

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER BELL OAKS TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630
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R0000	<p>This visit was for the Investigation of Complaint IN00121187.</p> <p>Complaint IN00121187 Substantiated, State findings related to the allegations are cited at R241 and R304.</p> <p>Survey dates: January 9 and 10, 2012</p> <p>Facility number: 004903 Provider number: 004903 AIM number: N/A</p> <p>Survey team: Anne Marie Crays RN TC Diane Hancock RN (1/9/13)</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census payor type: Other: 39 Total: 39</p> <p>Sample: 4</p>	R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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.

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	<p>These state findings cited are in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 14, 2013, by Jodi Meyer, RN</p>						

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R0241	<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 interview and record review, the facility failed to ensure a medication was administered by qualified nursing staff, in that a CNA administered a narcotic pain medication for 1 of 4 residents reviewed who received medication, in a sample of 4. Resident A</p> <p>State findings include:</p> <p>1. On 1/9/13 at 9:40 A.M., the Residence Director [RD] provided a list of residents, indicating those who were considered alert and interviewable. Resident A was indicated as being interviewable.</p> <p>On 1/9/13 at 9:40 A.M., the RD provided an "Indiana State Department of Health Incident Report Form." The document included: "...Incident Date: 12/15/12, Incident Time: 1:30 am, Resident Name: [Resident A]...Brief Description of Incident: During 3rd shift on 12/15/12, [Resident A] rang his call light and</p>	R0241	<p>Citation #1 R 241 410 IAC 16.2-5-4(e) (1) Health Services- Offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? The Employees involved with the above incident were suspended pending investigation upon prompt notification of incident. The community Residence Director and Regional team immediately notified the Indiana Department of Health of the incident within the appropriate time frame. Neither employee is currently employed at Bell Oaks Terrace at this time.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. The Residence</p>	02/26/2013			

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	<p>requested pain medication. One of the C.N.A.s working that shift called and reported to the Residence Director [name], that his co-worker and fellow CNA [CNA # 1] was found administering the narcotic pain medication to the resident...Internal investigation was initiated...[CNA # 1] stated that she had phoned Wellness Director [name] to notify her of the resident's request. She then stated that [the Wellness Director] had advised her to administer the medication to the resident because there was not a nurse available to come in...."</p> <p>On 1/9/12 at 10:20 A.M., Resident A was interviewed. Resident A indicated, "The nurse usually gives me my medication." Resident A then indicated there was 1 occasion in which a CNA administered his medication. Resident A indicated, "I knew it wasn't kosher. I guess the evening shift nurse called in. I needed my pain medication and the CNA called the head nurse. Guess she told her how to get the keys or whatever. The night shift aide reported it; he knew it wasn't right." Resident A indicated the CNA administering the medication was CNA # 1, and indicated, "She was only trying to help me out."</p> <p>On 1/9/13 at 11:10 A.M., the clinical record of Resident A was reviewed.</p>		<p>Director completed a staff in-service at the community following the incident to review the Indiana state Nurse Practice Act, Scope of Practice, and the disciplinary process. The Residence Director emphasized a "no tolerance" approach regarding non-compliance with the above referenced regulation and if individual or individuals were found to be in violation through our investigation process they would be reported to appropriate licensing board and the Department of Health.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Staff were re-educated to our policy and procedure regarding Medication Administration, Scope of Practice, and the Indiana Nurse Practice Acts. The Licensed Nurses at Bell Oaks Terrace will be held in strict accordance to the above referenced regulation when delegating tasks for completion to Personal Service Assistants and Qualified Medication Aid's to tasks that may be completed under licensure. Failure for personnel employed at Bell Oaks Terrace to adhere to our states nurse practice act will result in prompt notification to the Indiana state Licensing Board, Indiana</p>				

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	<p>A Service Plan, dated 8/24/12, indicated, "Nurses are administering oral medications."</p> <p>A Physician's order, dated 12/6/12, indicated, "Lortab 7.5 [two tablets] [every] 6 [hours] routine."</p> <p>On 1/9/13 at 10:50 A.M., LPN # 1 was interviewed. LPN # 1 indicated she knew Resident A had an order to receive a routine pain medication at 11:00 P.M., but that "an agency nurse probably wouldn't have known that." LPN # 1 indicated the evening shift agency nurse had apparently left the facility and had not given Resident A his pain medication. LPN # 1 indicated that she received a text from the Wellness Director [WD] at approximately 12:45 A.M. on 12/15/12. The WD informed her that "[CNA # 1] gave pain medication to [Resident A]." LPN # 1 indicated the WD stated, "I need you to help me - I need you to sign for [CNA # 1]." LPN # 1 indicated she had not been called the prior evening to administer the medication, and she had not entered the facility, so she was not going to sign the medication out.</p> <p>On 1/10/13 at 9:35 A.M., the RD was interviewed. She indicated she received a phone call from CNA # 2 on 12/15/12 at</p>		<p>State Department of Health, and the ALC Human Resource Department for review and possible disciplinary action as indicated within our Assisted Living Concepts Employee Handbook. The Wellness Director and/or Designee will be responsible to ensure medications are administered by licensed nursing personnel or qualified medication aides per our policy and procedure to ensure compliance with Indiana state ruling R 241 410 IAC 16.2-5-4(e) (1) Health Services.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of Medication Administration Records to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Bell Oaks Terrace Quality Assurance process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? February 26 th , 2013</p>				

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	<p>approximately 12:30 A.M. CNA # 2 informed her that [CNA # 1] "just gave [Resident A] a pain pill." The RD indicated she was aware that the QMA who had been scheduled to work the night shift had called in, and that the WD was responsible for coming in or getting a nurse to come to the facility if medication administration was needed, since 2 CNAs would be working the night shift. The RD indicated she interviewed both CNA # 1 and CNA # 2 via telephone, and CNA # 1 admitted to administering the medication to Resident A. CNA # 1 informed the RD that the WD had texted her and told her to give the medication. The RD indicated CNA # 1 then "kept changing her stories." The RD indicated the WD and CNA # 1 were terminated.</p> <p>2. On 1/9/13 at 1:40 P.M., the Regional Nurse provided the current facility policy on "Administration of Medications/Treatments," dated 7/2009. The policy included: "...Medications and treatments are administered only by personnel trained in the competencies required and legally authorized to do so...."</p> <p>This state finding relates to Complaint IN00121187.</p>			
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R0304	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure authorized personnel were given access to a medication room and cart, in that a CNA had keys to the room and cart and was able to administer medication, for 1 of 1 medication rooms and 1 of 1 carts observed.</p> <p>State findings include:</p> <p>On 1/9/13 at 9:40 A.M., the RD provided an "Indiana State Department of Health Incident Report Form." The document included: "...Incident Date: 12/15/12, Incident Time: 1:30 am, Resident Name: [Resident A]...Brief Description of Incident: During 3rd shift on 12/15/12, [Resident A] rang his call light and requested pain medication. One of the C.N.A.s working that shift called and reported to the Residence Director [name], that his co-worker and fellow CNA [CNA # 1] was found administering the narcotic pain medication to the resident...Internal investigation was</p>	R0304	<p>Citation #2 R 304 410 IAC 16.2-5-6(e) Pharmaceutical Services- Deficiency</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? The Employees involved with the above incident were suspended pending investigation upon prompt notification of incident. The community Residence Director and Regional team immediately notified the Indiana Department of Health of the incident within the appropriate time frame. Neither employee is currently employed at Bell Oaks Terrace at this time.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	02/26/2013			

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	<p>initiated...[CNA # 1] stated that she had phoned Wellness Director [name] to notify her of the resident's request. She then stated that [the Wellness Director] had advised her to administer the medication to the resident because there was not a nurse available to come in...."</p> <p>On 1/9/13 at 10:50 A.M., LPN # 1 was interviewed. LPN # 1 indicated she knew Resident A had an order to receive a routine pain medication at 11:00 P.M., but that "an agency nurse probably wouldn't have known that." LPN # 1 indicated the evening shift agency nurse had apparently left the facility and had not given Resident A his pain medication. LPN # 1 indicated that she received a text from the Wellness Director [WD] at approximately 12:45 A.M. on 12/15/12. The WD informed her that the QMA scheduled for the night shift had called in and the WD "had the agency nurse give the keys to [CNA # 1]."</p> <p>On 1/10/13 at 9:35 A.M., the RD was interviewed. She indicated she received a phone call from CNA # 2 on 12/15/12 at approximately 12:30 A.M. CNA # 2 informed her that [CNA # 1] "just gave [Resident A] a pain pill." The RD indicated she was aware that the QMA who had been scheduled to work the night shift had called in, and that the WD was</p>		<p>No other residents were found to be affected. The Residence Director completed a staff in-service at the community following the incident to review the Indiana state Nurse Practice Act, Scope of Practice, and the disciplinary process. The Residence Director emphasized a "no tolerance" approach regarding non-compliance with the above referenced regulation and if individual or individuals were found to be in violation through our investigation process they would be reported to the appropriate licensing boards and the Department of Health.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director, Wellness Director, licensed nurses, and Qualified Medication Aids were re-educated to the regulation R 304 IAC 16.2-5-6(e) Pharmaceutical Services, Scope of Practice, and our Indiana state Nurse Practice Acts. The medication keys will be placed in a locked box requiring combination for accessibility. Only licensed nursing staff or Qualified Medication Aides will be given access to the combination required to obtain medication keys. The Wellness Director and/or Designee will be responsible for ensuring that only</p>				

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	<p>responsible for coming in or getting a nurse to come to the facility if medication administration was needed, since 2 CNAs would be working the night shift. The RD indicated she interviewed both CNA # 1 and CNA # 2 via telephone, and CNA # 1 admitted to administering the medication to Resident A. CNA # 1 informed the RD that the WD had texted her and told her to give the medication. The RD indicated CNA # 1 then "kept changing her stories." The RD indicated the evening agency nurse had apparently left the keys to the medication room and medication cart for CNA # 1. The RD indicated CNA # 1 would not address why or how she had the keys.</p> <p>On 1/10/13 at 1:15 P.M., LPN # 1 demonstrated there was a key to the medication room, which was kept locked, a key to the medicine cart, and a key for the narcotic box. LPN # 1 indicated that the keys were handed to the oncoming nurse or QMA, and that there was only one set of keys, besides the WD's set.</p> <p>This state finding relates to Complaint IN00121187.</p>		<p>authorized personnel are given access to the medication room and medication cart per our policy and procedure to ensure compliance with R304 410 IAC 16.2-5-6(e) Pharmaceutical Services.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of Medication Administration Records, combination lock process, and staff operation within their scope of practice to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Bell Oaks Terrace Quality Assurance process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? February 26 th , 2013</p>				

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