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	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF CARMEL	5829 EAST 116TH STREET CARMEL, IN 46033

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00349478. Complaint IN00349478 - Substantiated. State Residential Findings are cited at R052 Survey dates: April 21 and 22, 2021 Facility number: 013217 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 29, 2021.	R 0000	The following is the Plan of Correction for the Bickford of Carmel in regard to the Statement of Deficiencies dated 04/22/2021. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure residents, who	R 0052	1. What is the corrective action to be taken:	05/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	were at risk of elopement, were free from neglect for 2 of 2 residents reviewed for elopement. (Resident C and A) The facility provided insufficient supervision for Resident C, who had successfully eloped from the facility and Resident A who resided on the memory care unit and was observed unsupervised in the common area of the facility on both days of the survey. Findings include: 1. The record for Resident C was reviewed on 04/22/2021 at 10:20 a.m. Diagnoses included, but were not limited to, significant dementia, ataxia (impaired balance or coordination) and leukemia. Preadmission history from the resident's physician, faxed to the facility on 11/16/2020, indicated "...memory loss. Getting worse...Her husband reports that he needs more assistance." The physician further indicated Resident C was no longer independent in her ADL's (Activities of Daily Living) and her husband was "...having trouble keeping her in the house. She unlocks the doors and goes to the neighbors...." and Resident C was "...wanting to go home with her parents...." A review of the progress notes for Resident C indicated the following: On 12/21/2020 at 4:30 p.m., "...Resident has been wandering halls since arrived in facility. Staff continues to redirect resident back to room...." On 12/22/2020 at 2:00 a.m., "...Resident up et (and) wandering halls (with) her coat, gloves et (and) flashlight. Opened the front door once setting off alarm...." On 12/28/2021 at 2:45 p.m., "...Noted res (resident)		Maintenance Coordinator contacted branch technical support 4/22/2021 to change door alarm notifications to send signal to the pagers 24/7. Director met with son/POA of resident C on 4/16/2021 and Resident C was moved to the secure memory care unit on 4/19/2021. Cut-band remains in place for safety. Service plan updated on 4/28 to include Cut-band check's and behavioral interventions. Resident A has had an updated service plan and Cut-band remains in place for safety. Service plan updated on 5/6/21 to include Cut-band checks and behavioral interventions. 2. 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? Residents in Branch will be evaluated routinely and as resident condition changes according to company policy and state regulatory guidelines using established assessment tools to determine when a resident meets triggers to require updates to service plan to meet safety needs of resident. 3. What measures will be put into place or what systemic changes the facility will make to	

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	to have increased confusion, restlessness and agitation. Res easily agitated after attempting to redirect...." On 02/28/2021 at 3:00 p.m., "...Resident has removed cut band multiple times after staff has reapplied. Staff attempted to put cut band on ankle which resident has since removed twice. Reported to other shifts to keep close watch on resident as she continues to remove cut band & (and) push on exit doors. Re-direction & one on one activities have been used when staff is available to do so...." During an interview, with the Facility Director, the Divisional Director of Resident Services (DDRS) and the RN Coordinator (RNC), on 04/22/2021 at 12:30 p.m., the DDRS indicated a "cut band" was a bracelet device worn by the resident which alerted when a resident had breached a pre-programmed perimeter in the facility. A progress note, on 03/10/2021 at 4:45 p.m., indicated "...Alerted by another resident and door alarm that resident was outside. Had pushed open front door setting alarm off. An alert resident rm (room) 101 walked with her to assure safety back into the facility. Resident was resistant refusing to walk to secure area inside building...." A physician's order, dated 02/26/2021, indicated "...Cut Band Monitoring - Check Cut Band each shift for placement and functioning. Report to Director if Cut Band is missing or not functioning...." Documentation of monitoring of the cut band was requested and received on 04/22/2021 at 12:30 p.m. and indicated the following:		ensure that the deficient practice does not recur. RN Coordinator will place order in facility EMAR to trigger employees to check cut-band for proper functioning and placement. In-service to be held by 5/14/21 to educate all employees on how to properly check cut-band monitors for proper functioning. Maintenance director to be re-educated on how to perform and document weekly audit of security system according to company policy by Director by 5/10/21 with documentation of reeducation. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. RN Coordinator to audit EMAR weekly to ensure resident cut-band checks are occurring, document date of audits on medication audit spreadsheet, and promptly follow up on missed checks by performing cut-band test. Maintenance Coordinator to report results to Director at weekly manager meetings and to Safety Committee team at bi-monthly Safety Committee meeting.	

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	On 02/26/2021 at 8:50 p.m., "LATE: new" On 02/27/2021 at 8:08 a.m., "cut band reapplied to ankle and removed once again by resident shortly after" On 02/28/2021 at 8:01 a.m., "has since removed cut band..again" On 02/28/2021 at 4:05 p.m., "per day shift was off" On 03/11/2021 at 8:22 a.m., "cut band missing" Documentation was lacking in the clinical record to indicate how the resident was able to remove the cut band or alternative measures taken to provide for the resident's safety and risk for elopement. Documentation was also lacking of an evaluation regarding the resident's elopement risk and evaluation regarding the use of the cut band. The resident's current service plan, dated 02/08/21, failed to address the resident's desire to leave the facility and the use of the cut band. Alert and oriented Resident K was interviewed on 04/22/2021 at 12:00 p.m. Resident K indicated he was often up and around the common area of the facility and almost always within eye view of the facility entrance. Although he was unable to recall the exact date, he relayed about a month ago, he had observed a couple exiting the facility and Resident C had followed the couple out of the facility as they exited. Resident K stated he knew Resident C was not an acquaintance of the couple so he followed the resident out of the facility to ensure her safety. He indicated Resident C had turned left after exiting through the front entrance and walked on the sidewalk next to parked vehicles. He caught up with Resident C just as the couple got into their vehicle. Resident K stated he walked with the resident, around the building to			

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	an entrance on the west side of the facility, where staff assisted Resident C and himself to re-enter the facility. During an interview, on 04/21/2021 at 3:00 p.m., the Director of Nursing indicated Resident C had been moved to the secure memory care unit on 04/19/2021 following conversations with the resident's family, 40 days following the resident's elopement from the facility. During an interview, on the secure memory care unit, on 04/22/2021 at 1:30 p.m., LPN 6 indicated each resident with a cut band was to be monitored every shift to ensure the band was still in place and fully operational. 2. Resident A was observed to ambulate independently, without supervision, with her walker in the common area of the facility on 04/21/2021 at 2:00 p.m. and on 04/22/2021 at 1:10 p.m. The resident ambulated with a slow steady gait. During an interview, on 04/21/2021 at 2:30 p.m., the Facility Director indicated Resident A was a resident of the secured memory care unit of the facility, adding the resident was allowed to be in the common area of the facility due to the resident's behaviors on the secured memory care unit. The resident had a cut band on her right ankle. The record for Resident A was reviewed on 04/22/2021 at 10:20 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, generalized muscle weakness, difficulty walking and abnormal gait. The progress notes for Resident A indicated the			

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	following behaviors of exit seeking: On 03/19/2021 at 9:20 a.m., "...Resident pushing on exit doors to leave MB (secured memory care unit). When taken up front to AL (Assisted Living), resident will sit for a short amount of time before she gets up and starts walking back to MB. This repeats all morning...." On 03/20/2021 at 10:00 a.m., "...Resident keeps getting anxious (and) agitated ramming walker against the door to try to get out...." On 03/22/2021 at 10:00 a.m., "...Resident pushing on door until it opens so she can go walk around assisted living...." On 04/05/2021 at 9:30 a.m., "...Resident is trying to escape (and) pulling fire alarm...." On 04/06/2021 at 2:00 p.m., "...exit seeking & pushing on doors...." A current service plan, dated 01/20/2021, was lacking documentation of Resident A's behavior of exit seeking or the use of the cut band. On 04/22/2021 at 1:10 p.m., a test of the cut band alarm system was requested. Resident A was observed, at this time, to be seated in a chair in the common area of the facility. The resident was observed to be wearing a cut band on her right ankle. The Facility Director and RN Coordinator assisted Resident A to ambulate with her walker to the facility entrance door. When Resident A approached the entrance door, an alarm panel on the wall next to the door was observed to light up with a red warning, however no audible alarm was heard and no staff were observed to respond to the alert. When questioned as to how staff were			

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	to be notified of the resident's breach of the perimeter, the Facility Director and RN Coordinator indicated they did not know. The Maintenance Supervisor standing nearby indicated facility staff received a notification on their pagers when the perimeter had been breached by a resident with a cut band. LPN 5 was observed to ambulate into the common area at this time. LPN 5 was questioned as to whether she had received an alert on her pager at 1:10 p.m. indicating the perimeter of the entrance had been breached by a resident with a cut band. LPN 5 indicated she had not received an alert at 1:10 p.m. During an interview, on 04/22/2021 at 1:30 p.m., LPN 6 indicated she had not received a notification on her pager at 1:10 p.m., informing her the perimeter of the entrance door of the facility had been breached by a resident wearing a cut band. During an interview, on 04/22/2021 at 3:30 p.m., the Maintenance Supervisor indicated he had contacted technical support for the cut band alarm system. He stated he was told by technical support the front entrance was not alarmed for the cut band system between the hours of 7:00 a.m. through 5:00 p.m. When questioned how staff were to know if a resident with a cut band and deemed high risk for elopement was monitored during the hours of 7:00 a.m. through 5:00 p.m., he indicated there was usually facility staff in the immediate area of the front entrance door during those hours to monitor residents at risk. Resident C had exited the facility at 4:45 p.m. Resident C's cut band monitoring indicated the cut band was documented as being on and working on 03/10/2021 at 9:40 am. and 4:06 p.m., the day Resident C's elopement from the facility.			

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	A current facility policy, regarding the use of cut bands and the alarm system, was requested on 04/22/2021 at 12:30 p.m., however no policy was received prior to or at the time of exit. This State Tag relates to Complaint IN00349478.			
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: (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 complete monthly fire drills and failed to invite the fire department to attend a fire drill every six months for 7 of 12 months reviewed for fire drills.	R 0092	1. The following corrective action has been taken: The Carmel Fire Department was contacted on April 28th, 2021 and requested to hold a fire and	05/10/2021

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	Finding includes: The Fire Drill Logs were reviewed, with the Maintenance Coordinator, on 04/22/21 at 9:17 a.m. During the review, he indicated he had not completed any fire drill for the first quarter of 2021 (January, February and March). Further review of the logs showed fire drills were not completed in April, May, June and September of 2020. Additionally, there was no documentation to indicated the fire department had been invited to observe any fire drills for the past year. At this time, the Maintenance Coordinator indicated he had no other documentation of fire dills for the missing periods and he was not aware the fire department needed to be invited to observe/participate in any fire drills. A current facility policy, titled "Fire Drill Schedule," dated as revised on 04/2016 and provided by the Maintenance Coordinator on 04/22/21 at 9:19 a.m., indicated "...Fire Drills shall be performed MONTHLY. This includes each shift having one drill each quarter...."		disaster drill in conjunction with the community. 2. 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? * All Residents have the potential to be affected by the deficient practice. The branch will be complaint with all fire drills effective 5/10/2020 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. *Maintenance Coordinator has been educated on a spreadsheet to track requests made to the Carmel Fire Department. Director or Designee and Maintenance Coordinator will have re-education, on the requirement for fire department involvement with fire drills at least every six months and the policy on drills to be conducted quarterly on each shift with at least 12 drills held every year. Maintenance Coordinator has been in-serviced on 410 IAC 16.2-5-1.3(i)(1-2) and company policy, titled “Fire Drill Schedule”. The local fire department has been invited to participate with the May 2021 fire drill on 5/10/2021. Communication with the fire department will be in writing and attached to the Fire Drill Report every six months.	

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			4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place *Executive Director or designee will monitor spreadsheet monthly and quarterly. *Results will be discussed at the Bi-monthly Safety Committee Meeting involving department managers and monthly involving the Director and Maintenance Coordinator.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties			

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	shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was a staff member certified in first aid and CPR (Cardiopulmonary Resuscitation) to cover all shifts for a 24 hour period for 7 of 7 days reviewed for first aid and CPR. Finding includes: Employee records were reviewed on 04/22/2021 at 3:30 p.m. The current as worked nursing schedule for 04/11/2021 thru 04/17/2021, indicated the following shifts were lacking staff coverage with first aid and CPR certifications: 04/11/2021 - day shift lacked first aid and CPR, evening shift lacked first aid and night shift lacked first aid and CPR 04/12/2021 - day shift lacked first aid and night shift lacked first aid and CPR. 04/13/2021 - day shift lacked first aid and night shift lacked first aid and CPR. 04/14/2021 - day shift and night shift lacked first aid and CPR. 04/15/2021 - day shift lacked first aid, evening shift and night shift lacked first aid and CPR 04/16/2021 - day shift lacked first aid and CPR, evening shift lacked first aid and night shift lacked first aid and CPR 04/17/2021 - day shift and evening shift lacked first aid, night shift lacked first aid and CPR During an interview, on 04/22/2021 at 4:00 p.m., the Executive Director indicated there was not adequate first aid and CPR coverage for the week of 04/11/2021 through 04/17/2021.	R 0117	In Response to R117 – What is the corrective action plan to be taken: 1. The Director will ensure a staff member is scheduled shift-to-shift to ensure every shift is covered by an employee certified in CPR and first aid. · Nursing employee files were audited on 04/23/2021 to validate the nursing staff first aid certification. 2. 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? · Current residents residing in the Branch have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. In-service to be completed by 5/14/21 to inform staff that all must be CPR and First Aid certified. Classes scheduled throughout May to achieve compliance by May 31st. Director or designee to audit staff records	05/31/2021

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	A current policy, titled "Certification and Licensure," dated 08/2020 and provided by the Executive Director on 04/22/2021 at 4:00 p.m., indicated "...7) it is required that each Bickford Family Member is CPR and First Aid certified...."		monthly for 3 months and demonstrate compliance of 100% and quarterly thereafter with classes scheduled to recertify staff prior to CPR and First Aid expiration. 4. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.· CPR and First aid certification for nursing staff will be completed by May 25th 2021. New nursing staff will be required to have current CPR and First Aid Certification within 60 days of hire.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (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.			

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	Based on interview and record review, the facility failed to have the HVAC (heating and ventilation) system inspected on a yearly basis. Finding includes: The HVAC (Heating, Ventilation and Air Conditioning) inspection records were reviewed with the Maintenance Coordinator on 04/22/21 at 9:20 a.m. At this time, he indicated the yearly HVAC inspection was not completed and he was not aware a yearly inspection needed to be done. During an interview, on 04/22/21 at 9:20 a.m., the Maintenance Coordinator indicated the facility did not have a policy addressing yearly inspections of the HVAC system.	R 0148	The following corrective action has been taken: 1. HVAC company was contacted and HVAC Inspection scheduled at the earliest opening and to be completed by June 8th, 2021 and annually thereafter. 2. 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? * All Residents have the potential to be affected by the deficient practice. HVAC system will be monitored routinely 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? HVAC annual inspection log sheets to be initiated by 05/21/2021 and monitored by the Maintenance Coordinator 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director or Designee will monitor the log sheets annually.	05/21/2021

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		A. BUILDING 00 B. WING	04/22/2021

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain an admission weight and failed to obtain a self-administration medication evaluation for 2 of 7 resident records reviewed. (Resident A and D) Findings include: 1. The record for Resident A was reviewed on 04/21/2021 at 3:00 p.m. Diagnoses included, but were not limited to, memory impairment and anxiety disorder. An admission documentation sheet indicated Resident A was admitted to the facility on 03/15/2021. A document, titled "Resident Vital Signs," indicated Resident A's weight was taken on 04/03/2021. During an interview, on 4/22/2021 at 4:30 p.m., the Divisional Director of Resident Services indicated	R 0216	1. The following corrective action has been taken: · Resident A weight was obtained on 04/03/2021. Resident D had their self-administration assessment completed on 4/22/2021. An audit was completed on 04/22/2021 of all residents who self-administer to ensure there is a self-administer assessment completed and no other concerns were identified. 2. 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? · All residents who self-administer medications have the potential to be affected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	04/30/2021

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	he could not provide an admission weight for Resident A and did not have a specific policy related to a time frame in which to obtain a resident's weight. He indicated the facility followed the state regulated guidelines related to weights obtained on admission and every 6 months there after. 2. The record for Resident D was reviewed on 04/21/2021 at 10:01 a.m. Diagnoses included, but were not limited to, frequent falls and chronic pain. A document, titled "Self-administer medications," indicated Resident D self-administered her own medications. A self-administration evaluation assessment was not located in the resident's record. During an interview, on 04/22/2021 at 4:15 p.m., the Divisional Director of Resident Services indicated he could not provide a self medication evaluation for Resident D and she should have had one completed to be able to self administer her own medications. A current policy, titled "Medication Management," dated 01/2021 and provided by the Divisional Director of Resident Services on 04/22/2021 at 4:15 p.m., indicated "...A resident who desires to self-administer medications will need to be assessed by an RN using the self-medication assessment (per state regulations)...."		recur · RN Coordinator or designee will audit all residents records that self-administer at move in and during service plan updates (Semi-Annually or upon significant change in condition) to ensure self-administration assessments are on record and audit admission checklist to ensure admission weight has been obtained and documented. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? RN Coordinator or designee will audit resident's records for residents who self-administer. RNC or designee to audit monthly until compliance at 100% x 3 months to ensure no resident self-administered medication without proper assessment. Admission packet and checklist constructed for each scheduled admission to include checklist item to obtain weight and vital sign record to record admission vitals and weight. Medication self administration assessment tool will be completed with every service assessment as directed by company policy and regulatory guidelines to verify residents' continue to be able to safely self administer medications.	
R 0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency			

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Bldg. 00	(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 the quat sanitizer was at appropriate levels, boxes were not stored on the floor of dry storage, dry goods were labeled with open dates and closed when put in dry good storage, refrigerator and freezer items were labeled with open dates and use by dates. These deficient practices had the potential to affect 31 of 31 residents who receive meals from the kitchen. Findings include: During an observation of the kitchen, with the Dietary Manager on 04/21/21 at 9:40 a.m., the following were observed: 1. The Quat Sanitizer (a sanitizer used to clean surfaces in the kitchen) was tested by the Dietary Manager using a litmus test strip (paper used to detect the concentration of sanitizer in water), dipped in the sanitizer solution, indicated the solution was 0 parts per million (PPM). At this time, the Dietary Manager indicated the correct range should have been 150-400 PPM. 2. In the dry storage pantry, a box of medium barley oats was found open on the shelf, the top of the box had been ripped off and did not have a label to indicated when it had been opened. The Dietary Manager indicated it should have been closed and labeled with the date it was opened. 3. On the floor, in the dry good storage pantry,	R 0273	1. The following corrective action has been taken: All compromised food items were immediately discarded. Kitchen Manager conducted an audit of all existing unopened food items to ensure proper labeling and dating of “use by” dates. Quat Sanitizer was Corrected the day of and Ecolab came out and increased the amount of solution. All boxes were removed and stored according to policy titled “Food Storage-Labeling and Dating”. 2. 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? All residents have the potential to be affected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. * Director or designee and Kitchen Manager will complete an audit of all food storage areas using the dining services audit tool by 5/10/21. Manager and all assistant cooks to be re-educated on proper storage and labeling of all food products and the documentation of sanitizing solutions checks	05/10/2021

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	was a box of coffee filters and individually wrapped packages of multi-cup coffee (each package made a pot of coffee) and a box of individually wrapped plastic dining utensils. The Dietary Manager indicated the boxes should not have been left on the floor. 4. On the shelf, of the dry good storage pantry, was an open bag of dry egg noodles, a three pound bag of spaghetti pasta and a bag of elbow noodles. They were all open to air and with out a label to indicated when they had been opened. The Dietary Manager indicated they should have been closed and labeled with the date they were opened. 5. On the can food rack, there was a six pound can of fruit cocktail mix and a six pound can of garbanzo beans. Both cans were found to be dented. At this time, the Dietary Manager indicated dented cans were to be removed and discarded. 6. In the reach in refrigerator, there was an opened plastic container of sour kraut, an opened container of peeled hard boiled eggs and an opened container of Caesar Dressing. The items did not have an open date label. Additionally a container of raspberry vinaigrette dressing was found with an open date of 7/31 and the expiration date on the container was 04/20/21. At this time, the Dietary Manager indicated an open date should have been put on the items and the raspberry dressing should have been discarded on the expiration date. 7. In the meat freezer, a bag of nine beef patties was found open to air and without an open date. The Dietary Manager indicated the bag should have been closed after opening and should have		throughout each day by 5/10/21. Director will audit all food storage areas, sanitizing solution logs of kitchen three times weekly for the next eight weeks and then weekly for eight weeks and then monthly indefinitely and document audits. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Director or designee and Kitchen Manager will audit all food storage areas, sanitizing solution logs of kitchen three times weekly for the next six weeks and then weekly for six weeks and then monthly and document audits	

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	been labeled with an open date. During an interview, on 04/22/21 at 10:03 a.m., the Administrator indicated there was no policy addressing not storing boxes on the floor in the dry storage area. A current facility policy, titled "Sanitizer Solution Log," dated as revised on 01/2018 and provided by the Dietary manager on 04/21/21 at 10:21 a.m., indicated "...Utilize Eco Lab Quat Sanitizer 146. Titration reading is to be between 150 PPM and 400 PPM...." A current facility policy, titled "Damaged Cans," dated as revised on 07/2012 and provided by the Dietary Manager on 04/21/21 at 10:21 a.m., indicated "...It is extremely important that food from...damaged cans not be served or used...Cans with...defects shall be returned...and reordered as necessary...." A current facility policy, titled "Food Storage-Labeling and Dating," dated as revised on 03/2017 and provided by the Dietary Manager on 04/21/21 at 10:21 a.m., "...It is the policy for the Food Service Department to wrap, cover, label date and store all foods in a safe, appropriate manner. This is to prevent foodborne illness and retain food quality from becoming stale or dried out...All dates are to be written on the container and represent the date it was opened or prepared...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious			

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	symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to assure each staff member was screened for Covid-19 signs and symptoms upon entry into facility and before working their scheduled shift. This deficient practice had the potential to affect 31 residents out of 31 residents residing on both the assisted living side and on the memory care unit. Finding includes: An "as worked" schedule provided by the Facility Director, on 04/21/2021 at 2:15 p.m., indicated on 04/20/2021, HHA 1 worked day shift on assisted living, LPN 2 worked night shift on assisted living, CNA 3 worked night shift on assisted living and day shift on memory care and CNA 4 worked evening and night shift on memory care. A document, titled "Entry and Exit Screenings," provided by the Facility Director on 04/22/2021 at 10:00 a.m., indicated HHA 1, LPN 2, CNA 3 and CNA 4 had not been screened for signs and symptoms including temperature monitoring upon entry to the facility and prior to working their scheduled shift on 04/20/2021. During an interview, on 04/22/2021 at 12:30 p.m., the Divisional Director of Resident Services indicated he could not locate the employees names on the entry screening document which	R 0407	. The following corrective action has been taken: All staff reeducated that entrance screenings must be completed, passed, and entered into computer tracking program prior to start of shift on 4/23/2021. 2. 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? All Residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Director or designee and RN Coordinator will perform and document re-education on the “Entry and Exit Screenings” for all employees by 5/14/21 or on next shift thereafter utilizing company policy on Infection Control practices. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	05/14/2021

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	would indicate they were not screened for Covid-19 prior to working on 04/20/2021. A current facility policy, titled "...Resident Health Check Screening Protocol," dated 11/2020 and provided by the Facility Director on 04/22/2021 at 3:30 p.m., indicated "...1...entry health check screenings, (required)...DFG (Directing Family Group - management) will be responsible for checking Entry and Health Check Screening for residents and BFM's (Bickford family members - staff)...."		Director or designee will audit scheduled employees daily against entrance screening records daily until 100% compliant with entry screening for 30 consecutive days and one day each week thereafter. Director will perform audit of infection control practices utilizing core-check tool by 5/21/21 and monthly thereafter to ensure compliance with current infection control guidelines as determined by company policy and Health Department guidance.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a yearly tuberculosis test or screen was completed for 1 of 7 residents reviewed for tuberculosis screening. (Resident H) Finding includes: The record for Resident H was reviewed on 04/22/21. Diagnoses included, but were not limited to, dementia, osteoarthritis and hypertension. There was no yearly tuberculosis test or screening found in the record for 2020. During an interview, on 04/22/21 at 3:35 p.m., the Administrator indicated they could not locate	R 0409	1. The following corrective action has been taken: *Resident H expired on 2/7/2021 therefore unable to administer TB. 2. 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? · All residents have the potential to be affected · An audit of all resident TB tests was completed on 4/28/2021. Any resident found to not be in compliance was administered a tuberculin skin test.	05/14/2021

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	documentation of the yearly tuberculosis screen or test for Resident H. A current facility policy, titled "Tuberculosis Screening-Resident," dated as revised on 12/2015 and provided by the Administrator on 04/22/21 at 4:05 p.m., indicated "...PPD (a tuberculosis test) test are not done routinely ...unless...required by state guidelines...."		3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur · All Nurses will be re-educated on the TB test policy/procedure by 5/14/21. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · RN Coordinator or designee will audit all annual TB tests due monthly to ensure compliance and TB tests administered prior to expiration for all residents · Results will be monitored/reported at the weekly managers meeting.	