

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/13/2024	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 5829 EAST 116TH STREET, CARMEL, , 46033					
(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: December 12 and 13, 2024. Facility number: 013217 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 18, 2024.	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: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	R092 Administration and Management - Noncompliance 0 residents were harmed by this deficient practice.			01/02/2025	

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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 interview and record review, the facility failed to ensure fire and disaster drills were conducted monthly for 2 of 10 months reviewed (December 2023 and January 2024) and to provide documentation to show the local fire department had been invited to participate in a fire/disaster drill every six (6) months. Finding includes: The fire drill logs were reviewed on 12/12/24. The facility was unable to provide a fire drill for the months of December 2023 and January 2024. The facility	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Fire drill completed 11/12/24 with Fire department. Fire drill completed every month after January 2024. 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 Director or other delegated staff member will be responsible for running an effective fire drill on a monthly basis. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient	
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was also unable to provide documentation to show the local fire department had been invited to attend or attended a fire and disaster drill prior to 11/12/24.

During an interview, on 12/12/24, the Executive Director indicated the facility did not have documentation to show a fire drill was held in December of 2023 or January of 2024 and they did not have documentation to show the fire department had been invited to attend a fire/disaster drill prior to 11/12/24.

During an interview, on 12/13/24 at 2:20 p.m., the Executive Director indicated the facility followed the State of Indiana regulations.

A current facility policy, titled "Disaster Policy and Procedure," dated as last revised 7/2012 and received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...The Director shall conduct fire drills monthly...."

Based on interview and record review, the facility failed to ensure fire and disaster drills were conducted monthly for 2 of 10 months reviewed (December 2023 and January 2024) and to provide documentation to show the local fire department had been invited to participate in a fire/disaster drill every six (6)

practice does not recur.

Divisional
Director of Operations will re-educate Director on policy pertaining to Fire Safety and frequency of drills.

How the
corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

Divisional
of Operations will review Fire Drill records on a monthly basis for three months and at least annually thereafter.

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months.

Finding includes:

The fire drill logs were reviewed on 12/12/24. The facility was unable to provide a fire drill for the months of December 2023 and January 2024. The facility was also unable to provide documentation to show the local fire department had been invited to attend or attended a fire and disaster drill prior to 11/12/24.

During an interview, on 12/12/24, the Executive Director indicated the facility did not have documentation to show a fire drill was held in December of 2023 or January of 2024 and they did not have documentation to show the fire department had been invited to attend a fire/disaster drill prior to 11/12/24.

During an interview, on 12/13/24 at 2:20 p.m., the Executive Director indicated the facility followed the State of Indiana regulations.

A current facility policy, titled "Disaster Policy and Procedure," dated as last revised 7/2012 and received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...The Director shall conduct fire drills monthly...."

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R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to ensure the heating, ventilation and air conditioning system (HVAC) was inspected at least yearly. Finding includes:	R 0148	R148 Sanitation and Safety Standards 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Maintenance Director checked all HVAC and changed filters and recorded by 1/2/2025 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	01/02/2025
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A request for documentation was made during the entrance conference on 12/12/24.

During an interview, on 12/13/24 at 2:26 p.m., the Maintenance Director indicated he did check the HVAC system and change filters, but he did not have any documentation to show it had been completed.

During an interview, on 12/13/24 at 2:20 p.m., the Executive Director indicated the facility followed the State of Indiana regulations.

A facility job description, titled "Maintenance Coordinator," dated at revised 12/22 and received from the Executive Director on 12/13/24 at 2:16 p.m., indicated "...Ensure equipment remains in working order and is used safely...Complete tasks necessary to comply with all applicable state and federal regulatory agencies...."

Based on interview and record review, the facility failed to ensure the heating, ventilation and air conditioning system (HVAC) was inspected at least yearly.

Finding includes:

A request for documentation was made during the entrance conference on 12/12/24.

Executive Director will complete HVAC quality audit to ensure compliance. Completed by 1/2/25

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 the Executive Director and Maintenance Director on the expectation of annual HVAC inspections. To be completed by 1/2/25.

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.

Divisional Director of Operations will review documentation of HVAC inspection annually to ensure compliance.

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	During an interview, on 12/13/24 at 2:26 p.m., the Maintenance Director indicated he did check the HVAC system and change filters, but he did not have any documentation to show it had been completed. During an interview, on 12/13/24 at 2:20 p.m., the Executive Director indicated the facility followed the State of Indiana regulations. A facility job description, titled "Maintenance Coordinator," dated at revised 12/22 and received from the Executive Director on 12/13/24 at 2:16 p.m., indicated "...Ensure equipment remains in working order and is used safely...Complete tasks necessary to comply with all applicable state and federal regulatory agencies...."			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the kitchen was	R 0154	R154 Sanitation and Safety Standards What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	01/02/2025

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maintained in a safe, sanitary manner and in good repair for 2 of 2 kitchens observed. (Assisted Living Kitchen and Memory Care Kitchen) Findings include: 1. During an observation of the Assisted Living Kitchen, on 12/12/24 at 10:53 a.m., with Kitchen Staff 1 present, the lower cabinet door on the left side of the sink was missing and a cabinet door to the left of the sink was also missing. A scoop was found left in the bulk sugar bin. The facility had four bulk item bins all observed to be soiled with dried food. During an interview, on 12/12/24 at 10:58 a.m., Kitchen Staff 1 indicated the scoop should not have been left in the sugar. 2. During an observation, on 12/12/24 at 11:38 a.m., the Memory Care Kitchen was found to be missing the lower cabinet door, under the steam table. The door was observed to be laying under the steam table. Another cabinet door, located under the counter to the right of the hand washing sink was found to be missing. There were also two drawers missing from the lower cabinet. In the Memory Care refrigerator,	No residents were affected by the 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 Executive Director will complete an audit open food containers to ensure they are labeled with date of opening if not dated items will be discarded and replaced. Completed by 1/2/25 Maintenance Coordinator will replace all missing cabinet doors. Completed by 1/2/25 Breadbasket Manager cleaned four bulk food storage containers. Completed 1/2/25 What measures will be put into place or what systemic changes the	
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two pitchers of red fluid were found without a label or date, a 13-ounce bottle of mustard was found without an open date, and a 10-ounce bottle of ketchup was also found without an open date. There was a 64-ounce container of prune juice, opened and belonging to a resident but missing the open date.

The thermometer in the refrigerator was found to have red across the scale in the capillary tube, and an accurate temperature could not be read due to the thermometer being broken.

During an interview, on 12/12/24 at 11:46 a.m., QMA 2 indicated the ketchup and mustard were not for resident use, the thermometer was broken, and she needed to get a new one.

3. During a return observation of the Assisted Living Kitchen, on 12/13/24 at 8:56 a.m., the freezer was found to contain mild breakfast sausage wrapped in plastic and without an open date. A container of okra was found in plastic without an open date, an unidentifiable food item in blue plastic was found without an open date or a label, a bag of French fries was found almost empty and without an open date, and a bag of sweet potato fries were found open to air and without an open date.

facility will make to ensure that the deficient practice does not recur.

Divisional Director of Operations will re-educate Executive Director and Breadbasket Manager on Policy 40450 Food Storage Labeling and dating. Completed by 1/2/25

Divisional Director of Operations will re-educate Executive Director and Breadbasket Manager on Policy 40445 Food Receiving and Storage. Completed by 1/2/25

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place

Divisional Director of Health & Operations will inspect kitchen condition of Kitchen every quarter to ensure compliance in Sanitation and Safety standards.

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During an interview, on 12/13/24 at 9:03 a.m., Kitchen Staff 1 indicated items were supposed to have labels and open dates.

In the reach-in refrigerator, located by the kitchen door, a one-quart container of orange juice was found open with approximately 1/8 of fluid left. There was no open date.

In the dry good storage, two open containers of dry spaghetti were found wrapped in plastic and without an open date, an open bag of mostaccioli pasta was found wrapped in plastic and without an open date, and elbow noodles were found wrapped in plastic without an open date.

During an interview, on 12/13/24 at 9:06 a.m., Kitchen Staff 1 indicated when items were opened a date should have been put on the items.

The QUAT (a sanitizer used to clean surfaces) was tested and the test strip turned dark blue and per the instructions on the test strip bottle the concentration of sanitizer was 0 parts per million (PPM).

A current facility policy, titled "Food Storage Labeling and Dating," received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...Label used to indicate the contents, date...Labeling

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	Requirements...Each label must include the following information...Product Name...Clearly indicate the name of the food item...Date of Preparation/Opening...Include the date the food was...opened...." A current facility policy, titled "Dining Services," dated as last revised 01/2018 and received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...To ensure proper concentration of sanitizer solution and to maximize the effectiveness of Sanitizer solution...Titration reading is to be between 150 PPM and 400 PPM...." Based on observation, interview and record review, the facility failed to ensure the kitchen was maintained in a safe, sanitary manner and in good repair for 2 of 2 kitchens observed. (Assisted Living Kitchen and Memory Care Kitchen) Findings include: 1. During an observation of the Assisted Living Kitchen, on 12/12/24 at 10:53 a.m., with Kitchen Staff 1 present, the lower cabinet door on the left side of the sink was missing and a cabinet door to the left of the sink was also missing.			
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A scoop was found left in the bulk sugar bin.

The facility had four bulk item bins all observed to be soiled with dried food.

During an interview, on 12/12/24 at 10:58 a.m., Kitchen Staff 1 indicated the scoop should not have been left in the sugar.

2. During an observation, on 12/12/24 at 11:38 a.m., the Memory Care Kitchen was found to be missing the lower cabinet door, under the steam table. The door was observed to be laying under the steam table. Another cabinet door, located under the counter to the right of the hand washing sink was found to be missing. There were also two drawers missing from the lower cabinet.

In the Memory Care refrigerator, two pitchers of red fluid were found without a label or date, a 13-ounce bottle of mustard was found without an open date, and a 10-ounce bottle of ketchup was also found without an open date. There was a 64-ounce container of prune juice, opened and belonging to a resident but missing the open date.

The thermometer in the refrigerator was found to have red across the scale in the capillary tube, and an accurate temperature could not be read due to the thermometer being

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broken.

During an interview, on 12/12/24 at 11:46 a.m., QMA 2 indicated the ketchup and mustard were not for resident use, the thermometer was broken, and she needed to get a new one.

3. During a return observation of the Assisted Living Kitchen, on 12/13/24 at 8:56 a.m., the freezer was found to contain mild breakfast sausage wrapped in plastic and without an open date. A container of okra was found in plastic without an open date, an unidentifiable food item in blue plastic was found without an open date or a label, a bag of French fries was found almost empty and without an open date, and a bag of sweet potato fries were found open to air and without an open date.

During an interview, on 12/13/24 at 9:03 a.m., Kitchen Staff 1 indicated items were supposed to have labels and open dates.

In the reach-in refrigerator, located by the kitchen door, a one-quart container of orange juice was found open with approximately 1/8 of fluid left. There was no open date.

In the dry good storage, two open containers of dry spaghetti were found wrapped in plastic and without an open date, an open bag of mostaccioli pasta was found wrapped in plastic

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and without an open date, and elbow noodles were found wrapped in plastic without an open date.

During an interview, on 12/13/24 at 9:06 a.m., Kitchen Staff 1 indicated when items were opened a date should have been put on the items.

The QUAT (a sanitizer used to clean surfaces) was tested and the test strip turned dark blue and per the instructions on the test strip bottle the concentration of sanitizer was 0 parts per million (PPM).

A current facility policy, titled "Food Storage Labeling and Dating," received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...Label used to indicate the contents, date...Labeling Requirements...Each label must include the following information...Product Name...Clearly indicate the name of the food item...Date of Preparation/Opening...Include the date the food was...opened...."

A current facility policy, titled "Dining Services," dated as last revised 01/2018 and received from the Executive Director on 12/13/24 at 1:20 p.m., indicated "...To ensure proper concentration of sanitizer solution and to maximize the

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	effectiveness of Sanitizer solution...Titration reading is to be between 150 PPM and 400 PPM...."			
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview and record review, the facility failed to ensure water temperatures were maintained at a safe temperature for 1 of 2 rooms observed for safe water temperatures. (Room 145) Finding includes: During an observation, on 12/12/24 at 11:03 a.m., with the Maintenance Director, the water temperature in Room 145 was found to be at 130 degrees.	R 0187	R187-Physical Plant Standard Deficiency 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Apartment observed to have unsafe water temperatures had regulator replaced. Date completed 1/2/25	01/02/2025

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During an interview, on 12/12/24 at 11:10 a.m., the Maintenance Director indicated he did not know what the water temperatures were supposed to be. He had just started in this position two weeks ago.

A facility job description, titled "Maintenance Coordinator," dated at revised 12/22 and received from the Executive Director on 12/13/24 at 2:16 p.m., indicated "...Ensure equipment remains in working order and is used safely...Complete tasks necessary to comply with all applicable state and federal regulatory agencies...."

Based on observation, interview and record review, the facility failed to ensure water temperatures were maintained at a safe temperature for 1 of 2 rooms observed for safe water temperatures. (Room 145)

Finding includes:

During an observation, on 12/12/24 at 11:03 a.m., with the Maintenance Director, the water temperature in Room 145 was found to be at 130 degrees.

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

Executive Director will complete an audit of all apartment water temperatures completed to ensure safe water temperatures, any apartments with unsafe water temperatures will be fixed by the maintenance coordinator. Completed by 1/2/25

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 Operation will review regulations of Physical Plant Standards with Executive Director and Maintenance Coordinator. Completed by 1/2/25

How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance

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FORM APPROVED

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OMB NO. 0938-0391

During an interview, on 12/12/24 at 11:10 a.m., the Maintenance Director indicated he did not know what the water temperatures were supposed to be. He had just started in this position two weeks ago.

A facility job description, titled "Maintenance Coordinator," dated at revised 12/22 and received from the Executive Director on 12/13/24 at 2:16 p.m., indicated "...Ensure equipment remains in working order and is used safely...Complete tasks necessary to comply with all applicable state and federal regulatory agencies...."

program will be put into place.

Divisional Director of Operations will monitor compliance on routine site visits and an audit will be completed annually.

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
SIGNATURE

TITLE

(X6) DATE