

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 05/22/2014
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 21-22, 2014</p> <p>Facility Number: 004903 Provider Number: 004903 AIM Number: N/A</p> <p>Survey Team: Barbara Fowler RN TC Denise Schwandner RN Diana Perry RN Anna Villain RN Diane Hancock RN 5/21/2014</p> <p>Census Bed Type: Residential: 34 Total: 34</p> <p>Census Payor Type: Other: 34 Total: 34</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with with 410 IAC 16.2.</p> <p>Qulaity review completed on May 27, 2014 by Jodi Meyer, RN</p>	R000000	<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 employee, 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.

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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			
R000036	<p>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.</p> <p>Based on record review and interview, the facility failed to notify the physician of a resident with low blood sugar results in 1 of 1 residents reviewed in a total sample of 7 residents who had diabetes mellitus and were receiving insulin coverage and hyperglycemic medications.. (Resident #29)</p> <p>Findings include:</p> <p>Resident #29's clinical record was reviewed on 5/21/14 at 10:45 a.m. Resident #29 had diagnoses including, but not limited to, diabetes mellitus type 2 (two), pulmonary fibrosis, and dementia.</p> <p>Resident #29 had a physician's order, dated 6/4/13, which indicated the resident was to receive Glucagon (a medication</p>	R000036	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #29 did not have an order to notify the attending physician for blood sugars below 70; however, resident #29 will be re-assessed by the Care Service Manager (CSM) and in consultation with attending physician will determine appropriate plan of care related to management of diabetes and blood sugar management. 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? Diabetic residents will be reviewed by the CSM and in consultation with their attending physicians will determine appropriate plan of care related to management of diabetes and blood sugar management. Any</p>	06/23/2014			

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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>used for hypoglycemia) 1 mg injected every hour for a blood sugar less than 70 mg/dl (milligram per deciliter) and Glucose Gm (grams) 4 chew 3 (three) tablets every 15 minutes for a blood sugar less than 70 mg/dl. The order further indicated the resident must be alert and not at risk for aspiration.</p> <p>The "Blood Glucose Monitoring" form indicated Resident #29 had a blood sugar obtained at "0600" (6:00 a.m.) on 5/14/14. The results indicated the blood glucose was 60 mg/dl.</p> <p>The "Blood Glucose Monitoring" form indicated Resident #29's blood glucose on 5/15/14 at 6:00 a.m. was 67 mg/dl.</p> <p>The "Nurse's Medication Notes," dated May 2014, indicated Resident #29 had a blood sugar of 45 mg/dl and received "Gluco [sic] tabs." The form further indicated Resident #29 had a follow-up blood glucose of 120 mg/dl. The notes lacked any documentation of the time of the initial blood glucose, the time the medication was given, or the time of the follow-up blood glucose.</p> <p>The MAR (Medication Administration Record), dated May, 2014, lacked any documentation indicating Resident #29 had received the Glucose tablets from</p>		<p>resident in the facility being assessed to have a change of condition will be placed on a short-term monitor which will include but will not be limited to documentation every shift as to the acute change as well as documentation of notification to the physician and responsible party. What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur? The CSM has been educated as to policies and procedures relating to notification of change of condition of a resident and reporting responsibilities to primary care physicians and responsible parties. The CSM will then re-educate all nursing staff responsible for assessment and medication administration as to same policy and procedure as well as the need for specific documentation related to the monitoring of blood sugars and related interventions and documentation.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CSM and/or Designee will audit diabetic residents' blood sugars and related follow up daily for a period of three months then weekly for</p>				

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 05/22/2014
--	---	--	---

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

(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>May 1, 2014 through May 21, 2014.</p> <p>The "Resident Service Notes" lacked documentation Resident #29 had received the medication for the hypoglycemia episodes or that the physician had been notified regarding the hypoglycemic episodes.</p> <p>During an interview on 5/21/14 at 4:10 p.m., LPN #1 indicated she had done the follow-up blood glucose on 5/21/14 at approximately 6:00 a.m. LPN #1 indicated the QMA (Qualified Medication Aide) on the night shift had obtained Resident #29's blood sugar "probably around 5:00 a.m. and was given the Glucose tablets at that time."</p> <p>During an interview on 5/21/14 at 5:25 p.m., the CSM (Case Service Manager) indicated she had not had time to go over Resident #29's clinical record. She indicated she had only been employed with the facility since April, 2014. The CMS further indicated the sliding scale insulin order was not an acceptable standard of practice and she would be notifying the physician regarding Resident #29's orders.</p> <p>A policy titled, "Change of Condition," dated 1/1/13, and obtained from the ED (Executive Director) on 5/21/14 at 1019,</p>		<p>an additional three months to ensure continued compliance. Findings will be reported and reviewed by the Bell Oaks Place QA process in determination as to the need for the ongoing monitoring plan based on findings regarding the above mentioned timeframe.</p>	

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 05/22/2014
--	---	--	---

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

(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
R000144	<p>indicated the Wellness Director, Healthcare Coordinator, or designee is responsible for making appropriate notifications and putting appropriate interventions in place.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the building was maintained in good repair, in that, window screens were broken, drywall/paint was chipped, and a black/green mold-like substance was observed in the common areas.</p> <p>Finding includes: On 5/21/14 at 9:15 a.m., the following was observed:</p> <p>1. The carpets outside of the dining area, the activity area, and upstairs lounge area were stained with large, black, discolored circles.</p>	R000144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? The carpet in the common areas is cleaned routinely through an outside service with additional spot cleaning by Bell Oaks Place staff in between cleanings. On 5/30/14 with the routine carpet cleaning, additional stain remover was applied in an effort to combat the reappearance of stains in high traffic areas. The screen noted to be in need of repair will be replaced. Areas identified as needing drywall repair and touch up paint will be completed by the Maintenance Director of designee. The black/green substance noted at the hookup of</p>	06/23/2014

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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>2. A window screen was broken on the South 100 Hall.</p> <p>3. Chipped paint was on the molding behind the hand rail at the end of the South 100 Hall.</p> <p>4. Chipped drywall/paint was behind the chairs at a sitting area on the South 100 Hall.</p> <p>5. Chipped drywall/paint was at the sitting area upstairs.</p> <p>6. Bubbling paint was below the upstairs water fountain.</p> <p>7. Chipped paint/drywall was outside the housekeeping area.</p> <p>8. A black/green mold-like substance surrounded the washer/dryer hookups in the upstairs laundry area.</p> <p>On 5/22/14 at 8:09 a.m., the same was observed.</p> <p>On 5/22/14 at 10:45 a.m., the housekeeper was interviewed. The housekeeper indicated a private company is responsible for cleaning the carpets.</p> <p>On 5/22/14 at 12:45 p.m., the ME #1</p>		<p>the washer and dryer was cleaned. 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? All residents of have potential to be affected by this practice. What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur? The Executive Director will re-educate the Maintenance Director and Housekeeper of expectations of daily rounds, tasks and general maintenance in maintaining the building. The Housekeeping schedule is being revised to more specifically identify common area assignments and expectations of housekeeping and designated staff. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Executive Director and/or Designee will make building rounds daily to monitor for maintenance and/or housekeeping issues and will follow up as needed to ensure repairs and cleaning are completed. Daily monitoring will be completed for a period of three months then weekly for an additional three months to ensure continued compliance. Findings</p>				

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 05/22/2014
--	---	--	---

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

(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
R000154	<p>(Maintenance Employee) indicated the building was inspected daily for damaged areas in the morning and again in the afternoon. The ME #1 further indicated damaged areas were repaired on a weekly basis unless the damage was severe. The ME #1 indicated he is responsible for the washer/dryer maintenance, which was completed weekly.</p> <p>On 5/22/14 at 12:50 p.m., the Executive Director indicated maintenance was responsible for assessing the building for damage. She further indicated it should be done on a daily basis.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, record review, and interview the facility failed to ensure foods were stored in appropriate containers, failed to ensure opened foods were dated and expired foods were discarded, failed to ensure frozen foods were on appropriate shelves in the</p>	R000154	<p>will be reported and reviewed by the Bell Oaks Place QA process in determination as to the need for the ongoing monitoring plan based on findings regarding the above mentioned timeframe.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Ongoing monitoring and audits of the kitchen area will be conducted by the Chef, Executive Director or designee to ensure that: Foods are stored in appropriate containers, Foods are</p>	06/23/2014

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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>freezer, failed to ensure utensils were clean and not left in containers of food, failed to ensure floors were clean and failed to ensure the handwashing sink was kept in good repair. These observations were made during 2 of 2 kitchen observations. This had the potential to affect 34 of 34 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial kitchen tour, on 5/21/14 at 9:25 a.m., with the Assistant Chef present, the following observations were made:</p> <ol style="list-style-type: none"> 1. A spoon was observed in a container of sugar. 2. A cup of yogurt was observed in the refrigerator with an expiration date of 4/19/2014 on it. 3. Bleu Cheese was found in an old pickle jar in the freezer which was dated 3/14/14. 4. The handwashing sink was observed to be pulled away from the wall and had cracked caulking. 5. A knife holder was located at the end of the preparation table. The knife holder 		<p>covered, dated and stored appropriately and that expired foods are discarded, that frozen foods are stored on appropriate shelves in the freezer, and that utensils are clean and not left in containers of food. The floors to the main kitchen are cleaned nightly with a product (Wash and Walk) specific for the type of tile in place and it was explained to the surveyor by the Executive Director there are enzymes in the cleaner that break down the dirt, but at times there can be a sticky appearance after the cleaning is completed. The hand washing sink will have new caulk applied to the wall in the kitchen. 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? All residents have potential to be affected by this practice. What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur? The Chef and other kitchen staff are being re-educated as to kitchen safety and sanitation. The Executive Director, Chef or designee will perform daily monitoring and follow up as to kitchen cleanliness, appropriate food storage, and overall compliance with the above referenced regulation regarding kitchen safety and sanitation.</p>				

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 05/22/2014
--	---	--	---

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

(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>and the knife handles were greasy to touch.</p> <p>6. An open bag of rice and an open box of rice were on a storage shelf in the dry storage room with no open dates on them.</p> <p>7. Eight (8) "Lean Cuisine" dinners were in a basket on the floor in the freezer with ice on them. Water was observed to be dripping from the cooler unit onto the dinners.</p> <p>8. The floors in the main kitchen were observed to be sticky.</p> <p>On 5/22/14 at 8:32 a.m. a tour of kitchen reflected the same findings as 5/21/14.</p> <p>During an interview on 5/21/14 at 9:40 a.m., the Assistant Chef indicated it was the responsibility of the chef to maintain the kitchen area as far as expiration dates, uncovered foods, and overall cleanliness of the kitchen were concerned. The Assistant Chef also indicated she was responsible for sweeping the floors but a CNA (certified nursing assistant) was to mop the floors during the night..</p> <p>A policy titled, "Kitchen Sanitation and Safety," dated 1/1/13 and obtained from the ED (Executive Director) on 5/22/14 at 1:00 p.m., indicated a schedule for</p>		<p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Daily monitoring will be completed for a period of three months then weekly for an additional three months to ensure continued compliance. Findings will be reported and reviewed by the Bell Oaks Place QA process in determination as to the need for the ongoing monitoring plan based on findings regarding the above mentioned timeframe.</p>	

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 05/22/2014
--	---	--	---

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

(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
R000214	<p>routine and deep cleaning should be maintained and followed.</p> <p>A policy titled, "Storage of Products," dated 1/1/13 and obtained from the ED on 5/22/14 at 1:00 p.m., indicated dry storage is appropriate for foods that are non-perishable, such as flour, sugar, salt ,dry cereals.... Items should be dated before being stored."</p> <p>The "Tasks Sheet and Weekly Cleaning Schedule for Cook and DSC (Dietary Sous Chef)," dated 1/1/13 and obtained from the ED on 5/22/14 at 1:00 p.m., indicated the floors should be mopped and the prep area cleaned daily,.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial</p>			

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 05/22/2014
--	---	--	---

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

(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>change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to evaluate a resident for a respiratory treatment in 1 of 1 resident in a total sample of 7 residents reviewed who had nebulizer treatments ordered. (Resident #29)</p> <p>Findings include:</p> <p>Resident #29's clinical record was reviewed on 5/14/14 at 10:45 a.m. Resident #29 had diagnoses including, but not limited to, pulmonary fibrosis, diabetes mellitus type 2, and dementia.</p> <p>Resident #29 had a physician's order, dated 4/11/14, for Duoneb 0.5-2.5 - 3 mg/ml (milligram/milliliter), give 3 ml by nebulizer every 6 hours prn (as needed) for wheezing.</p> <p>A "Resident Services Notes," dated April 11, 2014, indicated Resident #29 had labored respirations with auditory wheezing, The note indicated "rhales [sic] and expiratory wheezes were present bilaterally." The note further indicated Resident #29 was taken to the Emergency Department at 11:55 a.m. by his daughter.</p>	R000214	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #29 will be re-assessed by the CSM as to respiratory status and in consultation with attending physician will determine appropriate plan of care related to management of respiratory needs. 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? Residents whom have current orders for nebulizer treatments have the potential to be affected by this practice and will be re-assessed by the CSM as to respiratory status and in consultation with attending physician will determine appropriate plan of care related to management of their respiratory needs. What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur? The CSM has been educated as to policies and procedures relating to evaluation of resident respiratory status and appropriate follow up as well as general evaluation of residents</p>	06/23/2014

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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 "Resident Services Notes," on April 11, 2014 at 4:35 p.m., indicated the facility had received a call from Resident #29's pharmacy who indicated they were unable to fill the prescription for the nebulizer machine.</p> <p>A "Resident Services Notes," dated April 11, 2014 at 4:37 p.m., indicated Resident #29's daughter was left a voicemail with the number of the facility to call.</p> <p>The MARs (Medication Administration Record) for April, 2014, and May, 2014, lacked documentation Resident #29 received any nebulizer treatments from April 11, 2014 through May 21, 2014.</p> <p>No further documentation of Resident #29's respiratory status was documented.</p> <p>During an interview on 5/14/14 at 4:10 p.m., LPN #1 indicated Resident #29 had not requested nor received the nebulizer treatments after returning from the ER. Upon further query, LPN #1 indicated Resident #29 would not have known to request the treatments due to his dementia and short term memory loss. LPN #1 further indicated no further evaluation was documented for Resident #29's respiratory status.</p>		<p>and reporting responsibilities to primary care physicians and responsible parties. The CSM will then re-educate all nursing staff responsible for assessment and medication administration as to same policy and procedure as well as the need for specific documentation related to the monitoring of respiratory status and related interventions. Any resident in the facility being assessed to have a change of condition will be placed on a short-term monitor which will include but will not be limited to documentation every shift as to the acute change as well as documentation of notification to the physician and responsible party. The CSM will monitor residents with current orders for nebulizer treatments to ensure appropriate assessment, administration and follow up monitoring related to respiratory status and nebulizer treatments is completed and documented.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CSM and/or Designee will monitor and audit current residents with nebulizer orders and those on the short term health monitor for pertinent individual resident documentation to ensure appropriate assessment, reporting, follow up and documentation is completed.</p>				

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 05/22/2014
--	---	--	---

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

(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
R000246	<p>A policy titled, "Change of Condition," dated 1/1/13 and obtained from the ED on 5/22/14 at 10:19 a.m., indicated the Wellness Director may direct staff regarding additional monitoring or interventions...</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications administered by a QMA (Qualified Medication Aide) were authorized and co-signed by a licensed nurse for 3 of 7 residents reviewed. (Resident #32, Resident #12, Resident #24)</p>	R000246	<p>Auditing will be completed by the CSM or designee daily for a period of three months then weekly for an additional three months to ensure continued compliance. Findings will be reported and reviewed by the Bell Oaks Place QA process in determination as to the need for the ongoing monitoring plan based on findings regarding the above mentioned timeframe.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? CSM was educated on the requirements for ensuring medications administered by a QMA are properly authorized and co-signed by a licensed nurse. CSM will then inservice all QMAs and licensed nurses on the same.</p>	06/23/2014

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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>Finding includes:</p> <p>1. On 5/21/14 at 10:45 a.m., Resident #32's clinical record was reviewed. Resident #32's MAR (Medication Administration Record) for 5/1/14 through 5/31/14 indicated Resident #32 received a prn (as needed) administration of Norco (a medication for the treatment of pain) on 5/13/14. LPN #1 indicated the medication had been given by a QMA (Qualified Medication Aide). The MAR lacked documentation of a nurse's prior authorization to administer the medication.</p> <p>On 5/22/14 at 9:15 a.m., the Executive Director provided a copy of the MAR. The MAR was reviewed at that time and noted to have unknown initials next to the QMA initials.</p> <p>On 5/22/14 at 9:25 a.m., the Executive Director was queried about the new initials. The Executive Director indicated the Case Service Manager signed the MAR the morning of 5/22/14 because the Case Service Manager was unaware a co-sign was required following a QMA prn medication administration.</p> <p>On 5/22/14 at 10:03 a.m., the Case Service Manager was interviewed. She</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? All residents have potential to be affected by this practice. What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur? CSM was educated on the requirements for ensuring medications administered by a QMA are properly authorized and co-signed by a licensed nurse as well as required documentation in resident care notes as to time and who authorized. CSM will then inservice all QMAs and licensed nurses on the same.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CSM and/or designee will audit PRN administration of QMAs on MARs and related documentation in resident care notes daily for a period of three months then weekly for an additional three months to ensure continued compliance. Findings will be reported and reviewed by the Bell Oaks Place QA process in determination as to the need for the ongoing monitoring plan based on findings regarding the</p>				

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 05/22/2014	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
(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 she was unaware an evaluation needed to be documented following a QMA prn medication administration.</p> <p>On 5/22/14 at 1:40 p.m., the Executive Director provided the "Qualified Medication Aides" policy. The policy indicated, "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call." The policy further indicated, "Ensure the resident's record is co-signed by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty."</p> <p>2. On 5/21/14 at 2:45 p.m. the May, 2014, MAR (Medication Administration Record) indicated Resident #12 had been administered Phenergan (an antiemetic) 25 mg (milligrams) on 5/15/14 at 12:30 p.m. by QMA (Qualified Medication Aide) #1.</p> <p>The MAR and nurses notes, dated May, 2014, lacked any documentation the Phenergan had been given and failed to have documentation of authorization by a licensed nurse or physician for the PRN (as needed) medication.</p> <p>3. On 5/21/14 at 3:00 p.m., LPN #1 was</p>		above mentioned timeframe.				

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 05/22/2014
--	---	--	---

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

(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>observed to co-sign a prn given by QMA #1 for Resident #12. The medication had been given on 5/15/14. LPN #1 indicated she was the nurse working that day and she had forgotten to co-sign the medication.</p> <p>4. Resident #24's clinical record was reviewed on 5/21/14 at 4:00 p.m. Resident #24 had a physician's order, dated 1/31/14 for Norco (a narcotic medication for the treatment of pain) 7.5 mg (milligram) orally every 8 hours prn (as needed) for pain and Melatonin (a supplemental aide for sleep) 6 mg orally every bedtime prn for insomnia.</p> <p>A MAR (Medication Administration Record), dated May 1 through May 31, 2014, indicated Resident #24 received a prn (as needed) administration of Norco (a narcotic medication for the treatment of pain). The medication had been given by a QMA (Qualified Medication Aide). Resident #24 received the medication as followed:</p> <p>A. 5/4/14 at 3:30 a.m. B. 5/5/14 at 9:00 p.m. C. 5/8/14 at 8:00 p.m. D. 5/9/14 at 8:00 p.m. E. 5/10/14 at 3:00 a.m. F. 5/10/14 at 8:00 p.m.</p>			

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 05/22/2014
--	---	--	---

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

(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. 5/12/14 at 8:00 p.m.</p> <p>The MAR, dated May 1, 2014 through May 31, 2014, indicated a QMA had administered the Melatonin to Resident #24 as followed:</p> <p>A. 5/8/14 at 8:00 p.m. B. 5/9/14 at 8:00 p.m. C. 5/12/14 at 9:00 p.m.</p> <p>The MAR lacked documentation of a nurse's prior authorization to administer the medications or to co-sign the medications.</p> <p>During an interview on 5/21/14 at 3:30 p.m.. LPN #1 indicated the QMA was to notify the Case Service Manager to receive authorization to administer a PRN medication.</p>			