STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAFAYETTE BICKFORD COTTAGE LLC	3633 REGAL VALLEY DR LAFAYETTE, IN 47901

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00359932 and IN00360062. Complaint IN00359932 - Substantiated. State Residential Findings are cited at R88, R95 and R273. Complaint IN00360062- Substantiated. No state residential findings related to allegations were cited. Survey dates: August 23, 24 and 25, 2021 Facility number: 004503 Residential Census: 18 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 31, 2021.	R 0000		
R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy			

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

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	in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview and record review, the facility failed to ensure a licensed Administrator was on-site to organize and implement the day to day operations of the facility. This deficient practice had the potential to affect 18 of 18 residents residing at the facility. Finding includes: During an interview, on 8/23/21 at 10:00 a.m., the Dietary Manager (DM) indicated there was not a current Administrator in the facility. During an interview, on 8/23/21 at 11:40 a.m., the Divisional Director of Operations indicated there had not been a licensed Administrator in the facility since the previous Administrator whose last day was 7/1/21. This State tag relates to Complaint IN00359932	R 0088	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. On 7/1/21 an advertisement for a licensed Administrator or AIT was placed on the Bickford website, "Indeed" job posting site, and Facebook. Divisional Director will actively and aggressively monitor applications and conduct interviews as appropriate to ensure licensed Director or AIT with Preceptor is in place. Date of completion: 9/12/21 and ongoing	09/12/2021
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the			

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	Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to ensure there was a Director to update the Alzheimer's disclosure and oversee the dementia special care facility. This deficient practice had the potential to affect 18 of 18 residents residing in the facility. Finding includes: During a record review, on 8/24/21 at 12:51 p.m., an Alzheimer's disclosure form for the facility was not located. During an interview, on 8/24/21 at 3:15 p.m., the Divisional Director of Operations indicated a current Alzheimer's disclosure form could not be located.	R 0095	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director, in the absence of a licensed Administrator will ensure Alzheimer's and Dementia special care unit disclosure form is submitted timely. Divisional Director will provide	09/20/2021

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	This State tag relates to Complaint IN00359932.		training to Licensed Administrator or AIT on the completion and timely filing of the Alzheimer's and Dementia special care unit disclosure form. The Alzheimer's and Dementia special care unit disclosure form will be submitted on 9/13/21 Date of completion: 9/20/21 and ongoing	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to maintain accurate employee files related to pre-employment health screenings for 2 of 5 employees reviewed for employee records (RN 2 and Activity 3). Finding includes: A review of the employee files, on 8/24/21 at 1:30 p.m., indicated the following employees did not have a health screening located in their file:	R 0116	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director will audit all employee files to ensure there are no other deficiencies in any	09/20/2021

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	a. RN 2 with a hire date of 9/3/20. b. Activity 3 with a hire date of 4/5/21. During an interview, on 8/24/21 at 3:00 p.m., the Divisional Director of Operations indicated the facility could not locate the health screenings for the employees. A current policy, titled "Personnel Files," dated as revised on 9/2016 and received from the RNC (Regional Nurse Consultant) on 8/25/21 at 11:05 a.m., indicated "...Personnel, Medical and Employment Eligibility files shall be kept current, confidential and secured in a locked office or file cabinet...All personnel file shall be kept in a secured file, and shall contain the following when applicable...The personnel file shall contain a separate Medical folder containing...Pre-Employment Physical Results...."		employee file. Divisional Director will provide in-service education to Licensed Administrator or AIT on the use of the Personnel file checklist to ensure pre-employment health screenings are completed for all employees. Identified and any additionally identified missing health screenings will be completed and filed accordingly. Date of completion: 9/20/21 and ongoing	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility			

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	regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of Cardio Pulmonary Resuscitation (CPR) and First Aid staffing for 21 of 42 shifts reviewed for CPR and First Aid. Finding includes: A record review, on 8/24/21 at 2:00 p.m., indicated multiple shifts from Monday 8/16/21 through Sunday 8/22/21 were not staffed with CPR and First Aid certified staff. The dates and shifts included were: a. Monday, 8/16/21 - No CPR coverage for night shift. b. Monday, 8/16/21 - No First Aid coverage for day shift, evening shift or night shift. c. Tuesday, 8/17/21 - No CPR coverage for night shift. d. Tuesday, 8/17/21 - No First Aid coverage for evening shift or night shift. e. Wednesday, 8/18/21 - No First Aid coverage day shift, evening shift or night shift. f. Friday, 8/20/21 - No CPR coverage for day shift, evening shift or night shift g. Friday, 8/20/21 - No First Aid coverage for day shift, evening shift or night shift.	R 0117	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director and/or Traveling RNC will in-service any incoming Licensed Administrator or AIT and RNC on the policy for CPR/1st aide training requirements. The current schedule will be reviewed and revised if needed, to ensure that there is CPR/1st aide coverage 24/7. A CPR/1st aide class will be scheduled and all employees deficient in these certifications will	09/20/2021

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	h. Saturday, 8/21/21 - No CPR for night shift. i. Saturday, 8/21/21 - No First Aid coverage for day shift, evening shift or night shift. j. Sunday, 8/22/22 - No First Aid coverage for day shift. During an interview, on 8/24/21 at 3:00 p.m., the Divisional Director of Operations (DDO) indicated she would check with the agency to get CPR and First Aid records for the agency staff. A current policy, titled "Certification and Licensure," dated as revised 8/2020 and received from the Regional Nurse Consultant (RNC) on 8/25/21 at 11:05 a.m., indicated "...Bickford requires Bickford Family Members to maintain current licensure and certification, including CPR and First Aid...It is required that each Bickford Family Member is CPR and First Aid certified. Those not certified are required to meet the job requirement within 30 days of hire...." A current policy, titled "Personnel Files," dated as revised 9/2016 and received from the RNC on 8/25/21 at 11:05 a.m., indicated "...All personnel files shall be kept in a secured file, and shall contain the following when applicable...Copy of current First Aid and CPR certification...."		be scheduled to attend. Class to be provided annually to ensure continued compliance. Date of completion: 9/20/21 and ongoing	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse			

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	aide or a home health aide. Based on interview and record review, the facility failed to ensure staff which provided resident care had a completed course certification or current license for 2 of 15 employees reviewed for licensure (SNA 6 and HHA 7). Findings include: 1. Student Nurse Aide (SNA) 6 was hired on 11/13/20 and worked until 8/24/21. SNA 6's file did not contain a SNA course certification or a valid license. 2. Home Health Aide (HHA) 7 was hired on 10/27/20 and worked until 8/24/21 on a expired license. HHA 7 license expired on 1/14/2010. During an interview, on 8/24/21 at 3:15 p.m., the Divisional Director of Operations indicated HHA 7 changed her work status to PRN (when necessary) on 8/6/21. SNA 6 and HHA 7 were taken off the the schedule as of 8/24/21 until their licenses are renewed. A current policy, titled "Certification and Licensure," dated as revised 8/2020 and received from the Regional Nurse Consultant on 8/25/21 at 11:05 a.m., indicated "...Bickford requires Bickford Family Members to maintain current licensure and certification, including CPR and First Aid...Bickford shall contact the State to confirm licensure or certification validity, prior to employing Bickford Family Members as a licensed nurse, certified nurse aide or medication aide...Contact the state Nurse Aide Registry or, in Indiana, the Indiana Central Repository to verify CNA/CMA current certification...."	R 0118	=”” span=””> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director will audit all employee files to ensure there are no other deficiencies in any employee file. Divisional Director will provide in-service education to Licensed Administrator or AIT on the use of the Personnel file checklist to ensure current licensure is in place all employees Prior to extending an offer letter to potential new employees, branch designee will ensure appropriate certification is in place. Divisional Director will review the Personnel File Checklist for the next five new hires within seven days of hire. Date of completion: 9/20/21 and ongoing	09/20/2021

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight			

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	loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees had current and valid Tuberculosis (TB) skin testing completed for 3 of 5 employees reviewed for TB skin testing (RN 2, RN 4 and LPN 5). Findings include: 1. RN 2 was hired on 9/3/20 and did not have a 1st step and 2nd step TB test or health assessment screening completed. 2. RN 4 was hired on 3/8/21 and did not have a 1st step and 2nd step TB test or health assessment screening completed. 3. LPN 5 was hired on 3/10/21 and did not have a 1st step and 2nd step TB test or health assessment screening completed. During an interview, on 8/25/21 at 3:15 p.m., the Divisional Director of Operations indicated they could not find the records in the employees file. A current policy, titled "Tuberculosis Screening - Bickford Family Member," dated as revised on 12/2005 and received by the Regional Nurse Consultant on 8/25/21 at 11:05 a.m., indicated "Tuberculosis (TB) screening will be done at the time of hire and annually...Upon hire, all Bickford Family Members must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis...Annual...Bickford Family Members must undergo a one-step Mantoux Purified Protein Derivate (PPD) testing to ensure that they are not infected with tuberculosis...." 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency	R 0121	=”” span=””> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director will audit all employee files to ensure there are no other deficiencies in any employee file. Divisional Director will provide in-service education to Licensed Administrator or AIT on the use of the Personnel file checklist to ensure TB 2-step are completed for all employees Divisional Director or Traveling RNC will review the TB screenings for the next five new hires to ensure that 1st step has been read and 2nd step scheduled prior to resident contact. Divisional Director will review the Personnel File Checklist for the next five new hires within seven days of hire. Date of completion: 9/20/21 and ongoing	09/20/2021
R 0273				

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Bldg. 00	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to provide a sanitary area where food was handled. This deficient practice practice had the potential to affect 18 of 18 residents residing in the facility. Findings include: During the kitchen observation, on 8/23/21 at 10:00 a.m., with the Dietary Manager (DM) the following were observed: 1. The kitchen floor was observed to have visible dirt and food across all areas of the kitchen. 2. The oven hood was observed to have a large amount of grease build up covered with a layer of dirt. 3. The kitchen drawer had visible dirt and food crumbs in with the clean utensils. 4. The kitchen floor was observed to have a film and was sticky when walking around in the kitchen. During an interview, on 8/23/21 at 10:20 a.m., the DM indicated she was aware of the sanitation concerns and had scheduled a company to clean the oven hood and vent. During an interview, on 8/25/21 at 3:24 p.m., the Divisional Director of Operations indicated the kitchen had a monthly cleaning schedule, which included the oven hood to be cleaned every	R 0273	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Kitchen Manager, assistant cook and all staff regularly scheduled to work in the kitchen will be educated on proper cleaning and disinfecting of kitchen. Divisional Director and Kitchen Manager will complete a full Bickford Dining Services core checks (auditing tool) together to determine areas of improvement needed. Any areas identified as out of compliance will be addressed or scheduled within 24 hours. Date of completion: 9/20/21 and ongoing	09/20/2021

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	month by kitchen staff. During exit conference, the facility had not provided the cleaning schedule for the kitchen. This State tag relates to complaint IN00359932.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview, the facility failed to dispose of expired and discontinued medication, ensure a Schedule II medication card was not retaped on the back and to ensure medications were stored properly in the medication cart for 1 of 1 medication cart and 1 of 1 medication room reviewed for medication storage. Finding includes: During an observation, on 8/24/21 at 9:45 a.m., the following were found: a. In the top drawer of the medication cart, 1	R 0298	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Divisional Director or Traveling RNC will provided in-serviced education to RNC, Nurses, QMA on the proper and timely disposal of expired and discontinued medications, storage of medications punched but not	09/20/2021

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	bottle of nasal spray saline solution, 1 inhaler of triamcinolonlone acetonide (treats asthma) and 2 bottles of vitamins were in the same divided section in the top drawer. b. In the top drawer of the medication cart, 2 bottles of sustain eye drops and 1 bottle of nasal spray saline solution were in the same divided section in the top drawer. c. A card of lorazepam (for anxiety) 0.5 mg (milligram) tabs had a pill retaped on the back of the card with a "Date Opened" sticker in the number 4 slot. d. In the medication storage room was a large full cardboard box containing expired and discontinued medication. During an interview, on 8/24/21 at 9:50 a.m., LPN 8 indicated she did not know the policy for storing medication and would ask someone. LPN 8 indicated the lorazepam should not be taped and she would tell management. During an interview, on 8/24/21 at 1:00 p.m., the Regional Nurse Consultant indicated she would get the policy for disposal and indicated the medications probably needed to be destroyed. During an interview, on 8/24/21 at 3:00 p.m., the Divisional Director of Operations indicated if there was a full box of medication than it was time to be sent back or destroyed. A current policy, titled "Medication Management," dated as revised on 01/2021 and received by the Regional Nurse Consultant on 8/24/21 at 9:40 a.m., indicated "Medication audits will occur once a week by the RNC. 25% of the apartments in the medication cart will be audited so that 100% of the apartments are audited every		administered, and medication storage in medication cart. Clinical Divisional Director or Traveling RNC will audit these areas for accuracy during the next 5 visits. Date of completion: 9/20/21 and ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAFAYETTE BICKFORD COTTAGE LLC	3633 REGAL VALLEY DR LAFAYETTE, IN 47901

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	4 weeks. The medication audit report will be completed weekly...Stored in an organized manner under proper conditions of sanitation, temperature moisture and light and in accordance with the manufacturer's instructions...Medications should be destroyed in a safe and timely manner according to the Department of Environmental Protection and Federal and State regulations. These include medication that have expired, been discontinued , or recalled, etc...All destruction of medications shall be reconciled in Quickmar under med disposition. RNC shall be directly involved as witness to destruction of narcotics. All other med's can be destroyed between 2 BFMs qualified for medication administration per State Regulations. Medication should be destroyed within 2 weeks...." 410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure Schedule II medications were stored under a double lock in 1 of 1 medication storage refrigerator reviewed for medication storage. Finding includes: During an observation, on 8/24/21 at 9:45 a.m., the refrigerator in the medication room had no lock. A bottle of lorazepam intensol 2 mg/ml (for anxiety) was found on the top self.			
R 0304 Bldg. 00		R 0304	/u> No residents were negatively affected by this deficient practice, although potential for harm did exist. Lock box in place in medication refrigerator to ensure all Schedule II medications are under double lock.	09/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	During an interview, on 8/24/21 at 9:45 a.m., LPN 8 indicated most facilities have a double lock and she did not know why this facility did not. During and interview, on 8/24/21 at 3:00 p.m., the Divisional Director of Operations indicated the refrigerator should be locked. A current policy, titled "Medication Management," dated as revised on 01/2021 and received by the Regional Nurse Consultant on 8/24/21 at 9:40 a.m., indicated "Storage and Disposal of Medication and Medical Supplies...If stored in a refrigerator, medication shall be kept in an area or container that is locked...Controlled substances shall be stored under double lock, separate from all other medications and with a separate key for access.		Divisional Director or Traveling RNC will provide education to branch RNC, nurses, and CMA/QMA on the proper storage of all Schedule II medications. Date of completion: 9/20/21 and ongoing	