

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 9, 10, 11, 12, 16 and 17, 2016</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Census bed type: SNF/NF: 47 SNF: 21 Residential: 64 Total: 132</p> <p>Census payor type: Medicare: 37 Medicaid: 17 Other: 78 Total: 132</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on May 19, 2016.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on May 17, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
------------------------	---	--------	--	--

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0164 SS=D Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to provide privacy for a resident during wound care (Resident # 161).</p>	F 0164	F 164 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #161 - 1). Provided education to RN #6 2).	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings Include:</p> <p>During a dressing change observation with RN #6 on 5/16/2016 at 11:19 a.m., the following observations were made:</p> <p>RN #6 entered Resident #161's room. She went into the bathroom to turn on the water. Resident #161's roommate was asleep in her bed. RN #6 then approached Resident #161's bed and pulled the privacy curtain so that the resident was covered by the curtain from head to knees. The resident's body from her knees to her feet were not behind the privacy curtain. The nurse then assisted the resident in pulling down her pants and brief. The clothing was pulled down to the resident's knees. RN#6 proceeded to provide the treatment. She provided treatment until it was brought to her attention that the door was open.</p> <p>During an interview with RN #6 on 5/16/2016 at 1:09 p.m., she indicated that it was her practice to pull the privacy curtain part of the way for Resident #161 when she provided treatment. Resident #161's roommate does not like to have the door closed.</p> <p>The document titled "Bill of Resident Rights" was dated 12/05/2002 and provided by the Director of Nursing</p>		<p>Observe care to ensure full visual privacy is provided.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Observe all residents requiring assistance with care to ensure full visual privacy is provided.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and CNAs on the following guideline: Bill of Resident Rights How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Observe residents requiring assistance with care to ensure full visual privacy is provided The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0176 SS=D Bldg. 00	<p>(DON) on 5/16/2016 at 2:03 p.m. It indicated:</p> <p>"Privacy and Confidentiality:</p> <p>17. You have the right to personal privacy and confidentiality of your personal and clinical records. Personal privacy includes privacy in accommodations, medical treatment, written and telephone communication, personal care, visits and meeting of family and resident groups...."</p> <p>3.1-3(p)(2)</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents, who self administered breathing treatments, had a physician's order to self administer medication for 2 of 2 residents reviewed for self administration of medication (Residents #102 and #162).</p> <p>Findings include:</p>	F 0176	<p>F 176 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #102 and #162 will be evaluated for self medication administration related to breathing treatment. If residents are deemed safe to self administer, the MD will be contacted and an order will be transcribed. Identification of other residents having the</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>1. On 5/12/16 from 9:30 a.m. to 9:42 a.m., Resident #102 was seated in his room without any staff members present. During this time, he was self administering a respiratory treatment.</p> <p>Resident #102's clinical record was reviewed on 05/12/2016 at 10:28 a.m. Resident #102's diagnoses included, but were not limited to, pleural effusion and chronic obstructive pulmonary disease (COPD).</p> <p>Resident #102 had a current, care plan regarding the need for a nebulizer treatment due to plural effusion. This care plan problem/need originated 3/1/16.</p> <p>Resident #102 had a current, care plan regarding the need for a nebulizer treatment due to COPD. This care plan problem/need originated 12/9/15.</p> <p>Resident #102's record lacked an order to self administer his nebulizer treatment.</p> <p>During a 5/12/16, 2:12 p.m., interview, the DON indicated Resident #102 did not have a physician's order to self administer his nebulizer treatment. She additionally indicated, a resident must have an order when they self administer any respiratory treatment.</p> <p>2. During an observation on 5/11/16 at</p>		<p>potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents who are able to self administer breathing treatments to ensure a physician's order is in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guideline: Self Administration of Medication How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Review residents who are able to self administer breathing treatments to ensure a physician's order is in place. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>7:37 a.m., RN #6 was administrating medications. She filled the nebulizer machine reservoir with medication and handed the filled reservoir to Resident #162. RN #6 turned on the nebulizer machine. Resident #162 began inhalation of the medication. RN #6 exited Resident #162's room. No staff were observed in the vicinity of Resident #162's view while he self administered his medication.</p> <p>During an observation on 5/11/16 at 7:52 a.m., RN #6 returned to Resident #162's room and turned the nebulizer machine off. Resident #162 handed the empty reservoir to RN #6. RN#6 placed the empty reservoir into a plastic bag which was attached to the nebulizer machine.</p> <p>Resident #162's clinical record was reviewed on 05/11/2016 at 10:49 a.m. Resident #162's current diagnoses included, but were not limited to, bronchopneumonia, chronic obstruction pulmonary disease, alcohol dependence and anxiety.</p> <p>Resident #162's, 4/26/16, physician's orders included, but were not limited to:</p> <p>Xopenex (a reparatory medication administered by nebulizer) solution for nebulazaton 1.25 mg.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0279 SS=E Bldg. 00	<p>Resident #162's record lacked an order for self administration</p> <p>During a 5/16/16, 9:29 a.m., interview, the DON indicated Resident #162 had not had a self administration of medication ordered prior to 5/12/16.</p> <p>A current, August 2011, facility policy, titled "GUIDELINES FOR SELF ADMINISTRATION OF MEDICATIONS", provided by the Director of Nursing on 5/16/16 at 9:10 a.m., indicated: "Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed for safety by a licensed nurse...Results of the assessment will be presented to the physician for evaluation and an order for self-medication...the order should include the type of medication(s) the resident is able to self-medicate.i.e.: all oral medication(s), oral medication(s) with the exception of...., nebulizer treatment only, all medications including injection oral, inhalers, drops, etc.</p> <p>3.1-11(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop care plans to address resident choice/preferences, psychoactive medication use, targeted behaviors treated by psychoactive medications and catheter use for 5 of 32 residents reviewed for care plan development (Residents #9, #98, #21, #30, and #34).</p> <p>Findings include:</p> <p>1. Resident #34's clinical record was reviewed on 5/12/16 at 2:36 p.m. Resident #34's diagnoses included, but were not limited to, urine retention, history of urinary tract infections, and surgery of the genitourinary system.</p>	F 0279	<p>F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident #98 had been discharged. 2). Resident #9 - care plan developed for resident's choice/preference to not use alarms as a fall prevention intervention. 3). Resident #21 - care plan developed for specific symptoms / interventions for when the resident feels anxious. 4). Resident #30 - care plan developed for specific targeted behaviors for the use of anti-anxiety medication. 5). Resident #34 - care plan developed for catheter use</p> <p>Identification of other residents having the potential</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>During a 5/10/16,10:13 a.m., interview, Unit Manager #3 indicated Resident #34 had an indwelling Foley catheter due to renal stones.</p> <p>During a 5/12/16, 2:21 p.m., interview, Unit Manager #3 indicated Resident #34 used a urinary leg bag when out of bed, which was concealed by her clothing.</p> <p>Resident #34 had a 3/16/16, admission, Minimum Date Set (MDS) assessment which indicated the resident used an indwelling catheter.</p> <p>Resident #34's clinical record lacked a care plan regarding the use of an indwelling catheter.</p> <p>During a 5/16/16, 9:51 a.m., interview, the DON indicated Resident #34 did not have a care plan to address her indwelling catheter use. She indicated the lack of care plan was simply an error.</p> <p>2. The clinical record for Resident #30 was reviewed on 5/11/16 at 9:46 a.m. Diagnoses for Resident #30 included, but were not limited to, dementia with behaviors, anxiety, and hypertension.</p> <p>Resident #30 had the following current physician orders:</p>		<p>to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with choice / preferences related to alarm use, psychoactive medication use related to specific symptoms/interventions , targeted behaviors treated by psychoactive medication use and catheter use to ensure a care plan is in place.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur during the daily clinical interdisciplinary review: Review residents with choice / preferences related to alarm use, psychoactive medication use related to specific symptoms/interventions , targeted behaviors treated by psychoactive medication use and catheter use to ensure a care plan is in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>a. Xanax (an anti-anxiety medication) 0.5 mg, 1 tablet by mouth every day. The original date of this order was 1/13/16.</p> <p>b. Xanax 0.5 mg, 1 tablet by mouth as needed for anxiety once a day. The original date of this order was 1/13/16.</p> <p>Resident #30 had a 3/16/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident had severe cognitive impairment.</p> <p>Resident #30 lacked a health care plan with specific targeted behaviors for the use of her anti-anxiety medication.</p> <p>During an interview on 5/17/16 at 10:01 a.m., LPN #8 indicated she would look at the progress notes, event notes, medication administration records and health care plans to learn if the behavior a resident was displaying was new or worsening.</p> <p>During an interview on 5/17/16 at 11:48 a.m., Unit Manager #2 reviewed the health care plans for Resident #30. Unit Manager #2 indicated the health care plan for Resident #30's anti-anxiety medication did not have targeted behaviors for use of the medication.3.</p> <p>The record of Resident #9 was reviewed</p>		compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>on 5/16/17. Resident #9 had current diagnoses which included, but were not limited to, chronic kidney disease, neuromuscular dysfunction of bladder, congenital deformities of feet, dysrhythmic disorder.</p> <p>Resident #9 had a, 4/30/16, quarterly, Minimum Data Set (MDS) assessment which indicated she was cognitively intact and her decisions were confident and reasonable. Resident #9's functional mobility required limited assistance with bed mobility, dressing and toilet use. She required supervision with her transfers, locomotion on and off the unit, eating, and personal hygiene.</p> <p>Resident #9 had a current, 5/2/16, care plan problem/need regarding falls, "I have a limitation in my ability to transfer self related to neuromuscular dysfunction, neuropathy and deformity of bilateral feet". This care plan problem/need originated 1/4/16. The goal for this problem/need was "I will transfer myself with assistance".</p> <p>Resident #9 had a current, 5/13/16, care plan problem/need regarding falls, "I have a history of falling related to diagnosis of dizziness, deformity of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>bilateral feet, neuromuscular dysfunction and neuropathy". This care plan problem/need originated 1/4/16. Approaches to this problem/need included, but were not limited to, "approach start date: 2/10/16 and on 10/23/16 pressure alarms were added then discontinued related to resident's wish to maintain a waiver that was signed 7/2015. Resident re-education provided...approach start date: 5/10/16 on 5/7/16 pressure alarm to bed and wheel chair related to fall on 5/9: bedside mat". Resident #9 had a, 7/30/15, "Self Determination of Care Request", which indicated Resident #9 has requested the following medication, treatment and/or physician order not be administered:... "resident and family request no alarms so resident can maintain independence". During an interview with Resident #9 on 5/16/16 at 11:09 a.m., Resident #9 indicated she did not want any alarms and wouldn't have them on her bed or wheel chair, and "no mat beside my bed". The resident's wishes were not included in the care plan.</p> <p>4. Resident #21's clinical record was reviewed on 5/10/2016 at 9:01 a.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Resident #21's current diagnoses included but were not limited to generalized anxiety disorder, chronic kidney disease and a history of falling.</p> <p>Resident #21 had current physician orders for Lexapro (anti-depressant medication used for antianxiety) 10 mg per day and Xanax (antianxiety) 0.5 mg PRN (as needed) three times per day.</p> <p>Resident #21 had a current, 4/4/2016, Minimum Data Set (MDS) assessment which indicated she was cognitively intact.</p> <p>During an interview with Resident #21 on 5/12/2016 at 11:02 a.m., she indicated she took antianxiety medication on a regular basis. She further indicated she felt anxious most of the time and the medication helped her to feel less anxious.</p> <p>During an interview with the DON on 5/12/2016 at 12:51 p.m., she indicated there was not a care plan for Resident #21 describing specific symptoms or interventions when the resident was feeling anxious.</p> <p>5. Resident #98's clinical record was reviewed on 5/9/2016 at 12:59 p.m. Resident #98's current diagnoses</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>included, but were not limited to, anxiety, atrial fibrillation, hypertension, and dysrhythmic disorder (major depressive disorder).</p> <p>Resident #98 had current a physician order for Seroquel (antipsychotic) 50 mg at bedtime.</p> <p>The current Minimum Data Set (MDS) assessment, completed on admission and dated 4/26/2016, indicated Resident #98 was cognitively intact.</p> <p>During an interview with the DON on 5/12/2016 at 10:43 a.m., she indicated Resident #98 was prescribed Seroquel while in the hospital due to hallucinations and it should have been discontinued before leaving the hospital. The DON indicated Resident #98 was admitted to the facility without a diagnosis for the Seroquel medication order. The DON indicated no behavior tracking had been completed for Resident #98. She further indicated the facility usually checked to see there was a diagnosis for antipsychotic medication upon admission and they somehow missed the lack of diagnosis for Resident #98.</p> <p>During an interview with the DON on 5/12/2016 at 12:51 p.m., she indicated there were no care plans related to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>anti-psychotic medication usage describing specific symptoms or interventions for Resident #161.</p> <p>A current, 2015 facility policy titled, "INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE" was provided by the DON on 5/16/2016 at 9:10 a.m. It indicated:</p> <p>"PURPOSE: To ensure appropriateness of services and communication that will meet the resident's needs, severity/ stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines.</p> <p>PROCEDURE: ...c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 3.0) i. Problem areas should identify the relative concerns. ii. Goals should be measurable and attainable. iii. Interventions should be reflective of the individual's needs and risk influence as well as strengths."</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a physician's order regarding reduced potassium rich foods for a resident, who received dialysis services, was followed for 1 of 1 resident reviewed for dialysis related care and treatment (Resident #112).</p> <p>Findings include:</p> <p>The clinical record for Resident #112 was reviewed on 5/11/16 at 2:29 p.m. Diagnoses for Resident #112 included, but was not limited to, end stage renal disease with dependence on renal dialysis, diabetes, and congestive heart failure.</p> <p>Resident #112 had a current physician's diet order for "REGULAR, NAS [no added salt], LOW K+ [low potassium]...No oranges, OJ [orange juice], bananas, melon, unboiled</p>	F 0282	<p>F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #112 - diet order clarified and is being followed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents to ensure the physician's diet order is correct and being followed. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guideline: Procedure for Ordering Individual Diets How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>potatoes, beans, prunes or prune juice." The order for this diet change originated 4/8/16. Resident #112 had a current, 3/23/16, physician's order for "DIALYSIS ON MONDAY, WEDNESDAY, AND FRIDAY...".</p> <p>During an interview on 5/12/16 at 9:40 a.m., Resident #112 indicated he ate his meals in his room and did not want to eat in the dining room. He further indicated he was "supposed to stay away from bananas and other foods high in potassium."</p> <p>During an interview on 5/12/16 at 9:56 a.m., the Dietary Manager indicated Resident #112 did not have any preferences listed on his meal ticket. The Dietary Manager indicated Resident #112 had a "regular" diet. She further indicated she had no dietary orders for Resident #112 related to low potassium food, or restriction of oranges, orange juice, bananas, melon, unboiled potatoes, beans, prunes or prune juice.</p> <p>During an interview on 5/12/16 at 12:51 p.m., the Director of Nursing (DON) provided the master diet order list titled "Resident Listing Report", from the Dietary Manager. The master list indicated Resident #112 had a "Regular" diet order.</p>		<p>by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing for this plan of correction will occur during all 3 meal services: Review residents to ensure the physician's diet order is correct and being followed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>During an interview on 5/16/16 at 11:16 a.m., the DON indicated Resident #112 did have a diet order for low potassium foods with instructions to avoid oranges, orange juice, bananas, melon, unboiled potatoes, beans, prunes and prune juice. She further indicated dietary did not have the correct diet order. The DON indicated one copy of the diet order change should have gone to the dietary department.</p> <p>Review of the current facility policy, revised 7/2013, titled "Procedure for Ordering Individual Diets", provided by the DON on 5/16/16 at 1:51 p.m., included, but was not limited to, the following:</p> <p>"GUIDELINE: The individual will be provided with the correct diet as ordered by the physician.</p> <p>PROCEDURE: ...5. The diet order or change in diet order will be transmitted to the Dining Services Department on a Briggs Diet Order Form.</p> <p>6. The diet order will include the name of the individual, room number, type of diet, date diet order was sent to Dining Services, the name of the physician, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0329 SS=D Bldg. 00	<p>the name of the person transmitting the physician order.</p> <p>7. A designee in the Dining Services Department will initiate or update the diet order in the tray card program.</p> <p>8. Once the diet order is initiated or updated, the written diet order will be initial and dated and filed within the Dining Services Department...."</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure behavioral indicators were documented and a medical assessment was completed prior to obtaining an order for an increase in an anti-anxiety medication (Resident #30).</p> <p>Findings include:</p> <p>1. During an observation on 5/9/16 at 10:53 a.m., Resident #30 was sitting in her wheelchair, near the nurse's station. She was calm with no behaviors noted.</p> <p>During an observation on 5/10/16 at 1:28 p.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/10/16 at 1:55 p.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/11/16 at 10:29 a.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p>	F 0329	<p>F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident #98 has been discharged from the campus. 2). Resident #30 - MD contacted and order received for gradual dose reduction of psychoactive medication. Behavioral indicator tracking was implemented. 3). Resident #47 - PRN pain medication orders were updated to include which medication addresses which level of pain per campus designated pain scale. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with on psychoactive medications to ensure behavioral indicator tracking is in place, increase psychoactive medications to ensure a medical assessment was complete prior to and PRN orders for pain to ensure parameters are in place the details which pain medication should address which level of pain as identified on the campus designated pain scale.</p> <p>Measures put in place and systemic changes made to</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>During an observation on 5/11/16 at 12:54 p.m., Resident #30 was sitting in her wheelchair, in the dining room. She was calm with no behaviors noted.</p> <p>During an observation on 5/11/16 at 2:16 p.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/12/16 at 7:04 a.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/12/16 at 9:59 a.m., Resident #30 was sitting in her wheelchair, in the front lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/12/16 at 12:04 p.m., Resident #30 was sitting in her wheelchair, in the dining room. She was calm with no behaviors noted.</p> <p>During an observation on 5/12/16 at 2:17 p.m., Resident #30 was sitting in her wheelchair, near the nurse's station. She was calm with no behaviors noted.</p> <p>During an observation on 5/12/16 at 4:21 p.m., Resident #30 was sitting in her wheelchair, in the hallway. She was calm</p>		<p>ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and Social Service on the following campus guidelines: 1). Psychoactive Drug Monitoring 2). PRN Medication Tracking How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. Monitoring / auditing of this plan of correction will occur during the daily clinical interdisciplinary review: Review residents with on psychoactive medications to ensure behavioral indicator tracking is in place, increase in psychoactive medications to ensure a medical assessment was complete prior to and PRN orders for pain to ensure parameters are in place that details which pain medication should address which level of pain as identified on the campus designated pain scale. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>with no behaviors noted.</p> <p>During an observation on 5/16/16 at 9:55 a.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/16/16 at 11:13 a.m., Resident #30 was sitting in her wheelchair, in the lounge with a visitor. She was calm with no behaviors noted.</p> <p>During an observation on 5/16/16 at 2:27 p.m., Resident #30 was sitting in her wheelchair, in the lounge. She was calm with no behaviors noted.</p> <p>During an observation on 5/16/16 at 4:02 p.m., Resident #30 was sitting in her wheelchair, near the nurse's station. She was calm with no behaviors noted.</p> <p>The clinical record for Resident #30 was reviewed on 5/11/16 at 9:46 a.m. Diagnoses for Resident #30 included, but were not limited to, dementia with behaviors, anxiety, and hypertension.</p> <p>Resident #30 had the following current physician orders:</p> <p>a. Xanax (an anti-anxiety medication) 0.5 mg, 1 tablet by mouth every day. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>original date of this order was 1/13/16. This was an increase in dosage from 0.25 mg.</p> <p>b. Xanax 0.5 mg, 1 tablet by mouth as need for anxiety once a day. The original date of this order was 1/13/16. This was an increase in dosage from 0.25 mg.</p> <p>"Resident Progress Notes", from 12/2/15 to 2/12/16, were reviewed for Resident #30. A note, dated 12/31/15, indicated Resident #30 had refused her breathing treatment. The notes lacked any other documentation of behaviors for Resident #30.</p> <p>Review of Resident #30's clinical record, from 11/30/15 to 5/11/16, contained one event note related to behaviors on 3/9/16.</p> <p>Resident #30's clinical record indicated she was seen by the Nurse Practitioner on 12/23/15 and 1/25/16, with no documentation related to her anxiety or her anti-anxiety medication.</p> <p>During an interview on 5/16/16 at 10:49 a.m., the Director of Nursing (DON) indicated she could not find any behavior documentation or a provider note which addressed the increase in Resident #30's anti-anxiety medication.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>During an interview on 5/16/16 at 2:28 p.m., Unit Manager #1 indicated behaviors were documented in the resident's progress notes or in the event notes. The resident's behavior, interventions tried, medication given (if applicable), and the results of all the actions taken should be documented. If the behavior was new for the resident, staff needed to inform social services also.</p> <p>During an interview on 5/16/17 at 2:38 p.m., the Social Services Assistant indicated resident behaviors were documented in progress notes or event notes.</p> <p>During an interview on 5/16/17 at 2:43 p.m., the Social Services Director indicated he could not find any documentation related to Resident #30's behaviors and/or increase in her anti-anxiety medication on 1/13/16. He further indicated the previous electronic medical record had behavior tracking but the current electronic record system did not have behavior tracking.</p> <p>During an interview on 5/16/17 at 4:01 p.m., Unit Manager #1 indicated she could not find any documentation in Resident #30's clinical record related to behaviors and/or the increase in her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>anti-anxiety medication on 1/13/16.</p> <p>2. The medical record for Resident #98 was reviewed on 5/9/2016 at 12:59 p.m. Resident #98's current diagnoses included but were not limited to anxiety, atrial fibrillation, hypertension, and dysthymic disorder (major depressive disorder).</p> <p>Resident #98 had a current physician order for Seroquel (antipsychotic) 50 mg at bedtime.</p> <p>The current, 4/26/2016, admission Minimum Data Set (MDS) assessment indicated Resident #98 was cognitively intact.</p> <p>The pharmacy review, dated 5/9/2016, was provided by the DON on 5/11/2016 at 10:58 a.m. It indicated Resident #98 was taking Seroquel, but lacked a diagnosis to support it's use.</p> <p>During an interview with the DON on 5/12/2016 at 10:43 a.m., she indicated Resident #98 was prescribed Seroquel while in the hospital due to hallucinations and it should have been discontinued before leaving the hospital. The DON indicated Resident #98 was admitted to the facility without a diagnosis for the Seroquel medication order. The DON indicated no behavior tracking had been completed for Resident #98. She further</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>indicated the facility usually checked to see there was a diagnosis for antipsychotic medication upon admission and they somehow missed the lack of diagnosis for Resident #98.</p> <p>An untitled 2012, facility policy provided by the DON on 5/16/2016 at 9:52 a.m., indicated the following:</p> <p>"PSYCHOACTIVE DRUG MONITORING</p> <p>POLICY</p> <p>Residents who receive antidepressant, antianxiety, or antipsychotic medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward effects.</p> <p>a) Residents receive a psychoactive medication only if designated medically necessary by the prescriber...</p> <p>c) Nonpharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber in assessing the continued need for psychoactive medication...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>g) All of the following conditions are satisfied prior to initiation and/or continuation of therapy...</p> <p>...4) The need for and response to therapy are monitored and documented in the resident's medical record.</p> <p>k) Psychoactive drug monitoring guidelines include but may not be limited to: Antianxiety/sedative Drugs...</p> <p>...4) Behavioral monitoring charts or a similar mechanism are used to document the resident's need for and response to drug therapy.</p> <p>l) Antipsychotics...</p> <p>1) Anti-psychotics are given only if the resident has been diagnosed with one of the following indications...</p> <p>a. Schizophrenia</p> <p>b. Schizo-affective disorder</p> <p>c. Delusional disorder</p> <p>d. Psychotic mood disorders (including mania and depression with psychotic features)</p> <p>e. Acute psychotic episodes</p> <p>f. Brief reactive psychoses</p> <p>g. Schizophreniform disorder</p> <p>h. Atypical psychosis</p> <p>i. Organic mental syndromes (including dementia, delirium, and amnesic and other cognitive disorders) with associated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>psychotic and/or agitated behaviors...</p> <p>4) The resident's physician provides a justification for the continued use of the drug and dosage as clinically appropriate, and this justification appears somewhere in the resident's medical record. The justification includes: a diagnosis with description of symptoms..."3. Resident #47's clinical record was reviewed on 5/16/16 at 9:54 a.m. Resident #47's diagnoses included, but were not limited to, diabetes mellitus, osteomyelitis of vertebra, lumbar spina bifida without hydrocephalus and right breast cancer metastasized to the liver.</p> <p>Resident #47 had 3 current physician's orders for the following as needed pain medications:</p> <p>a. "acetaminophen 500 mg - give 1 tablet every 4 hours as needed for pain," ordered 4/13/16. This order did not include parameters as to the level of pain to be treated by this pain medication nor a standardized method to assess for pain.</p> <p>b. "hydrocodone-acetaminophen 5-325 mg - give 2 tablets (10-650 mg) every 4 hours as needed for pain," ordered 4/13/16. This order did not include parameters as to the level of pain to be treated by this pain medication nor a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>standardized method to assess for pain.</p> <p>c. "hydrocodone-acetaminophen 5-325 mg - give 1 tablet every 6 hours as needed for pain," ordered 4/13/16. This order did not include parameters as to the level of pain to be treated by this pain medication nor a standardized method to assess for pain.</p> <p>Resident #47 had a current, 2/25/16, care plan problem regarding pain secondary to right breast cancer metastasized to the liver. This care plan problem/need originated 8/21/15. Approaches to this problem included, but were not limited to, "Encourage resident to request pain medication before pain becomes unbearable."</p> <p>Resident #47's Medication Administration Record for 4/16/16 to 5/16/16 indicated the resident received as needed pain medication during the following dates and times:</p> <p>"4/16/16, 3:57 p.m. - hydrocodone-acetaminophen 5-325 mg, 7/10 on pain scale (the first number was the number stated by the resident on a 1 to 10 pain scale) , severe pain</p> <p>4/16/16, 8:14 p.m. - hydrocodone-acetaminophen 10-650 mg,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>7/10 on pain scale, severe pain</p> <p>4/17/16, 4:38 a.m. - acetaminophen 500 mg, 3/10 on pain scale, moderate pain</p> <p>4/17/16, 8:47 p.m. - hydrocodone-acetaminophen 5-325 mg, 7/10 on pain scale, severe pain</p> <p>4/18/16, 8:35 p.m. - hydrocodone-acetaminophen 5-325 mg, 4/10 on pain scale, moderate pain</p> <p>4/19/16, 6:38 p.m. - hydrocodone-acetaminophen 10-650 mg, 4-5/10 on pain scale, moderate pain</p> <p>4/20/16, 7:15 p.m. - hydrocodone-acetaminophen 5-325 mg, 5/10 on pain scale, moderate pain</p> <p>4/21/16, 7:20 p.m. - hydrocodone-acetaminophen 10-650 mg, 7/10 on pain scale, severe pain</p> <p>4/22/16, 6:40 p.m. - hydrocodone-acetaminophen 5-325 mg, 7/10 on pain scale, severe pain</p> <p>4/23/16, 9:13 p.m. - hydrocodone-acetaminophen 10-650 mg, 7/10 on pain scale, severe pain</p> <p>4/25/16, 2:00 p.m. - acetaminophen 500</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>mg, 3/10 on pain scale, moderate pain</p> <p>4/28/16, 7:07 p.m. - hydrocodone-acetaminophen 5-325 mg, 5/10 on pain scale, moderate pain</p> <p>4/29/16, 8:50 a.m. - hydrocodone-acetaminophen 10-650 mg, 4/10 on pain scale, moderate pain</p> <p>4/29/16, 9:08 p.m. - hydrocodone-acetaminophen 10-650 mg, 5/10 on pain scale, moderate pain</p> <p>4/30/16, 7:31 p.m. - hydrocodone-acetaminophen 5-325 mg, 7/10 on pain scale, severe pain</p> <p>5/1/16, 1:52 p.m. - hydrocodone-acetaminophen 5-325 mg, 6/10 on pain scale, severe pain</p> <p>5/4/16, 9:28 p.m. - hydrocodone-acetaminophen 5-325 mg, 6/10 on pain scale, severe pain</p> <p>5/6/16, 8:31 a.m. - hydrocodone-acetaminophen 10-650 mg, 5/10 on pain scale, moderate pain</p> <p>5/13/16, 10:37 p.m. - hydrocodone-acetaminophen 5-325 mg, 5/10 on pain scale, moderate pain</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>5/14/16, 7:41 p.m. - hydrocodone-acetaminophen 10-650 mg, no score pain scale"</p> <p>During a 5/16/16, 1:40 p.m., interview, the DON indicated Resident #47's orders should have indicated which medication should address which level of pain as identified on the "Pain Scale." She indicated traditionally acetaminophen 500 for mild pain, hydrocodone-acetaminophen 5-325 for moderate pain and hydrocodone-acetaminophen 10- 650 for severe pain. Lastly she indicated the 3 as needed pain medication orders should have been clarified to ensure the mediation which was used addressed the level of pain the resident was experiencing.</p> <p>A current, 9/11/12, facility form titled "PRN [as needed] Medication Tracking", provided by the DON on 5/16/16 at 1:40 p.m., indicated the following: "Pain Scale: Verbal: 1-2 Mild, 3-5 Moderate, 6-8 Severe, 9-10 Excruciating".</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview, the facility failed to ensure food was stored under safe and sanitary conditions regarding dating and labeling food. This deficient practice had the potential to impact 68 residents who were served food from the facility's kitchen.</p> <p>During the kitchen tour with the Dietary Manager on 05/09/2016 at 9:03 a.m., the following observations were made:</p> <p>a. The front one door refrigerator contained five bowls of cottage cheese and one bowl of a brown substance, two plates with lettuce and tomatoes, two bowls of applesauce, five bowls of grapes, and four uncovered bowls of sliced fruit none of these food items were dated or labeled. The Dietary Manager indicated she did not know what the brown substance was. She touched the top of the brown substance and indicated it was hard.</p>	F 0371	<p>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit / observation of storage areas to ensure food items have been dated and labeled when opened</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food Labeling and Dating How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>b. The walk-in cooler contained 1 1/2 bags of chopped lettuce. The lettuce was not dated or labeled.</p> <p>c. The two door freezer #1 contained one gallon sized Ziploc bag of uncooked biscuits with no label or date.</p> <p>d. On the food prep table was a clear container labeled as "thick-it". A scoop was submerged in the thickener.</p> <p>The document titled "Topic: Trilogy Food Labeling & Dating Policy" was provided by the Dietary Manager on 5/16/2016 at 11:09 a.m., indicated the following: "WHO: Anyone that breaks an original seal of any food container or stores food that is any stage of production or leftover. WHAT: All food once it is opened, or has the manufactory's [SIC] seal broken, or has been prepped in any way, needs to be labeled and dated with the correct shelf life from the Food Dating Guide...We MUST have a label that contains the following: ...Item name, Date & Time (that the food was labeled), Use BY Date, Initials of the person labeling the item, Securely cover food item, Must the same label at all times in all areas...When: A label must be made immediately when the food product is going into storage, this is non negotiable...."</p>		<p>Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on day and evening shift when the kitchen is in use: 1). Audit / observation of storage areas to ensure food items have been dated and labeled when opened The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0431 SS=E Bldg. 00	<p>3.1-21(I)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Based on observation, interview and record review, the facility failed to ensure a medication cart was locked while unattended in the hallway. This deficient practice had the potential to affect 1 mobile cognitively impaired resident who resided on the 600 hallway.</p> <p>Findings include:</p> <p>During an observation on 5/12/16 at 7:09 a.m., an unlocked and unattended medication cart was parked between Room 604 and Room 606. The door to Room 603 opened and RN #11 emerged from the room. RN #11 walked to the medication cart, retrieved supplies for blood glucose testing from the top of the cart and returned to Room 603 and shut the door. At 7:10 a.m., RN #11 returned to the cart, opened the bottom drawer and retrieved cleaning supplies for the glucometer. RN #11 indicated he did not realize he had left the medication cart unlocked until he was observed. He further indicated medication carts need to be locked when not attended.</p> <p>A list of residents with medications stored in the 600 hall medication cart at the time of the observation of the unattended and unlocked medication cart was provided by the Director of Nursing on 5/12/16 at 11:17 a.m. The list</p>	F 0431	<p>F 431 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The medication cart was locked immediately when noted to be unlocked during the survey. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses / QMAs on the following guideline: Medication Storage in the Facility How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Observation of the medication carts on all hallways to ensure they are locked. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6</p>	06/16/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016	
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>included Schedule II drugs and other drugs subject to abuse, which needed to be double locked. Medications on the 600 hall medication cart included, but were not limited to the following: 100 tablets of Norco 5-325 mg, 65 tablets of Norco 7.5 mg, 63 tablets of oxycodone/apap 5-325 mg, 3 patches of Fentanyl 12 mcg and 4 patches of Fentanyl 25 mcg.</p> <p>During an interview on 5/16/16 at 2:18 p.m., Unit Manager #3 indicated one resident was mobile and cognitively impaired on the 600 hall. Unit Manager #3 further indicated medication carts are to be locked when unattended.</p> <p>Review of the current facility policy, revised 9/17/12, titled "MEDICATION STORAGE IN THE FACILITY", provided by the Director of Nursing on 5/16/16 at 9:29 a.m., included, but was not limited to, the following:</p> <p>"...Policy Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier... ...Medication rooms, carts and medication supplies are locked or attended by persons with authorized access...."</p>		months then randomly thereafter for further recommendation.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>3.1-25(m)</p> <p>This visit was for a State Residential Licensure Survey. This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Residential Census: 64</p> <p>Sample: 11</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on May 19, 2016.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on May 17, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication was given per physician order for 1 of 5 residents observed during medication administration observation (Resident #R35)</p> <p>Findings include:</p> <p>During a medication administration observation on 5/17/16 at 7:58 a.m., RN #12 retrieved 1 tablet of Colace (a laxative) 100 mg from the Emergency Drug Kit (EDK). The Colace tablet was then administered to Resident #R35 orally by RN #12.</p> <p>The clinical record for Resident #R35 was reviewed on 5/17/16 at 1:03 p.m.</p>	R 0241	<p>requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>R 241 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #R35 - 1). A medication error event was opened and the resident was monitored for adverse reaction. 2). Medication pass will be observed to ensure medications are administered as ordered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will complete 3 medication pass observations to ensure medications are administered as ordered. Measures put in place and systemic changes made to ensure the alleged deficient</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Diagnoses for Resident #R35 included, but were not limited to, dementia, chronic pain, and constipation.</p> <p>Resident #R35 had a current physician order for Colace 50 mg/ml, 5 ml by mouth twice daily. The original date of this order was 10/27/15.</p> <p>During an interview with the Director of Nursing (DON), on 5/17/16 at 1:50 p.m., additional information related to Resident #R35's physician orders was requested.</p> <p>During an interview on 5/17/16 at 3:15 p.m., the DON indicated she had spoke with RN #12. RN #12 indicated she had looked at the physician order wrong and the wrong dose of the medication had been given. The DON provided the "EMERGENCY DRUG KIT USAGE REPORT", dated 5/17/16. The report indicated 1 Colace 100 mg tablet was removed from the EDK by RN #12 for Resident #R35</p> <p>Review of the current facility policy, dated 2/1/10, titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES", provided by the DON on 5/12/16 at 3:30 p.m., included, but was not limited to, the following:</p> <p>"Policy</p>		<p>practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guideline: Specific Medication Administration Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: Complete a medication pass observation to ensure medications are administered as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	To administer medications in a safe and effective manner.... ...E. Check MAR [Medication Administration Record] for order... ...G. Read medication label three (3) times: 1) prior to removing the mediation package/container from the cart/drawer; Compare label to MAR..."				