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	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BICKFORD OF CROWN POINT	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 12 and 13, 2025 Facility number: 012940 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/19/25.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on record review and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 58 residents of the facility. Finding includes: A general tour of the facility was conducted at 3/12/25 at 9:52 a.m. and again on 3/13/25 at 8:35 a.m. A sign was posted that indicated the Survey Results Binder was near the entryway. There were no binders located at or near the front entryway. During an interview on 3/13/25 at 11:05 a.m., the Director of Nursing indicated a staff member had picked up the binder on 3/12/25 and did not return it to the table. It should have been on the table	R 0042	**R042 Residents' Rights - Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the noncompliant practice? No residents were affected by this deficient practice however 58 residents had the potential to be affected by this noncompliant practice.	03/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Tengerstrom	Executive Director	04/02/2025

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	near the entryway.		What corrective action will be taken? The Survey Results Binder will remain out for resident viewing near the front entryway with the most recent annual survey and plan of correction. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate the Executive Director on the facilities requirement to have the Survey Results Binder with the most recent annual survey results and plan of correction readily available at or near the front entryway for residents to review by 3/24/25 The Executive Director will be responsible for ensuring the Survey Results binder is at or near the front entryway daily. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional of Operations to monitor compliance monthly x 6 months upon visits to the community that Survey Results Binder is at or near the front entryway. :	

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure fire drills were completed on each shift quarterly as required. This had the potential to affect all 58 residents in the facility. Finding includes: On 3/12/25 and 3/13/25 fire drills for the past year were requested for review. During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been there for a couple months. He provided a fire drill record completed on 3/5/25. He indicated he did not know where the remaining fire drills would be located. During an interview on 3/13/25 at 12:45 p.m., the Director of Nursing indicated the Administrator would probably know about the fire drills but she was out of town and unavailable. The current document, "Fire Drill Schedule", indicated, "...Fire Drills shall be performed MONTHLY. This includes each shift having one drill each quarter...."	R 0092	**R092 Administration and Management - Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the noncompliant practice, but 58 residents had the potential to be affected by this noncompliant practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Executive Director will re-educate the maintenance coordinator on the completion of fire drills on each shift quarterly as required by 3/31/25 The maintenance coordinator will be responsible for conducting and documenting drills.	03/31/2025

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			What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on policy 410 IAC 16.2-5-1.3 completed by 3/24/25 The Executive Director is responsible for ensuring all fire drills are completed on each shift quarterly as required. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive director will monitor compliance monthly x 3 months and quarterly thereafter. Divisional Director of Operations will audit annually to ensure continued compliance.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on record review and interview, the facility failed to ensure the HVAC (heating and ventilation system) was inspected annually. This had the potential to affect all 58 residents of the facility. Finding includes: On 3/12/24 and 3/13/24, the annual HVAC	R 0148	**R148 Sanitation and Safety Standards - Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the	03/31/2025

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	inspection was requested to review. It was not provided. During an interview on 3/13/25 at 11:25 a.m., the Maintenance Director indicated he had been there for a couple of months and did not have knowledge of the annual HVAC inspection. A maintenance schedule was provided by the Director of Nursing that indicated, "...check interior HVAC vent registers in all areas (excluding apartments) and clean as necessary...." This was to be completed annually in July.		deficient practice? No residents were affected by the noncompliant practice, but 58 residents had the potential to be affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The Executive Director will re-educate the maintenance coordinator on the completion of annual HVAC inspections as required 3/24/25. The maintenance coordinator will be responsible for conducting and documenting annual HVAC inspections. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Maintenance coordinator will perform HVAC inspection by 3/31/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The Executive Director is responsible for ensuring annual	

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			HVAC inspection thereafter by the maintenance coordinator. The Divisional Director of Operations will monitor documentation of annual HVAC inspections annually to ensure continued compliance.	
R 0151 Bldg. 00	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 provide proof of current vaccination records...."	R 0151	**R151 Sanitation and Safety Standards - Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? O residents were harmed by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. 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 changes the facility will make to ensure that the deficient practice does not recur.	03/31/2025

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			Executive director to re-educate administrative assistant that any pet housed in the facility shall have periodic veterinary examinations and required immunizations by 3/31/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive Director to audit all pet records monthly x 6 months to ensure compliance.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, record review, and interview, the facility failed to ensure Physician Orders were followed during medication pass for 1 of 5 residents observed during medication pass. (Resident 10 and QMA 1) Physician Orders were also not followed related to a blood pressure medication given outside parameters and not documenting the amount of insulin given for 2 of 7 records reviewed. (Residents 5 and 8) Findings include: 1. On 3/13/25 at 8:55 a.m., QMA 1 was observed preparing Resident 10's medications. Included in the medications were Vitamin D3 1000 international units (IU) and rivastigmine patch 13.3 milligrams (mg)/ 24 hours. The QMA gave the medications to the resident, who took them whole with water. She then placed the rivastigmine patch	R 0241	**R241 Health Services - Offense** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 3 were affected by the offense, but 58 residents had the potential to be affected by this offense. 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 Health and Wellness Director	03/31/2025

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	on the resident's right chest. The resident's record was reviewed on 3/13/25 at 9:55 a.m. The current Physician's Orders, dated 3/13/25, indicated Vitamin D3 2000 IU daily and rivastigmine patch 4.6 mg/ 24 hours. During an interview on 3/13/25 at 10:45 a.m., the QMA indicated the Vitamin D3 was entered into the Medication Administration Record incorrectly as 1000 IU and would need to be corrected. She also indicated she may have given the resident the incorrect rivastigmine patch. The QMA went to Resident 10's room and removed the patch, which she indicated was incorrect. 2. Record Review for Resident 5 was completed on 3/12/25 at 1:10 p.m. Diagnoses included, but were not limited to, stage 3 chronic kidney disease and stroke. The March 2025 Physician's Order Summary (POS) indicated an order for metoprolol (medication to lower blood pressure) 25 mg (milligrams). Give 1/2 tablet daily, hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 115. The January 2025 Medication Administration Record (MAR) indicated the resident received the metoprolol when the blood pressure (BP) was out of parameters on the following dates and times: - 1/1/25 at 5:00-8:00 p.m., the BP was 94/58 - 1/8/25 at 5:00-8:00 p.m., the BP was 102/73 - 1/23/25 at 7:00-10:00 a.m., the BP was 105/60 The February 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times: - 2/8/25 at 5:00-8:00 p.m., the BP was was 93/64 - 2/21/25 at 5:00-8:00 p.m., the BP was 98/66		will audit all resident physician orders and e-mars to ensure physician ordered parameters are noted and followed and insulin amount given is documented by med passers. Completed by 4/30/25 Health and Wellness Director is responsible for ensuring medication is given that follows parameters on the physician orders. Health and Wellness Director is responsible for ensuring that the amount of insulin given is documented. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Divisional Director of Health and Wellness will re-educate Director of Health and Wellness on documentation of insulin and administering medication within physician ordered parameters by 3/24/25. Health and Wellness Director to in-service all medication passers of documentation of insulin and administering medication within parameters noted in physician orders by 3/31/25. How the corrective actions will be monitored to ensure the deficient	

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	- 2/24/25 at 5:00-8:00 p.m., the BP was 98/68 - 2/25/25 at 5:00-8:00 p.m., the BP was 91/70 The March 2025 MAR indicated the resident received the metoprolol when the BP was out of parameters on the following dates and times: - 3/7/25 at 5:00-8:00 p.m., the BP was 99/64 During an interview on 3/13/25 at 1:00 p.m., the Director of Nursing indicated she could not provide any documentation that the metoprolol was held and not given outside of parameters on the above dates and times. 3. Resident 8's record was reviewed on 3/12/25 at 2:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and dementia. The Service Plan, dated 9/25/24, indicated the resident was cognitively intact, required medication management, and was independent with activities of daily living. She required blood sugar (bs) checks before each meal and received insulin. A Physician's Order, dated 1/9/25, indicated Humalog Kwikpen (insulin) injection 100 units/milliliter, inject per sliding scale with meals: 200-250=6 units (U), 251-300=8U, 301-350=10U, 351-400=12U, 401 and above=14U and recheck in 2 hours. The February and March 2025 Medication Administration Record (MAR) indicated the Humalog was administered on the following dates and times, however the number of units of insulin administered were not available for review. - At 8:00 a.m. on 2/5 (bs -111), 2/6 (bs - 98), 2/16 (bs -134), 2/17 (bs - 350), 2/18 (bs - 148), 2/26 (bs -		practice will not recur, what quality assurance program will be put into place. Health and Wellness Director will audit 1 resident MAR with blood pressure parameters weekly x4 weeks, then monthly x 6 months. Health and Wellness Director will audit 1 resident MAR with insulin weekly x4 weeks, then monthly x 6 months Divisional Director of Health and Wellness will review e-mars during routine branch visits x's 2 months and annually thereafter to ensure compliance.	

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	138), 2/27 (bs - 78), 3/1 (bs - 119), 3/2 (bs - 131), 3/10 (bs - 186), and 3/11/25 (bs - 144) - At 12:00 p.m. on 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 (bs - 203) - At 5:00 p.m. on 2/8 (bs - 168), 2/9 (bs - 188), 2/13 (bs - 256), 2/14 (bs - 218), 2/19 (bs - 216), 2/22 (bs - 151), 2/23 (bs - 248), 3/4 (bs - 179), and 3/8 (bs - 208) A Physician's Order, dated 9/13/24, indicated Lantus Solostar (long-acting insulin) 100U/ml solution, inject 38 units subcutaneously twice daily and hold nighttime insulin for blood sugar less than 150. The February and March 2025 MAR indicated the Lantus Solostar was marked as administered at 7:00 p.m. when the resident's blood sugar (bs) was less than 150 on 2/13 (bs - 112) , 2/18 (bs - 112), 2/19 (bs - 111), 2/20 (bs - 100), 2/26 (bs - 122), 2/28 (bs - 112), and 3/4/25 (bs - 130). During an interview on 3/13/25 at 12:47 p.m., the Director of Nursing indicated she had no further information to provide. She was unable to see documentation of the amount of insulin given and was not able to pull a report to determine how many units were administered.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe and were the proper consistency. This had the potential to affect 1 resident who resided in the facility and received a puree diet.	R 0270	**R270 Food and Nutritional Services - Deficiency** What corrective actions will be	04/01/2025

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	Finding includes: On 3/12/25 at 11:50 a.m., Server 1 was observed preparing a puree modified diet. She took one baked fish fillet from a serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender, and turned the blender on for 10 seconds. She poured the fish puree into a bowl with solid pieces of fish visible as she was pouring. She added one packet of thickener to the bowl and stirred the fish. She then placed the bowl on the serving cart. The puree consistency was liquid with whole pieces visible. She washed the blender and then began to prepare the puree cooked spinach. She took one scoop of spinach from the serving pan, put it in the blender, poured an unmeasured amount of 2% milk directly from the gallon into the blender and turned on the blender for 10 seconds. She poured the spinach into a small bowl, added half a packet of thickener, and stirred the spinach. She then placed the bowl on the serving cart. The puree consistency was gel like and not blended together with the diced pieces of spinach visible. During an interview at that time, Server 1 indicated she was done with the puree, and it was ready to serve. When asked about the consistency, she indicated maybe the baked fish puree was too thin. She provided the puree recipe book for review. She indicated she had been instructed not to add water, only milk, because water did not have any protein. She was also supposed to use milk if broth was not available. At this time, Server 1 was stopped and asked to consult the Kitchen Manager regarding the puree preparation, recipe, and consistency.		accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this deficient practice but had the potential to harm 1 resident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Divisional Director of dining services to in-service Dietary Director on pureed diet recipes by 3/28/25 Kitchen staff will be in-service on modified diets including preparation of pureed diets and following recipes by 4/1/25. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Dietary Director to observe preparation of pureed diets 3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	

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	During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the puree preparation concerns. No further information was provided. A facility recipe for pureed baked fish, received as current, indicated to use fish stock and instant thickener when preparing the puree. "...2. Blend cooked fish with hot broth until smooth. Stir in puree appeal..." A facility recipe for pureed vegetables, received as current, indicated to use water and margarine when preparing the puree. "1. Measure 1/2 c [cup] drained vegetables, 1 tsp [teaspoon] of water/vegetable liquid, and 1 tsp margarine for each pureed serving needed. Using a food processor, add vegetables, margarine and half the liquid. Stop and scrape down sides. Add remaining liquid and blend until smooth..."		place. Executive Director will observe a pureed diet preparation audit monthly x 3 months to ensure continued compliance in the preparation of modified diets per recipe. Divisional Director of Operations will observe pureed diet preparation during routine branch visits x3 months and annually thereafter to ensure compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to maintain proper food sanitation related to low food holding temperature. This had the potential to affect the 58 residents who received food from the kitchen. Finding includes: On 3/12/25 at 11:45 a.m., Cook 1 was observed taking the food temperatures on the steam table prior to serving lunch. She took a thermometer and placed it in one of the baked fish fillets. She indicated the temperature was 100 F (degrees Fahrenheit). She then moved on and checked the temperatures of the remaining food on the steam table and indicated she was ready to begin	R 0273	**R273 Food and Nutritional Services - Deficiency** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 58 residents had the potential to be affected by this deficient practice. How the facility will identify other residents having the potential to	04/01/2025

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	serving the food. During an interview at that time, Cook 1 indicated the baked fish temperature should be between 75 F to 100 F and it was ok to serve. Server 1, who was also in the kitchen during this time, indicated she thought the temperature had to be 175 F. At this time, Cook 1 was stopped and asked to consult the Kitchen Manager to determine the correct food temperature. During a continued interview at 11:55 a.m., Cook 1 indicated she had spoken with the Kitchen Manager and the baked fish temperature should be 140 F, so she would put the fish back into the oven. During an interview on 3/12/24 at 12:10 p.m., the Director of Nursing was made aware of the food temperature concern. No further information was provided. A facility recipe for baked fish, received as current, indicated "...Hold seafood for hot service at 140 degrees F or higher..." The Retail Food Establishment Sanitation Requirements, dated 11/13/04, indicated "...Holding temperatures...Potentially hazardous food; hot and cold holding...Sec. 187. (a) Except during preparation, cooking, or cooling... potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above..."		be affected by the same deficient practice and what corrective action will be taken Divisional Director of dining services to inservice Dietary Director on proper food holding temperature by 3/28/25 Kitchen staff will be in-service on proper food holding temperature by 4/1/25. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Dietary Director to observe temping of proteins 3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed. Dietary will monitor the temping log 3 times per week x 1 month, then weekly x 3 months then monthly x 6 months to ensure recipes are followed. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive Director will observe the cook temp the proteins monthly x 3 months to ensure proper temping procedures. Executive Director will audit the temp log monthly x 3 months to ensure proper documentation of	

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	03/13/2025

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

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			temps. Divisional Director of Operations will audit temp log during routine branch visits x's 2 months and annually thereafter to ensure compliance.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review 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) Findings include: The resident Emergency Binder was reviewed on 3/12/25 at 11:10 a.m. a. Resident 4 was missing a photograph. b. Resident 6 was missing a hospital preference. c. Resident 7 was missing allergy information. Resident 7's record was reviewed on 3/12/25 at 1:05 p.m. Her allergies were listed as: latex, belladonna and Zosyn. During an interview on 3/12/25 at 3:00 p.m., Director of Nursing was made aware of the missing items from the Emergency Binder. No additional information was provided.	R 0356	**R356 Clinical Records - Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 58 residents had the potential to be affected by this noncompliant practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Health and Wellness Director will audit Emergency Binder to ensure that it contains all the necessary information for all residents by 3/31/25. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.	03/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Divisional Director of Health and Wellness to re-educate Health and Wellness Director and Executive Director on all necessary information to be contained in the emergency binder by 3/24/25. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Executive Director will audit Emergency Binder for all necessary information monthly x's 6 months. Divisional Director of Health and Wellness with review Emergency Binder during routine visits x's 3 months and annually thereafter to ensure compliance.	