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 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 2, 3, 4, 5, 9,10, 2013 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Tina Smith-Staats, RN Toni Maley, BSW (12/9/13, 12/10/13) Census bed type: SNF/NF: 67 SNF: 16 Total: 83 Census payor type: Medicare: 20 Medicaid: 54 Other: 9 Total: 83 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.	F000000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this 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 respectfully requests paper compliance for this Recertification and State Licensure Survey.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the physician of weight gain in accordance with his orders for 1 of 3 residents reviewed for nutrition.	F000157	1. The physician was notified of Resident #162's weight gain. Orders were clarified to include obtaining weights immediately following dialysis weekly and to notify with weight changes greater	01/09/2014

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	(Resident #162) Findings include: The clinical record for Resident #162 was reviewed on 12/4/13 at 10:01 a.m. Diagnoses for Resident #162 included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure. A physician's order, dated 12/5/13, indicated Resident #162 was to be weighed daily. The physician was to be notified if the resident had a weight gain of two pounds in one day and five pounds in seven days. Review of the December 2013, daily weights, on 12/10/13, indicated the resident weighed 155.2 pounds on 12/8/13 and weighed 158.2 pounds on 12/9/13. This was a weight gain of three pounds in one day. The clinical record lacked any documentation of the physician having been notified of the three pound weight gain from 12/8/13 to 12/9/13 for Resident #162. During an interview with the RN Consultant and the Director of		than five pounds in one week. 2. All residents with daily weight orders have the potential to be affected. A 100% audit was completed on residents with daily weight orders over the past 30 days to ensure notifications were completed. 3. Nursing staff inserviced. The Restorative Aide/designee is responsible to obtain daily weights and report these to the appropriate charge nurse. The charge nurses are then responsible to notify the physician if indicated and place a progress note. Daily weights will be reviewed by the Respiratory Therapist. 4. The DON/designee will perform a daily audit five days a week for eight weeks, then weekly for eight weeks, then monthly times two to ensure physician notification is completed. Results of the audits will be forwarded to QA for review times twelve months. 5. Date of Completion: January 9, 2014.	

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	Nursing (DoN) on 12/10/13 at 11:00 a.m., additional information was requested related to the lack of physician notification of the three pound weight gain on 12/9/13 for Resident # 162. During an interview with the RN Consultant on 12/10/13 at 3:38 p.m., she indicated the physician had not been notified of the resident's three pound weight gain on 12/9/13. 3.1-5(a)(2) 3.1-5(a)(3)			

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F000252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview the facility failed to ensure the residents maintained the right to reside in a homelike environment by prohibiting the use of personal items within the resident's living space for 1 of 22 residents interviewed . (Resident #14) Findings include: During an observation of the room for Resident #14 on 12/2/13 at 10:15 a.m., the walls were bare and devoid of any personal items of the resident. During an interview with Resident #14 on 12/2/13 at 10:15 a.m., the resident indicated the facility denied her the right to hang her "butterflies" on the walls after the walls had been repainted. The Resident stated the butterflies had been on the wall prior to the walls being painted. She also indicated the facility sent her son a letter informing him that her recliner needed to be removed from the facility or they would donate it.	F000252	1. HFA and SSD will meet with Resident 14 and/or family and discussion will be held regarding having personal items that do not affect the safety or cleanliness of her room while providing a comfortable, homelike environment. 2. All residents have the potential to be affected. 3. The facility "Policy for Personal Equipment/Furniture Items in the Facility" has been revised. Current residents or families will be informed of this new policy change and new residents will be informed during admission paperwork review. 4. (A) Any issues regarding a breach in a safe, clean, and homelike environment will be addresseed via "Grievance/Concern Form". (B) Social Services/designee will contact the resident and/or family regarding the concern. (C) A mutually agreed upon resolution will be reached and documented based on the Indiana State regulatory requirements. Any concerns will be brought to the QA Committee times twelve months. 5. Date of Completion - January 9, 2014.	01/09/2014

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	During an interview 12/10/13 at 1:18 p.m., the Administrator indicated the facility discourages residents from putting "heavy" pictures on the walls for fear of them falling off. When asked to define "heavy", she indicated that she and the Maintenance Manager made the decision on what "heavy" entailed. The Administrator confirmed the family of Resident #14 had been asked to remove the recliner. The Administrator indicated that "overstuffed recliners" were being discouraged because they over crowded the residents' rooms. The Administrator provided a, 1/1/13, policy entitled "Policy for Personal Equipment/Furniture Items in the Facility", on 12/10/13 at 1:55 p.m. The policy indicated: "Policy for Personal Equipment/Furniture Items in the Facility TLC Management Facilities Effective: January 1, 2013 Purpose: Due to changes in the healthcare environment and resident 'medical' needs, TLC Management has been working very hard on (sic) the past few years to be on the 'cutting edge' when it comes to providing the proper			

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	equipment and furniture items in the facility in resident rooms. Guidelines are required to provide a safe and clean environment for residents. Policy: Electrical Equipment Prohibited for use in Resident's Room 1. Microwaves 2. Hot Plates 3. Coffeemakers 4. Refrigerators 5. Overstuffed Chairs/Electric Recliners-Residents are not allowed to bring their own for personal use. NOTE: Due to room size and the possibility of sharing the room with another resident, recliners or chairs, especially those large in size, would create an unsafe environment for both residents. The fabrics on personal furniture items are not Fire Flame Rated nor are they capable of being properly cleaned. The facility reserves the right to inspect all furniture being brought into the facility. All furniture must first have the approval the administrator before it can be placed in the resident's room.... Resident's Personal Pictures, Calendars, and etc. 1. Personal items to be mounted in the resident's room MUST not be			

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	'taped', 'push-pinned', at no time are nails to be used in the resident's room. The facility can install a large bulletin board in the room for resident's use for such items...." On 12/10/13 at 2:23 p.m., an undated copy of the Resident Rights was provided by office personnel. The copy indicated: "RESIDENT RIGHTS ... L. Personal Property The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing as space permits unless to do so would infringe upon the rights or health and safety of other residents...." 3.1-9(a)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on interview and record review, the facility failed to ensure a resident's "Code Status" order was in accordance with the resident's and family's wishes for 1 of 6 residents reviewed for nursing care related to advanced directives (Resident #63) and the facility failed to complete an evaluation of the dialysis port each shift as ordered for 1 of 1 resident reviewed for dialysis services. (Resident #162) Findings include: 1.) Resident #63's record was reviewed on 12/9/13 at 2:30 p.m. Resident #63's current diagnoses included, but were not limited to, chronic kidney disease, hypertension, chronic airway obstruction and atrial fibrillation. Resident #63 had a current, 10/17/13, "Code Status" form which indicated the resident and family wanted the	F000309	1. Resident 63's code status order was immediately clarified and placed upon noting conflict. Resident 162's missing dialysis assessments could not be completed. The order was placed correctly containing the prompt for documentation of the catheter site assessment. 2. All residents have the potential to be affected by the code status finding. A 100% audit was completed to ensure all code status forms and orders match. Two dialysis residents have the potential to be affected by the dialysis assessment finding. A 100% audit was completed to ensure orders contain appropriate prompt for documentation of site assessment. 3. Nursing staff inserviced. All code status forms for new admit residents are to be reviewed daily during morning meeting and checked against written orders. 4. The DON/designee will perform a daily audit five days a week on all new admit residents to ensure code status orders follow the resident/POA's wishes. This audit will be ongoing. The	01/09/2014

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	resident to be a full code and receive CPR (cardiopulmonary resuscitation) in the event the resident's heart would stop beating. The practice of choosing a code status was also known as formulating an advanced directive. Resident #63 had a current, 10/17/13 order for Do Not Resuscitate, which means do not perform CPR. The current order and "Code Status" form were in conflict with one another. Review of an untitled, list provided by the Administrator on 12/9/13 at 12:05 p.m. indicated the facility believed Resident #63 had a current order for Do Not Resuscitate. During a 12/9/13, 11:25 a.m., interview, LPN #1 indicated she would check a resident's current orders to determine if CPR should be initiated should the resident require rescue measures. During a 12/9/13, 11:30 a.m., interview LPN #2 indicated she would check a resident's current orders to determine if CPR should be initiated should the resident require rescue measures. During a 12/9/13, 11:32 a.m., interview RN #3 indicated she would		DON/designee will perform daily audits five times a week on dailysis catheter sites to ensure documentation of site assessment is complete for four weeks, then weekly for eight weeks, then monthly times three. Results of the audits will be forwarded to QA for review times twelve months.5. Date of Completion - January 9, 2014.	

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	check a resident's current orders to determine if CPR should be initiated should the resident require rescue measures. During a 12/9/13, 11:35 a.m., interview LPN #4 indicated she would check a resident's current orders to determine if CPR should be initiated should the resident require rescue measures. During a 12/9/13, 3:00 p.m., interview, the Director of Nursing looked at the computerized record and indicated Resident #63's "Code Status" form and current Do Not Resuscitate order were in conflict. She indicated she would clarify the issue. During a 12/9/13, 4:00 p.m., interview the Director of Nursing indicated Resident #63's family desired the resident to be a "Full Code" and have CPR if indicated. The Director of Nursing indicated she did not know how the error had occurred and the order now reflected the desires of Resident #63's and her family. During a 12/10/13, 11:50 a.m., interview, the Administrator indicated the "Code Status" form, which had been completed by Resident #63's			

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	family, was the facilities current practice for residents and families to formulate advanced directives. 2.) A current, 4/2013, facility policy titled "End of Life", which was left on the conference room table for surveyors on 12/10/13 at 7:00 a.m., indicated the following: "Purpose: To promote the physical, mental and psychological well-being of a resident who is approaching the end of life... 1. Offer Advanced Directive choices at the time of admission and review these choices during care plan reviews...." 3.) The clinical record for Resident #162 was reviewed on 12/4/13 at 10:01 a.m. Diagnoses for Resident #162 included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure. A current health care plan problem, initiated 12/5/13, indicated the resident had end stage renal disease which required dialysis treatments. Interventions for this problem included, but were not limited to, check the dialysis catheter every shift.			

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	Current physician's orders, dated 11/27/13, included, but were not limited to, "check site of dialysis catheter every shift for drainage and condition of dressing (N=no drainage dressing intact Y=see nurses notes for abnormals)." The order for the dialysis catheter assessment every shift was present on the physician's orders, but was not listed on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) for the months of November 2013 and December 2013. The clinical record contained 12 dialysis catheter assessments from 11/28/13 to 12/9/13 out of 32 opportunities. This indicated only 12 dialysis catheter assessments had been completed in a 12 day time period. During an interview with the RN Consultant and the Director of Nursing on 12/10/13 at 9:29 a.m., additional information was requested related to the lack of dialysis catheter assessments for Resident #162. During an interview with the RN Consultant on 12/10/13 at 2:13 p.m., she indicated the order for the dialysis			

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	catheter assessment every shift was present on the physician's orders, but the order had not been entered correctly into the computer. The order did not appear on the Medication and/or the Treatment Administration Records for the months of November 2013 and December 2013. She further indicated she had no other information to provide related to the lack of dialysis catheter assessments for Resident #162. 3.1-37(a)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure personal alarms were applied to function at optimal performance to alert staff of a resident rising unassisted for 1 of 3 residents reviewed for falls. (Resident #62) Findings include: Resident #62's clinical record was reviewed on 12/9/13 at 8:24 a.m. The resident's diagnoses included, but were not limited to, lack of coordination, muscle weakness, and Alzheimer's disease. There were Physician's Orders signed and dated 11/26/13. The resident had an order for an alarm in her wheelchair and an alarm when in bed. Review of an 11/13/13, Quarterly Minimum Data Set assessment indicated the resident had severe cognitive impairment. The assessment indicated the resident had a history of falls since admission	F000323	1. Resident 62's pull tab alarm string was shortened on 9/28/13, the bed alarm was replaced on 11/16/13 as the alarm was found to have a delay setting at the time of the fall. 2. All residents with orders for alarms have the potential to be affected. A 100% audit was completed on all alarms to ensure appropriate string lenth, functioning, and no delay mode settings in place. 3. Nursing staff inserviced. Alarm inservice to be added to the EMR nurse orientation packet.4. DON/designee will perform audits daily five times a week for two weeks, then weekly times twn, then monthly times three. Results of the audits will be forwarded to QA for twelve months. 5. Date of Completion - January 9, 2014.	01/09/2014

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 12/10/2013
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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	to the facility. Review of a Fall Progress Note, dated 9/28/13 at 3:35 a.m., indicated the resident was found sitting on the floor. The note indicated the bed alarm was intact and not sounding. Review of the 9/30/13, 7:42 p.m., Fall IDT [Interdisciplinary Team] Progress Note, indicated the team met to review Resident #62's 9/28/13 fall. The note indicated the resident had a pull tab alarm in place but the alarm did not sound due to the string being long enough to reach the resident without becoming disengaged. The intervention was "Staff immediately shortened cord to pull tab alarm and check for proper functioning...." Review of a Fall Progress Note dated 11/16/13 at 2:42 a.m., indicated the resident's roommate was yelling "SOS SOS" at 1:30 a.m. The staff found Resident #62 on the floor with her head laying on the legs of the over the bed table. The immediate intervention was replacing the bed alarm. Review of the 11/18/13, 3:2 p.m., Fall IDT Progress Note, indicated the team met to review Resident #62's 11/16/13 fall. The note indicated			

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	"Root cause of fall: Staff checked alarm for proper functioning and noted that the alarm had a delay setting. It appeared that when staff had turned alarm on it was inadvertently placed on delay mode. The delay mode on the alarm allow the resident to rise out of bed unassisted without notifying staff immediately. During an interview with the Director of Nursing and the Corporate Nurse Consultant on 12/10/13 at 10:48 a.m., they both indicated the strings on the pull tab alarms were to be of a length to allow the resident freedom of movement but should be short enough to disengage when the resident leaned forward or started to stand up. They indicated the alarm with the delay mode was an older alarm and they had not been aware of the delay setting prior to the resident's fall. 3.1-45(a)(2)			

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure the list of "nursing staff on duty" was posted and updated on a daily basis as required. This had the potential to effect 83 residents who resided in the	F000356	1. The Nurse Staffing on Duty information for 12/2/13 was posted immediately. 2. All residents have the potential to be affected by the Nurse Staffing on Duty information not being posted. The Staffing Coordinator	01/09/2014

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	facility. Findings include: During the initial tour of the facility on 12/2/13, at 8:13 a.m., the "nursing staff on duty" posting was observed on the wall of the West Unit near the nurses' station. The posting was dated 11/29/13. During an interview with the Administrator on 12/2/13, at 8:15 a.m., she indicated she was aware the list of "nursing staff on duty" posted was dated 11/29/13. She further indicated the list of "nursing staff on duty" should have been updated daily including on the weekends. 3.1-17(a)		is to ensure the Nurse Staffing on Duty information is completed and posted every day. 3. 1:1 inservicing was provided to the Staffing Coordinator on posting the Nurse Staffing on Duty information daily. The Staffing Coordinator will complete and post the Nurse Staffing on Duty sheet daily five times a week. The Staffing Coordinator will complete the sheet for Saturday and Sunday prior to leaving on Friday. A weekend nurse will be designated as responsible to post these daily sheets two times a week. 4. DON/designee will perform daily audits five times a week for four weeks, then twice weekly times eight weeks, then weekly times four, then monthly therafter. Results of the audits will be forwarded to QA monthly for review times twelve months. 5. Date of completion: January 9, 2014.	

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview and record review, the facility failed to ensure food was stored and prepared in a sanitary environment. This deficient practice had the potential to impact 79 of the facility's 79 residents who ate food prepared in the kitchen. Findings include: During the initial kitchen tour on 12/2/13, at 8:31 a.m., with the Dietary Manager, a magnetic knife rack was observed on the wall behind the stove and under the vent hood. A film was noted covering the knife blades. A thick black crusty substance was noted covering the bottom of the drip pans under the burners of the stove. Dark dry debris and trash noted on the floor and baseboard behind the hand washing sink in the main kitchen area. The window ledge beside the stove was noted with thick dust and dead insects on the ledge. The top of the window was noted covered with a black fuzzy substance above an air	F000371	1. All unsanitary areas cited in the kitchen were cleaned immediately. The storeroom floor was stripped and resealed immediately. The knife rack was moved from behind the stove and is no longer under the vent hood. 2. All residents have the potential to be affected. 3. An inservice was provided to the dietary staff. The cleaning schedule was updated and has been placed in a notebook in the kitchen for notification of staff. Weekly cleaning tasks were reassigned. The dishwashing aide has been assigned their specific tasks. The AM and PM cooks are to be responsible for completing the Dietary Cleaning Checklist daily at the beginning of their shift. These are to then be presented to the Dietary Manager. 4. The Dietary Manager/designee will audit the Dietary Cleaning Schedules and Dietary Checklist daily five times a week for twelve weeks, then weekly times four, then monthly times two. Results of the audits will be forwarded to QA monthly for review times twelve months. 5. Date of Completion - January 9, 2014.	01/09/2014

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	conditioning unit. The floor in the dry storage room was soiled with debris, food particles, sticky areas and stains. Areas under the storage racks were noted with visible dust, an onion, and paper. During a follow up kitchen tour on 12/3/13 at 1:55 p.m., there was dark dry debris and trash noted on the floor and baseboards behind the hand washing sink in the main kitchen, as noted on the previous day. The thick dust, dead insects and the black fuzzy substance remained on the window ledge. The debris, food particles, sticky areas and stains remained on the floor of the dry storage room. Areas under the storage racks continues to have visible dust, an onion, and paper. During an interview with the Dietary Manager on 12/3/13, at 1:55 p.m. she indicated the area by the window had recently been covered by a shelving unit that held pots and pans for food preparation. She gave no indication as to why the cleaning had not been completed as scheduled. The Dietary Manager provided the cleaning schedule for the month of November and December 2013. November 2013 AM Cook - Cleaning			

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	Schedule indicated that on 11/19 thru 11/22/13, the can opener, stove drip pans, stove tops and steamtables were not cleaned per the schedule. 11/25 thru 11/30/13, the can opener, stove drip pans, stove tops and steamtables were not cleaned per the schedule. Weeks 2,3 and 4 on Tuesday and Saturday the kitchen cabinet doors were not cleaned per schedule. Weeks 1,3 and 4 on Thursday the dishwasher legs and baseboards were not cleaned per schedule. Weeks 1,3,and 4 on Friday the doors and thresholds were not wiped off per the cleaning schedule. November 2013 AM Dietary Aide - Cleaning Schedule 11/17 thru 1130/13, the can opener, food carts, grill, refrigerator doors, floors and handwashing sink were not cleaned per the cleaning schedule. Week 2 on Thursday the legs of the 3 compartment sink and baseboards were not cleaned per the cleaning schedule. Weeks 3 and 4 cleaning scheduled Monday thru Friday was not performed. November 2013 PM Cook - Cleaning Schedule			

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	11/26, the can opener, stove drip pans, stove top, plate and dish holders, coffee pot, steamtable were not cleaned per cleaning schedule. The left overs in the refrigerators were not checked for greater than 3 days per schedule. Weeks 1 and 2 on Monday the shelves below the steamtable were not cleaned per the cleaning schedule. Weeks 1,3 and 4 on Friday the 3 compartment sink was not cleaned per the cleaning schedule. November 2013 PM Dietary Aide - Cleaning Schedule 11/17 thru 11/18/13 and 11/22 thru 11/30/13, the food cart, microwave, floors, dishwasher booster heater and wall and the handwashing sink were not cleaned per the cleaning schedule. Week 4 Monday thru Friday the convection oven, ovens under stove, steamtable (delimed), fire extinguisher and fans were not cleaned per the cleaning schedule. December 2013 AM Cook - Cleaning Schedule 12/1 and 12/12/13, the can opener, stove drip pans, stove top and steamtables were not cleaned per the cleaning schedule.			

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	Week 1 on Monday and Tuesday the kitchen cabinet doors and the condiment containers were not cleaned per the cleaning schedule. December 2013 Am Dietary Aide - Cleaning Schedule 12/1 thru 12/2/2013, the can opener, food cart, grill, refrigerator doors, floors and handwashing sink were not cleaned per the cleaning schedule. Week 1 on Monday and Tuesday the steamer, steamer racks and spice containers were not cleaned per the cleaning schedule. December 2013 PM Cook - Cleaning Schedule 12/1/13 the can opener, stove drip pans, stove top, plate/dish holder, coffee pot and steamtable were not cleaned per the cleaning schedule. Week 1 on Tuesday the windows and sills were not cleaned per the cleaning schedule. December 2013 PM Dietary Aide - Cleaning Schedule 12/1 thru 12/2/13, the food cart, microwave, floors, dishwasher booster heater and wall, and the handwashing sink were not cleaned per the cleaning schedule. Week 1 on Monday and Tuesday the convection oven and the ovens under			

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	the stove were not cleaned per the cleaning schedule. 3.1-21(a)(3)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to a resident's passing for 1 of 5 residents reviewed for death of a resident in the facility. (Resident #160) Findings include: The clinical record for Resident #160 was reviewed on 12/4/13, at 3:43 p.m. Admission orders, dated 11/28/13, indicated the resident was a "full code". Diagnoses for Resident #160 included, but were not limited to, congestive heart failure, diabetes mellitus, and hypertension.	F000514	1. The facility was unable to correct Resident 160's assessment as resident no longer resides at the facility. 2. All residents with Full Code orders have the potential to be affected. A 100% audit was completed on those residents with orders for Full Code. 3. 1:1 inservicing was provided to RN 8. Nursing staff inserviced. A CPR class has been scheduled for January 4, 2014. 4. DON/designee will perform an audit daily five times a week for four weeks, then weekly for eight weeks, then monthly times three to ensure nurses know correct Code Blue procedure and documentation requirements. Results of this audit will be forwarded to QA for review times twelve months. 5. Date of Completion - January 9, 2014.	01/09/2014

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	A nursing note entry, completed by RN #8, dated 12/8/13, at 9:15 a.m., indicated Resident #160 had received tracheotomy care and suctioning. The note indicated the resident had no signs or symptoms of pain or distress at that time. The next nursing note entry, completed by RN #8, dated 12/8/13, at 10:15 a.m., indicated RN #8 had been called to the resident's room by CNA #9. RN #8 noted the resident was not breathing and had CNA #9 get LPN #10. RN #8 "listened for heartbeat for 60 seconds and heard no heartbeat or respirations at this time." LPN #10 also "verified no signs of life." The family, the physician, and the nurse on-call were notified. Review of the current facility policy, dated 2/13, titled "CPR Policy (Non-DNR Residents)," provided by the Director of Nursing on 12/9/13 at 9:51 a.m., included, but was not limited to, the following: "Purpose: To identify the viable signs of life that the licensed nurse must evaluate when determining " to administer" or "not to administer" the medical treatment of CPR to a			

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	non-DNR resident.... ...2) If the nurse observes that the resident is unresponsive but the resident's body temperature is not cold, cyanosis is not present and liver mortis is not present, the nurse shall immediately assess circulatory and respiratory function and proceed to administer CPR, requesting emergency medical services. If the nurse observes that a resident is unresponsive, the resident's body temperature is cold relative to the resident's normal temperature, cyanosis is present, liver mortis is present, and the pupils are bilaterally fixed and dilated, there has been cessation of circulatory and respiratory function that must be definitively assessed via attempted pulse taken at the carotid, radial, and femoral sites for at least two minutes and the absence of respiratory function for at least two minutes...." During a telephone interview with RN #8 on 12/9/13, at 2:45 p.m., she indicated she had worked from 6:00 a.m. to 9:45 p.m. on 12/8/13. Indicated she had provided tracheostomy care and suctioning for the resident at approximately 9:15 a.m. and the			

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	resident was not showing any signs or symptoms of distress or pain when she left him. CNA #9 called her to the resident's room because CNA #9 did not think the resident was breathing. RN #8 indicated she listened for 2 minutes for heartbeat and respirations with stethoscope and motioned for CNA #9 to go and get LPN #10. She indicated she knew resident was a full code but the resident was cold and starting to get stiff. She further indicated the resident's lips and fingers were a purplish color. LPN #10 also listened for 2 minutes for signs of viable life. She did not know why she documented listening for heartbeat and respirations for only 60 seconds and no information regarding body temperature, color of lips and fingers, or stiffness of resident's body. She indicated the 60 seconds documentation was "a mistake, I did listen for 2 minutes." 3.1-50(a)(1) 3.1-50(a)(2)			

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F000520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility failed to successfully implement a plan of action to address dietary physical plant cleanliness issues regarding the cleanliness of floors and window ledges. Of the facility's 83 residents this deficient practice had the potential to impact the 79 residents who consumed meals prepared in the facility kitchen.	F000520	1. The concerns with unsanitary areas in the kitchen will be reviewed by the QA Committee at the next monthly meeting for review and action. 2. All residents have the potential to be affected. 3. Staff will be inserviced on the role of the QA Committee. 4. The QA Committee will meet monthly to identify issues and develop and implement appropriate plans of action to correct identified issues. The QA Committee will review the status of action plans monthly. The Administrator/designee will	01/09/2014

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 12/10/2013
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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	Findings include: During the initial kitchen tour on 12/2/13 at 8:31 a.m., with the Dietary Manager, dark dry debris and trash was noted on floor and baseboard behind the hand washing sink in the main kitchen area. The window ledge beside the stove was noted with thick dust and dead insects on the ledge. The top of the widow was noted with a black fuzzy substance above an air conditioning unit. The floor in the dry storage room was soiled with debris, food particles, sticky areas and stains. Areas under the storage racks were noted with visible dust, an onion, and paper. During a follow up kitchen tour on 12/3/13, at 1:55 p.m., the dark dry debris and trash noted on floor and baseboards behind the hand washing sink in the main kitchen, as previously noted. The thick dust, dead insects and the black fuzzy substance remained on the window ledge. The debris, food particles, sticky areas and stains remained on the floor of the dry storage room. Areas under the storage racks continued to have visible dust, an onion, and paper. During a 12/10/13, 12:20 p.m., interview the Administrator indicated		maintain minutes of the meetings. 5. Date of Compltion - January 9, 2014.	

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	the facility had identified a concern in the area of kitchen cleanliness in the recent past. She indicated an action plan had been developed. The Administrator indicated she would review the QAA minutes and provide information regarding when the issue had been identified. During a 12/10/13, 12: 40 p.m. interview, the Administrator indicated the QAA committee had reviewed kitchen sanitation and food sanitation on 9/26/13. The facility identified multiple areas of concern at this time. Floor cleanliness and window ledge cleanliness were identified areas. In response to the identified 9/26/13 concerns, the facility developed an action plan which contained a component for monitoring which indicated "Dietary manager will monitor findings on a daily basis. Concerns noted will be fixed immediately and brought to QA the next month..." During a 12/10/13, 12:45 p.m., interview, the Dietary Manager indicated she completed QA audit tools weekly and more often if needed. She indicated if she saw a problem she would have staff to correct the problem.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

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	3.1-52(b)(2)			