STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/23/2021		
	ROVIDER OR SUPPLIE		140 E	ADDRESS, CITY, STATE, ZIP COD 107TH AVENUE 'N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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 0000	REGULTION	RESCRIPTION TRACERS ORGANIZATION	IIIG		BATE
Bldg. 00	This visit was for a Survey.	a State Residential Licensure	R 0000		
	Survey dates: June	22 and 23, 2021.			
	Facility number: 0	12940			
	Residential Census	s: 53			
	These State Reside accordance with 4	ential Findings are cited in 10 IAC 16.2-5.			
	Quality review cor	mpleted on 6/24/21.			
R 0117	410 IAC 16.2-5-1	• •			
Bldg. 00	qualifications, an applicable state I twenty-four (24) If unscheduled nees services provided and training of starequired to provide the residents. An staff person, with certificates, shall fifty (50) or more regularly receive or administration least one (1) nursite at all times. Fover one hundred receiving resident administration of have at least one	sufficient in number, d training in accordance with aws and rules to meet the nour scheduled and ds of the residents and d. The number, qualifications, aff shall depend on skills de for the specific needs of minimum of one (1) awake current CPR and first aid be on site at all times. If residents of the facility residential nursing services of medication, or both, at sing staff person shall be on Residential facilities with d (100) residents regularly tial nursing services or medication, or both, shall e (1) additional nursing staff d on duty at all times for			
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2021	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT		140 E	ADDRESS, CITY, STATE, ZIP COD 107TH AVENUE /N 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
	shall be assigned they are trained to shall conform with Based on record reversitied to ensure their current first aid cert shifts reviewed. Finding includes: Facility staffing sche 6/19/21 were review schedules indicated who were first aid cand shifts: Day shifts on 6/15/2 Evening shifts on 6/15/2 Interview with the A/10/23/21 at 10:40 a.r. there needed to be a shift with first aid constitution.		R 0117	No residents were harmed by deficient practice however potential harm did All employee files will be audit to ensure current first aid certification is on file for staff members with first aid. Divisional Director of Resident Services will re-educate Administrator and Nurse Coordinator on policy/proced for the requirement to have or staff member with a current fir aid certificate on each shift. Nurse Coordinator will scheduland ensure all staff members remain current with first aid. Divisional Director will audit employee files monthly x3 monand annually to ensure compliancy Completion Date 7/26/21	ted t ure ne rst
R 0247 Bldg. 00	shall be noted in t physician shall be medication admin				

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 2 of 11

AND PLAN OF CORRECTION DENTIFICATION NUMBER A BUILDING Q0 COMPLETED 06/23/2021
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Summary indicated carbidopa/levodopa 25/100 mg (milligrams) 1.5 tabs to equal 27.5/150 mg by
(milligrams) 1.5 tabs to equal 27.5/150 mg by
mouth three times daily.
Interview with QMA 1 on 6/22/21 at 3:18 p.m.
indicated LPN 1 had already gone home for the
day. She reviewed the Physician's Order in the
computer and compared it to the medication card.
They both indicated carbidopa/levodopa 25/100
mg (milligrams) 1.5 tabs to equal 27.5/150 mg total.
She indicated she would call the pharmacy to get
clarification.
Clarification.
Interview with the Assistant RNC (Registered
Nurse Coordinator) on 6/23/21 at 11:10 a.m.,
indicated the correct order should have read

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>00</u> COMPL		LETED	
			B. W	ING		06/23/2021		
				CTREET	ADDRESS OF A STATE SID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 07TH AVENUE			
BICKEOE		INT			N POINT, IN 46307			
BICKFORD OF CROWN POINT			CROW	N POINT, IN 40307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	carbidopa/levodopa	25/100 mg (milligrams) 1.5						
	tabs to equal 37.5/1	50 mg total. They had clarified						
	the order and update	ed the Physician's Order						
	summary.							
R 0297	410 IAC 16.2-5-6(. , .						
		ervices - Noncompliance						
Bldg. 00	• •	ntrols, handles, and						
		ations for a resident, the						
	•	following for that resident:						
	` '	nents to ensure that						
	•	rvices are available to						
	•	with prescribed medications						
	in accordance with applicable laws of Indiana.							
		on, record review, and	R 0	297	No residents were harmed by		07/26/2021	
		ty failed to ensure a medication			deficient practice although the			
		led and packaged per			potential for harm did exist.			
	-	r 1 of 5 residents observed			Resident was administered co			
		on pass observation.			dose of medication. Labeling	error		
	(Resident 9)				by pharmacy.			
					Divisional Director will re-educ			
	Finding includes:				Nurse Coordinator on verifying	3		
					orders entered into eMar by			
		a.m. LPN 1 was observed			pharmacy, including the corre	ct		
		9's medication. LPN 1			dose.			
		ation Administration Record			Nurse Coordinator will verify			
	,	ated the resident should			correct labelling and packagin	-		
	receive carbidopa/le	- :			all incoming meds from pharm	-		
		treat Parkinson's disease)			for 3 weeks. If any error is fou			
		ams) 1.5 tabs to equal 27.5/150			repeat audit will continue and			
	-	viewed the medication card			done weekly for three weeks ι	ıntıl		
		ed carbidopa/levodopa 25/100			compliant.			
		ve 1.5 tabs to equal 27.5/150 mg.			Divisional Director will audit			
		d was observed to have 1.5			medication label and packagir	-		
		each blister pack. LPN 1 then os of the medication to the			audits completed weekly for 3			
		epackaged medication pack.			weeks by Nurse Coordinator to			
	resident from the pr	ераскадей песисаноп раск.			verify compliance, during bran	CU		
	Decord review for I	Desident Q was completed on			visits.			
		Resident 9 was completed on						
	0/22/21 at 3:13 p.m	. The 6/2021 Physician's Order						

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 4 of 11

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

PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		l í	JILDING	NSTRUCTION 00	(X3) DATE : COMPL 06/23/	ETED	
	PROVIDER OR SUPPLIER			140 E 10	DDRESS, CITY, STATE, ZIP COD D7TH AVENUE N 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)	TE	(X5) COMPLETION DATE
	Summary indicated	carbidopa/levodopa 25/100 mg os to equal 27.5/150 mg by					
	indicated LPN 1 had day. She reviewed computer and comp They both indicated mg (milligrams) 1.5 She indicated she we clarification of the compared to the padd not match. Interview with the A Nurse Coordinator) indicated the correct carbidopa/levodopa tabs to equal 37.5/1	A 1 on 6/22/21 at 3:18 p.m. d already gone home for the the Physician's Order in the pared it to the medication card. It carbidopa/levodopa 25/100 to tabs to equal 27.5/150 mg total. Fould call the pharmacy to get correct medication amount as exet label since the amounts Assistant RNC (Registered on 6/23/21 at 11:10 a.m. et order should have read 25/100 mg (milligrams) 1.5 to mg total. They had clarified ed the Physician's Order					
R 0298	410 IAC 16.2-5-6(, , ,					
Bldg. 00	(2) A consultant plemployed, or under (A) be responsible in 856 IAC 1-7; (B) review the drupractices in the factorial procedures of order administering, and as medication record (D) report, in writing his or her designed dispensing or admition (E) review the drugely and the consultant of the consult	Itation on methods and ering, storing, d disposing of drugs as well					

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2021	
	ROVIDER OR SUPPLIER		140 E	ADDRESS, CITY, STATE, ZIP COD 107TH AVENUE /N 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
	failed to ensure a phrecords every 60 darecords reviewed. (In Findings include: 1. Resident 2's close 6/22/21 at 9:45 a.m. 11/5/20, and discharate one pharmacy reviewed. (In Findings include: 2. Resident 3's close 6/22/21 at 2:26 p.m. on 10/16/20 and the 3/19/21. 3. Resident 4's reconstruction of the second of the secon	riew and interview, the facility narmacist reviewed resident ys for irregularities for 7 of 7 Residents 2, 3, 4, 5, 6, 7 and 8) Red record was reviewed on The resident was admitted on reged on 5/10/21. There was we completed on 3/19/21. Red record was reviewed on There was a pharmacy review enext one was completed on at a pharmacy review on at one was completed on the red was reviewed on 6/22/21 at as a pharmacy review on at one was completed on at a pharmacy review on at one was completed on the red was reviewed on 6/23/21 at as a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was completed on at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy review on at one was reviewed on 6/23/21 at a pharmacy reviewed on 6/23/21 at a phar	R 0298	No residents were harmed by deficient practice, however, potential harm did exist. Divisional Director will re-educative coordinator and pharma manager on policy/procedure pharmacist reviews every 60. A pharmacist review has been completed on March 19, 2021 May, 18, 2021 with written recommendations sent to the Nurse Coordinator for review physician response. Physician responses will be forwarded to the pharmacy are any new orders completed perprotocol. Divisional Director of Resident clinic records every 60 days x2 and annually to ensure compliance. Completion date 7/26/21	cate acy for days. n l and and er

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 6 of 11

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

PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIP A. BUILDIN B. WING	ng <u>00</u>	(X3) DATE SU COMPLE 06/23/2	TED	
	PROVIDER OR SUPPLIER		140	REET ADDRESS, CITY, STATE, ZIP COD 0 E 107TH AVENUE ROWN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE APPROPR	E	(X5) COMPLETION DATE
	5/18/21. Interview with Nurse Comp.m., indicated the programment of t	see Coordinator and Assistant coordinator, on 6/22/21 at 1:00 pharmacist wouldn't come into				
	COVID-19 outbrea	he facility was having a k. They were unable to say ren't completed remotely.				
R 0354 Bldg. 00	(1) Identification d (2) Name of the tr (3) Name of the re of transfer. (4) Resident 's petransferred to an a (5) Nurses 'notes (A) functional abili limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and (6) Diagnosis. (7) Date of chest of tuberculosis.	Noncompliance a shall include the following: ata. ansferring institution. ecciving institution and date ersonal property when acute care facility. s relating to the resident 's: ties and physical	D 0254			07/26/2021
	failed to complete of paperwork for 1 of (Resident 2) Finding includes: The closed record for the closed rec	view and interview, the facility lischarge and transfer 2 closed records reviewed. For Resident 2 was reviewed on . The resident was discharged in 5/10/21.	R 0354	No residents were harmed be deficient practice although the potential for harm did exist. Nurse Coordinator will audit clinical charts of residents the have been transferred out or within the last 60 days to entransfer document has been completed properly. Divisional Director of Reside Services will re-educate Nur	ne nat f facility sure a	07/26/2021

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLI		ETED				
			B. W	ING		06/23/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				07TH AVENUE		
BICKFORD OF CROWN POINT				N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· · ·	ted 5/10/21, indicated the			Coordinator on policy/procedu	re	
	resident had been p	•			for transferring a resident out of	of	
		ld be by to pick up some			the facility.		
	belongings. There	was no additional information			Divisional Director will audit		
	regarding the discha	arge.			resident transfers for the next	60	
					days to ensure the transfer		
		Nurse Coordinator on 6/22/21			document has been completed	t	
	• .	ted information had been faxed			properly.		
		and the POA (power of			Completion date 7/26/21		
		d the medication sheet to					
	-	cked up her medications. She					
		no additional paperwork					
	completed.						
R 0356	410 IAC 16.2-5-8.	1(i)(1-8)					
	Clinical Records -						
Bldg. 00		gency information file shall					
		cessible for each resident,					
	in case of emerge	ncy, that contains the					
	following:						
	(1) The resident 's	s name, sex, room or					
		r, phone number, age, or					
	date of birth.						
		s hospital preference.					
		phone number of any					
	legally authorized	·					
	` '	phone number of the					
	resident 's physic						
		telephone number of the					
		r other persons to be					
		vent of an emergency or					
	death.						
		any known allergies.					
		for identification of the					
	resident).	an dimensioner if available					
		ce directives, if available.	D 0	256	No regidente ware harmed by	thio	07/26/2021
		arrent emergency information	R 0	330	No residents were harmed by	นแร	07/26/2021
		and accurate for staff to review			deficient practice although the potential for harm did exist.		
	_	reviewed. (Residents 6, 7, and			Nurse Coordinator will audit al		
	101 5 01 5 Testuellis	icviewed. (Residents 0, /, and	1		I marse Coordinator will addit at		

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING	<u>00</u> COMPLE		ETED
			B. WING	G		06/23/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			07TH AVENUE		
BICKEOE	RD OF CROWN PO	INIT			N POINT, IN 46307		
DICKFOR	ND OF CROWN FO	VIII I		CKOWI	1 FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	8)				patient emergency file informa		
					to ensure all required informat	ion	
	Findings include:				is completed.		
					Divisional Director of Resident		
		binder was reviewed on			Services will re-educate Nurse	;	
	6/22/21 at 1:35 p.m				Coordinator on emergency file		
					information per state		
	Resident 6 did n	ot have allergies listed.			requirements.		
					Divisional Director will audit		
		ot have a hospital preference			emergency file information on		
	or physician's name	and phone number listed.			routine visits for 60 days and t	hen	
					annually thereafter to ensure		
	3. Resident 8 did not have allergies listed.				compliance.		
					Completion date 7/26/21.		
		Nurse Coordinator and the					
	_	d Nurse Coordinator on					
	-	., indicated they were unaware					
		on that needed to be listed in					
	the emergency file l	binder.					
R 0407	410 IAC 16.2-5-12	2(b)(1.4)					
11 0407	Infection Control -	, , , ,					
Bldg. 00		st establish an infection					
Blug. 00	·	nat includes the following:					
		enables the facility to					
	. ,	of known infectious					
	symptoms.	T KIIOWIT IIIICOLOGO					
	, ,	tation and in-service					
	, ,	ction prevention and control,					
	including universa	•					
	-	information to residents,					
	, ,	limited to, infection					
	transmission and						
		municable disease to					
	public health auth						
	'	on, record review, and	R 040	17	No residents were harmed by	this	07/26/2021
		ty failed to ensure infection	1,040	<i>)</i>	deficient practice although the		0772072021
	· ·	vere in place and implemented,			potential for harm did exist.		
	_	cific to properly prevent			All residents will be monitored		
		/ID-19, related to staff and			daily for signs and symptoms		
	· - ·	,	1		,		i

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING 06/23/2021			/2021	
		l	 	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			07TH AVENUE		
BICKEOL	RD OF CROWN PC	NNT			N POINT, IN 46307		
DICKFUR	VD OF CKOMM PC	/IIN I		CKUW	N FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ng for symptoms of COVID-19			COVID-19 using Bets-E		
	_	residents daily for signs and			(Bickford's internal electronic		
		ID-19 for random Infection			COVID-19 tracking system).		
		observations and 3 of 3			All healthcare personnel, visito		
	resident records rev	viewed. (Residents 5, 7, and 8)			and vendors entering the facili	ty	
					will be actively (in-person)		
	Findings include:				temperature screened for		
					COVID-19. Healthcare persor	nnel,	
		05 a.m. in the foyer of the			visitors, and vendors will use		
	-	kiosk for visitors to sign in			self-screening questionnaire for		
	-	ns regarding signs and			symptoms of COVID-19 and a	•	
		ID-19, and if they had been in			history of being a close contac	ct or	
		one with COVID-19. There was			exposed to COVID-19.		
	-	ng on the desk for visitors to			Divisional Director of Resident	İ	
		perature and record it in the			Services will re-educate		
		member would answer the door			Administrator and Nurse		
		signed in before allowing them			Coordinator on the current Ind		
	-	further active monitoring was			Department of Health docume		
	completed.				"COVID-19 LTC Facility Infect	ion	
	0 D 11 45	1 (/22/21)			Control Guidance Standard		
		ord was reviewed on 6/22/21 at			Operating Procedure," includir	-	
	_	rd did not have any daily			sections indicating daily reside	ent	
	monitoring for CO	VID-19 signs or symptoms.			screening and healthcare,	_	
	2 Davidant 7la mana	nd vysa navisavyad an 6/22/21 at			personnel, visitors and vendor		
		ord was reviewed on 6/22/21 at ord did not have any daily			screening. Divisional Directors will audit		
		VID-19 signs or symptoms.			Bets-E to ensure compliance		
	monitoring for CO	viii-17 signs of symptoms.			·	V	
	4 Resident 8's reco	ord was reviewed on 6/23/21 at			weekly x4 weeks, and routinel after.	у	
		rd did not have any daily			anor.		
		VID-19 signs or symptoms.					
	monitoring for CO	. 12 17 signs of symptoms.					
	The Indiana Depart	ment of Health document,					
	-	Facility Infection Control					
		Operating Procedure",					
		licated, "Actively (in person)					
	*	e personnel, visitors, vendors					
		for symptoms of COVID-19					
	-	peing a close contact or					
		-19" the document also					
			1	J			1

State Form Event ID: VCDS11 Facility ID: 012940 If continuation sheet Page 10 of 11

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

PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 06/23/2021			LETED	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT			140 E	T ADDRESS, CITY, STATE, ZIP COD E 107TH AVENUE WN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
1713	indicated, "Asses COVID-19 infection and daily during the During an interview p.m., she indicated checked monthly assigns of COVID-19 February. She also and took her own to the facility. During an interview Assistant on 6/23/2 they used to take viand kept a log, but lifting some COVII She later indicated	ss resident's symptoms of on upon admission to the facility	1740			

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