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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0000	This visit was for the Investigation of Complaint IN00108966. Complaint IN00108966 - Substantiated. State residential findings related to the allegations are cited at R52, R217 and R406. Unrelated state residential findings are cited. Survey dates: June 6 and 7, 2012 Facility number: 004903 Provider number: 004903 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: Residential: 40 Total: 40 Census payor type: Other: 40 Total: 40 Sample: 5 These state residential findings are cited	R0000	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.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	in accordance with 410 IAC 16.2. Quality review 6/12/12 by Suzanne Williams, RN			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to immediately notify the physician of a resident who choked, requiring the Heimlich maneuver, for 1 of 3 residents reviewed for physician notification, in a sample of 5. Resident B Findings include: 1. The clinical record of Resident B was reviewed on 6/6/12 at 3:20 P.M. Diagnoses included, but were not limited to, Parkinson's disease and senile dementia. Resident Services Notes included the following notations, signed by a QMA: 5/13/12 at 12:15 P.M.: "Resident got choked on a piece of pot roast. Resident was removed from DR [dining room] into hallway where QMA proceeded to administer the Heimlich. Unable to dislodge food due to resident stiffening backwards in w/c [wheelchair]. QMA	R0036	**Citation #1 R 036 410 IAC 16.2-5-1.2(k) (1-2) Resident Rights-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident B had the incident involving choking in the dining room communicated with the physician and family. **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. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Bell Oaks staff were re-educated to our policy and procedure regarding change of condition, physicians orders,and documentation. The Wellness Director and/or Designee will be	07/30/2012

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	[and] CNA placed resident on floor and proceeded to do upward abd. [abdominal] thrust. Lg [large] piece of meat was expelled and resident was able to breath [sic]. Resident requested to go to his room and sit in recliner...Res c/o [complained of] feeling very tired and didn't want to finish his meal. 1 pm Resident was resting comfortably. Will con't to observe." Documentation was lacking in the clinical record regarding if a nurse or physician was notified of the choking episode. Resident Services Notes continued: 5/17/12 at 6:00 P.M.: "Resident choked on food @ evening meal...removed per CNA to hallway; resident did then cough et dislodge...." 5/17/12 at 6:15 P.M.: "Notified Hospice earlier of c/o [complaint of] resident choking...Residence Director informed et instructed nurse to send resident out D/T [due to] continuing c/o choking [with] periods of [not] able to get his breath [sic]. After cough improved, but again would feel like [illegible] blocking airway." The resident was transferred to the hospital on 5/17/12 at 6:30 P.M., and returned to the facility on 5/17/12 at 11:15		responsible to ensure continued compliance with the following policies and procedures. **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 reviews of incident reports and documentation to ensure continued compliance with physician and family notification as indicated within our policy and procedures when a resident experiences a change of condition for a period of six months. Findings will be reviewed through our Bell Oaks Terrace QA process after six months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** July 30, 2012 .	

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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.M. A Resident Services Note, dated 5/18/12 at 4:22 P.M., indicated, "D/T [due to] choking x 2 episodes on meat: N.O. [new order] per [physician] for ground meat...." On 6/7/12 at 8:30 A.M., the Residence Director provided an "Universal Incident/Occurrence Report." The report included: "...Incident Date: 5/13/12, Incident Time: 12:15 PM, Reported By: [QMA # 1]...Type of Injury/Complaints: Choked...Name of Nurse Notified: [LPN # 1], Date: 5-13-12, Time: 8:00 PM, Nurse's Instructions: Will notify physician for new orders...Name of Family Member/Authorized Representative Notified: [name], Date: 5/14/12, Time: [Left Blank] AM, Name of Physician notified: [name], Date: 5-14-12, Time: [Left blank] AM...Steps Taken to Prevent Recurrence: Other: Request order for ground meat from physician...." On 6/7/12 at 11:05 A.M., during interview with the Residence Director, she indicated an order was received from the physician for ground meat for the resident. She indicated the order was "4 days later," but the resident had been on ground meat previously, but it just wasn't documented.			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	2. On 6/7/12 at 11:30 A.M., the Residence Director provided the current facility policy on "Change of Condition," undated. The policy included: "A change in condition is a change in mental or physical status that results in a need for the provision of more or different services...A change in condition can occur gradually over time, or quickly, with a single event...The residence team should notify the Residence Director and Wellness Director immediately upon noting a resident change of condition...The Residence Director and/or Wellness Director should notify the family and physician in accordance with resident preferences and licensing requirements...."			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident a resident remained free from abuse and neglect, in that a staff member taped a call light string against the wall, out of reach of the resident; and a staff member fed a resident and poked him intentionally with a fork, making fun of the resident, for 1 of 5 residents reviewed for abuse, in a sample of 5. Resident A Findings include: 1. The clinical record of Resident A was reviewed on 6/6/12 at 12:00 P.M. Diagnoses included, but were not limited to, probable dementia. A hospice note summary, dated 5/11/12, indicated, "...Since admission the pt [patient] has declined from ambulation with two assists [sic] to total lift with two assists with little to no wt [weight] bearing...Pt is disoriented to person, place, and time...had gone from assist feeding to total feed due to decreased	R0052	**Citation #2 R 052 410 IAC 16.2-5-1.2(v) (1-6) Resident Rights-offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident A no longer resides at Bell Oaks Terrace. PSA #2 was suspended upon learning of the incident and later terminated upon completion of Bell Oaks Terrace's internal investigation into the alleged occurrence. **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. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** Bell Oaks staff were re-educated to our policy and procedure regarding resident abuse and neglect and our ALC reporting requirements. The Wellness Director and/or	07/30/2012

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	mental status...." A Service Plan Summary, dated 5/16/12, included: "...Resident requires assistance with eating. Hospice Aid/Nurse to assist one meal daily. Staff to assist all other meals...." A hospice aide visit note, dated 5/21/12, indicated, "...NA [name] Notified of: Pt call light was taped to wall. Facility staff aware of problem...." On 6/6/12 at 11:50 A.M., CNA # 3 was interviewed. CNA # 3 indicated she was working 2nd shift, and CNA # 2 came in Resident A's room. CNA # 3 indicated Resident A had been playing with his call light string earlier in the shift, and CNA # 2 stated, "We're not having that." CNA # 2 then proceeded to use the tape off of an incontinence brief, and taped the call light string to the wall. CNA # 2 told CNA # 3 she "was not going to deal with that all night." CNA # 3 indicated she took the call string down after CNA # 2 left the room. CNA # 3 indicated, "I guess the call string was taped back up the next morning." CNA # 3 indicated she did not report the incident to the nurse. CNA # 3 indicated, "I know I should have told the nurse." During further interview with CNA # 3,		Designee will be responsible to ensure continued compliance with the following policies and procedures as noted within the Indiana State regulation R 052410 IAC 16.2-5-1.2(v) (1-6) Resident Rights. **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 reviews of incident reports, documentation, and rounds of the residence to ensure continued compliance with Indiana state regulation R 052410 IAC 16.2-5-1.2(v) (1-6) Resident Rights for a period of six months. Findings will be reviewed through our Bell Oaks Terrace QA process after six months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** July 30, 2012	

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	she indicated she had observed CNA # 1 feeding Resident A. CNA # 1 indicated, "Watch this," and poked the resident's lips a few times with a fork. CNA # 1 then would put the resident's fork in the resident's mouth and let it stay a few seconds and pull it out, laughing. CNA # 3 indicated she did inform the Residence Director. CNA # 3 indicated the private sitter asked her to write a statement. On 6/6/12 at 10:40 A.M., the Residence Director provided an "Indiana State Department of Health Incident Report Form." The form included: "...Incident Date: 5/21/12...Resident Name: [Resident A]...Diagnosis...Probable Dementia...Staff Name: [CNA # 1], Staff Name: [CNA # 2]. Brief Description of Incident: It was reported this AM by a private duty caregiver of [Resident A] that his call light had been taped to the wall out of reach by the resident. It was further reported that when [CNA #1] fed the resident (with a fork) she would poke at his lower lip in an attempt to get the resident to open his mouth...Both C.N.A.s were suspended pending further investigation. Resident's call light was placed in reach and all staff were re-inserviced as to call light in reach and feeding resident." Included with the report was a document,			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	dated 5/20/12, which indicated: "To whom it may concern: I (CNA # 3) have witnessed that when [CNA # 1] is feeding [Resident A], she is poking his lip [with] the fork thinking it is funny and she leaves the fork in his mouth for a few seconds til it falls out of his mouth. I have witnessed this several times, and have reported to [Residence Director] the administrator...." Included with the report form were "Resident Administrative Notes." A note, dated 5/28/12, indicated, "This writer received call from [CNA # 2]...employee admitted she had placed call light on wall and taped because resident had wrapped string around his hand earlier that day. Employee acknowledged violation and employee was termed [sic] for violation of facility policy and Resident Rights." On 6/7/12 at 9:05 A.M., during interview with the Residence Director, she indicated she had spoken with CNA # 2, and CNA # 2 indicated she taped the call light string to the wall to keep the resident from playing with it. The Residence Director indicated Resident A did not ever use his call light, and CNA # 2's intent was not to keep the resident from using it. During further interview with the Residence Director, she indicated she had			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	never seen CNA # 1 jab at Resident A's lip. She indicated CNA # 1 told her that she always used a spoon to feed the resident, and she knew that was not true. The Residence Director indicated other staff told her they saw CNA # 1 poke the resident with a fork, and that CNA # 1 was terminated. 2. On 6/6/12 at 10:30 A.M., the Residence Director provided the current facility policy on "Abuse/Neglect/Exploitation," dated 6/2008. The policy included: "Any complaints of abuse, neglect or exploitation should be viewed as very serious and must be reported to your Regional Director of Operations immediately...Abuse may be defined as an act by any individual which injures, exploits or in any way jeopardizes an individual's health, welfare, or safety...Neglect may be defined as conduct resulting in the deprivation of care necessary to maintain an individual's minimum physical and mental health including: physical and material deprivation...lack of resident care...If abuse, neglect or exploitation of a resident is suspected, act immediately to protect the resident from additional harm...." This state finding relates to Complaint IN00108966.			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview, and record review, the facility failed to update residents' service plans in regard to fall prevention, for 2 of 3 residents reviewed for falls, in a sample of 5. Residents A and E Findings include:	R0217	**Citation #3 R 217 410 IAC 16.2-5-2(e) (1-5) Evaluation-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident A and resident E no longer resides	07/30/2012

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	1. On 6/6/12 at 11:10 A.M., Resident A was observed sitting in his recliner. CNA # 3 indicated she was going to transfer the resident from the recliner to the wheelchair to his bed. CNA # 3 and a private caregiver assisted the resident with much encouragement to stand and pivot to his wheelchair, and then stand and pivot to the bed. CNA # 3 indicated the resident no longer ambulated. The clinical record of Resident A was reviewed on 6/6/12 at 12:00 P.M. Diagnoses included, but were not limited to, probable dementia. A Nursing Comprehensive Evaluation, dated 10/25/11, indicated the resident had an impaired memory, was continent of bowel and bladder, and was independent with transferring, ambulation, and hygiene. Resident Services Notes included the following notations: 4/10/12 at 7:30 A.M.: "CNA reported to this nurse resident on floor, entered room noted resident on floor on left side in front of w/c [wheelchair], fully dressed, shoes intact...denies pain...Resident assisted up [with] [two] assist...resident to be assisted to common area [after] getting		at Bell Oaks Terrace **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. **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, and staff were re-educated to our policy and procedure regarding resident fall protocol, documentation, and service planning. The Wellness Director and/or Designee will be responsible to ensure continued compliance with the following policies and procedures. **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 reviews of incident reports, documentation, and service planning to ensure continued compliance with our policies and procedures for a period of six months. Findings will be reviewed through our Bell Oaks Terrace QA process after six months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will	

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	up in w/c to prevent reoccurrence [sic]." 4/11/12 at 7:30 A.M.: "CNA reported to his nurse resident on floor, entered resident's room, noted resident on knees @ bedside [with] head in space between headboard [and] mattress, staff moved furniture out of way to assist resident to seated position on floor...abrasion to [left] knee...resident assisted to w/c [with] [two] assist, head board removed from bed [and] bed placed against wall to prevent reoccurrence...." 4/23/12 at 10:50 A.M.: "Another resident reported to this nurse resident on floor in activity room, entered activity room, noted resident on floor in front of w/c, fully dressed [with] shoes intact, lying on [right] side...assist up [with] [two] assist...hospice to eval [evaluate] w/c for appropriateness [and] positioning to prevent reoccurrence...." 5/2/12 at 10:50 A.M.: "Hospice rep here to eval w/c, states resident on floor, this nurse entered activity rm, noted resident on floor on [left] side in front of w/c...assisted up [with] 2 assist, therapy to bring new w/c for better positioning to prevent reoccurrence...." A hospice note, dated 5/7/12, indicated, "...totally dependent on ALF [assisted		result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** July 30, 2012	

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	living facility] and hospice for all ADL's [activities of daily living] D/T [due to] tremors and decreased cognition; full assist w [with] transfers; decreasing cognition...frequent falls D/T decreased mental status...." Resident Services Notes continued: 5/11/12 at 9:50 P.M.: "Resident found per QMA on floor @ HOB [head of bed]...No injury noted. [Right] side of bed against wall - floor mats on [left] side of bed on floor, low bed [with no] headboard...." 5/23/12 at 6:40 A.M.: "This nurse entered the room to find res. [resident] on the floor in front on his recliner. Fall mats et [and] call light were in place...." 5/23/12 at 6:45 P.M.: "...Resident was in dining room in w/c et slid out onto [right] side on floor...." A Service Plan, dated 5/16/12, included: "Resident is incontinent of bowel and bladder...Resident is dependent on staff for dressing, grooming and hygiene...Resident at risk for falls. WC [wheelchair] seating/positioning has been evaluated with chair provided by Therapy One/Hospice. Resident has low bed with safety mats to floor when in bed. Scoop mattress." The Service Plan indicated the			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	resident had fallen in the last month, and required assistance with mobility. The previous service plan/nursing comprehensive evaluation, dated 10/25/11, did not document interventions to prevent falls. On 6/7/12 at 11:05 A.M., during interview with the Residence Director, she indicated the family was seeking placement in a skilled nursing facility for Resident A due to his decline. The Residence Director offered no further information regarding the service plan and fall prevention interventions. 2. The clinical record of Resident E was reviewed on 6/7/12 at 10:15 A.M. Diagnoses included, but were not limited to, dementia. Resident Services Notes included the following notations: 4/2/12 at 4:35 P.M.: "CNA notified nurse resident on floor in bathroom [after] was transferring self from toilet to w/c [wheelchair] (unlocked) et [and] slid to floor. [Did not] use call cord...." 4/12/12, untimed: "This nurse found resident on floor beside his bed @ 0430 AM. Res. [resident] states 'he was trying to get out of bed to go to toilet [and]			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	fell'...Three people assisted resident off the floor...." 4/26/12 at 8:30 P.M.: "CNA reported finding resident on bathroom floor...was going to sit in w/c - w/c moved et resident sat down on floor. W/C brakes [not] locked...." 5/1/12 at 4:05 A.M.: "Res. yelling for help. This nurse entered room found Res on floor @ foot of bed...Laceration to forehead [with] blood draining down temple/cheek...instructions to call 911 et transport to E.R. d/t [due to] head inj. [sic]...." The resident returned to the facility on 5/1/12 at 8:30 A.M. with physician orders indicating "Apply ice to area QID [four times a day] x 20 min [and] PRN [as needed], call MD if any s/s [signs or symptoms] of concussion." A Resident Services Note, dated 5/15/12 and untimed, indicated, "...hospice services in place...Some difficulty noted with R [right] sided weakness secondary to CVA or when resident becomes tired...For safety resident is 2 p transfer to bed as he at times is unsteady...." A Service Plan, dated 5/16/12, included: "...Have you ever fallen? In the last			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	month...Resident can bear weight and stand by grabbing onto bar in bathroom. Resident can assist with transfers however at times when tired requires 2P [two person] transfer assistance. For safety reasons resident should always be transferred with the assistance of two persons...." Documentation regarding interventions for fall prevention was lacking on the service plan. On 6/7/12 at 10:40 A.M., CNA # 4 and QMA # 1 indicated they were going to transfer Resident E from the wheelchair to bed. With extensive assistance of the two staff, the resident stood and pivoted to bed. The resident kept his eyes closed, and barely responded when spoken to. Mats were observed on either side of the resident's bed. CNA # 4 indicated the mats were there "for when he falls again." On 6/7/12 at 11:05 A.M., during interview with the Residence Director, she indicated Resident E was one of the residents the facility was awaiting approval for to transfer him to a skilled nursing facility. The Residence Director offered no further information regarding the service plan and lack of fall prevention interventions. 3. On 6/7/12 at 11:30 A.M., the Residence Director provided the current			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	facility policy on fall prevention, dated 6/2008. The policy included: "...The Residence Director shall consult with the regional team to determine other on-site interventions such as: Internal Prevention...The Wellness Director should assess the resident after the fall. The assessment/evaluation should include...the Wellness Director's contacts and interventions provided and any measures implemented to prevent further occurrences of falls and document in the Resident Service Notes. It is recommended that the Residence Director or Wellness Director contact the Regional Director...for any resident who falls two or more times in one month to obtain assistance in developing a proactive plan for preventing future falls...." This state finding relates to Complaint IN00108966.			

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0406	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation and interview, the facility failed to ensure soap was provided by the facility for each resident room, potentially affecting 40 current residents. Findings include: On 6/6/12 at 3:45 P.M., during interview with CNA # 3 and CNA # 5, following observation of care, the two CNAs were observed to wash their hands with soap and water in a resident room. When interviewed regarding the provision of soap, CNA # 3 indicated hospice provides soap for the residents who have hospice, and most of the other residents have soap in their rooms. When queried what they do if they don't have soap, CNA # 3 indicated, "I guess we would go to another resident's room or somewhere." CNA # 5 indicated she carried hand sanitizer in her pocket. CNA # 3 indicated she did not have any in her pocket at that time. On 6/7/12 at 10:40 A.M., during interview with QMA # 1 and CNA # 4,	R0406	**Citation #4 R 406 410 IAC 16.2-5-12(e) Infection Control-Offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **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. **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 and Wellness Director were re-educated to Indiana State ruling R 406410 IAC 16.2-5-12(e) Infection Control. The Residence Director and/or Designee will be responsible to ensure soap and paper towels are provided within our residents rooms in order to ensure continued compliance with the above referenced citation. **How will the corrective action(s) will be monitored to ensure the deficient practice**	07/30/2012

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 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	CNA # 4 indicated if a resident room did not have soap, she would use hand sanitizer. CNA # 4 indicated she did not have hand sanitizer in her pocket. CNA # 4 indicated she knew all of the residents currently had hand soap, because she bought some for everyone. CNA # 4 indicated the facility had soap in gallon containers, but did not have dispensers for the soap. On 6/7/12 at 11:05 A.M., during interview with the Residence Director, she indicated the facility did keep gallon containers of soap, but did not have dispensers. The Residence Director indicated the marketing director developed a checklist that families can check which addresses if they will buy handsoap, or wish for the facility to obtain it. The Residence Director indicated staff should keep hand sanitizer on them at all times. This state residential finding relates to Complaint IN00108966.		**will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random weekly rounds of the residence to ensure paper towels and soap are available within the residents rooms for a period of six months. Findings will be reviewed through our Bell Oaks Terrace QA process after six months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** July 30, 2012	