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	08/14/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 8/13/24 and 8/14/24 Facility number: 003466 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 16, 2024.	R 0000		
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Crispen	Residential Care Administrator	09/03/2024

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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	resident understands. Based on interview and record review, the facility failed to ensure residents had a signed resident bill of rights upon admission for 2 of 7 residents (Resident 13, Resident 16). Findings include: 1. Review of Resident 13's clinical record was completed on 8/13/24 at 12:15 p.m. Diagnoses included chronic kidney disease stage III, Dementia without behavioral disturbance and hypothyroidism. Review of the clinical record indicated the facility failed to provide the resident with a copy of the resident rights, acknowledged by a resident and/or resident representative signature. 2. Review of Resident 16's clinical record was completed on 8/13/24 at 2:19 p.m. Diagnoses included dementia, hypertension and sleep disturbance. Review of the clinical record indicated the facility failed to provide the resident with a copy of the resident rights, acknowledged by a resident and/or resident representative signature. During an interview, on 8/14/24 at 9:36 a.m., the acting Administrator indicated she was unable to provide a signed copy of the resident bill of rights for Resident 13 and Resident 16. Residents should be given a copy of the resident rights to review and acknowledge with their signature prior to admission. A current facility policy, titled "Move- in Policy," last revised 5/2014 and provided by the acting Administrator, on 8/14/24 at 12:00 p.m., indicated	R 0026	**Resident Rights – 0026 – 410 IAC 16.2-5-1.2(a)** Resident Bill of Rights were reviewed with Residents #13 and #16, and signatures were obtained. The original will be maintained in the resident's file; each resident was provided with a copy. Executive Director and Interim Administrator will audit current resident files to ensure that all current resident and/or resident's representative have been provided with and signed the Resident Bill of Rights. Any resident file missing the Resident Bill of Rights will be provided with the Resident Bill of Rights for review and signature. Interim Administrator will review 410 IAC 16.2-5-1.2(a), Residents' Rights, with Executive Director and Health and Wellness Director to ensure understanding and future regulatory compliance. Interim Administrator will conduct audits of new resident files monthly x 3, to ensure that new residents/representatives have been provided with Resident Bill of Rights. Results of the audit will be reviewed during the Quality Assurance meeting. Findings of compliance x 3 months will indicate understanding of the regulatory requirements, and audits will end. Findings of	09/03/2024

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	"...The following forms must be completed and returned prior to move in ...i) Resident Bill of Rights ...."		non-compliance will require additional audits x 3 months, with findings presented during the QA meeting.	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure the survey results binder included the results (the 2567 report from the Indiana Department of Health) of the facility's most recent surveys and any related plan of corrections for 1 of 1 survey results binder reviewed. Findings include: During an observation, on 8/13/24 at 3:54 p.m., a picture frame on a desk in the main foyer indicated the annual survey results were located in the center drawer. In the center drawer was a binder labeled Bickford Cottage ISDH survey documents. The binder contained the last annual Residential Licensure Survey completed on 9/6/23 and a revisit letter dated 10/26/23. The binder did not include two State Residential Licensure Complaint Surveys completed on 7/23/24 and 3/19/24. During an interview, on 8/14/24 at 11:30 a.m., the acting Administrator indicated the binder included their most recent survey, completed in September 2023. She was unaware the binder needed to include any complaint survey 2567's or the	R 0042	**Survey Binder – 0042 – 410 IAC 16.2-5-1.2(p)** Survey / POC for surveys conducted on 3-19-2024 and 7-24-2024 were placed in the binder on 8-28-2024 by the Executive Director. Interim Administrator reviewed 410 IAC 16.2-5-1.2(p) with both the Health and Wellness Director and with the Executive Director, who is already familiar with the IDOH Gateway and the location of all surveys conducted by IDOH for this facility. Interim Administrator will audit the Facility Survey Binder monthly x 3 months to ensure that all completed Surveys / POCs have been added to the contents of the binder. Results of audit findings will be reviewed at the Quality Assurance meeting. Findings of compliance x 3 months will indicate understanding of the regulatory requirements, and audits will end.	09/02/2024

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	facilities Plan of Correction (POC) for any deficiencies. During an interview with the acting Administrator, on 8/14/24 at 11:30 a.m., she indicated she did not have a policy related to the Indiana Department of Health Survey Binder.		Findings of non-compliance will require additional audits x 3 months, with findings presented during the QA meeting.	
R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance 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. (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 Based on interview and record review, the facility failed to employ a licensed administrator to manage day to day facility operations. This deficient practice had the potential to affect 19 of 19 residents residing in the facility. Findings include: During an interview, on 8/13/24 at 3:54 p.m., the acting Administrator indicated she was not licensed. Her prior class was canceled, and she was scheduled to start classes in September 2024. A Residential Care Administrator consultant came into the building on Tuesdays and was available to her 24/7 if any needs arose.	R 0088	**License – 0088 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2)** August 26, 2024, Executive Director resubmitted the Administrator Change form dated February 1, 2024, naming Lori Crispen as the Facility Administrator. ED emailed the Administrator Change form to ltcproviderservices@isdh.in.gov. Executive Director has registered for the four-week Success Development Residential Care Administrator class, which will	09/02/2024

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	During an interview, on 8/13/24 at 4:20 p.m., the Residential Care Administrator consultant indicated she was the interim Administrator until the acting Administrator received her license. She was an independent contractor and was on the facility payroll. She physically came to the facility every Tuesday and was available by phone. She was unsure why someone else's name was listed as the Administrator and that she had the facility's corporation notify the Indiana Department of Health (IDOH) when she started in February 2024. During record review, on 8/13/24 at 4:30 p.m., the Residential Care Administrator's file had an Administrator or Director of Nursing Change SF (State Form) completed and dated 2/1/24. There was no confirmation that the form was submitted to IDOH by either fax or email. During an interview, on 8/14/24 at 11:13 a.m., the acting Administrator was unable to provide documentation that an Administrator or Director of Nursing Change SF form was faxed to the IDOH. A current, undated facility policy, provided by the acting Administrator on 8/14/24 at 10:45 a.m., titled "Director Requirements," indicated Bickford shall employ an administrator/operator who has completed the training requirements pursuant to the State Law.		begin 9-17-24 and end 10-11-2024. A copy of the completed Registration and Receipt for payment is attached. Interim Administrator will monitor class attendance for the four-week duration. Interim Administrator will also assist ED with review of course materials following the completion of the RCA class to further assist with preparation for the Indiana Juris Prudence RCA test.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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:			

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	(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 interview and record review, the facility failed to ensure fire drills were conducted quarterly as required. This deficient practice had the potential to affect 19 of 19 residents residing in the facility. Findings include: A review of the fire drill records, provided by the Maintenance Director, on 8/13/24 at 10:15 a.m., lacked fire drills records between the months of January 2024 through April 2024. During an interview with the Maintenance Director, on 8/13/24 at 4:02 p.m., he indicated during the transition of him taking over as the Director, papers had been misplaced and he could not locate any other fire drills. An undated current facility policy, provided by	R 0092	**Fire Drills – 0092 – 410 IAC 16.2-5-1-1.3(i)(1-2)** The current Maintenance Director was able to locate some of the missing fire drills (conducted prior to his employment) and placed them in the binder for Fire Drills. Copies of fire drills will also be maintained in the Executive Director's office. Interim Administrator will review 410 IAC 16.2-5-1-1.3(i)(1-2) with Executive Director, Health and Wellness Director and the Maintenance Director to ensure understanding of the regulatory requirements regarding the	09/02/2024

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	the Administrator, on 8/14/24 at 9:47 a.m., titled "Fire Drill Schedule," indicated the following: " ...fire drills shall be performed monthly. This includes each shift having one drill each quarter ...."		completion of Quarterly Fire Drills and completion of and maintenance of the necessary documentation. Interim Administrator will audit Fire Drill completion records monthly x 3 to ensure that fire drills have been conducted and the necessary documentation has been completed and is maintained in the appropriate binder. Results of audit findings will be reviewed at the Quality Assurance meeting. Findings of compliance x 3 months will indicate understanding of the regulatory requirements, and audits will end. Findings of non-compliance will require additional audits x 3 months, with findings presented during the QA meeting.	
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, interview and record review, the facility failed to ensure food was stored in a sanitary manner regarding dating and labeling foods and failed to ensure the kitchen and kitchen equipment was maintained in a sanitary manner. This deficient practice had the potential to impact 19 of 19 residents who received meals prepared in the kitchen. Findings include:	R 0273	**Food and Nutritional Services – 0273 – 410 IAC 16.2-5-5.1(f)** Kitchen staff labeled and dated food that were cited during the survey and began cleaning areas cited by survey staff. Interim Administrator will review Food and Nutritional Services, 410 IAC 16.2-5-5.1(f) with the Executive Director to ensure understanding of this regulatory	09/02/2024

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	During an initial tour of the kitchen with Cook 5 present, beginning on 8/13/24 at 9:34 a.m., the following was observed: a. A container of dry cereal did not have a label or date identifier and an opened package of powdered sugar was in a cabinet. b. Inside the countertop microwave there was orange and yellow debris scattered across the top of the microwave. c. On the countertop next to the microwave was an open canvas bag with clothing and storage containers in it and a backpack located on the floor next to the Lazy Susan. Cook 5 indicated they were her personal items and she should store them in the manager's office. d. A countertop stand mixer had splattered yellow and cream colored substance on the steel plate where mixer attachments would be attached. e. There was a sticky substance on the face of the drawers that were located below the stand mixer, labeled "scoops", "misc.," "whisk and rolling pin." f. Inside a shoulder height cupboard located to the right of the sink, a sticky gray and black substance was located on the corners of the cupboard doors. The bottom shelf inside the cupboard contained small plates, saucers, dessert dishes and cereal bowls, and beneath the items was a thick black and gray film that coated the bottom of the cupboard. g. The dairy refrigerator contained an uncovered, undated, and unlabeled pan of a burgundy - colored gelatin, an unlabeled and undated		requirement. Interim Administrator and Executive Director will review Food and Nutritional Services – 0273 – 410 IAC 16.2-5-5.1(f) with kitchen staff to ensure understanding of the regulatory requirements. Executive Director will review kitchen staff job descriptions and previously conducted Job Specific Orientation to ensure that they understand the requirements of their positions. Executive Director will review the following policies with kitchen staff to ensure understanding: · Food Storage, Labeling, and Dating · Stainless Steel Top Tables with Cupboards - Cleaning · Cupboards/Drawers – Cleaning · Cleaning Logs Interim Administrator and Executive Director will audit the kitchen Cleaning Logs weekly x 4 weeks, then monthly x 2 months. Interim Administrator and Executive Director will audit food labels/dates, and kitchen cleanliness weekly x 4, then x 2 months. Results of audit findings will be reviewed at the Quality Assurance meeting. Findings of compliance x 3 months will indicate understanding of the regulatory requirements, and audits will end. Findings of non-compliance will require additional audits x 3	

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	container of cream colored liquid, and a container labeled French dressing, dated 7/2 with a use by date of 8/1. Cook 5 indicated the raspberry gelatin salad was made the day before and should be covered, the poppy seed dressing should had been label, and they would normally dispose of the French dressing after the use by date. h. On the doors of the lower cabinets near the stove, the doors had a brown, black and dark gray film covering them, and there was a cream-colored substance splattered and running down the cabinet door. The Dietary Manager entered the kitchen, and she proceeded to tour the rest of the kitchen. The Dietary Manager indicated they cleaned the cabinets once a week. i. A side by side countertop fryer near the stove had a steel lid on the left side of the fryer, under the lid were brown and black flakes and crumbs scattered amongst the fryer, around the edges, coating from the basket with grease in it, up to the face of the thermostat dial. The Dietary manager indicated they hardly ever used the fryer and it was most likely chicken and grease particles. The last time they used the fryer was about a week and a half ago. They normally changed the grease after three uses. The food and grease particles around the top had been like that since she started in March 2024. j. A steel prep table in the middle of the kitchen with two lower shelves the length of the table had crumbs and debris scattered across both shelves. The shelves contained steam table pans, a small stack of face down Styrofoam containers, and sheet pans.		months, with findings presented during the QA meeting.	

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	k. At the back of the kitchen in the refrigerator, there was an unlabeled and undated mixing bowl of orange and green cubed fruit with clear plastic wrap over the top. The Dietary Manager indicated it was mixed fruit containing cantaloupe and honeydew melons served this morning and the container should have been labeled and dated. l. A lower cabinet between the sink and the dairy refrigerator had brown crumbs and debris scattered at the base of the cabinet just inside the cabinet doors. The cabinet contained trays, five mixing bowls and a colander. The Dietary Manager indicated they did not use the trays but did use the colander. m. In the dry storage room, there was an unlabeled and undated large clear container with a lid that had a white powdery substance inside. The Dietary Manager indicated that was flour and it should have been labeled and dated. During the observation, the Dietary Manager indicated there was no general cleaning checklist. During an interview, on 8/13/24 at 12:01 p.m., the Dietary Manger indicated the facility did not have a cleaning log. During an interview, on 8/13/24 at 12:18 p.m., the acting Administrator provided a kitchen rotation cleaning schedule. She indicated the kitchen was not using the cleaning schedule, but they needed to be, and she would provide education to the Dietary Manager. A current facility policy, revised 3/2017, titled "Food Storage- Labeling and Dating," provided by the acting Administrator, on 8/14/24 at 12:00 p.m., indicated the following: "...It is policy for the			

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	Food Service Department to wrap, cover, label, date and store all foods in a safe manner ...." A current facility policy, revised 10/2016, titled "Stainless Steel Top Tables with Cupboards-Cleaning," provided by the acting Administrator, on 8/14/24 at 12:00 p.m., indicated the following: " ...after each use wash thoroughly with warm detergent sanitizing solution ...." A current facility policy, revised 10/2016, titled "Cupboards/Drawers- Cleaning," provided by the acting Administrator, on 8/14/24 at 12:00 p.m., indicated the following: " ...Weekly: 2. Wash inside thoroughly with warm, detergent sanitizing solution ...4. Wash exterior thoroughly with warm, detergent sanitizing solution and dry with clean, soft cloth ...."			