

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 03/30/2012
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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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00104848.</p> <p>Complaint IN00104848 - Substantiated. A state residential deficiency related to the allegation is cited at R0091.</p> <p>Survey dates: March 22, 23, 26, 27, 28, 29, and 30, 2012</p> <p>Facility number: 004903 Provider number: 004903 AIM number: N/A</p> <p>Survey Team: Diane Hancock, RN TC Vickie Ellis, RN Barbara Fowler, RN (3/22, 3/23, 3/26, 3/27, 3/28, and 3/29/12) Amy Winger, RN (3/22 and 3/23/12)</p> <p>Census bed type: Residential: 41 Total: 41</p> <p>Census payor type: Other: 41 Total: 41</p> <p>Sample: 7 Supplemental sample: 11</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 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.

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	<p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 4/5/12 by Jennie Bartelt, RN.</p>			

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R0002	<p>410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who required comprehensive nursing care were discharged in accordance with the rules, for 2 of 2 sampled residents who were observed to require assistance with bathing, grooming, transferring, toileting, and eating/hydration, in the sample of 7, in that the residents required increased assistance, the assistance was not being provided as needed, and the residents continued to reside at the facility. Residents were developing pressure areas and/or experiencing falls due to lack of assistance. (Residents #22, #27)</p> <p>Findings include:</p> <p>1. During the initial tour, on 3/22/12 at 10:40 a.m., CNA #1 indicated Resident #22 was incontinent and wore incontinence briefs, required two persons to transfer from surface to surface, was being followed by a hospice provider and had no skin issues.</p> <p>On 3/22/12 at 12:00 noon, CNAs #1 and #2 indicated Resident #22 was in a lot of pain and they would be taking her meal to</p>	R0002	<p>We respectfully disagree with the below citation and would like to introduce for your review additional documentation by way of the face to face Informal Dispute Resolution in an effort to overturn this finding. SCOPE OF RESIDENTIAL CARE-OFFENSE What corrective action will be accomplished for those residents found to have been affected by this deficient practice? No other residents were found to be affected. Resident #22 was reviewed and determined to require alternative placement due to the further deterioration in clinical status as of March 14, 2012. Bell Oaks Terrace assisted the resident in finding placement at Cypress Grove prior to survey entry however was delayed due to SWIRCA pre-screening. Despite providing necessary documentation to the surveyors upon query the resident was still cited. Resident #22 no longer resides at the Bell Oaks Terrace. Resident #27 was re-assessed utilizing the Service Level Assessment and Negotiated Service Plan as to the appropriateness and continued stay at Bell Oaks Terrace. Resident #27 is able to demonstrate ability to bear weight</p>	05/20/2012			

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	<p>her room to try to feed her. At 12:15 p.m., CNA #2 indicated she had fed the resident the chicken and rice, but not the carrots as the resident didn't like the carrots. The CNA indicated the food was pureed, however it was observed to have larger pieces of food in the mixtures of both the meat and rice and the carrots. She indicated she left the glass of water in the resident's room so they could "push fluids."</p> <p>The Wellness Director indicated, at 12:15 p.m. on 3/22/12, the resident would be moving to a local facility certified to provide comprehensive care the following week. On 3/27/12 at 3:40 p.m., the Wellness Director and Regional Administrator indicated it would be a couple more weeks, since the local agency on aging was requiring additional mental health assessments.</p> <p>On 3/22/12 at 3:10 p.m., Resident #22 was observed seated in her recliner, reclined back, with food particles in her mouth. There was a full glass of water out of reach of the resident, on the table beside her chair. The resident did not have access to a call light; it was on the wall across the room. She did not have a pendant call light on her person. The resident's hands were sticky and her fingernails were long and soiled.</p>		<p>as referenced within the citation indicating resident does not meet criteria by definition of total dependence with transfer. Resident is able to participate in assisting himself with feeding and is considered not to meet the definition for total feeding based on Indiana definition of total feed. 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. Residents at Bell Oaks Terrace had their current service plans reviewed and were found to be appropriate for continuing stay at Bell Oaks Terrace. Bell Oaks Terrace will continue to review residents prior to admittance, semi-annually and upon a change of condition to ensure continued compliance with the above referenced regulation R 002 410 IAC 16.2-5-0.5 (b) scope of residential care. 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 Residence Sales Manager were re-educated as to the above referenced citation R 002 410 IAC 16.2-5-0.5 (b) Scope of Residential Care, Service Level Assessment and Negotiated Service Plan per our policy and procedure as defined within our residency agreement. The House</p>				

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	<p>On 3/23/12 at 8:32 a.m., Resident #22 was observed to be up in her recliner chair, reclined, with the newspaper in her lap. A glass of water was present on the table 3 feet away from the resident. It was full and had orange food residue on the rim. The resident was moaning and calling out. She was asked if she was in pain and she indicated "yes." There was no call light or pendant for the resident to summon help. The resident's hands were sticky and her nails were long and soiled.</p> <p>At 8:40 a.m. on 3/23/12, CNA #2 was observed to transfer Resident #22 from her recliner chair to a wheelchair. She reached around the resident and lifted the resident to a standing position, at which time, the resident did bear some weight. She was observed to be very thin. The CNA indicated, "When she's hurting this bad, we wait to take her to breakfast until it's ready." CNA #2 indicated the resident had been gotten up that morning and put in her recliner chair when the CNA arrived at work, 6:15-6:30 a.m. The resident was assisted to the dining room. The CNA fed the resident a mixture of eggs and sausage ground up together. The texture was more ground than pureed. The resident was observed to drink rapidly a 10-12 ounce glass of orange juice, at which time, the CNA obtained</p>		<p>Trifecta team and/or designee will be responsible for ensuring continuing compliance through assessment and interpretation of the Indiana State ruling R 002 410 IAC 16.2-5-0.5 (b) Scope of Residential Care by way of our Service Level Assessment and Negotiated Service Plan. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Residence Director and/or designee will perform a random weekly audit to include 25% of resident's service plans in addition to semi-annually and upon a change of condition for a period of six months to ensure continued compliance with admission and continued stay. Each resident's service plan will be reviewed at least one time monthly for six months, followed by quarterly for six months and upon admission, seminannually and with change of condition thereafter to ensure continuing compliance. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted.</p>				

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	<p>another glass of juice.</p> <p>At 11:20 a.m. on 3/23/12, CNAs #1 and #2 were observed to take Resident #22 to the bathroom. They both assisted the resident to stand. The resident's skin was observed at that time. The central spine area had a reddened area that did not blanch, 1/2 centimeter [cm] in diameter. Bilateral buttocks had reddened areas, slightly less than 1 cm. The resident's incontinence brief was dry. The CNAs indicated they had not toileted the resident since before breakfast. The resident was observed to dribble a small amount of urine into the toilet. The urine was observed to be dark amber in color. At that time, the resident was assisted to stand by the two CNAs and ambulated with extensive assistance to the recliner chair in the room. It was reclined with her in it. The same full glass of water was present in the room, with the orange food debris on the rim. It was out of reach of the resident. CNA #2 indicated, at that time, the resident had two glasses of orange juice total that morning with breakfast and she had not given the resident anything else. The resident's hands were sticky and her fingernails were long and soiled.</p> <p>At 12:42 p.m. on 3/23/12, CNA #2 was observed feeding Resident #22 in the</p>						

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	<p>resident's room. The meal consisted of blended chow mein, filling 1/3 of the plate, and a serving of pudding. The resident had a 10 ounce glass of orange juice.</p> <p>At 3:28 p.m. on 3/23/12, Resident #22 was observed to be in the recliner chair in her room, reclined with no way to summon help. She indicated, "Hurting." LPN #3 was informed of the resident's complaint. At 3:30 p.m., LPN #3 entered the room, assisted the resident to reposition in the recliner chair, using the electric lift chair controls, and pulled the call light across the room to alert the CNA the resident needed attention. The resident continued to yell out after repositioned. The same glass of water that had been present continued to be on a shelf in the room with no water missing. The resident reached out and her hands were observed to be sticky and nails were soiled.</p> <p>On 3/26/12 at 9:47 a.m., Resident #22 was observed in her room, seated in her recliner chair with the chair reclined. There was no means to summon help. The same glass of water, with the orange food debris on the rim, was present in the room on a shelf out of reach of the resident. A four ounce blue cup was observed on the kitchenette counter over</p>			

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	<p>1/2 filled with water, with a straw, out of reach of the resident. The resident's mouth had food debris in it.</p> <p>On 3/26/12 at 11:45 a.m., Resident #22 was observed to continue to be in the recliner chair, reclined, with no means to call for assistance. The same water glass was on the shelf out of reach and the same water glass on the kitchenette counter, with no additional water missing. Food debris was still in the resident's mouth. CNAs #1 and #2 assisted the resident to transfer from the recliner chair to the wheelchair, by hooking their arms under her arms. CNA #2 indicated the resident's arm was hurting "real bad" that morning. Both CNAs indicated the resident had not been toileted since before breakfast. The brief was slightly wet, a quarter-sized spot of wetness. The resident did not urinate any while seated on the toilet. The resident's skin was observed, at that time, as follows:</p> <p>Two bony processes on the middle spine were reddened, non-blanchable. The right buttock had a larger, greater than 1 cm, area of darkened redness. The left buttock had a less than one cm area of redness.</p> <p>On 3/27/12 at 12:30 p.m., Resident #22 was observed in the dining room with a 6 ounce glass of orange juice. The resident</p>			

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	<p>was fed by CNA #2 at 12:42 p.m. The CNA indicated, during interview at 2:10 p.m., the resident drank all of the first glass of juice and most of a second glass.</p> <p>Resident #22's clinical record was reviewed on 3/22/12 at 2:06 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, aortic stenosis, and a history of a subdural hematoma. The resident did have a hospice provider; review of the hospice "Patient Activity Log," dated 2/8/12, indicated the nurse visited once a week and a home health aide visited twice a week. The facility staff were responsible for care at all other times. The resident's assessment and negotiated service plan summary, dated 2/9/12, indicated the resident was at the maximum level of services provided by the facility, level 6 plus 1. The evaluation indicated the resident needed assistance as follows:</p> <ul style="list-style-type: none"> <li>-administration of medications, including special preparation of medications, and nebulizer treatments</li> <li>-assistance with bath or shower</li> <li>-assistance with using the bathroom, including assistance on and off the commode, clothing assistance, changing protective undergarments</li> <li>-assistance with incontinence, soiling clothes, bedding, furniture, or carpets</li> <li>-assistance with dressing and grooming,</li> </ul>			

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	<p>including daily dressing and TED [support stockings] application</p> <p>-assistance with walker or manual wheelchair</p> <p>-assistance of one person getting out of chair or bed or transferring from chair to bed</p> <p>-instruction on the use of the emergency call system</p> <p>-assistance with nutritional supplements</p> <p>-swallowing difficulties</p> <p>-assistance in the dining room, to include special attention with set-up of meal</p> <p>-assistance with behavior management, anxiety or agitation, resistance to Activities of Daily Living</p> <p>-assistance with coordination of care with the physician and hospice provider</p> <p>-assistance with wound care</p> <p>Resident Services Notes included, but were not limited to, the following: 1/2/12 1550 [3:50 p.m.] "Called to res. [resident] rm [room] where she had slid out of lounge chair. ROM [range of motion] performed [with] [no] c/o [complaint of] discomfort and [no] hurting. Picked res. up and took to BR [bathroom]. B/P [blood pressure 168/86 P [pulse] 60 R [respirations] 16. DoN [Director of Nursing] notified. One sm [small] lounge burn [sic] on back [with] [no] bleeding." 1/20/12 1755 [5:55 p.m.] "Pressure area</p>						

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	<p>along curved area of spine - new w/c [wheelchair]. Call placed to Hospice nurse, Wellness Director [DoN] notified. Await return call from Hospice."</p> <p>1/20/12 1820 [6:20 p.m.] "Hospice nurse notified [Therapy company] about w/c earlier..."</p> <p>1/25/12 1700 [5:00 p.m.] "Hospice nurse here et [and]tx [treatment] orders for resident - change dressing q [every] 3 d [days]..."</p> <p>2/9/12 0920 [9:20 a.m.] "Call placed to [name], POA [power of attorney] to inform of [increased] LOC [ level of care] completed per assessment et to discuss SNF [skilled nursing facility] placement..."</p> <p>2/9/12 10:45 a.m., "Spoke [with] POA - [name] apprised of [increased] level of care et need for potential SNF placement. Discussed [name of facility]...POA is agreeable et concurs [with] need for [increased] LOC [level of care]..."</p> <p>3/14/12 10:40 a.m. "Spoke [with] [Name of nurse] @ [name of hospice agency] re [regarding] pocketing of food. Requested ST [speech therapy] eval.</p> <p>3/20/12 1630 [4:30 p.m.] "Resident c/o pain - non specific area/ prn [as needed] Lortab [narcotic pain medication] given for comfort. Taking P.O. [by mouth] fluids well - Independently."</p> <p>3/21/12 2145 [9:45 p.m.] "Resident on floor near end of her bed - per reported</p>			

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	<p>CNA. No red areas; no c/o pain upon exam - moves extremities as [before] fall." "No s/s [signs/symptoms] of fracture. Alert as [before] fall. T 98.6 P 72 R 18 B/P 134/72. No bruising noted..."</p> <p>A Physician Fax Transmission/Phone order document, dated 2/15/12, indicated a request to get a UA [urinalysis] and C and S [culture and sensitivity] for Resident #22, due to cloudy and strong smelling urine. The response from the physician was "OK." The record lacked evidence of any urinalysis being collected or tested. An additional fax communication from the facility to the physician, dated 3/14/12, indicated the following: "Could we have an order for a UTI [urinary tract infection] for her? Her urine is very strong and she c/o's [complains of] hurting when urinating." The physician returned the fax with an order for a urinalysis and culture and sensitivity. The record lacked any evidence a urinalysis and culture and sensitivity had been done. The Wellness Director [DoN] indicated, on 3/28/12 at 9:40 a.m., the hospice agency did not get the urinalysis in February and the facility did not get one in March, as ordered by the physician.</p> <p>2. During the initial tour on 3/22/12 at</p>			

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	<p>10:50 a.m., CNA #1 indicated Resident #27 required assistance with showers and laundry, he was able to feed himself, and required one person assistance for transfers.</p> <p>On 3/22/12 at 12:10 p.m., Resident #27 was observed seated at the dining room table. His food was in front of him. He made no attempts to feed himself. CNA #1 tapped the resident on the shoulder and asked if he could feed himself. He indicated, "It would help if I had help." LPN #1 was observed to feed the resident 3-4 bites of food.</p> <p>On 3/23/12 at 8:32 a.m., Resident #27 was observed in the dining room being fed his breakfast by LPN #1.</p> <p>At 9:25 a.m. on 3/23/12, CNA #1 indicated during interview, "[Resident #27's name] takes care of himself. He's got pull-ups [underpant-type incontinence product]. He can transfer himself. Needs occasional help with clothes." Resident #27 was observed, at that time. He was in a wheelchair in his room. His clothing was soiled with food debris; his hands were sticky; his fingernails were long and soiled; there was dried up food particles on his wheelchair. The toilet was grossly soiled [with] feces. There was feces on the floor beside the toilet. A paper</p>			

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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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	<p>hand-written sign was observed on the kitchenette counter, with no date. The sign indicated, "Please offer and encourage patient to drink fluids - preferably water. Try to have a cup of water in room for him." No cups or containers of water were observed in the room.</p> <p>On 3/23/12 at 12:25 p.m., Resident #27 was observed in the main dining room. He had a bowl of cottage cheese setting on the table in front of him. LPN #1 sat down and fed the resident a few bites.</p> <p>At 12:30 p.m. on 3/23/12, the resident's main course plate was setting in front of him. He was making no effort to feed himself. LPN #1 sat down and fed the resident his lunch.</p> <p>On 3/23/12 at 3:15 p.m., Resident #27 was observed in his bathroom, seated on the commode. He indicated he needed help. He pointed to the incontinent brief he was wearing and his clothing pants and indicated the "pants came apart when I stood up." He was wearing the traditional incontinence brief with sticky tabs that held it together. It had come apart. He indicated, "You're the 1st one to check on me. I pulled the cord." The call cord was checked to see if it had been activated, and it had. LPN #3 entered the bathroom</p>			

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	<p>and indicated the CNAs would come in awhile to get to him. She indicated she had checked on him and told him to pull the cord.</p> <p>On 3/23/12 at 3:22 p.m., LPN #3 re-entered the bathroom. She indicated the facility knew when they hired her she could not lift. She did stay in the room and assisted the resident to grab the bar on the wall. He was gradually able to pull himself to a standing position. The nurse fastened the incontinence brief and pulled the resident's pants up. He was slowly transferred to the wheelchair.</p> <p>On 3/26/12 at 9:47 a.m., Resident #27 was observed to be up in his wheelchair in his room. He indicated he "could use a Milky Way or a Babe Ruth." There was no water available for drinking in his room.</p> <p>Resident #27's clinical record was reviewed on 3/23/12 at 9:00 a.m. The resident's most recent Assessment and Negotiated Service Plan Summary, dated 12/29/11, included, but was not limited to, the following: The resident needed assistance with: -medication administration -physical assistance with a shower or bath -use of protective undergarments or pads -dressing and grooming</p>						

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	<p>-use of a walker and wheelchair -set-up of meal (cutting meats, opening packets, etc.) -had trouble recalling the day, date, time, or where located.</p> <p>The resident's Resident Services Notes included, but were not limited to, the following: 12/30/11 1705 [5:05 p.m.] "Summoned to room resident found lying on (L) side of body w/ [with] hands folded under head. Stated, 'on my way to bathroom et just went down!' ROM [Range of Motion] done MAE's [moves all extremities] [without] difficulty, [no] c/o [complaint of] pain..." 2/7/12 1705 [5:05 p.m.] "Heard resident calling out/found lying on public bathroom floor. Alert. He was transferring from toilet to w/c [wheelchair] (one wheel locked) w/c moved et resident sat on floor letting body onto floor [after] sat down. Moves joints [without] c/o. C/O bottom hurting when sitting...no c/o pain upon palpation. No s/s [signs/symptoms] fx. [fracture]. T [temperature 99.3 P [pulse] 102 R [respirations] 18 B/P [blood pressure] 155/88." 2/11/12 1:00 p.m. "Res. has had c/o of (R) [right] hand and arm numbness; not working properly. No other complaints, has been lethargic for resident. Couldn't</p>			

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	<p>eat brkfst [breakfast], et [and] to be fed @ lunch, some drooling noted, no slurred speech, breathing non-labored @ 19, BP 148/107, P 97, T 96.9..." The resident was hospitalized from 2/11/12 to 2/16/12. 2/17/12 0400 [4:00 a.m.] "Res. sitting in w/c - [no] c/os when asked - res. ref. [refused] assist of ii [two] to bed..." 3/5/12 2120 [9:20 p.m.] "Resident [not] use call cord. Lying on floor near unlocked w/c - got self up out of bed. Lying on his (L) [left] side - Denies injury. [no] s/s of fx..." 3/20/12 2300 [11:00 a.m.] "Resident found on floor in front of w/c in bathroom. Did not use call cord for assist. Slid out of w/c. No injury noted. Alert. Moves all extremities as [before] fall..."</p> <p>Information regarding the facility admission agreement and policies for continued stay at the facility was provided by the Wellness Director on 3/26/12 at 8:45 a.m. The information included, but was not limited to, the following: A copy of the State Rules regarding Residential Care Facilities, Scope of residential care facilities, Rule 5. The rules included, but were not limited to, the following:</p> <p>"(b) A residential care facility may not provide comprehensive nursing care</p>			

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	<p>except to the extent allowed under this rule.</p> <p>(d) Notwithstanding subsection (f), a resident is not required to be discharged if receiving hospice services through an appropriately licensed provider of the resident's choice.</p> <p>(e) Notwithstanding subsection (f)(2), (f) (3), (f) (4), and (f)(5), a residential care facility that retains appropriate professional staff may provide comprehensive nursing care to residents needing care for a self-limiting condition.</p> <p>(f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others;</p> <p>(2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight;</p> <p>(3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident's choice to provide those services;</p> <p>(4) is not medically stable; or</p> <p>(5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident's needs:</p> <p>(A) Requires total assistance with eating.</p> <p>(B) Requires total assistance with</p>						

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	toileting. (C) Requires total assistance with transferring."			

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R0052	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to provide supervision to residents at risk for elopement, in that 1 of 1 resident reviewed for elopement, in a sample of 7 residents, was able to leave the facility unknown to the staff and ended up .4 miles away with potential for harm due to a roadway, a large ditch and a small pond being present between the facility and the where the resident ended up being found. (Resident #32)</p> <p>Finding includes:</p> <p>Resident #32's clinical record was reviewed on 3/23/12 at 12:00 p.m. The record indicated Resident #32 had a diagnosis of dementia.</p> <p>A document titled Elopement Risk Assessment, dated 10/20/11, indicated Resident #32 had a potential for elopement due to his diagnosis of dementia, change in usual orientation, confusion, and a pattern of wandering. It</p>	R0052	<p><b>410 IAC 16.2-5-1.2 (v) (1-6) Resident's Rights- Offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected. Resident #32 was re-assessed utilizing the Elopement assessment and is considered to have a reduced risk for an elopement based on further deterioration of resident's condition resulting in limited endurance and requirement for wheelchair as to the primary method of locomotion. Resident has a wander guard bracelet that is monitored routinely for function and placement as a precautionary measure. The Regional Director of Quality and Care Management conducted a follow up Elopement Drill that was provided to surveyors prior to exit indicating staff had been re-educated after occurrence and prior to survey entry with appropriate response. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</b></p>	05/20/2012

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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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	<p>had a written note at the bottom which stated, "No risk for elopement. Will place wander-guard x 30 until established in house."</p> <p>A nurse's note dated 12/12/11 at 10:30 a.m., indicated Resident #32 was confused and pacing in the hallway with his jacket and two hats on.</p> <p>A nurse's note dated 12/23/11 at 5:00 p.m., indicated Resident #32 had confusion and stated " he had to go to work."</p> <p>A nurse's note dated 12/23/11 at 7:00 p.m., indicated Resident #32 was wandering up and down the hall and agitated. He was caught 2 times going out the front door to the outside and one attempt was made to exit via the side door.</p> <p>A nurse's note dated 1/10/12 at 7:35 p.m., indicated Resident #32 was banging on a table and when asked what was wrong he stated "I am trying to get out of here."</p> <p>A nurse's note dated 1/10/12 at 8:00 p.m., indicated Resident #32 was following LPN #2 around and she took him back to his room. He was talking about work.</p> <p>A nurse's note dated 1/10/12 at 8:20 p.m.,</p>		<p><b>taken?</b> No other residents were found to be affected. Resident's considered to be at risk for elopement or showing exit seeking behaviors have individualized interventions utilizing Bell Oaks Terrace Task Sheets and Service Plans. Resident's requiring wander guard placement are routinely checked for placement and function with documentation on the Medication Administration Record. Elopement Drills are held and completed per our policy and procedure to ensure appropriate response as defined within the Elopement Drill. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Wellness Director, and licensed staff were re-educated to our policy and procedure as to our Elopement Drill to ensure continued compliance with Indiana State regulation R 052 410 IAC 16.2-5-1.2 (v) (1-6) Resident's Rights. <b>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?</b> The Residence Director and/or Designee will review the Medication Administration record of all residents with wander guard bracelets to ensure appropriate</p>				

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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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	<p>indicated Resident #32 was not in his apartment and not seen anywhere, so a door to door check of entire building and perimeter was done two times and Resident #32 was not found.</p> <p>A nurse's note dated 1/10/12 at 8:30 p.m., indicated the DoN was notified of Resident #32's exiting the building and not being found.</p> <p>A nurse's note dated 1/10/12 at 8:40 p.m., indicated the local County Sheriff's Department called the facility to notify them they had found an elderly gentleman walking and stumbling.</p> <p>A nurse's note dated 1/10/12 at 8:50 p.m., indicated LPN #2 drove to the location, found Resident #32, and brought him back to the facility.</p> <p>A nurse's note dated 1/10/12 at 9:10 p.m., indicated Resident #32 had a very unsteady gait, an altered mental status and stated "gonna get ready to leave."</p> <p>A nurse's note dated 1/10/12 at 10:00 p.m., indicated a doctor's order was received to send Resident #32 to [local hospital] Emergency Room.</p> <p>In an interview with LPN #2 on 3/26/12 at 9:30 a.m., LPN #2 indicated she was</p>		<p>function and placement and all resident's with exit seeking behaviors to ensure appropriate interventions are in place. Audits of the wander guard system and of resident's with exit seeking behaviors shall be weekly x 6 months, monthly x 4 months and quarterly thereafter. The Residence Director will continue to hold Elopement drills per our policy and procedure to ensure appropriate response. <b>Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed?</b> May 20, 2012</p>				

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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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	<p>the nurse on duty on 1/10/12 second shift, and Resident #32 had exited the building via the side door with no alarm sounding. A search of the building and the perimeter was done and then the DoN was notified. LPN #2 retrieved Resident #32 in an apartment complex parking lot behind the local grocery store after a call from the local County Sheriff's Department notifying her they had found an elderly gentleman. LPN #2 indicated the side exit doors were not programmed to alarm for the wanderguard ankle bracelets. She indicated at the time of the elopement, the doors at each end of the facility were alarmed during the evening and night, but had not been on at the time of the resident's exit and had not sounded. LPN #2 indicated he had a small scrape to his right elbow and left knee.</p> <p>In an interview with the DoN on 3/26/12 at 9:25 a.m., The DoN indicated Resident #32 came down the second floor back stairwell and exited the building through a side door with no exit alarm. The exit alarm was set to go off after a programmed time of day, and it was not yet that time of day. The DoN indicated Resident #32 had a wanderguard ankle bracelet in place, but the wanderguard system was only programmed for the front door and not the side doors.</p>			

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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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	<p>The DoN indicated Resident #32 was found in an apartment complex parking lot behind the local grocery store. The DoN also indicated Resident #32 had not tried to exit the facility since the 1/10/12 incident.</p> <p>The parking lot where Resident #32 was found was observed to be 0.4 miles from the facility by roadway. Another potential route through the trees and grass had a large ditch and a small pond in the line between the facility and the parking lot of the apartment complex.</p> <p>A document, provided by the DoN on 3/26/12 at 10:00 a.m., titled Elopement Risk Assessment and dated 1/31/12, indicated Resident #32 was a high risk for elopement.</p> <p>A nurse's note dated 2/13/12 at 4:45 p.m., indicated Resident #32 had his coat and sock hat on in the hallway and stated "leaving."</p> <p>A nurse's note dated 2/13/12 at 7:50 p.m., indicated Resident #32 was in the hallway with his coat on and voiced to the staff his intention to leave.</p> <p>A nurse's note dated 2/13/12 at 8:20 p.m., indicated Resident #32 was in the hallway and stated, "go out."</p>						

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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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	<p>A nurse's note dated 2/14/12 at 4:30 p.m., indicated Resident #32 had his coat and cap on and stated, "going outside to check my car."</p> <p>A nurse's note dated 2/14/12 at 9:30 p.m., indicated Resident #32 kept coming to the front lobby with different coats on.</p> <p>A nurse's note dated 3/1/12 at 8:00 p.m., indicated Resident #32 was wandering in the halls on the first and second floor.</p> <p>A nurse's note dated 3/19/12 at 7:00 p.m., indicated Resident #32 was in his wheelchair trying to go out the front lobby door.</p>			

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R0091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on record review and interview, the facility failed to ensure implementation of policies related to severe weather warnings, in that they failed to alert residents of a tornado warning and potential immediate threat to the facility. The facility also failed to schedule a tornado drill in February 2012 in accordance with facility policy. Three (3) of 3 supplemental sample residents interviewed regarding weather alerts, in the supplemental sample of 11, reported not being made aware of the impending tornadic storm by the staff on 2/29/12. (Residents D, C, B) This had the potential to affect 41 of 41 residents residing in the facility.</p> <p>Finding includes:  On 3/27/12, Resident D was confidentially interviewed. She indicated there had been a couple bad storms in the</p>	R0091	<p><b>R 091</b> <b>410 IAC 16.2-5-1.3 (h) (1-4)</b> <b>Administration and Management- Noncompliance</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected.</p> <p><b>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?</b> No other residents were found to be affected.</p> <p><b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director and/or Designee was re-educated as to</p>	05/20/2012			

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 03/30/2012	
NAME OF PROVIDER OR SUPPLIER  BELL OAKS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
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	<p>past month. The first event, she indicated, was on a Wednesday morning early. She indicated she knew nothing about it until her daughter called to check on her. No one has awakened her or encouraged her to leave her second floor apartment and go to a safer location. She indicated the second event was during lunch and they were assisted to move from the dining room to the hallway.</p> <p>On 3/27/12, Resident C was confidentially interviewed. She indicated they had one bad storm warning during lunch, and the residents were assisted to the hallway outside of the dining room. She indicated they stayed there about an hour. Prior to that event, she indicated she was in her apartment early in the morning. She heard sirens, from outside the building. She heard them say on the television to get in a hallway. She indicated she took a chair with her and went out in the hallway. She indicated she was the only one in the hallway and didn't see anyone while she was there.</p> <p>On 3/27/12, Resident B was confidentially interviewed. She indicated she was unaware of any early morning storm, until her family member called her. She indicated when she queried staff later that morning as to why she wasn't alerted, they indicated to her not to worry about it,</p>		<p>our policy and procedure regarding tornado drills along with time frames as to completion. Upon completion of required drill the Residence Director and/or Designee will fax required documentation of drill onto the corporate office for archive. Prior to survey exit a tornado drill was completed with appropriate response documented and provided to surveyors before exit on 3/30/12.</p> <p><b>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?</b> The Residence Director and/or Designee will perform monthly tornado drills to ensure continued compliance with our policy and procedure. Monthly tornado drills will be documented and reviewed through our Bell Oaks Terrace QA process for intervention if needed on an ongoing basis.</p> <p><b>By what date will the systemic changes be completed?</b> May 20, 2012</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 03/30/2012	
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	<p>it was over.</p> <p>LPN #2 was interviewed on 3/27/12 at 12:15 p.m. She indicated she remembered the morning of 2/29/12 because there were tornado warnings and storms and she thought she'd be late so she called ahead. She indicated she arrived at the facility around 6:15 a.m. At that time, a few residents were up, but most were in their rooms and/or beds. She indicated QMA [Qualified Medication Aide] #1 and the former Residence Director were at the facility during the night. She indicated the QMA had told her she had started going around and closing drapes.</p> <p>The Wellness Director [WD, Director of Nursing] provided the Tornado policy and procedure, dated 4/2008, on 3/27/12 at 8:45 a.m. The policy and procedure included, but was not limited to, the following: "Monitor Warnings: -In periods of inclement weather and high winds, be alert for potential tornado activity and monitor weather alerts. Keep radio/TV tuned for storm information updates. Listen to news reports for local warnings. DO NOT WAIT FOR A TORNADO SIREN TO TAKE ACTION." "If a tornado WARNING is issued follow</p>						

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	<p>these procedures:</p> <p><b>Tornado Preparation</b></p> <ul style="list-style-type: none"> <li>-When a tornado alert exists, keep radio/TV tuned for storm information updates. Listen to news reports for local warnings. <b>DO NOT WAIT FOR A TORNADO SIREN TO TAKE ACTION.</b></li> <li>-A Tornado Watch means a tornado is likely.</li> <li>-A Tornado Warning means a tornado has been sighted in the area or is indicated by radar.</li> <li>-Contact the Residence Director and/or wellness Director will evaluate the situation to determine if additional staff should be called in. Take into account the current weather and the safety of the staff prior to calling them in.</li> </ul> <p>If a tornado WATCH is issued:</p> <ul style="list-style-type: none"> <li>-Move chairs from the activity room and dining room to the tornado-safe area, sufficient for each ambulatory resident.</li> <li>-Move Emergency Supply Kit and Emergency Guidebook to the tornado-safe area.</li> <li>-Assign a staff member to monitor the weather alert station for tornado WARNINGS.</li> </ul> <p>If a tornado WARNING is issued:</p> <ul style="list-style-type: none"> <li>-Begin preparations to evacuate residents and staff to a tornado safe area (e.g. a tornado-safe area should have few</li> </ul>						

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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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	<p>windows and plenty of space for all residents and staff members to gather).</p> <p>-During the evening/night time hours, or if little warning is given, please move the residents into the closest safe area. In the individual resident apartments this would be the bathroom. The residents should take a blanket to the bathroom. If the Tornado siren is sounded, the residents should sit in the shower and cover themselves with blankets."</p> <p>-If the tornado appears likely to hit, assist residents to floor and cover with blanket to protect from flying glass..."</p> <p>A policy and procedure regarding Disaster Drill Procedures, dated 6/2008, was provided by the Wellness Director on 3/26/12 at 10:30 a.m. The procedure included, but was not limited to, the following:</p> <p>"Ensure scheduling at designated times.</p> <p>-Tornado---complete in February."</p> <p>"Inform staff that a hypothetical emergency situation exists and there is a need to institute disaster procedures. The drill may be an actual physical response drill or may be conducted as a written drill..."</p> <p>"Include movement of residents to safe areas...Exception: This condition is not required for infirmed or bed-ridden residents."</p>						

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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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	<p>Interview with the Wellness Director on 3/30/12 at 9:30 a.m., indicated no Tornado drills had been completed.</p> <p>According to the National Weather Service, a Tornado Watch was issued for the local area on 2/29/12 at 4:40 a.m. Central Standard Time. A Tornado Warning for the specific local area was issued at 5:30 a.m.</p> <p>According to The Associated Press, on 2/29/12 at 7:48 p.m., "The National Weather Service confirms it was a tornado that swept across the southwestern Indiana town of Newburgh, damaging several homes in a historic district... The weather service says in a preliminary damage assessment that the 100-yard-wide tornado had peak winds of 90 mph [miles per hour] when it slammed into the Ohio River town just after 6 a.m. CST [Central Standard Time] Wednesday and traveled two miles on the ground..."</p> <p>This state residential finding relates to Complaint IN00104848.</p>			
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R0144	<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 it was clean, comfortable, and orderly, for 3 of 5 resident rooms reviewed, in the sample of 7, and for 2 of 2 supplemental sample rooms, in the supplemental sample of 11, in that there was accumulated soil and debris, and urine odors. (Residents #32, #19, B, #27, #7)</p> <p>Findings include:</p> <p>1. On 3/22/12 at 3:00 p.m., Resident #32 was observed lying in his recliner. A strong odor of urine was present and an incontinent pad was noted to be saturated with urine lying beside the resident.</p> <p>On 3/23/12 at 11:50 a.m., Resident #32 was observed in his recliner. There was a strong odor of urine present.</p> <p>On 3/26/12 at 1:35 p.m., an observation of Resident #32 was made. He was in his recliner. A strong odor of urine present.</p> <p>On 3/27/12 at 10:45 a.m., an observation was made of Resident #32 in his recliner. There was a strong odor of urine present.</p>	R0144	<p><b>Citation #4 R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards- Deficiency</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> Resident # 27's toilet, bathroom floor, and wheelchair were cleaned by Bell Oaks Terrace staff. Resident #7 and #19's rooms were cleaned by housekeeping prior to survey exit on 3/30/12. Resident #32's room was inspected and cleaned to remove the urine smell from his room. Resident B's carpet was shampooed and bathroom was deep cleaned. <b>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?</b> No other residents were found to be affected. The Residence Director reviewed resident rooms with the housekeeper and developed a room cleaning list for completion. The housekeeper will provide documentation as to rooms cleaned prior to end of shift for the Residence Director and/or Designee to review to ensure continued compliance with</p>	05/20/2012			

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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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	In an interview on initial tour on 3/22/12 at 10:30 a.m., CNA #1 indicated Resident #32 was a total assist for care.		Indiana state regulation R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The House keeper was re-educated to our newly developed room cleaning list to be completed and turned into the Residence Director at the end of each shift for review as well as our cleaning expectations. The Residence Director and/or Designee will be responsible to ensure the housekeeper is completing tasks as assigned and to our cleaning expectation. <b>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?</b> The Residence Director and/or Designee will complete weekly walking reviews to include 25% of resident rooms each week via the newly implemented housekeeping room cleaning schedule to ensure continued compliance with Indiana state regulation R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards for a period of six months followed by quarterly for six months. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. <b>By what</b>				

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 03/30/2012
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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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	<p>2. On observation on 3/22/12 at 11:40 A.M., Resident #19 was observed to be sitting in her wheelchair in her room. Resident #19's room had a strong odor of urine.</p> <p>On observation on 3/23/12 at 8:45 A.M., Resident #19's room had strong smell of urine present.</p> <p>On observation on 3/23/12 at 10:23 A.M., Resident #19 was observed in her room, sitting in her wheelchair, visiting with another resident. Resident #19's room smelled of urine.</p> <p>On observation on 3/23/12 at 11:15 A.M., Resident #19's room door was open; her room had strong urine odor present.</p> <p>On observation on 3/23/12 at 11:55 A.M., Resident #19 was taken to her room to have her disposable brief changed. Resident #19's brief was saturated with urine and had feces in it. Her room had a strong urine odor present.</p> <p>On observation on 3/26/12 at 10:00 A.M., Resident #19 was observed sitting in her room in her wheelchair. Her room had strong urine odor present.</p> <p>On observation on 3/26/12 at 1:20 P.M., Resident #19 was sitting in her wheelchair in her room by the bathroom door. Resident's room had strong smell of urine. Upon interview with Resident #19, she indicated she had just had her brief</p>		<p><b>date will the systemic changes be completed? May 20, 2012</b></p>	
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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 03/30/2012
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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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	<p>changed.</p> <p>On observation on 3/27/12 at 8:45 A.M., Resident #19 was observed to be sitting in her wheelchair in her room. Resident #19's room had a strong smell of urine.</p> <p>On observation on 3/27/12 at 11:30 A.M., Resident #19 was observed to be sitting in her wheelchair in her room. The resident's room had strong urine smell present.</p> <p>On observation of Resident #19's bathroom on 3/28/12 at 8:37 A.M., the bathroom was found to have a strong urine odor, no toilet paper was on the holder and a urine collection container had feces on it.</p> <p>3. During interview on 3/27/12 at 8:50 A.M., Resident B indicated she had asked for new carpeting to be placed in her room as her carpeting was old and dirty. Resident B indicated she was told by the facility she would need to pay for the carpeting if she wanted new carpet. Also, during the interview, Resident B indicated her bathroom was not cleaned most of the time. On observation of Resident B's bathroom on 3/28/12 at 1:20 P.M., the shower was observed to have dirt on the floor and the bathroom floor around the commode and behind the commode was soiled with an accumulation of dirt and lint.</p> <p>4. Resident #27's room was observed on</p>			

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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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	<p>3/23/12 at 9:25 a.m. The toilet was grossly soiled with feces. There was feces on the floor to the side of the toilet. The resident's wheelchair had an accumulation of dried on food/liquids on the frame and seat. The bathroom was the same at 3:15 p.m. on 3/23/12, when the resident was observed seated on the toilet and requesting assistance to get up and get re-dressed.</p> <p>5. On 3/27/12 at 3:20 p.m., Resident #7's family expressed concern about the cleanliness of the resident's apartment. The family member had a Swiffer-type dust mop with an excessive amount of dirt and lint. She indicated she had swiped the bathroom floor with the dust mop and the dirt and lint found was the result. She indicated it upset her to see her family member's bathroom so filthy.</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 03/30/2012	
NAME OF PROVIDER OR SUPPLIER  BELL OAKS TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630			
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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, record review and interview, the facility failed to protect residents from the potential ingestion of harmful chemicals by not storing the items appropriately behind locked doors and failed to keep dryers free from lint, causing a potential fire hazard. This had the potential to affect 41 of 41 residents residing at the facility.</p> <p>Findings include:</p> <p>1. During an environmental inspection done on 3/27/12 at 9:15 a.m., an observation was made of an unlocked door to a maintenance office. Paint spackle, liquid heat, and Lysol disinfectant were observed to be out in the</p>	R0148	<p><b>R 148 410 IAC 16.2-5-1.5 (e)(1-4) Sanitation and Safety Standards- 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. Bell Oak Terrace staff prior to survey exit ensured chemicals were removed and secured as well as lint traps cleaned of lint accumulation. 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</b></p>	05/20/2012			

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 03/30/2012	
NAME OF PROVIDER OR SUPPLIER  BELL OAKS TERRACE				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>open within reach of facility residents.</p> <p>2. During the environment tour done on 3/27/12 at 9:15 a.m., an observation was made of an employee only room, which housed the furnace, unlocked and accessible to facility residents. In this room was multi-purpose latex primer with a hazard label stating "if swallowed call poison control," paint thinner with a hazard label stating "combustible vapor harmful or fatal if swallowed," and light weight spackle with a warning label stating, "caution if ingested take to emergency room immediately."</p> <p>3. During the environment tour done on 3/27/12 at 9:15 a.m., an observation was made of the first and second floor laundry rooms. There was an accumulation of lint behind the dryers in both laundry rooms, and the lint catchers in the dryers in the second floor laundry room were observed to be full.</p> <p>In an interview on 3/27/12 at 11:55 a.m., the maintenance man acknowledged he had left his office door unlocked, but stated "I was only gone for a minute."</p> <p>A document provided by the DoN on 3/29/12 at 9:45 a.m., with a title Life Safety Resource Guide (G) hazardous conditions, dated 6/2008, indicated all</p>		<p><b>or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> Bell Oaks Terrace Personal Service Assistant's were re-educated to the newly updated task sheets indicating chemicals were to be secured and lint traps checked with each use of the dryer to prevent lint accumulation. Bell Oaks Terrace staff was also re-educated to possible consequences if not completed as assigned to the resident population if not performed. The Wellness Director and/or Designee will be responsible to ensure through random walking rounds continued compliance with the Indiana state regulation R 148 410 IAC 16.2-5-1.5 (e) (1-4) Sanitation and Safety Standards.</p> <p><b>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?</b> The Wellness Director and/or designee will perform random audits of the dyers and locked storage areas where chemicals are stored weekly for six months and monthly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. <b>By what date will the systemic changes be completed?</b> May 20, 2012</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 03/30/2012
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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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	appliances and equipment should be kept in good working order. Appendix (e) of that same document titled Storage and Disposal of Hazardous Materials, indicated combustible materials, specifically mentioned "paint thinner," were required to be stored in a location away from heat. The document indicated all hazardous products would be stored behind a locked door or cabinet and staff should not leave hazardous chemicals unattended or in locations which were accessible to residents or visitors.			

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R0154	<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 and interview, the facility failed to keep all kitchen areas, common dining areas, equipment and utensils clean and in good repair, for 1 of 1 kitchen/dining area in the facility. This had the potential to affect 41 of 41 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 3/22/12 at 11:15 A.M., the FSC [Food Service Coordinator] was interviewed regarding the sanitizer in the dishwasher. The FSC indicated she could not find the strips to test the sanitizer and had not been able to test the dishwasher sanitizer since she started in February, 2012. The shelf above the preparation sink where the spices were placed was dirty. During interview of the FSC, the FSC indicated she had just been hired and was trying to clean the entire kitchen. The floor in the common dining room was also dirty and sticky. The FSC indicated the floor in the common dining room area was to be cleaned by the night shift nursing assistants. The FSC also indicated the</p>	R0154	<p><b>R 154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards- 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. The kitchen shelf above the preparation sink in the kitchen has been cleaned. All staff were re-inserviced on taking dirty dishes directly into the dishwashing area through the direct access door. The floor in the dining area has been thoroughly 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? No other residents were found to be affected. During survey Dining Service Coordinator admitted to surveyors she was unclear as to what exactly they were asking in reference to the test strips. She stated "I thought they were asking for test sticks". She did understand and was completing the necessary calibration of the appropriate amount of sanitation solution as indicated on the side</b></p>	05/20/2012			

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	<p>dirty dishes were brought into the dishwashing area through the food serving door which was in the food preparation area. The FSC indicated no one had used the door directly into the dishwasher area since she began working there in February 2012.</p> <p>On 3/23/12 at 9:50 A.M., the FSC indicated the large coffee maker was leaking and she had turned it off. The FSC indicated she was using the small coffee maker all the time since the large coffee maker was not working.</p> <p>On 3/23/12 at 10:20 A.M., a bin with fluid in it was observed to be in the floor of the dry storage area and the ceiling above the door appeared to be wet. During interview of the FSC at this time, she indicated the ceiling began leaking a few days ago. The FSC indicated she was informed the leak was from the air conditioner and the air conditioner was supposed to be "checked out." The FSC indicated she placed a bin on the floor to catch the water.</p> <p>On 3/27/12 at 11:20 A.M., the FSC reported she had just received serving size ladles for food. The FSC indicated she did not have all of the serving sizes. The FSC indicated they were having difficulty with receiving ladles as the dietician did</p>		<p>of the strip container and explained to the surveyor her misunderstanding during the survey. The large coffee maker found recently leaking had a work order in process for evaluation by maintenance that was provided to surveyors prior to survey exit. Bell Oaks Terrace maintained a working coffee maker to ensure residents were served coffee upon request in the meantime. The Maintenance Director has been notified of the leaking ceiling and has rectified the issue. The Maintenance Director has also evaluated the steamer and maintains it is in working condition. The Dining Service Coordinator has been furnished appropriate utensils to ensure we are serving portions based on our "liberalized diet" policy and procedure. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Dining Service Coordinator, and Maintenance Director have been re-educated to the Indiana state regulation R 154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards. It is the responsibility of the Residence Director, Maintenance Director, and or Designee to ensure continued compliance with the above citation through routine rounds throughout the community. <b>How will the</b></p>				

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	<p>not want them. The FSC indicated she had made a list of items she needed ordered for the kitchen, as when she came to work there were several items missing. The FSC indicated she had received two baking sheets already.</p> <p>On 3/27/12 at 11:57 A.M., water was observed coming across the floor from the steamer, and a water stain was observed on the floor under the standing oven. During interview of the FSC at this time, she indicated the steamer worked sometimes and other times it didn't. The FSC indicated the steamer drain was not draining properly, and the steamer had been repaired four times during the current month.</p>		<p><b>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 Residence Director and/or Designee will perform a weekly random walking round of the residence to ensure continued compliance with kitchen, kitchen areas, common dining areas, equipment and utensils to ensure they are clean and in a state of good repair for a period of six months followed by monthly thereafter. The Residence Director and/or designee will perform a daily audit for 30 days followed by weekly x 6 months and monthly thereafter at mealtime to ensure staff are using the door directly into the dishwashing area when clearing dishes. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012</b></p>				

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R0185	<p>410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E) Physical Plant Standards - Noncompliance</p> <p>(i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall:</p> <p>(1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level.</p> <p>(2) Provide each resident the following items upon request at the time of admission:</p> <p>(A) A bed:</p> <p>(i) of appropriate size and height for the resident;</p> <p>(ii) with a clean and comfortable mattress; and</p> <p>(iii) with comfortable bedding appropriate to the temperature of the facility.</p> <p>(B) A bedside cabinet or table with a hard surface and washable top.</p> <p>(C) A cushioned comfortable chair.</p> <p>(D) A bedside lamp.</p> <p>(E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device.</p> <p>(3) Provide cubicle curtains or screens if requested by a resident in a shared room.</p> <p>(4) Provide a method by which each resident may summon a staff person at any time.</p> <p>(5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.</p> <p>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.</p> <p>(7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing</p>						

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	<p>storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 residents reviewed who were placed in recliner chairs and required extensive to total assistance, in the sample of 7, had a means to summon help while in the recliner chairs, in that there was no call system accessible to the residents. (Residents #32, #22)</p> <p>Findings include:</p> <p>1. On 3/22/12 at 3:00 p.m., Resident #32 was observed lying in his recliner with his head all the way back, feet up, and his eyes closed. There was no call light in reach and no call pendant around Resident #32's neck. The call light for the room was across the room on the wall.</p> <p>On 3/23/12 at 10:00 a.m., an observation of CNA #1 and CNA #2 was made. The CNAs assisted Resident #32 into his recliner. CNA #1 laid the recliner back and adjusted the foot of the recliner to the up position and left Resident #32 without any way to call for assistance.</p> <p>On 3/23/12 at 11:50 a.m. Resident #32</p>	R0185	<p><b>R 185 410 IAC 16.2-5-1.6 (i)(1-2) (A) (i-iii) (B-E) Physical Plant Standards- Noncompliance</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected. Resident #33 and #32 has their pull cords anchored beside their recliners upon finding by the Maintenance Director in order to provide a means to summon assistance if needed prior to survey exit. Resident #22 no longer resides at Bell Oaks Terrace. <b>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?</b> No other residents were found to be affected. Residents residing at Bell Oaks Terrace had their current service plans reviewed with appropriate measures implemented and documented within the service plans to ensure resident's had necessary accommodations made so as to summon assistance when needed. Bell Oaks Terrace will continue to review residents prior to admittance, semi-annually, and</p>	05/20/2012

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	<p>was observed in his recliner with the head of the recliner all the way back and the foot of the recliner all the way up. His eyes were closed, no call light was in reach, and no call pendant was around Resident #32's neck.</p> <p>On 3/26/12 at 1:35 p.m., Resident #32 was observed in his recliner with his head back and feet up. No call light was in reach and no call pendant was around his neck.</p> <p>On 3/27/12 at 10:45 a.m., an observation was made of Resident #32 in his recliner. His head was back and feet up. There was no call light within reach and no call pendant around his neck.</p> <p>In an interview on initial tour on 3/22/12 at 10:30 a.m., CNA #1 indicated Resident #32 required total assistance for all activities of daily living.</p> <p>In an interview with the Wellness Director [DoN] on 3/26/12 at 9:25 a.m., the DoN indicated Resident #32 could not get out of his recliner if it was tilted all the way back with his feet up, thus could not get to the call light across the room from the recliner chair.</p> <p>2. On 3/22/12 at 3:10 p.m., Resident #22 was observed seated in her recliner,</p>		<p>upon a change of condition to ensure continued compliance with the above referenced regulation R 185 410 IAC 16.2-5-1.6 (i)(1-2) (A) (i-iii) (B-E) Physical Plant Standards. All staff were re-inserviced on making sure call light systems are within reach of residents who cannot move independently. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Wellness Director, and Residence Sales Manager were re-educated as to Indiana state regulation R 185 410 IAC 16.2-5-1.6 (i)(1-2)(A) (i-iii) (B-E) Physical Plant Standards and our policy and procedure regarding our Service Level Assessment and Negotiated Service Plan to ensure residents were reviewed prior to admittance, semi-annually, and upon a change of condition and have the necessary accommodations for summoning assistance based on the resident individual needs.</p> <p><b>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?</b> The Wellness Director and/or Designee will conduct a random weekly audit of all resident's who cannot move independently to ensure call lights are within reach for a period of six</p>				

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	<p>reclined back. The resident did not have access to a call light; it was on the wall across the room. She did not have a pendant call light on her person.</p> <p>On 3/23/12 at 8:32 a.m., Resident #22 was observed to be up in her recliner chair, reclined, with the newspaper in her lap. The resident was moaning and calling out. She was asked if she was in pain and she indicated "yes." There was no call light or pendant for the resident to summon help.</p> <p>At 8:40 a.m. on 3/23/12, CNA #2 was observed to transfer Resident #22 from her recliner chair to a wheelchair. CNA #2 indicated the resident had been gotten up that morning and put in her recliner chair when the CNA arrived at work, 6:15-6:30 a.m. There was no call light accessible from the recliner chair.</p> <p>At 11:20 a.m. on 3/23/12, CNAs #1 and #2 were observed to take Resident #22 to the bathroom. The CNAs indicated they had not toileted the resident since before breakfast. After toileting, the resident was assisted to stand by the two CNAs and ambulated with extensive assistance to the recliner chair in the room. It was reclined with her in it. There was no call light in reach while the resident was seated in the recliner chair.</p>		<p>months followed by monthly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. <b>By what date will the systemic changes be completed?</b> May 20, 2012</p>				

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	<p>At 3:28 p.m. on 3/23/12, Resident #22 was observed to be in the recliner chair in her room, reclined with no way to summon help. She indicated, "hurting." LPN #3 was informed of the resident's complaint. At 3:30 p.m., LPN #3 entered the room, assisted the resident to reposition in the recliner chair, using the electric lift chair controls, and pulled the call light across the room to alert the CNA the resident needed attention.</p> <p>On 3/26/12 at 9:47 a.m., Resident #22 was observed in her room, seated in her recliner chair with the chair reclined. There was no means to summon help.</p> <p>On 3/26/12 at 11:45 a.m., Resident #22 was observed to continue to be in the recliner chair, reclined, with no means to call for assistance. CNAs #1 and #2 assisted the resident to transfer from the recliner chair to the wheelchair. Both CNAs indicated the resident had not been toileted since before breakfast.</p> <p>The observations of residents being placed in recliner chairs with no call system was reviewed during interview with the Wellness Director on 3/27/12 at 3:40 p.m. He indicated call lights would be located in reach of the residents when they were in recliner chairs.</p>						

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R0214	<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 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 observation, interview and record review, the facility failed to ensure evaluations were updated at least semiannually and upon significant change in condition, for 1 of 7 sampled residents who had resided at the facility more than six months, in the sample of 7, and for 1 of 7 supplemental sample residents who had been at the facility more than six months, in the supplemental sample of 11. (Resident #28, Resident B)</p> <p>Findings include:</p> <p>1. Resident #28's clinical record was reviewed on 3/22/12 at 3:15 p.m. The most recent Assessment and Negotiated Service Plan Summary was dated 5/5/2011. The evaluation indicated the resident only needed "reminders to independently use the bathroom or to change your protective garments." It indicated she needed physical assistance with a bath or shower. The evaluation indicated the resident used a walker.</p>	R0214	<p><b>R 214 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management- Noncompliance</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected. Resident #28's Service Level Assessment and Negotiated Service Plan was updated to include this resident's current clinical condition along with necessary provisions to be implemented by Bell Oaks Terrace staff to care for Resident #28's scheduled and unscheduled needs. <b>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?</b> No other residents were found to be affected. Residents residing at Bell Oaks Terrace had their current service plans reviewed to ensure timeliness of completion with the appropriate interventions were documented to ensure our resident's scheduled and</p>	05/20/2012			

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	<p>During the initial tour on 3/22/12 at 10:40 a.m., CNA #1 indicated Resident #28 required total assist with care. She was observed to be seated in a wheelchair in the lobby.</p> <p>On 3/27/12 at 10:20 a.m., Resident #28 was observed to be taken to the bathroom by CNAs #1 and #2. Her fingernails were observed to be soiled and long. Both CNAs assisted the resident to stand, using a support bar on the wall. They indicated, during interview at that time, the last time they had assisted the resident with toileting was 7:00 to 7:30 a.m. that morning. They indicated she could not transfer herself.</p> <p>The lack of an evaluation for greater than 6 months was reviewed during interview with the Wellness Director on 3/27/12 at 3:40 p.m. No response was given and no further evaluations were provided.</p>		<p>unscheduled needs were being met. Bell Oaks Terrace will continue to review residents prior to admittance, semi-annually, and upon a change of condition to ensure continued compliance with the above referenced regulation R 214 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Wellness Director, and Residence Sales Manager were re-educated as to Indiana state regulation R 214 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management and our policy and procedure regarding the acceptable time frames for completion of the Service Level Assessment and Negotiated Service Plans. Residents will be reviewed prior to admittance, semi-annually, and upon a change of condition and have the necessary accommodations for their scheduled/unscheduled needs. . <b>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?</b> The Residence Director and/or Designee will perform a weekly audit to include 25% of</p>				

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	2. Resident B's clinical record was reviewed on 3/27/12 at 2:00 p.m. The resident had not had an Assessment and Negotiated Service Plan since 7/6/11. The lack of evaluation since 7/6/11 was reviewed during interview with the Wellness Director on 3/27/12 at 3:40 p.m. No response was given and no further evaluations were provided.		resident's service plans in addition to seminannual review and upon a change in condition for a period of six months to ensure continuing compliance with admission and continued stay. Each resident's service plan will be reviewed at least one time monthly for six months followed by quarterly for six months and upon admission, semiannually and with change of condition thereafter to ensure continuing compliance. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012				

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R0217	<p>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:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 2 supplemental sample residents reviewed for falls, in the supplemental sample of 11, had his service plan reviewed and revised as needs changed, in that the resident continued to have falls, resulting in injury, with no changes in the</p>	R0217	<b>R 217 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management- Noncompliance</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected. Resident #17's Service Level Assessment	05/20/2012			

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	<p>plan. (Resident #17)</p> <p>Finding includes:</p> <p>During the initial tour on 3/22/12 at 11:00 a.m., CNA #2 indicated Resident #17 was very confused, had a urinary catheter, used a wheelchair, and tried to do a lot for himself. She indicated he required one staff assistance for most activities. She indicated he had not had recent falls.</p> <p>Resident #17's clinical record was reviewed on 3/29/12 at 3:00 p.m. The resident was admitted to the facility 6/13/11 with diagnoses of atrial fibrillation, urinary retention, and bronchitis. Resident Services Notes included, but were not limited to, the following: 12/21/11 0429 [4:29 a.m.] "Answered resident call (with pull cord)-Resident lying on bathroom floor on (L) [left] side; (L) arm under resident et some blood from (L) side of head (laceration above (L) ear down to ear/ reviewed [after] resident moved per EMTs [Emergency Medical Technicians]) unable to access (L) arm/ all other extremities able to move [with] [no] c/o [complaint of] pain. Alert - hit head on floor. Was up in w/c [wheelchair] et attempted to put package of briefs on shelf - slid out of w/c. T [temperature] 97.6 P [pulse] 105 R</p>		<p>and Negotiated Service Plan was updated to include potential fall interventions in hopes of minimizing the risk for future falls with injury. <b>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?</b> No other residents were found to be affected. Residents residing at Bell Oaks Terrace who are considered to be "at risk" for falls or identified as having multiple falls had appropriate interventions documented within their service plans in effort to minimize the risk for falls with injury. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director and Wellness Director were re-educated as to our policy and procedure regarding the Service Level Assessment and Negotiated Service Plan. Residents will be reviewed prior to admittance, semi-annually, and upon a change of condition and have the necessary provisions made to minimize the risk for falls with injury. <b>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?</b> The Wellness Director and/or Designee will</p>				

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	<p>[respirations] 18 B/P [blood pressure] 144/72. Notified [home health agency], Wellness Director, Residence Director et Dr. [doctor]..."</p> <p>12/21/11 1615 [4:15 p.m.] "Summoned to rm. [room] Resident had fallen et called [name of home health agency]. [Home health agency] called facility. Pendant for emergencies or assist not on resident. found lying on (L) side beside of bed. W/C beside him. B/P 148/82 P 82 R 18 T 97.4. ROM [Range of Motion] done. MAE's [moves all extremities] [without] difficulty. Assisted [up] per ii [two]. Very unsteady; stated while attempting to transfer from w/c to bed sat on floor on buttocks. Had rolled to (L) side trying to get up. Pendant placed on resident et encouraged to use for assist."</p> <p>1/17/12 2005 [8:05 p.m.] "CNA responded to call pendant - resident sitting on floor beside bed - was up et reaching for billfold on locked w/c; sat self down on floor. [no] injury...T 99.2 P 99 R 18 B/P 160/84..."</p> <p>2/11/12 [no time] Res. [resident] was found on floor by his bedside. Res. got a skin tear to left elbow..."</p> <p>2/16/12 1200 [12:00 noon] "Summoned to room. (L) [left] hand bleeding.</p>		<p>perform weekly reviews of service assessments of residents considered to be "at risk" for falls or who have experienced falls to ensure necessary interventions are documented in effort to minimize the risk for falls with injury for a period of six months followed by monthly for six months and quarterly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance and further action if warranted. <b>By what date will the systemic changes be completed? May 20, 2012</b></p>				

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	<p>Resident in W/C. Stated leaned forward in w/c to adjust TV and slipped et hit hand and head on TV. [No] obvious reddened or raised areas noted on head. States it's OK. Refused to be sent to hospital..."</p> <p>2/23/12 0545 [5:45 a.m.] B/P 146/68 P 64 Accu [check] [blood sugar test] 76. Res. was lying on floor on rt. [right] side -ROM performed [with] [no] c/o [complaint of] discomfort. He was pulled up [and] put in lounge chair..."</p> <p>2/27/12 1700 [5:00 p.m.] "[No] use pendant or call light. has pendant on. Calling out/CNA found resident on floor in Rm [number of his room]. Lying in front of unlocked w/c. Was reaching et slid out of w/c to floor. 1.2 cm [centimeter] S/T [skin tear] on forehead above (L) eyebrow. Alert et oriented X 3...Refuses to go to ER [Emergency Room]...Steri strips to S/T [after] cleansed - bandaid to site (L) forehead."</p> <p>3/24/12 1330 [1:30 p.m.] "CNA found resident had pulled pendant on floor, nurse arrived res. lying on (L) side, (L) side of forehead bleeding (R) had large contusion on top. C/O head and hip pain. 911 called..."</p> <p>The resident returned to the facility on</p>						

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	<p>3/26/12. An orthopaedic surgery consult, dated 3/25/12, indicated the following: "Left hand, there is a complex superficial skin laceration of the dorsum of the hand with a stellate type pattern. Total length of the laceration is approximately 12 cm [centimeters]..."</p> <p>The resident was observed in the dining room on 3/30/12 at 8:40 a.m. feeding himself breakfast. He indicated he was better today as he could move his fingers without excessive pain.</p> <p>Resident #17's Assessment and Negotiated Service Plan Summary, dated 1/31/12, indicated the resident required assistance as follows: -medication administration -reminders and preparation for the bath or shower. "You are then able to complete your bath or shower independently." -reminders to independently use the bathroom or to change protective garments. -staff to empty a catheter drainage bag -dressing or grooming supplies set up but then able to dress and groom without assistance. -experienced falls in the past 3 months -coordination of care with home health provider</p> <p>Interviews with CNAs #1 and #2 on</p>			

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	<p>3/30/12 at 8:45 and 9:50 a.m. indicated Resident #17 required assistance with his catheter, assistance to bed, checking to see if he was clean, and physical assistance with the shower. "He can get in with one assist, then we do the shower."</p> <p>There was no indication the service plan was reviewed and revised in an attempt to decrease the number of falls the resident experienced.</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 observation, interview and record review, the facility failed to ensure medications and residential nursing care were provided by licensed nursing staff, as ordered by the residents' physicians, for 1 of 1 sampled resident who experienced cardiopulmonary arrest, in the sample of 7, for 1 of 1 resident who had medicated pain relief cream applied by non-licensed personnel, in the sample of 7, and for 4 of 5 residents observed during medication administration. A resident with a physician's order for no CPR had CPR performed; a resident with a physician's order for medicated pain relief cream had it applied by non-licensed personnel, and 4 of 5 residents observed during medication administration had medications administered in error. (Residents #28, A, #21, #27, #36, #25)</p> <p>Findings include:</p> <p>1. During the initial tour, CNA #1 indicated Resident #28 required total care except she fed herself. The resident was</p>	R0241	<p>We respectfully disagree with the below citation and would like to request face to face Informal Dispute Resolution in effort to overturn this ruling. <b>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?</b> No residents were found to be affected. Please note a discrepancy in the finding stating CPR was performed by the Wellness Director. On 3/23/12 Resident #28 had CPR performed by the beautician under the Good Samaritan law until such a time staff had declared she was a DNR in which it was immediately stopped. Prior t survey exit staff were re-educated to CNA scope of practice regarding applying lotions that are considered to be OTC medications. Documentation was provided to surveyors upon completion. LPN #1 and #2 was re-educated to the "Seven Rights of Medication Administration" when administering medications.</p>	05/20/2012			

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	<p>observed sitting in a wheelchair in the front lobby.</p> <p>Resident #28's clinical record was reviewed on 3/22/12 at 3:15 p.m. The resident was admitted to the facility on 4/12/10 with diagnoses including, but not limited to, osteoporosis and dementia. The record included an "Out of Hospital Do Not Resuscitate Declaration." The declaration was dated April 12, 2010. The declaration included a signed physician's order as follows: "...I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out of Hospital Do Not Resuscitate Declaration is revoked." The order was signed by the physician on 4/12/10. There was no revocation of the Do Not Resuscitate Declaration.</p> <p>Resident #28's clinical record binder was observed to have a pinkish-red dot on the visible part of the binder when it was on the chart rack. The face sheet in the record also had the pinkish-red dot. According to the Wellness Director on 3/26/12 at 11:10 a.m., the pinkish-red dot indicated the resident was not to be resuscitated.</p>		<p>Resident # 27, #36, #21 and #25 had their primary care physicians and responsible parties notified of the occurrence with no further orders given. <b>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?</b> No other residents were found to be affected. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> Bell Oaks Terrace PSA's were re-educated as to the certified nurse aid scope of practice regarding application of lotions or creams considered to be OTC medications. Licensed nurses and QMA's were re-educated to the "Seven Rights of Medication Administration" during medication administration as indicated by physician order. Staff were also re-educated to our policy and procedures regarding CPR and First Aid. <b>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 a random weekly audit of medication administration and resident care to ensure continued compliance for six</b></p>				

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	<p>On 3/23/12 at 9:40 a.m., Resident #28 was observed in the beauty shop, seated in a wheelchair. At 10:10 a.m., LPN #4 was observed carrying Resident #28's clinical record and approaching the beauty shop door. As the door opened, Resident #28 was observed on the floor, with the Wellness Director doing chest compressions of CardioPulmonary Resuscitation [CPR]. The Corporate Nurse was in the room and LPN #1 was in the room. At that time, LPN #4 indicated the resident had orders for Do Not Resuscitate. CPR was stopped. At 10:25 a.m., Resident #28 was observed to be lying on the beauty shop floor. Respirations were observed; her eyes were closed; oxygen was on via nasal cannula at 2 liters per minute. At that time, Emergency Services Personnel arrived. The Wellness Director reported to the Emergency Services Personnel the resident had become unresponsive in the beauty shop. The beautitian had called for help. The resident was assessed to have no pulse and no respirations and CardioPulmonary Resuscitation had been initiated. He indicated when they realized the resident had a Do Not Resuscitate order, they stopped CPR and the resident began breathing on her own. The blood pressure was low at first but then came up. The resident was observed to be responsive to her name.</p>		<p><b>months followed by weekly audits for three months and quarterly thereafter. Audits will occur on each shift where medications are administered. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012</b></p>				

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	<p>Nurses' notes reviewed on 3/26/12 at 2:00 p.m. included the following: 3/19/12 1800 [6:00 p.m.] "[Medical equipment supply company] here et picked up nebulizer unit [after] completion of 10 d [day] usage as ordered." 3/23/12 1010 [10:10 a.m.] "Was called to beauty shop by beauty shop operator where res. [resident] collapsed on floor [and] was unresponsive. 9-1-1 called [and] face sheet, labs, transfer sheet. Ambulance took res. to [name of hospital]. Niece [and] nephew notified." 3/23/12 2200 [10:00 p.m.] "Resident admitted to [name of hospital] to...neuro ICU [intensive care unit] [with] DX [diagnosis]: cardiac arrest..."</p> <p>2. During initial tour on 3/22/12 at 10:35 a.m., Certified Nurse Aide [CNA] #1 explained Resident A was alert, oriented, interviewable, independent, self administered medications, and only required assistance with rubbing pain lotion on her back.</p> <p>In an interview with Resident A on 3/22/12 at 3:15 p.m., she explained she used prescription pain lotion Pennsaid (nonsteroidal anti-inflammatory drug) four times a day to her back and hips. Resident A also explained she did everything independently except for</p>						

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	<p>applying the pain lotion to her back. She stated, "If a nurse does it, they charge me more, so the girls come in and do it for me." Resident A indicated "the girls" were the facility's CNAs.</p> <p>In an interview with Resident A on 3/27/12 at 8:55 a.m., Resident A indicated the CNA's rubbed her pain lotion on her back for her.</p> <p>Review of Resident A's record on 3/26/12 at 10:30 a.m., indicated a doctor's order dated 3/2/12, for Resident A to have Pennsaid applied to her hips and back 4 times a day.</p> <p>3. On 3/27/12 at 11:27 a.m., LPN #2 was observed passing medication to Resident #21. LPN #2 gave Diazepam [anti-anxiety medication] 5 mg [milligrams] by mouth with 60 milliliters [ml] of water.</p> <p>On 3/27/12 at 11:40 a.m., a record review of Resident #21's record indicated a physician's order dated 8/5/09 for Diazepam 5 mg by mouth 4 times a day. A review of the Medication Administration Record [MAR], indicated Diazepam was to be given at 7:00 a.m., 1:00 p.m., 5:00 p.m., and 8:00 p.m.</p> <p>On 3/27/12 at 11:50 a.m. in an interview</p>			

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	<p>with LPN #2, she indicated a mistake had been made and she did give Resident #21 Diazepam 5 mg by mouth at 11:27 a.m. and it was not scheduled until 1:00 p.m.</p> <p>4. On 3/27/12 at 11:30 a.m., LPN #2 was observed giving medications to Resident #27. LPN #2 gave Depakote [a mood stabilizer] 125 mg 1 tablet by mouth and Atarax (anti-itching medication) 10 mg 1 tablet by mouth with 60 ml of water.</p> <p>On 3/27/12 at 11:45 a.m., a record review of Resident #27's record indicated a physician's order dated 2/16/12 for Depakote 125 mg by mouth 3 times a day and Atarax 10 mg by mouth 3 times a day. A review of the MAR indicated Depakote 125 mg was to be given at 9:00 a.m., 2:00 p.m., and 8:00 p.m. and Atarax 10 mg was to be given at 7:00 a.m., 2:00 p.m., and 8:00 p.m.</p> <p>On 3/27/12 at 11:50 a.m. in an interview with LPN #2, she indicated a mistake had been made and she did give Resident #27 Depakote 125 mg and Atarax 10 mg at 11:30 a.m. and they were not scheduled to be given until 2:00 p.m.</p> <p>A document provided by the DoN on 3/29/12 at 9:45 a.m. titled Life Safety Resource Guide (a) Distribution Times, with a date of 6/2008, indicated</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 03/30/2012	
NAME OF PROVIDER OR SUPPLIER  BELL OAKS TERRACE				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>distribution times of medications and treatments would be given within 1 hour of the scheduled time.</p> <p>5. On 3/22/12 at 11:42 A.M., Resident #36 was complaining of "dry eyes." LPN #1 gave Resident #36 Systane Ultra Ophthalmic drops (lubricant eye drops) 1 drop in each eye.</p> <p>The clinical record for Resident #36 was reviewed on 3/23/12 at 12:24 p.m. Systane Ophthalmic drops were ordered 8/29/11 to be given 2 times a day at 8:00 A.M. and 8:00 P.M. Resident #36 had Artificial Tears Ophthalmic drops (dry eye lubricant) ordered 11/16/11 to be instilled in each eye as directed as needed for dry eyes.</p> <p>6. On 3/22/12 at 11:50 A.M., LPN #1 was observed to remove Carbidopa-Levodopa 25/100 1/2 tablet from the medication package belonging to another resident and place it into a medication cup for Resident #25. Upon interview of LPN #1, at that time, she indicated Resident #25 and the other resident had the same dose (1/2 tablet) and Resident #25 was out of his Carbidopa-Levodopa. LPN #1 then administered Carbidopa-Levodopa 25/100 1/2 tablet to Resident #25.</p> <p>Resident #25's clinical record was</p>						

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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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	<p>reviewed on 3/23/12 at 12:24 p.m. The resident had a physician's order, dated 5/26/11, and signed by the physician in February 2012 [no specific date], for Carbidopa-Levodopa 25-100 tab give 1 tablet orally 3 times a day.</p>			

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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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R0268	<p>410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements.</p> <p>Based on observation, interview and record review, the facility failed to ensure well-planned and cooked meals were served, for 6 of 6 supplemental sample residents interviewed regarding food, in the supplemental sample of 11, in that meat was tough and dry, sweet potatoes were hard, dried up, and serving sizes were inconsistent. (Residents B, #47, #48, #49, #50, and #51)</p> <p>Findings include:</p> <p>On observation of the dining room on 3/22/12 at 12:30 P.M., the residents were served a pork chop and sweet potato slice. Upon interview of Resident B, she indicated the servings were inconsistent. Resident B indicated she brought up the serving size inconsistency at the food committee meetings, as the facility did not have the correct scoops. Resident #47 indicated the pork chop was too dry and the sweet potato was "dried up." Resident #48 and Resident #49 indicated the pork chop was dry and the sweet potato was not cooked and was hard. Resident #50 indicated the carrots were cold and she</p>	R0268	<p><b>R 268 410 IAC 16.2-5-5.1 (a) Food and Nutritional Services-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. The Dining Service Coordinator has ordered and received ladles to ensure appropriate portions are being served as referenced by our recipes. The Dining Service Coordinator has received additional training as to appropriate food portioning, food preparation, and food temperatures in effort to enhance the flavor and intake of our meals. 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 Dining Service Coordinator and cooking staff have received additional training as to appropriate portioning, food</b></p>	05/20/2012			

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	<p>received no bread. Resident #51 indicated she could not cut or chew the pork chop.</p> <p>Upon interview of the FSC [Food Service Coordinator] on 3/27/12 at 11:20 a.m., she indicated she did not have the serving-sized ladles; she indicated she had received some of the serving-sized ladles but not all of the sizes she had requested had arrived. The FSC indicated she was having trouble getting the ladles as the dietician did not really want the ladles ordered.</p>		<p>preparation, and food temperatures in effort to enhance the flavor and intake of our meals. Bell Oaks Terrace has obtained appropriate ladles to ensure portioning of food items are served as indicated by our recipes. Bell Oaks Terrace will continue to perform monthly Food Committee Meetings in effort to provide residents with a means of voicing food concerns so that we may improve our services and improve their overall quality of life.</p> <p><b>. 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 Residence Director and/or Designee will perform weekly random reviews of dining services regarding food preparation portion sizes, food temperature and interview ten residents weekly for resident satisfaction with dining services for six months and quarterly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012</b></p>				

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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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R0269	<p>410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician.</p> <p>Based on interview and record review, the facility failed to ensure menu substitutions were approved by a registered dietician, for 1 of 1 record of food substitution reviewed. This had the potential to affect 41 of 41 residents currently in the facility.</p> <p>Findings include:</p> <p>During interview of the Food Services Coordinator [FSC] on 3/29/12 at 10:40 A.M., regarding substituting items for meals, the FSC indicated she substituted when she did not have items available the menus required. The FSC indicated a record was kept in a binder for food substitutions.</p> <p>The "Record of Food Substitution" was obtained from the FSC on 3/29/12 at 10:40 A.M. The "Record of Food Substitution" listed the original menu item, food substituted, reason for the substitution, menu reference (season/week), and initials. Food substitutions were documented for 2/1, 2/6, 3/11, 3/15, 3/22, and 3/22/12. The initials documented were the initials of</p>	R0269	<p><b>R 269 410 IAC 16.2-5-5.1 (b) Food and Nutritional Services- Noncompliance 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, Dining Service Coordinator, and cooking staff were re-educated as to our policy and procedure regarding food substitutions and Dietician notification upon a change in the menu as referenced by Indiana state regulation R 269 410 IAC 16.2-5-5.1 (b) Food and Nutritional Services. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</b></p>	05/20/2012			

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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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	<p>the Food Services Coordinators. Documentation was lacking to indicate a Registered Dietician approved the substitutions on the "Record of Food Substitution." The FSC stated she did not know if the dietician was notified or what was done with the "Record of Food Substitution," as there were many in the binder.</p> <p>On 3/29/12 at 11:05 A.M., the dietician's report from 12/5/11 was obtained from the DoN (Wellness Director). Under the operations compliance comments, letter "b" - utilize [name of corporation] menus and recipes, the dietician documented, "Unaware new menus are out. Will start next week."</p>		<p><b>program will be put into place? The Dining Services Coordinator and/or Designee will perform weekly reviews of the food Substitution Log to ensure the Dietician has documented notification upon a food substution for a period of six months, followed by monthly for three months and quarterly thereafter. Audits will be reviewed through our Bell Oaks QA process for continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012</b></p>				

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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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R0270	<p>410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.</p> <p>Based on observation, record review and interview, the facility failed to meet the daily dietary requirements for 1 of 1 resident on a pureed diet, in the sample of 7, and for 1 of 1 supplemental sample resident not provided what was menued, in the supplemental sample of 11, in that recipes were not used to prepare the food to ensure daily requirements were met, and a resident was served a half serving the the protein instead of a whole serving. (Resident #22, Resident B)</p> <p>Findings include:</p> <p>1. On 3/23/12 at 9:56 A.M., the Food Services Coordinator [FSC] was interviewed regarding preparing puree foods. She indicated Resident #22 was the only resident receiving a pureed diet; she was preparing the puree food for Resident #22. The FSC indicated she put the food into the food processor and added chicken broth to it. The FSC indicated she went by looks and did not have recipes to follow for preparing puree</p>	R0270	<p><b>R 270 410 IAC 16.2-5-5.1 (c) (1-3) Food and Nutritional Services- 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 #22 no longer resides at Bell Oaks Terrace. Resident B recieves measured portions as indicated by the recipes. 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 Dining Service Coordinator and cooking staff were re-educated as to our policy and procedure and recipes regarding pureed foods. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>	05/20/2012			

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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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	<p>foods. She indicated she had added thickener to the puree food in the past but the resident who received puree foods did not like the thickener. On 3/27/12 at 11:35 A.M., the FSC indicated she did not have recipes for puree foods. On 3/29/12 at 10:40 A.M. the FSC indicated she did not have recipes for puree foods.</p> <p>On 3/27/12 at 11:35 A.M., the FSC placed an unmeasured amount of hot potatoes into blender and turned the blender on. After potatoes were blended, the FSC placed the potatoes onto a serving plate for the resident and the plate was placed on the counter. The blender bowl and blade were cleaned by the FSC.</p> <p>On 3/27/12 at 11:44 A.M., the FSC placed a piece of hot chicken into the blender and turned the blender on. The chicken was checked and four ounces of broth from the pan was placed into the blender with the partially blended chicken and the chicken was blended. The FSC then placed the chicken onto the serving plate and the plate was placed on the counter. The blender bowl and blade were then cleaned by the FSC.</p> <p>On 3/27/12 at 12:17 P.M., the FSC placed 1/2 cup of mixed vegetables with peas into the blender and started the blender. The FSC then added approximately 2</p>		<p><b>i.e., what quality assurance program will be put into place?</b> The Dining Service Coordinator and/or Designee will perform random weekly reviews to include all three meals of residents requiring a medically altered or pureed diet as well as portion sizes to ensure compliance for a period of six months followed by monthly for three months and quarterly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. <b>By what date will the systemic changes be completed?</b> May 20, 2012</p>				

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	<p>ounces of liquid from the mixed vegetables and cut off a slice of butter (not measured) and placed them into the blender with the already partially blended mixed vegetables. The vegetables were then placed onto the serving plate and the plate was placed on top of the steam table uncovered.</p> <p>The policy for puree food, obtained on 3/29/12 at 10:20 A.M. from the DoN (Wellness Director), indicated, "All foods will be pureed to the consistency of pudding and special recipes will be followed to ensure that the amounts of calories and protein served are equivalent to a regular diet."</p> <p>2. On interview on 3/27/12 at 8:50 A.M., Resident B indicated the serving sizes were inconsistent. Resident B indicated she had mentioned this several times during the food service committee meetings. On interview with Resident B on 3/28/12 at 1:20 P.M., the resident indicated she received only 1/2 of a salmon patty for lunch. Resident B indicated she would have eaten a whole salmon patty if she had been served a whole one. The menu, posted on the dining room wall that date, and reviewed at that time, indicated the serving size was a whole salmon patty.</p>						

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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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(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

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R0273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure food was prepared and served in accordance with safe food handling standards, for 1 of 1 kitchen area in the facility, in that food was not maintained at a safe temperature, hands were not washed, hair was not covered, and outdated moldy food was observed stored in the kitchen. This had the potential to affect 41 of 41 residents currently residing in the facility.</p> <p>Findings include:</p> <p>On observation of the kitchen on 3/23/12 at 9:50 A.M., the following observations were made.</p> <p>On the bread shelves where bread was stored for use by the residents: Blueberry Crumble bread: 1 loaf dated "best used by 2/11/12"</p> <p>Brown-Sugar Cinnamon bread: 2 loaves dated "best used by 2/10/12" 1 loaf dated "best used by 2/18/12" 1 loaf dated "best used by 2/25/12" 2 loaves dated "best used by 3/12/12"</p>	R0273	<p><b>R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services-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. The Dining Service Coordinator, cooking staff, and staff were re-educated to our policy and procedures regarding serving meals at appropriate food temperatures, hand washing, and donning of hair nets. Foods found to be moldy or outdated were removed and discarded upon finding. 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 Dining Service Coordinator, cooking staff, and staff were re-educated to our policy and procedures regarding serving meals at appropriate food temperatures, hand washing,</b></p>	05/20/2012			

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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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	<p>2 loaves dated "best used by 3/17/12"</p> <p>Hot dog buns: 1 package dated "best used by 2/18/12" with a small amount of mold 1 package dated "best used by 3/10/12"</p> <p>Hamburger buns: 3 packages dated "best used by 2/25/12" 5 packages dated "best used by 3/17/12" 3 packages had no dates on them.</p> <p>In the refrigerator there was a bag of watery shredded cabbage with a small bag of shredded carrots in it that had been opened and resealed and dated 3/19/12. The bag had "best used by 2/20/12" on it.</p> <p>In the large refrigerator, sitting on a tray, there was a ham with a slice cut off the top, covered with aluminum foil dated 3/15/12. There was an open bag of lettuce that was beginning to brown, dated 3/20/12 on the tape used to reseat the bag, but the box was dated 2/20/12. There was also an open package of non-dairy whipped topping, with the decorating tip in the bottom of the package in the refrigerator, opened with no date on it.</p> <p>The FSC was observed dishing up grapes out of a bin, dated 3/15/12, that had mold growing on other grapes in the bin. Upon interview of the FSC, she indicated the</p>		<p>donning of hair nets, and discarding of outdated or expired food items. The Dining Service Coordinator and/or Designee will be responsible to ensure continued compliance with Indiana state regulation R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services. <b>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 Dining Services Coordinator and/or Designee will perform random weekly reviews to include all three meals of staff handwashing, adherence to donning of hairnets and removal/discarding of expired or outdated food items as indicated within our policy and procedure for a period of six months, monthly for three months and quarterly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process to ensure continuing compliance or further action if warranted. By what date will the systemic changes be completed? May 20, 2012</b></p>				

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	<p>grapes were rinsed off prior to placing them into the bin. She indicated she did not rinse the grapes prior to placing them in the bowls to serve to the residents. She indicated she would need to pick the molded grapes out.</p> <p>In the freezer was a bag of frozen vegetables that had been opened and resealed, with no date on the sealing tape.</p> <p>On 3/27/12 at 11:35 A.M., the FSC blended Resident #22's potatoes and placed them onto a plate and left them on the countertop with no lid on it. At 11:44 A.M., the FSC blended Resident #22's chicken, placed it onto the same plate and left it on the countertop with no lid on it. At 12:17 P.M., the FSC blended Resident #22's mixed vegetables, placed them on the same plate, and placed the plate on top of a steam table lid. The plate was left uncovered. At 12:28 P.M., the FSC removed the plate to serve to Resident #22. It was requested for the temperature be checked; the temperature of the potatoes was 80 degrees and the temperature of the chicken was 90 degrees. The FSC then placed the plate of food into the microwave and turned the microwave on to reheat the food. At 12:41 P.M., the FSC reheated the plate of food in the microwave and handed it to the server for Resident #22. Upon</p>						

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	<p>interview of the FSC, at that time, she indicated she did not have any covers for the plates.</p> <p>On 3/27/12 at 11:20 A.M., the facility's Maintenance man was observed to be standing in the kitchen near the food preparation area while food was being prepared with no hairnet on or beard cover on. The Maintenance man was observed to stand in the kitchen for approximately 20 minutes.</p> <p>On 3/27/12 at 11:40 A.M., an outside contractor was observed to be checking the refrigerators in the food preparation areas. The outside contractor did not apply a hairnet or a beard cover while he was in the kitchen checking the refrigerators. The outside contractor also leaned into the refrigerators with a large flashlight. Food was stored in both refrigerators while the outside contractor was inspecting them.</p> <p>On 3/27/12 at 12:00 P.M., CNA #3 was observed to enter the kitchen, open the refrigerator, and remove pitchers of drinks. CNA #3 had a hairnet on but did not wash her hands. The FSC informed CNA #3 that she needed to wash her hands; CNA #3 then left the room, leaving the refrigerator door open. At that time, CNA #2 was observed to enter the</p>			
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	kitchen and remove pitchers of fluid to serve to the residents. No handwashing was observed by CNA #2.			

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on observation, interview and record review, the facility failed to ensure clinical records were complete and accurate, for 2 of 7 sampled clinical records, in the sample of 7, and for 1 of 7 supplemental sample records in the supplemental sample of 11, in that Cardiopulmonary Resuscitation was administered to a resident and it was not documented in the record, and wrong physician names were on physicians' orders. (Residents #28, #19, B)</p> <p>Findings include:</p> <p>1. Resident #28's clinical record was reviewed on 3/22/12 at 3:15 p.m. The resident was admitted to the facility on 4/12/10 with diagnoses including, but not limited to, osteoporosis and dementia. The record included an "Out of Hospital Do Not Resuscitate Declaration." The declaration was dated April 12, 2010. The declaration included a signed</p>	R0349	<p>We respectfully disagree with the below citation and would like to introduce for your review documentation and request a face to face Informal Dispute Resolution. <b>R 349 410 IAC 16.2-5-8.1 (1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> No residents were found to be affected. Please note a discrepancy in the finding stating CPR was performed by the Wellness Director. On 3/23/12 Resident #28 had CPR performed by the beautician under the Good Samaritan law until such a time staff had declared she was a DNR in which it was immediately stopped. Resident # 19 is a very independent resident who is able to demonstrate ability to self medicate and take care of matters concerning her financial and medical needs. Resident #19 decided to change physicians</p>	05/20/2012			

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	<p>physician's order as follows: "...I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out of Hospital Do Not Resuscitate Declaration is revoked." The order was signed by the physician on 4/12/10. There was no revocation of the Do Not Resuscitate Declaration.</p> <p>Resident #28's clinical record binder was observed to have a pinkish-red dot on the visible part of the binder when it was on the chart rack. The face sheet in the record also had the pinkish-red dot. According to the Wellness Director, on 3/26/12 at 11:10 a.m., the pinkish-red dot indicated the resident was not to be resuscitated.</p> <p>On 3/23/12 at 9:40 a.m., Resident #28 was observed in the beauty shop, seated in a wheelchair. At 10:10 a.m., LPN #4 was observed carrying Resident #28's clinical record and approaching the beauty shop door. As the door opened, Resident #28 was observed on the floor, with the Wellness Director doing chest compressions of CardioPulmonary Resuscitation [CPR]. The Corporate Nurse was in the room and LPN #1 was in the room. At that time, LPN #4 indicated</p>		<p>without consulting or providing information onto Bell Oaks staff for a documented change within the resident's medical record. Physician of record was changed prior to survey ending and was review with surveyors prior to exit on 3/31/12. <b>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?</b> No other residents were found to be affected. The Residence Director reviewed resident face sheets to ensure appropriate information was documented concerning resident health care needs and preferences. <b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Residence Sales Manager, Wellness Director, and licensed staff were re-educated to ensuring medical records are maintained and updated as needed to ensure they are (1) Complete (2) Accurately documented (3) Readily accessible and (4) Systematically organized. <b>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?</b> The Wellness Director and/or</p>				

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	<p>the resident had orders for Do Not Resuscitate. CPR was stopped. At 10:25 a.m., Resident 28 was observed to be laying on the beauty shop floor. Respirations were observed; her eyes were closed; oxygen was on via nasal cannula at 2 liters per minute. At that time, Emergency Services Personnel arrived. The Wellness Director reported to the Emergency Services Personnel the resident had become unresponsive in the beauty shop. The beautician had called for help. The resident was assessed to have no pulse and no respirations and Cardiopulmonary Resuscitation had been initiated. He indicated when they realized the resident had a Do Not Resuscitate order, they stopped CPR and the resident began breathing on her own. The blood pressure was low at first but then came up. The resident was observed to be responsive to her name.</p> <p>Nurses' notes reviewed on 3/26/12 at 2:00 p.m. included the following: 3/19/12 1800 [6:00 p.m.] "[Medical equipment supply company] here et picked up nebulizer unit [after] completion of 10 d [day] usage as ordered." 3/23/12 1010 [10:10 a.m.] "Was called to beauty shop by beauty shop operator where res. [resident] collapsed on floor [and] was unresponsive. 9-1-1 called</p>		<p>Designee will perform weekly reviews to include 25% of all resident face sheets (100% monthly) to ensure the resident's clinical record is in compliance with Indiana state regulation R 273 410 IAC 16.2-5-8.1 (1-4) Clinical Records. Audits will be conducted for aperiod of six months, followed by monthly audits x three months and quarterly thereafter. Audits will be reviewed through our Bell Oaks Terrace QA process for continuing compliance or further action if warranted. <b>By what date will the systemic changes be completed?</b> May 20, 2012</p>				

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	<p>[and] face sheet, labs, transfer sheet. Ambulance took res. to [name of hospital]. Niece [and] nephew notified." 3/23/12 2200 [10:00 p.m.] "Resident admitted to [name of hospital] to...neuro ICU [intensive care unit] [with] DX [diagnosis]: cardiac arrest...."</p> <p>The clinical record failed to indicate Cardiopulmonary Resuscitation was administered to the resident.</p> <p>2. Resident #19's clinical record was reviewed on 3/22/12 at 11:40 A.M. Resident #19 had cumulative orders in her chart for 7/1/11-7/31/11 and 10/1/11-10/31/11 with a nephrologist's physician name on the orders, not her primary care physician. Resident #19's physician signed the cumulative orders for 7/1/11-7/30/11, even though the nephrologist's name was typed on them.</p> <p>On review of the clinical record of Resident #19, on 3/22/12 at 11:40 A.M., Resident #19 had a physician's order faxed to the physician for his signature on 3/16/12 for a CBC [complete blood count], CMP [comprehensive metabolic panel], and a U/A [urinalysis]. There were no results for 3/16/12 for any of the tests. On interview of the DoN [Wellness Director] on 3/28/12 at 9:00 A.M., the DoN produced results for a U/A from 3/1/12 and results from a CBC and CMP</p>			

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	<p>from 3/13/12.</p> <p>3. On review of the clinical record of Resident B on 3/27/12 at 11:05 A.M., the resident's cumulative orders had a physician's name typed on them that was not the resident's physician. The cumulative orders that were signed on 1/13/11 were the last orders that were signed by Resident B's physician, and these orders had the incorrect physician's name on them.</p>			