

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/23/2013
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NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
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F000000	<p>This visit was for the Investigation of Complaint IN00136796.</p> <p>Complaint IN00136796 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F514 and F999.</p> <p>Survey dates: October 22 and 23, 2013</p> <p>Facility number: 000565 Provider number: 155546 AIM number: 100267630</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 68 SNF: 16 Total: 84</p> <p>Census payor type: Medicare: 19 Medicaid: 53 Other: 12 Total: 84</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. This facility requests paper compliance for this Complaint IN00136796.</p>	
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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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	IAC 16.2.  Quality review completed by Debora Barth, RN.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a resident's legal representative was contacted when the resident's lower dentures were noted to be broken</p>	F000157	<p>1. Resident B's son was notified of the broken dentures in August 2013. The facility is unable to correct the notification of family for treatment Resident B received following the dental exam. 2. All</p>	11/22/2013

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	<p>requiring an evaluation from the dentist and subsequent treatment orders for 1 of 1 resident reviewed with a lower broken denture in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 10/22/13 at 2:15 p.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, Alzheimer's disease, vascular dementia with delusions and hallucinations, dementia with behavioral disturbances, and congestive heart failure.</p> <p>During an interview on 10/23/13 at 8:45 a.m., with Resident #B's son, who was listed as her Durable Power of Attorney and Health Care Representative in a legal document dated 5/23/03, he indicated his mother's lower denture was broken sometime in June 2013 and he had not been notified of the broken dentures and subsequent dental visit until sometime in late August 2013.</p> <p>During an interview with the resident's daughter on 10/23/13 at 12:10 p.m., she indicated she resided in Alaska</p>		<p>residents with dentures have the potential to be affected. Unable to make the corrective action due to the resident no longer residing in the facility. 3. Social Services Consultant will present an inservice to the Social Services department. The Social Services Director will be responsible to notify the appropriate family member when a resident's dentures are in need of repair. A log of residents requiring dental services will be completed by the Social Services Director. 4. The Administrator or Designee will perform an audit of the resident dental services log to ensure family notification was completed weekly times eight, then twice monthly for two months, then monthly times two. The audit results will be forwarded to QA for review.5. Date of Completion: November 22, 2013.</p>		

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	<p>and was unaware her mother's lower denture was broken until her visit to the facility in late August 2013 when she noted her mother was not wearing the lower denture.</p> <p>The clinical record lacked any information related to the resident's lower denture having been broken in June 2013 or any family notification of the broken denture.</p> <p>During an interview with the Social Services Director (SSD) on 10/23/13 at 10:15 a.m., she indicated she was notified of the broken lower denture by a note placed under her door on 6/13/13 by LPN #1. She indicated she visited the resident the next day and obtained the broken denture to be given to the dentist during a dental visit on 6/19/13. She indicated she added Resident #B's name and the broken denture information on a list of residents to be seen by the dentist during the 6/19/13 visit. She indicated she had not notified the family of the broken denture and newly scheduled dental visit because she assumed LPN #1 had notified the family on 6/13/13.</p> <p>A dental exam note, dated 6/19/13, indicated the resident was seen by the dentist on that date and "sore</p>			

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	<p>areas" were noted on the lower gums and inside of the lower lip. The note indicated a treatment would be ordered.</p> <p>A new order, dated 6/19/13, indicated the staff were to apply triamcinolone acetonide ointment 1% to the inside lower lip three times a day for the sore in her mouth until healed.</p> <p>The clinical record lacked any information related to family notification of the dental visit and/or treatment ordered by the dentist on 6/19/13.</p> <p>Review of a current facility policy, updated 8/2013, provided by the DoN on 10/23/13 at 2:35 p.m., titled "Physician/Family/Responsible Party Notification for Change in Condition", included, but was not limited to, the following:</p> <p>"Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner....</p> <p>Policy:</p> <p>1. Physician and family/responsible party notification is to include, but is</p>				

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	<p>not limited to:</p> <p>...*Any accident or incident... *Change in condition that may warrant a change in current treatment...</p> <p>2. Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained.</p> <p>This federal tag relates to Complaint IN00136796.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurate in regards to broken dentures, dental consultations, dental records, facility incidents, and resident behaviors for 2 of 3 residents reviewed for complete and accurate clinical records in a sample of 5. (Residents #B and #E)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 10/22/13 at 2:15 p.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, Alzheimer's disease, vascular dementia with</p>	F000514	<p>1. The facility is unable to correct inaccuracies related to Resident B. Resident B no longer resides at the facility. Social Services Director placed a progress note in Resident E's medical record indicating that she had not shown any adverse effects related to the incident that occurred on August 28, 2013, with notation from psych services visits which were completed weekly. 2. All residents have the potential to be affected. Social Services Director to review all other residents whom have had dentures broken over the past thirty days to ensure family notification occurred. Documentation regarding resident to resident incidents within the past thirty days will be reviewed. 3. Social Services Consultant will present an inservice to the Social Services department. The Social Services Director will be</p>	11/22/2013			

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	<p>delusions and hallucinations, dementia with behavioral disturbances, and congestive heart failure.</p> <p>During an interview with the Social Services Director (SSD) on 10/23/13 at 10:15 a.m., she indicated she was notified that Resident #B's lower denture was broken by a note placed under her door on 6/13/13 by LPN #1. She indicated she visited the resident the next day and obtained the broken denture to be given to the dentist during a dental visit on 6/19/13.</p> <p>The clinical record lacked any information related to the resident's lower denture having been broken on June 13, 2013 or any family notification of the broken denture.</p> <p>A dental exam note, dated 6/19/13, indicated the resident was seen by the dentist on that date. The note indicated the resident had both upper and lower dentures present. The note indicated an adjustment had been done on the lower denture that day. The note lacked any information related to the lower denture being broken.</p> <p>During an interview with the Administrator, DoN, RN Consultant,</p>		<p>responsible to notify the appropriate family member when a resident's dentures are in need of repair and will place documentation of such in the clinical record. A log of residents requiring dental services will be completed by the Social Services Director. The Social Services Director, Director of Nursing, and Administrator placed a call to the Service Manager for the facility's dental provider to request that the facility receives appropriate documentation for receipt of resident dentures. Per their policy, they will provide the facility a Denture Repair Request form upon receipt of resident dentures during onsite visits. The Service Manager had discussions with their team regarding discrepancies noted within their documentation presented to the facility. An inservice will be provided to the Nursing department on completing oral/dental evaluations. An inservice will be provided to the Nursing and Social Services department on appropriate documentation of resident behaviors.4. The Administrator or Designee will perform an audit of the resident dental services log to ensure family notification was completed weekly times eight, then twice monthly for two months, then monthly times two. The Director of Nursing or Designee will audit three oral/dental assessments weekly</p>		

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	<p>and SSD on 10/23/13 at 10:15 a.m., additional information was requested related to the discrepancies between the SSD information and the dental exam note.</p> <p>During a review of a faxed document from the dental provider Director of Clinical Services, dated 10/23/13, the following information was provided:</p> <p>"After review of resident chart and information provided by the facility, the possibility exists that the clinical assistant documented in error.</p> <p>Dentures presented to the dental team at the time of the visit. The upper denture was able to be placed in the resident's mouth. Orders were written for kenalog with orabase due to sore areas on the lower gums and inside of lower lip.</p> <p>Lower denture would not have been recommended due to the above order."</p> <p>The June 2013 medication record for Resident #B indicated the treatment for the sore gums was given throughout the month of June.</p> <p>A Oral/Dental Evaluation, dated 6/24/13, completed by LPN #1,</p>		<p>times eight, then twice weekly times four, then will spot check monthly times two. Results from the audits will be forwarded to QA for review. 5. Date of Completion - November 22, 2013.</p>		

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	<p>indicated "No" to the question "Are there any sores, lesions, or ulcers in oral cavity (including under dentures)?" The "comments" section of the evaluation lacked any info related to the resident having a current treatment order for sore gums. The note indicated the resident attempted to "bite the dentist" during the 6/19/13 dental visit. The nursing notes, social service notes, and dental exam notes for the 6/19/13 visit lacked any information related to the resident attempting to bite the dentist during the visit.</p> <p>Review of an "Incident Report Form", dated 8/28/13, faxed to the Indiana State Department of Health on 8/29/13, indicated Resident #B had been involved in a incident on 8/28/13 at 1:05 p.m. with two other residents. The "Brief Description of Incident" information included, but was not limited to, the following:</p> <p>"...[Name of Resident #B] propelled self in wheelchair up to [name of Resident #E] and made a motion with the back of her right hand at the left side of [name of Resident #E's] body. Staff did not see any contact between residents. [Name of Resident E] did say "If you hit me again, I will hit you."</p>						

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	<p>Staff immediately separated residents."</p> <p>The form indicated the resident's family and physician were notified and the resident was sent to ER [emergency room] for evaluation and possible "Psych services".</p> <p>The clinical record contained a "Behavior Sheet" completed by the DoN on 8/28/13 that gave a summary of the above incident but did not identify the other residents involved.</p> <p>During an interview on 10/23/13 at 1:20 p.m., the DoN indicated she had not witnessed the incident and had completed the behavior sheet information from the reports of other staff members.</p> <p>A "Situation Background Assessment and Recommendation" [SBAR] note, completed by LPN #2, dated 8/28/13 at 2:42 p.m., indicated the resident was being transferred to ER for evaluation due to "resident has had an increase in behaviors over last few weeks, today resident has been combative." No specific incident information was documented.</p> <p>The nursing and/or social services notes for Resident #B, lacked any</p>				

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	<p>specific information from the staff involved related to the incident between Resident #B and Resident #E leading to the need for Resident #B to be transferred from the facility for evaluation and possible treatment.</p> <p>The only nursing note for the day shift on 8/28/13 was completed by LPN #2 as noted below:</p> <p>8/28/13 at 3:41 p.m. - "[name of ambulance service] here to transport resident to ER for psych evaluation. Report called to ...."</p> <p>During an interview with the DoN and SSD on 10/23/13 at 1:00 p.m., additional information was requested related to the lack of documentation of the dental concerns and incident concerns noted.</p> <p>The facility failed to provide any additional information as of exit on 10/23/13.</p> <p>2.) The clinical record for Resident #E was reviewed on 10/23/13 at 12:05 p.m.</p> <p>Diagnoses for Resident #E included, but were not limited to, paranoid schizophrenia and anxiety disorder.</p>			

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	<p>Review of an "Incident Report Form", dated 8/28/13, faxed to the Indiana State Department of Health on 8/29/13, indicated Resident #E had been involved in a incident with Resident #B on 8/28/13 at 1:05 p.m. The "Brief Description of Incident" information included, but was not limited to, the following:</p> <p>"...[Name of Resident #B] propelled self in wheelchair up to [name of Resident #E] and made a motion with the back of her right hand at the left side of [name of Resident #E's] body. Staff did not see any contact between residents. [Name of Resident E] did say "If you hit me again, I will hit you." Staff immediately separated residents."</p> <p>The nursing notes and social service notes for Resident #E lacked any information related to the incident occurring on 8/28/13 with Resident #B. A "weekly skin assessment" sheet completed on 8/28/13 and 8/29/13 indicated there were no skin concerns. The assessments lacked any information related to Resident #E possibly being struck by Resident #B or any other incident information.</p> <p>During an interview with RN Consultant on 10/23/13 at 1:35 p.m.,</p>			

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	<p>she indicated she was unable to find any nursing and/or SS notes related to the incident in Resident #E's clinical record.</p> <p>3.) Review of the current facility policy, dated 1/2012, provided by the DoN on 10/23/13 at 2:35 p.m., titled "Documentation Procedure and Guidelines", included, but was not limited to, the following:</p> <p>"Purpose:</p> <ol style="list-style-type: none"> <li>To reflect the quality of care provided to each resident.</li> <li>...3. To serve as the basis for monitoring activities, education programs, risk management, and other management statistics.</li> </ol> <p>...General Guidelines:</p> <ol style="list-style-type: none"> <li>...3. Any change in condition, will require written evaluation.</li> </ol> <p>...Nursing Documentation:</p> <ol style="list-style-type: none"> <li>Each health care professional shall be responsible for making their own prompt, factual, concise entries that are complete, appropriate and readable.</li> <li>Each entry will include the date, time, signature and position (title) of</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/23/2013
NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304		
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	<p>the individual making the entry.</p> <p>3. Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner...."</p> <p>This federal tag relates to Complaint IN00136796.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

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F009999	<p>3.1-9 PERSONAL PROPERTY</p> <p>(b) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure a resident's lower denture was not given to the dentist and/or lost for 1 of 1 resident reviewed with a broken lower denture. (Resident #B)</p> <p>Findings:</p> <p>The clinical record for Resident #B was reviewed on 10/22/13 at 2:15 p.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, Alzheimer's disease, vascular dementia with delusions and hallucinations, dementia with behavioral disturbances, and congestive heart failure.</p> <p>An "Inventory of Personal Effects" record for Resident #B, dated</p>	F009999	<p>1. The facility has offered to replace Resident B's dentures at the provider of her and/or her family's choice. 2. All residents requiring services to their dentures are potentially at risk. Social Services will review dental services to be reviewed for the past thirty days to ensure residents received their dentures. 3. The Social Services Director, Director of Nursing, and Administrator placed a call to the dental provider Service Manager and requested documentation of receipt of every residents' dentures. Facility provider is to provide the Social Services Director, at the time of the onsite visits, a Denture Repair Request form to notify receipt of the resident's dentures. When the facility releases any residents' dentures to the dental provider, the information will be placed on the resident dental services log. The Social Services Director is responsible to ensure the facility receives the resident's dentures back from the dental provider. 4. The Administrator or Designee will complete an audit of the resident dental services log to ensure facility receipt of resident dentures from the facility's dental provider weekly times eight, then twice monthly for two months, then monthly times two. The audit results will be forwarded to QA for review. 5. Date of completion -</p>	11/22/2013	

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	<p>10/17/05, indicated the resident had both upper and lower dentures when she was admitted to the facility.</p> <p>During an interview on 10/23/13 at 8:45 a.m., with Resident #B's son, who was listed as her Durable Power of Attorney and Health Care Representative in a legal document dated 5/23/03, he indicated his mother's lower denture was broken sometime in June 2013. He indicated staff had told him the resident had seen the dentist in June 2013 and the broken lower denture had been given to the dentist and had never returned to the resident. He indicated he was not aware of the broken dentures and subsequent dental visit until sometime in late August 2013.</p> <p>During an interview with the Social Services Director (SSD) on 10/23/13 at 10:15 a.m., she indicated she was notified of the broken lower denture by a note placed under her door on 6/13/13 by LPN #1. She indicated she visited the resident the next day and obtained the broken denture to be given to the dentist during a dental visit on 6/19/13. Additional information was requested as to the current location of the lower denture and if it had been given to the dentist as indicated by the resident's son</p>		November 22, 2013.				

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	<p>above.</p> <p>During an interview with the SSD on 10/23/13 at 12:30 p.m., she indicated the broken lower denture had been given to the dentist during the visit on 6/19/13 for assessment. She indicated the dentures had not been seen again since that visit. She indicated the dental provider was to give the facility a receipt slip when dentures were taken. She indicated the facility did not have a receipt slip for the dentures. She indicated she had contacted the dental provider and they indicated they did not have the resident's denture. She indicated the location and/or status of the missing denture was unknown.</p> <p>This State tag relates to Complaint IN00136796.</p>				