to the locked unit which had a microwave and a steam table on the unit. The CNAs were going to be alerted the food was cold so they could microwave it up to the appropriate temperature. The Administrator was notified of the concern on 4/23/26 at 1:53 p.m. No further information was provided.		having the potential to be affected by the same deficient practice and what corrective action will be taken? • Divisional Director of Operation to re-educate the Executive Director and Dietary Director on pureed food temperatures by 4/27/26. • Executive Director and Dietary Director to in-service cook staff on pureed food temperatures by 4/27/26. • Cook staff will log puree food temps upon leaving the kitchen and staff to temp puree food again and log prior to meal service. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?	

	A facility policy titled, " Adherence to Correct Food Temperatures," indicated, "1. All foods are prepared as closely to serving time as possible. A. Hot Food Service...Hot foods are served at proper temperatures: ...Meat 150 - 160 degrees Fahrenheit Vegetables 160 - 170 degrees Fahrenheit...2. Routine food temperature checks are done by the Dietary Manager and/or cook on duty...		• Dietary Director to observe temperature of puree 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure puree is being served at a safe and appropriate temperature. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. • Executive Director will observe a pureed diet preparation audit monthly x 3 months to ensure continued compliance with puree dishes being served at a safe and appropriate temperature. • Divisional Director of Operations will observe pureed diet preparations x 2 months on routine branch visits to ensure compliance.	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local	R 0273	**R273 Food and Nutritional Services - Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	04/30/2026

	sanitation and safe food handling standards, including 410 IAC 7-24. Based on record review and interview, the facility failed to maintain proper food sanitation related to unlabeled and undated food, cooking and serving utensils stored incorrectly, a dirty stove top, floors, baseboards, walls, fire extinguisher and sealant beneath a window, not sanitizing the temperature probe, and inappropriate glove use. This had the potential to affect all 55 residents who received food from the kitchen. Findings include: 1. On 4/22/26 at 9:24 a.m., the following was observed with AM Cook 1: a. In the reach-in cooler, there was bacon in a zip-lock bag labeled with a resident's name. There was no date on the bag. There was a bowl of pineapple covered with clear plastic wrap with no label or date. There was a container of sausage links with no label or date. b. The floors underneath the steam table and the oven/stove and along the baseboards had a build up of debris and grease.		• 55 residents had the potential to be affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken • Divisional Director of Operation to re-educate the Executive Director and Dietary Director on maintaining sanitary and safe food handing standards by 4/27/26. • Executive Director and Dietary Director to in-service dietary staff on maintaining sanitary and safe food handling standards by 4/30/26. • Dietary staff re-educated by Executive Director and Dietary Director on daily, weekly and monthly cleaning schedules, cleaning tasks logged as completed, cleaning wipes put into use for sanitizing food thermometers between use, Inservice conducted on proper glove use in the kitchen, proper labeling and dating of food, pots and plates being stored inverted,	

	c. There were plates stored on the counter upright and uncovered. d. The cooking pots were stored upright on a shelf. 2. On 4/22/26 at 11:33 a.m., during the follow-up kitchen tour with AM Cook 1, the following was observed: a. The white sealant layer under the window and behind the sink was pealing off and also had black speckled discoloration. b. The stove top was dirty and had a build-up of grease and debris. c. The fire extinguisher and wall behind the stove-top both had splattered grease on them and were dirty. At the time, AM Cook 1 indicated the food should have had labels and the areas observed were in need of cleaning. 3. On 4/22/26 at 11:58 a.m., AM Cook 1 was observed checking temperatures of the food prior to meal service. At the time, she indicated the facility staff were working on getting appropriate wipes for the temperature probes to clean them in between use, however they had not purchased any of the wipes yet. Instead, she would have to		and window sealant properly sealed. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. • Dietary Director to monitor rotational cleaning schedule 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure sanitation is maintained. • Dietary Director will observe the sanitation of food thermometers 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure standard is met. • Dietary Director will observe glove use in the kitchen 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure proper donning and doffing of gloves and handwashing between glove use. • Dietary Director will audit labeling and dating of food 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure proper storage.	

	use a wet paper towel to clean the temperature probe between uses. 4. On 4/22/26 at 12:17 p.m., AM Cook 1 was observed preparing a grilled cheese sandwich. She had finished checking temperatures of the lunch meal with gloved hands, removed those gloves, and then donned new gloves. She did not wash her hands between glove changes. She then opened a container and used a brush to spread some liquid butter onto the cook top. She opened a bag of sliced bread with the same gloved hands, reached into the bag and pulled out two slices of bread. She placed those onto the cook top. At the time, AM Cook 1 indicated she should not have touched the food items after touching other non-food items in the kitchen. On 4/23/26 at 1:53 p.m., the Administrator was notified of the concerns and there was no further information provided. A facility policy titled, "Preventing Contamination from Hands," indicated, "1. Employees follow hand washing procedure at all times. Hands are to always be washed between the handling of a contaminated item and a clean item...3. Ready-to-eat foods are		• Dietary Director will audit storage of pots and plates 2 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure inverted storage. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. • Executive Director will monitor rotational cleaning schedule 3x/month for 3 months to ensure sanitation is maintained. • Executive Director will observe the sanitation of food thermometers 3x/month for 3 months to ensure standard is met. • Executive Director will observe glove use in the kitchen 3x/month for 3 months to ensure proper donning and doffing of gloves and handwashing between glove use. • Executive Director will audit labeling and dating of food 3x/month for 3 months to ensure proper storage. • Executive Director will audit storage of pots and plates 3x/month for 3 months to ensure inverted storage.	

	handled with suitable utensils as deli tissue, spatula, tongs, single-use gloves or dispensing equipment..."		• Divisional Director of Operations will review audits and complete a walk through of the kitchen on routine branch visits for 3 months to ensure compliance.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREElizabeth Tengerstrom	TITLEExecutive Director	(X6) DATE05/07/2026