	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	FICATION NUMBER A. BUILDING <u>00</u> COM		COMPL	3) DATE SURVEY COMPLETED 03/13/2025	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT			140 E 10	DDRESS, CITY, STATE, ZIP COD 07TH AVENUE N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0000 Bldg. 00	Survey dates: Marc Facility number: 01 Residential Census:	2940 58 atial Findings are cited in 0 IAC 16.2-5.	R 000	00			
R 0042 Bldg. 00	failed to ensure the results were readily the potential to affe facility.  Finding includes:  A general tour of th 3/12/25 at 9:52 a.m a.m. A sign was por Results Binder was  There were no bind entryway.  During an interview Director of Nursing picked up the binder	- Noncompliance  view and interview, the facility most recent annual survey available for review. This had ct all 58 residents of the  e facility was conducted at and again on 3/13/25 at 8:35 sted that indicated the Survey	R 004	12	R042 Residents' Rights - Noncompliance  What corrective actions will be accomplished for those reside found to have been affected by noncompliant practice?  No residents were affecte this deficient practice however residents had the potential to affected by this noncompliant practice.	ents y the d by	03/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Beth Tengerstrom Executive Director 04/02/2025

Any defiency statement 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 disclodays 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.

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 1 of 15

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

PRINTED: 04/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		03/13/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				07TH AVENUE		
BICKEOF	RD OF CROWN PO	INT			N POINT, IN 46307		
DIOIN OF				L			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	near the entryway.				What corrective action will be		
					taken?		
					The Survey Results Binde		
					will remain out for resident vie	-	
					near the front entryway with th		
					most recent annual survey and	d	
					plan of correction.		
					Miles to a second a second because of the	_	
					What measures will be put into		
					place or what systemic change		
					the facility will make to ensure that the deficient practice does		
					recur.	S HUL	
					Divisional Director of		
					Operations will re-educate the		
					Executive Director on the facil		
					requirement to have the Surve		
					Results Binder with the most	, y	
					recent annual survey results a	nd	
					plan of correction readily avail		
					at or near the front entryway for		
					residents to review by 3/24/25		
					The Executive Director w		
					be responsible for ensuring the		
					Survey Results binder is at or		
					the front entryway daily.		
					, , ,		
					How the corrective actions will	l be	
					monitored to ensure the defici	ent	
					practice will not recur, what qu	ıality	
					assurance program will be put	into	
					place.		
					Divisional of Operations to	)	
					monitor compliance monthly x	6	
					months upon visits to the		
					community that Survey Result	s	
					Binder is at or near the front		
					entryway. :		

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 2 of 15

		ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED			
			B. W	ING		03/13/2025
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  140 E 107TH AVENUE  CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0092 Bldg. 00	410 IAC 16.2-5-1. Administration and Noncompliance Based on record reversities a first quarterly as restored affect all 58 resides. Finding includes: On 3/12/25 and 3/1 were requested for a couple months completed on 3/5/2 know where the restlement of the complete on a couple months completed on 3/5/2 know where the restlement of Nursing would probably known and the current docume indicated, "Fire Director of the current docume indicated, "Fire Director o	3(i)(1-2) d Management -  view and interview, the facility drills were completed on each quired. This had the potential lents in the facility.  3/25 fire drills for the past year review.  3/25 fire drills for the past year review.  3/25 at 11:25 a.m., the for indicated he had been there is. He provided a fire drill record for the indicated he did not maining fire drills would be findicated the Administrator ow about the fire drills but she d unavailable.  2 ent, "Fire Drill Schedule", brills shall be performed includes each shift having one	R 0	092	R092 Administration and Management - Noncompliance  What corrective actions will be accomplished for those reside found to have been affected be deficient practice?  No residents were affected the noncompliant practice, but residents had the potential to affected by this noncompliant practice.  How the facility will identify off residents having the potential be affected by the same deficipractice and what corrective a will be taken  The Executive Director wire-educate the maintenance coordinator on the completion fire drills on each shift quarter required by 3/31/25  The maintenance coordin will be responsible for conductant documenting drills	e ents by the ed by t 58 be her to ient action ill of dy as nator

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 3 of 15

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 03/13/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  140 E 107TH AVENUE  CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				What measures will be put into place or what systemic change the facility will make to ensure that the deficient practice does recur.  Divisional Director of Operations will re-educate Executive Director on policy 4 IAC 16.2-5-1.3 completed by 3/24/25  The Executive Director is responsible for ensuring all fire drills are completed on each squarterly as required.  How the corrective actions will monitored to ensure the deficient practice will not recur, what quassurance program will be put place.  Executive director will mocompliance monthly x 3 month and quarterly thereafter.  Divisional Director of Operations will audit annually ensure continued compliance.	es a not a not	
R 0148 Bldg. 00	410 IAC 16.2-5-1. Sanitation and Sa	5(e)(1-4) fety Standards - Deficiency				
3	failed to ensure the ventilation system)	view and interview, the facility HVAC (heating and was inspected annually. This affect all 58 residents of the	R 0148	R148 Sanitation an Safety Standards - Deficiency  What corrective actions will be accomplished for those reside		
	On 3/12/24 and 3/1	3/24, the annual HVAC		found to have been affected b		

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 4 of 15

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

PRINTED: 04/08/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/13/2025
	PROVIDER OR SUPPLIE RD OF CROWN PO		140 E	ADDRESS, CITY, STATE, ZIP COD 107TH AVENUE /N POINT, IN 46307	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	regulatory of inspection was required inspection was required provided.  During an interview Maintenance Director a couple of more knowledge of the an Amaintenance schule Director of Nursing interior HVAC ven (excluding apartmeter)			deficient practice?  No residents were affer by the noncompliant practice 58 residents had the potent be affected by this deficient practice.  How the facility will identify residents having the potent be affected by the same de practice and what corrective will be taken.  The Executive Director re-educate the maintenance coordinator on the completi annual HVAC inspections a required 3/24/25.  The maintenance coord will be responsible for cond and documenting annual HV inspections.  What measures will be put place or what systemic chart the facility will make to ensure the deficient practice do recur.  The Maintenance coord will perform HVAC inspections monitored to ensure the deficient practice do recur.  The Maintenance coord will perform HVAC inspections monitored to ensure the deficient practice will not recur, what	ected ee, but ial to  other ial to ficient e action  will e on of s  dinator ucting VAC  into nges ure pes not edinator on by  will be ficient
				assurance program will be place.  The Executive Director responsible for ensuring an	is

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 5 of 15

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2025
		140 E	107TH AVENUE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
			HVAC inspection thereafter by maintenance coordinator.  The Divisional Director of Operations will monitor documentation of annual HVAI inspections annually to ensure continued compliance.	С
	, ,			
Based on record revialled to ensure pets vaccinations for 1 or reviewed. (Room 4d) Finding includes: The Pet Policy and reviewed on 3/13/2, the cat in room 409 vaccines on 2/19/21 During an interview Administrative Assisten attempting to vaccines updated. The current policy allowing residents to indicated in the Adibbe cared for with resafety hazards and in Prior to move in, and	pet vaccination records were 5. Veterinary records indicated was last seen for an exam and 7 on 3/13/25 at 11:20 a.m., the istant indicated the facility had contact the family to have the  For pets indicated, "3. In to keep pets at Bickford, as mission Agreement, pets shall spect to sanitation issues, in compliance with local codes. In the second of the contact the family to have the second ongoing, the Resident must	R 0151	R151 Sanitation an Safety Standards - Deficiency  What corrective actions will be accomplished for those resider found to have been affected by deficient practice?  O residents were harmed this deficient practice.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective awill be taken.  The Executive Director will perform an audit of all pet vaccination records to ensure compliance by 3/31/25.  What measures will be put into place or what systemic change the facility will make to ensure	nts y the  by  er to ent ction ill
	SUMMARY: (EACH DEFICIEN REGULATORY OR  410 IAC 16.2-5-1. Sanitation & Safet -Noncompliance Based on record rev failed to ensure pets vaccinations for 1 or reviewed. (Room 40 Finding includes:  The Pet Policy and reviewed on 3/13/2: the cat in room 409 vaccines on 2/19/21  During an interview Administrative Assibeen attempting to ov vaccines updated.  The current policy of allowing residents to indicated in the Adi be cared for with re safety hazards and if Prior to move in, and	PROVIDER OR SUPPLIER RD OF CROWN POINT  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance Based on record review and interview, the facility failed to ensure pets were up to date on vaccinations for 1 of 4 pet vaccination records reviewed. (Room 409)  Finding includes:  The Pet Policy and pet vaccination records were reviewed on 3/13/25. Veterinary records indicated the cat in room 409 was last seen for an exam and vaccines on 2/19/21.  During an interview on 3/13/25 at 11:20 a.m., the Administrative Assistant indicated the facility had been attempting to contact the family to have the	A BUILDING B. WING  PROVIDER OR SUPPLIER  RD OF CROWN POINT  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance Based on record review and interview, the facility failed to ensure pets were up to date on vaccinations for 1 of 4 pet vaccination records reviewed. (Room 409)  Finding includes:  The Pet Policy and pet vaccination records were reviewed on 3/13/25. Veterinary records indicated the cat in room 409 was last seen for an exam and vaccines on 2/19/21.  During an interview on 3/13/25 at 11:20 a.m., the Administrative Assistant indicated the facility had been attempting to contact the family to have the vaccines updated.  The current policy for pets indicated, "3. In allowing residents to keep pets at Bickford, as indicated in the Admission Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move in, and ongoing, the Resident must	PROVIDER OF CROWN POINT  SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION  410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance Based on record review and interview, the facility failed to ensure pets were up to date on vaccinations for 1 of 4 pet vaccination records reviewed. (Room 409)  Finding includes:  The Pet Policy and pet vaccination records were reviewed on 3/13/25. Veterinary records indicated the cat in room 409 was last seen for an exam and vaccines on 2/19/21.  During an interview on 3/13/25 at 11:20 a.m., the Administrative Assistant indicated the facility had been attempting to contact the family to have the vaccines updated.  The current policy for pets indicated, "3. In allowing residents to keep pets as Bickford, as indicated in the Administon Agreement, pets shall be cared for with respect to sanitation issues, safety hazards and in compliance with local codes. Prior to move in, and ongoing, the Resident must provide proof of current vaccination records"  A BUILDING BATTER ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT. IN 46307  BATTER ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT. IN 46307  BATTER ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT. IN 46307  BATTER ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT. IN 46307  FROMERICAN.  THE DIOVIDENS RAN OF CORRECTION EXCLUSIONS IN EXAM OF CORRECTION. TAG IN EXCLUSIONS IN EXAM OF CORRECTION. THE ADDRESS. CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT. IN 46307  HVAC Inspection thereafter by maintenance coordinator. The Divisional Director of Operations will monitor documentation of annual HVA inspection thereafter by maintenance coordinator. The Divisional Director of Operations will monitor documentation of annual HVA inspection thereafter by maintenance coordinator. The Divisional Director of Operations will monitor documentation of annual HVA inspection thereafter by maintenance coordinator. The

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 6 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	COMPLETED	
			B. WING			03/13/	2025	
			СТ	DEET A	DDDESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
BICKEOE	RD OF CROWN PO	INIT			N POINT, IN 46307			
DICKFOR	ND OF CROWN FO	IIN I		NOVIN	N FOINT, IN 40307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE	
R 0241	410 IAC 16.2-5-4(	e)(1)			Executive director to re-educate administrative assistant that any pet housed the facility shall have periodic veterinary examinations and required immunizations by 3/31/25.  How the corrective actions will monitored to ensure the deficie practice will not recur, what quassurance program will be put place.  Executive Director to au all pet records monthly x 6 months to ensure compliance.	be ent ality into		
Bldg. 00	Health Services -	Offense						
Blug. 00	Based on observation	on, record review, and	R 0241		R241 Health Service		03/31/2025	
		ty failed to ensure Physician	10211			es	03/31/2023	
	Orders were follow	ed during medication pass for 1			- Offense			
	of 5 residents obser	ved during medication pass.						
	(Resident 10 and Q	MA 1) Physician Orders were			What corrective actions will be	;		
	also not followed re	lated to a blood pressure			accomplished for those reside	nts		
	_	atside parameters and not			found to have been affected by	y the		
	_	nount of insulin given for 2 of			deficient practice?			
	7 records reviewed.	(Residents 5 and 8)			3 were affected by the			
					offense, but 58 residents had t			
	Findings include:				potential to be affected by this			
	1 0 2/12/25 + 2.5	75 OMA 1 1 1			offense.			
		55 a.m., QMA 1 was observed						
		10's medications. Included in			How the facility will identify oth			
	the medications wer				residents having the potential			
		IU) and rivastigmine patch g)/ 24 hours. The QMA gave the			be affected by the same defici			
		esident, who took them whole			practice and what corrective a	ction		
		n placed the rivastigmine patch			will be taken	otor		
	with water. She the	i piaced the rivastignine paten			Health and Wellness Dire	cior		

State Form Event ID: V9WK11 Facility ID: 012940 If continuation sheet Page 7 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		03/13/	2025
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
DIOLEGO					07TH AVENUE		
BICKFOR	RD OF CROWN PO	DIN I		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.C.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	on the resident's rig	ht chest.			will audit all resident physician		
					orders and e-mars to ensure		
	The resident's recor	ed was reviewed on 3/13/25 at			physician ordered parameters	are	
	9:55 a.m. The curre	ent Physician's Orders, dated			noted and followed and insulir		
		Vitamin D3 2000 IU daily and			amount given is documented b		
	rivastigmine patch	4.6 mg/ 24 hours.			med passers. Completed by	,	
	,				4/30/25		
	During an interview	y on 3/13/25 at 10:45 a.m., the			Health and Wellness Dire	ctor	
	QMA indicated the	Vitamin D3 was entered into			is responsible for ensuring		
	the Medication Adr	ministration Record incorrectly			medication is given that follow	s	
	as 1000 IU and wou	ald need to be corrected. She			parameters on the physician		
	also indicated she n	nay have given the resident			orders.		
	the incorrect rivasti	gmine patch. The QMA went			Health and Wellness Dire	ctor	
	to Resident 10's roo	om and removed the patch,			is responsible for ensuring tha	t the	
	which she indicated	l was incorrect. 2. Record			amount of insulin given is		
	Review for Residen	at 5 was completed on 3/12/25			documented.		
	at 1:10 p.m. Diagn	oses included, but were not					
	limited to, stage 3 c	hronic kidney disease and			What measures will be put into	)	
	stroke.				place or what systemic change	es	
					will the facility make to ensure		
	The March 2025 Ph	nysician's Order Summary (POS)			that the deficient practice does	not	
	indicated an order f	or metoprolol (medication to			recur.		
	lower blood pressur	re) 25 mg (milligrams). Give 1/2			Divisional Director of Hea	lth	
	tablet daily, hold fo	r SBP (systolic blood pressure,			and Wellness will re-educate		
	top number of blood	d pressure reading) less than			Director of Health and Wellnes	ss	
	115.				on documentation of insulin ar	nd	
					administering medication withi	n	
	I -	Medication Administration			physician ordered parameters	by	
	Record (MAR) indi	cated the resident received the			3/24/25.		
	metoprolol when th	e blood pressure (BP) was out			Health and Wellness		
	of parameters on the	e following dates and times:			Director to in-service all		
	- 1/1/25 at 5:00-8:0	0 p.m., the BP was 94/58			medication passers of		
	- 1/8/25 at 5:00-8:0	0 p.m., the BP was 102/73			documentation of insulin and		
	- 1/23/25 at 7:00-10	0:00 a.m., the BP was 105/60			administering medication withi	n	
					parameters noted in physician		
	The February 2025	MAR indicated the resident			orders by 3/31/25.		
	received the metopi	rolol when the BP was out of					
	parameters on the fo	ollowing dates and times:					
		0 p.m., the BP was was 93/64			How the corrective actions will	be	
	- 2/21/25 at 5:00-8:	00 p.m., the BP was 98/66			monitored to ensure the defici-	ent	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	DER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (2)		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
			B. W	ING		03/13/2025	
		1	1	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			07TH AVENUE		
BICKEOF	RD OF CROWN PC	INT	CROWN POINT, IN 46307				
	1				, 10007		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	- 2/24/25 at 5:00-8:00 p.m., the BP was 98/68				practice will not recur, what qu	-	
	- 2/25/25 at 5:00-8:	00 p.m., the BP was 91/70			assurance program will be put	into	
	TI M 1 2025 M	IAD ' 1' 4 14			place.		
		IAR indicated the resident			Health and Wellness Dire	ctor	
	_	rolol when the BP was out of			will audit 1 resident MAR with	leb e	
	_	following dates and times: 00 p.m., the BP was 99/64			blood pressure parameters we	екіу	
	- 3/ //25 at 5:00-8:0	o p.m., me or was 99/04			x4 weeks, then monthly x 6 months.		
	During an interview	v on 3/13/25 at 1:00 p.m., the			months.  Health and Wellness Dire	ctor	
	_	g indicated she could not			will audit 1 resident MAR with	CiOi	
	_	entation that the metoprolol			insulin weekly x4 weeks, then		
		iven outside of parameters on			monthly x 6 months		
	the above dates and	-			Divisional Director of Hea	lth	
		ord was reviewed on 3/12/25 at			and Wellness will review e-ma		
		es included, but were not limited			during routine branch visits x's		
		mellitus, high blood pressure,			months and annually thereafte		
	and dementia.	, ,			ensure compliance.		
					'		
	The Service Plan, d	lated 9/25/24, indicated the					
	resident was cognit	ively intact, required					
	medication manage	ement, and was independent					
	with activities of da	aily living. She required blood					
	sugar (bs) checks b	efore each meal and received					
	insulin.						
	-	r, dated 1/9/25, indicated					
		(insulin) injection 100					
	_	ect per sliding scale with meals:					
	·	J), 251-300=8U, 301-350=10U,					
		and above=14U and recheck in 2					
	hours.						
		6 1 2025 N 1 1					
		March 2025 Medication					
		cord (MAR) indicated the					
		inistered on the following dates					
	· ·	the number of units of insulin					
	administered were	not available for review.					
	At 8:00 a m an 2	/5 (bs -111), 2/6 (bs - 98), 2/16					
		- 350), 2/18 (bs - 148), 2/26 (bs -					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		03/13/2025
NAME OF P	ROVIDER OR SUPPLIER	8		T ADDRESS, CITY, STATE, ZIP COD	
BICKEOE		MNIT		107TH AVENUE	
BICKFOR	RD OF CROWN PO	JIN I	CRO	VN POINT, IN 46307	_
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		3/1 (bs - 119), 3/2 (bs - 131),	TAG	DET CHENCT!	DATE
	3/10 (bs - 186), and				
		2/7 (bs - 230), 2/14 (bs - 221),			
	2/23 (bs - 252), 3/3	(bs - 213), 3/5 (bs - 255), 3/9 (bs			
	- 248), and 3/10/25				
	_	/8 (bs - 168), 2/9 (bs - 188), 2/13			
		- 218), 2/19 (bs - 216), 2/22 (bs -			
	151), 2/23 (bs - 248 208)	s), 3/4 (bs - 179), and 3/8 (bs -			
	200)				
	A Physician's Order	r, dated 9/13/24, indicated			
	Lantus Solostar (lor	ng-acting insulin) 100U/ml			
		units subcutaneously twice			
		ttime insulin for blood sugar			
	less than 150.				
	The February and M	March 2025 MAR indicated the			
		s marked as administered at			
	7:00 p.m. when the	resident's blood sugar (bs) was			
		13 (bs - 112), 2/18 (bs - 112),			
		0 (bs - 100), 2/26 (bs - 122), 2/28			
	(bs - 112), and 3/4/2	25 (bs - 130).			
	During an interview	v on 3/13/25 at 12:47 p.m., the			
	~	; indicated she had no further			
	•	ide. She was unable to see			
		ne amount of insulin given and			
	-	a report to determine how			
	many units were ad	ministered.			
R 0270	410 IAC 16.2-5-5.	1(c)(1-3)			
		nal Services - Deficiency			
Bldg. 00		-			
		on, record review, and	R 0270	R270 Food and	04/01/2025
		ty failed to ensure modified		Nutritional Service	.e _
		properly according to the proper consistency. This had			-
	*	ct 1 resident who resided in		Deficiency	
	the facility and rece				
	-	-		What corrective actions will be	е
			1		

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STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  03/13/2025
NAME OF PROVIDER OR SUBJECTION		STREET ADDRESS, CITY, STATE, ZIP C 140 E 107TH AVENUE CROWN POINT, IN 46307	OD
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE COMPLETION PPROPRIATE
Finding includes on 3/12/25 at preparing a public blender, pour milk directly turned the blender to then placed the puree consists visible.  She washed the prepare the puscoop of spins the blender, puilk directly turned on the the spinach in of thickener, a placed the bor consistency with the diced.  During an into she was done serve. When	es:  11:50 a.m., Server 1 was observed ree modified diet. She took one of the from a serving pan, put it in the dian unmeasured amount of 2% rom the gallon into the blender, and oder on for 10 seconds. She poured into a bowl with solid pieces of fish was pouring. She added one packet the bowl and stirred the fish. She is bowl on the serving cart. The new was liquid with whole pieces are blender and then began to ree cooked spinach. She took one of from the serving pan, put it in oured an unmeasured amount of 2% rom the gallon into the blender and blender for 10 seconds. She poured to a small bowl, added half a packet and stirred the spinach. She then of on the serving cart. The puree as gel like and not blended together pieces of spinach visible.	PREFIX TAG  CROSS-REFERENCED TO THE A DEFICIENCY)  accomplished for those found to have been affed deficient practice?  No residents were this deficient practice be potential to harm 1 residents having the potential to harm 1 residents having the potential between the affected by the same practice and what correwill be taken  Divisional Director services to in-service Director on pureed died 3/28/25  Kitchen staff will be in-service on modified including preparation of diets and following recidents and following recidents and following recidents and the deficient practice recur.  Dietary Director to	e residents ected by the harmed by but had the ident.  Intify other otential to be deficient ective action  or of dining Dietary trecipes by the diets of pureed ipes by put into e changes ensure ce does not opened in the ident into ensure into en
thin. She pro review. She i to add water, have any prot milk if broth v 1 was stopped	be the baked fish puree was too ided the puree recipe book for idicated she had been instructed not only milk, because water did not in. She was also supposed to use was not available. At this time, Server and asked to consult the Kitchen ding the puree preparation, recipe, y.	preparation of pureed of per week x 1 month, the x 3 months then month months to ensure recipiful followed.  How the corrective action monitored to ensure the practice will not recur, assurance program will	en weekly  lly x 6  les are  lons will be e deficient  what quality

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
R 0273	Director of Nursing preparation concern provided.  A facility recipe for current, indicated to thickener when prepared cooked fish with ho pure appeal"  A facility recipe for as current, indicated when preparing the [cup] drained veget water/vegetable lique each pureed serving processor, add veget liquid. Stop and sor remaining liquid an 410 IAC 16.2-5-5.	on 3/12/24 at 12:10 p.m., the was made aware of the puree as. No further information was pureed baked fish, received as puse fish stock and instant paring the puree. "2. Blend thought broth until smooth. Stir in pureed vegetables, received at to use water and margarine puree. "1. Measure 1/2 cables, 1 tsp [teaspoon] of aid, and 1 tsp margarine for gneeded. Using a food tables, margarine and half the cape down sides. Add delend until smooth"		Executive Director will observe a pureed diet prepara audit monthly x 3 months to ensure continued compliance the preparation of modified die per recipe.  Divisional Director of Operations will observe pureediet preparation during routine branch visits x3 months and annually thereafter to ensure compliance.	in ets d	
Bldg. 00	review, the facility sanitation related to temperature. This h 58 residents who re Finding includes:  On 3/12/25 at 11:45 taking the food temprior to serving lune and placed it in one indicated the tempe Fahrenheit). She th temperatures of the	on, interview, and record failed to maintain proper food low food holding had the potential to affect the ceived food from the kitchen.  To a.m., Cook 1 was observed peratures on the steam table ch. She took a thermometer of the baked fish fillets. She rature was 100 F (degrees en moved on and checked the remaining food on the steam she was ready to begin	R 0273	R273 Food and Nutritional Service Deficiency  What corrective actions will be accomplished for those reside found to have been affected be deficient practice?  58 residents had the potential to be affected by this deficient practice.  How the facility will identify other residents having the potential	ents y the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/13/2025			
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT			STREET ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
IAU	serving the food.  During an interview the baked fish temp F to 100 F and it wa was also in the kitch she thought the tem this time, Cook 1 w consult the Kitchen correct food temper interview at 11:55 a spoken with the Kit fish temperature she put the fish back int During an interview Director of Nursing temperature concern provided.  A facility recipe for current, indicated ". at 140 degrees F or The Retail Food Est Requirements, dated "Holding temperation, potentially hazardor	r at that time, Cook 1 indicated erature should be between 75 as ok to serve. Server 1, who men during this time, indicated perature had to be 175 F. At as stopped and asked to Manager to determine the ature. During a continued .m., Cook 1 indicated she had chen Manager and the baked buld be 140 F, so she would to the oven.  Ton 3/12/24 at 12:10 p.m., the was made aware of the food in. No further information was baked fish, received asHold seafood for hot service higher"  Tablishment Sanitation 11/13/04, indicated turesPotentially hazardous holdingSec. 187. (a) Except cooking, or cooling is food shall be maintained as hundred thirty-five (135)	IAG	be affected by the same defice practice and what corrective a will be taken Divisional Director of dinition services to inservice Dietary Director on proper food holding temperature by 3/28/25 Kitchen staff will be in-set on proper food holding temperature by 4/1/25.  What measures will be put interplace or what systemic change the facility will make to ensure that the deficient practice does recur.  Dietary Director to observe temping of proteins 3 times perweek x 1 month, then weekly months then monthly x 6 monto ensure recipes are followed.  Dietary will monitor the temping log 3 times per week month, then weekly x 3 month then monthly x 6 months to ensure recipes are followed.  How the corrective actions will monitored to ensure the defici practice will not recur, what quassurance program will be purplace.  Executive Director will observe the cook temp the proteins monthly x 3 months to ensure proper temping procedures.  Executive Director will authe temp log monthly x 3 month to ensure proper documentation to ensure proper documentation.	ient action  ng  g  vice rature  o es  s not  re er  x 3  ths  d.  x 1  is  I be ent  uality  t into		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
			B. WING			03/13/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹	140 E 107TH AVENUE				
BICKFOF	RD OF CROWN PC	DINT		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S		PROVIDER'S PLAN OF CORRECTION	'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	J DEFICIENCE!		DATE
					temps. Divisional Director of Operations will audit temp log during routine branch visits x's months and annually thereafte ensure compliance.		
R 0356	410 IAC 16.2-5-8. Clinical Records -	***					
Bldg. 00	Cillical Records -	Noncompliance					
2.49.00	19. 00		R 0356   R356 Clinical			03/31/2025	
		view and interview, the facility					
	failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 4, 6 and 7)				Records -		
					Noncompliance		
	Findings include:				What corrective actions will be accomplished for those reside		
	The resident Emerg 3/12/25 at 11:10 a.ı	gency Binder was reviewed on m.			found to have been affected by deficient practice?	y the	
	a. Resident 4 was n	nissing a photograph.			58 residents had the potential to be affected by this noncompliant practice.		
	b. Resident 6 was n	nissing a hospital preference.					
	Resident 7's record 1:05 p.m. Her aller belladonna and Zos	nissing allergy information. was reviewed on 3/12/25 at regies were listed as: latex, syn.  y on 3/12/25 at 3:00 p.m.,			How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken  Health and Wellness Directive will audit Emergency Binder to	to ent ction ctor	
	Director of Nursing	was made aware of the the Emergency Binder. No			ensure that it contains all the necessary information for all		
	additional informat	ion was provided.			residents by 3/31/25.  What measures will be put into place or what systemic change the facility will make to ensure	es	
					that the deficient practice does recur.	s not	

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

PRINTED: 04/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/13/2025			
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT			STREET ADDRESS, CITY, STATE, ZIP COD 140 E 107TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		) BE	(X5) COMPLETION DATE	
				Divisional Director of I and Wellness to re-educat and Wellness Director and Executive Director on all necessary information to be contained in the emergency by 3/24/25.  How the corrective actions monitored to ensure the depractice will not recur, what assurance program will be place.  Executive Director will Emergency Binder for all necessary information more 6 months.  Divisional Director of I and Wellness with review Emergency Binder during visits x's 3 months and and thereafter to ensure complete.	e Health e e y binder e will be eficient at quality put into audit hthly x's Health routine hually		

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