

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155696	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2015
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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 6, 7, 8, 12, & 13, 2015</p> <p>Facility number: 003732 Provider number: 155696 AIM number: 200374360</p> <p>Census bed type: SNF: 17 SNF/NF: 42 Residential: 22 Total: 81</p> <p>Census payor type: Medicare: 13 Medicaid: 28 Other: 18 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL			

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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Bldg. 00	<p>PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, a dependent resident admitted without a pressure ulcer on the right heel, developed a pressure ulcer on the right heel (Resident #78) and/or a dependent resident admitted without a pressure ulcer on the left posterior thigh developed a Stage 2 pressure ulcer on the left posterior thigh (Resident #116) for 2 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #78 experiencing an Unstageable pressure ulcer on the right heel.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 5/6/15 at 12:30 P.M., Resident #78 was observed sitting in a wheelchair in the dining room with shoes on. The right heel was observed, at that time, to be in contact with the surface of the wheel 	F 0314	<p>Campus is respectfully requesting an IDR for this tag as we would like the opportunity to appeal the citation of F314. We would like to request a face to face review of this citation. We do not believe the contents as cited meets the criteria for the citation as well as we believe it does not meet the level of scope and severity as cited. Resident #78 no longer resides in skilled nursing facility.</p> <p>Resident #116 skin is intact and healed. Staff that provide care to her have been updated on the careplan. No other residents were affected by the deficient practice and through inservices and changes in procedure will ensure that pressure ulcer prevention interventions are implemented timely to prevent breakdown. Systemic change will include nursing inservice on pressure prevention interventions. DHS/Designee will observe 2 residents for implementation of wound prevention interventions and treatments per day/5 days</p>	05/29/2015			

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	<p>chair foot pedal.</p> <p>On 5/6/15 at 2:00 P.M., Resident #78 was observed lying in bed with socks on. The right heel was observed, at that time, to be in contact with the surface of the bed.</p> <p>The clinical record of Resident #78 was reviewed on 5/7/15 at 9:00 A.M. The clinical record indicated Resident #78 was admitted to the facility on 4/01/15 with no skin impairment to the right heel and diagnoses including, but not limited to, right hip fracture, CVA (stroke), and Diabetes.</p> <p>On 5/7/15 at 10:00 A.M., Resident #78 was observed sitting in a wheel chair in the Physical Therapy Room with shoes on. The right heel was observed, at that time, to be in contact with the surface of the floor.</p> <p>On 5/7/15 at 12:20 P.M., Resident #78 was observed sitting in a wheel chair in the dining room with shoes on. The right heel was observed, at that time, to be in contact with the surface of the wheel chair foot pedal.</p> <p>On 5/8/15 at 1:30 P.M., Resident #78 was observed lying in bed with socks on. The right heel was observed, at that time,</p>		<p>per week x 30 days, then 2 residents per week x 30 days, then 2 residents per month thereafter to ensure they are accurately assessed and careplanned for risks. Results of audits will be forwarded to the QA committee monthly for six months and quarterly thereafter with further suggestions/recommendations as deemed necessary by committee.</p>				

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	<p>to be in contact with the surface of the bed.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 4/13/15 indicated Resident #78 was at risk for the development of a pressure ulcer, experienced mild cognitive impairment, had functional limitation to the lower extremities on one side, and required the extensive assistance of two staff for bed mobility.</p> <p>The Admission Physician's Orders dated 4/1/15 lacked any orders and/or interventions related to the prevention of pressure ulcer development to the right heel.</p> <p>The Nursing Admission Assessment dated 4/1/15 indicated Resident #78 was at risk for the development of a pressure ulcer and had no skin impairment to the right heel upon admission to the facility.</p> <p>A Care Plan dated 4/3/15 indicated, "...I have potential for alteration in skin integrity...related to decreased mobility and diabetes...provide me assistance as I need it for bed mobility..." The care plan lacked documentation related to providing pressure relief to the heels of Resident #116.</p>			

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	<p>An Assessment Review and Considerations plan dated 4/2/15 indicated Resident #78 was at risk for skin breakdown related to mobility impairment.</p> <p>A PT (Physical Therapy) progress note dated 4/2/15 at 7:00 P.M. indicated, "...Pt [patient] demonstrates dec [decreased] ROM [range of motion], strength...r/t [related to] right hip fx [fracture]..."</p> <p>An OT (Occupational Therapy) Daily Treatment note dated 4/7/15 indicated, "...participated in bed mobility...rolling side to side with max [maximum] A [assist] & [and] 75% verbal cues..."</p> <p>The Physician's Telephone Orders from 4/1/15 through 4/10/15 were reviewed and lacked any pressure relief interventions for the right heel.</p> <p>A Nurse's note dated 4/11/15 at 5:00 A.M. indicated, "...while completing routine bed checks noted resident has a 2 cm [centimeter] X 1 cm dk [dark] purple unstageable area to rt [right] heel..."</p> <p>A "Pressure...Ulcer Assessment dated 4/11/15 indicated Resident #116 experienced a pressure wound to the right heel. The assessment further indicated, "...Stage E [un-stageable...non-removable</p>			

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	<p>dressings, slough/eschar, suspected deep tissue injury in evolution]...dk [dark] purple...length...2 [two centimeters]...width...1 [one centimeter}..."</p> <p>During an interview on 5/12/15 at 2:15 P.M., the DON (Director of Nursing) indicated Resident #78 was admitted without skin impairment to the right heel, but experienced an unstageable wound after admission to the facility. The DON then indicated, no documentation could be provided to indicate complete pressure relief was provided to the right heel of Resident #78 between 4/1/15 through 4/10/15.</p> <p>The Policy and Procedure for Pressure Prevention provided by WCN (Wound Care Nurse) #1 on 5/8/15 at 10:15 A.M. indicated, "...care plan interventions shall be implemented based on risk factors identified in the nursing assessments... Interventions may include, "...elevate heels off the bed..."</p> <p>2. During an interview on 5/6/15 at 2:30 P.M., Resident #116 indicated staff assistance was required for bed mobility.</p> <p>During an interview on 5/7/2015 at 9:32 A.M., LPN #5 indicated Resident #116 experienced a blister on the left posterior</p>			

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	<p>thigh after admission to the facility. LPN #5 then indicated the blister was related to the rubbing of an immobilizer against the left posterior thigh.</p> <p>During an interview on 5/7/15 at 2:00 P.M., WCN (Wound Care Nurse) #1 indicated Resident #116 experienced a Stage 1 pressure ulcer to the left posterior thigh after admission to the facility. WCN #1 then indicated, the root cause of the pressure ulcer was related to the use of an immobilizer on the left lower extremity.</p> <p>The clinical record of Resident #116 was reviewed on 5/8/15 at 10:00 A.M. The record indicated Resident #116 was admitted to the facility on 4/14/15 with diagnoses including, but not limited to, left femur fracture and muscle weakness.</p> <p>The Admission Nursing Assessment dated 4/14/15 indicated Resident #116 experienced no cognitive impairment, was at risk for the development of pressure ulcers, required the extensive assistance of two staff for bed mobility, and/or experienced no skin impairment to the left posterior thigh.</p> <p>A Care Plan for "Skin" dated 4/17/15 indicated, "...I have potential for alteration in my skin integrity related to</p>			

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	<p>decreased mobility...provide me with assistance as I need it for bed mobility...use a draw sheet for turning and repositioning me to decrease the probability of my getting shear or friction injuries..."</p> <p>A Care Plan for "Skin" dated 4/28/15 indicated, "...I have a pressure ulcer as evidence [sic] by my skin breakdown. I have [sic] stage 1 on my...upper thigh...This occurred related to my decreased mobility and immobilizer left leg..."</p> <p>The Admission Physician's Orders dated 4/28/15 included, but were not limited to, orders for, "...1/2 [half] positioning [bars] up X [times] 2 to aid in turning and repositioning...NWB [non-weight bearing] to (L) [left] leg...immobilizer to (L) leg may be removed for skin care...turn/reposition q [every] 2 [hours] et [and] prn [as needed]..."</p> <p>A Nurse's note dated 4/28/15 at 9:00 A.M. indicated, "...noticed a pressure area to the back of residents [sic] (L) thigh where the immobilizer presses onto the back of the thigh..."</p> <p>A Pressure...Ulcer Assessment dated 4/28/15 indicated Resident #116 experienced a Stage 1 pressure area to the</p>			

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	<p>back of (L) thigh...Length 1 [one centimeter] width 0.5 [half a centimeter].</p> <p>A Pressure...Ulcer Assessment dated 5/12/15 indicated wound was assessed as, "...Stage 2 [Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.]...L [length] 0.3 X W [width] 0.2...color: red..."</p> <p>During an observation of care on 5/8/15 at 11:01 A.M., Resident #116 was observed lying in bed in supine (lying on the back) position with an immobilizer on the left leg. CNA #10 indicated, at that time, she was preparing to reposition Resident #116 to lay on the right side. CNA #10 was then observed to grasp an incontinence pad underneath Resident #116, pull the resident across the surface of the bed, and reposition Resident #116 to lay on the right side. CNA #10 indicated, at that time, Resident #116 required the assistance of one person to reposition in bed. RN #5 was then observed to enter the room and indicated, she was preparing to change the dressing to the left posterior thigh of Resident #116. The wound was observed to be a red, shallow, and open ulcer. RN #5 was then observed to measure the ulcer and indicated, at that time, the ulcer measured</p>			
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F 0322 SS=D Bldg. 00	<p>0.8 cm [centimeters] length X 0.2 cm width X unknown depth and met the criteria for a Stage 2 pressure ulcer.</p> <p>During an interview on 5/13/15 at 10:00 A.M., the DON (Director of Nursing) indicated a dependent resident should be repositioned by lifting the resident off the surface of the bed. The DON further indicated, at that time, it was not facility practice to pull a resident across the surface of the bed with an incontinence pad during the repositioning procedure.</p> <p>The Policy and Procedure for Pressure Prevention provided by WCN #1 on 5/8/15 at 10:15 A.M. indicated, "...care plan interventions shall be implemented based on risk factors identified in the nursing assessments... Interventions may include, "...lift, do not slide resident..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat</p>			

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	<p>enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication was properly administered, in that, gastric tube (peg/enteral tube) placement was not checked before medication was administered for 1 of 1 resident who met the criteria for review of gastric tube medication administration. (Resident #80)</p> <p>Findings include:</p> <p>During an observation on 5/13/15 at 11:30 A.M., RN #5 was observed to administer fluids and a medication to Resident #80. RN #5 was observed to flush Resident #80's gastric tube with 60 milliliters of water, administer 10 ml's of Carafate and then flush the tube with 60 ml's of water. During that observation RN #5 was observed to not check placement of the gastric tube by auscultation and/or check for residual prior to administration. At that time,</p>	F 0322	<p>Res #80 suffered no ill effects from the deficient practice and staff that care for her have been inserviced on verification of tube placement procedure.</p> <p>There were no other residents affected by the alleged deficient practice and staff education will ensure the resident has tube placement verified prior to medication administration.</p> <p>RN #1 as well as all licensed staff will have directed inservice on G-tube medication administration procedures.</p> <p>DHS/Designee will audit medication administration via tube 5 days daily</p>	05/29/2015

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	<p>during an interview with RN #5 she indicated placement of the tube should be checked prior to administration.</p> <p>The clinical record of Resident #80 was reviewed on 5/13/15 at 12:10 A.M., diagnoses included, but were not limited to, history of gastric hemorrhage, diabetes, and hypertension and altered gastric status.</p> <p>The Physicians Order Recap dated 5/1/15 included, but were not limited to, flush peg tube with 60 ml's of water prior to and after med's [medication] and placement checked prior to use.</p> <p>The care plans were reviewed and included, but were not limited to, a care plan for potential aspiration related to gastric tube initiated 2/23/15. The interventions included, but were not limited to, administer my feedings as ordered, check residual prior to each feeding, continue to verify placement.</p> <p>A quarterly Minimum Data Set assessment (MDS) dated 02/20/15 was reviewed. It indicated Resident #80 had a Brief Interview for Mental Status score (BIMS) of 12 indicating Resident #80 was cognitively intact. The MDS also indicated Resident #80 required extensive assist of one person for eating</p>				<p>x2 weeks, then 1x/ week for 8 weeks, and 1x monthly thereafter to ensure proper technique is followed.</p> <p>Results of monitoring will be forwarded to QA committee monthly x6months and quarterly thereafter.</p>		

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	<p>and has a gastric tube.</p> <p>The Assistant Director of Nursing (ADON) was made aware of the concern on 5/13/15 at 12:20, at this time during an interview she indicated it was the facility policy to check placement prior to use of a gastric tube.</p> <p>An undated policy titled "GUIDELINES FOR ADMINISTERING GASTRIC TUBE MEDICATIONS" was provided by the facility on 5/13/15 at 12:20 P.M. The policy included, but was not limited to, "...Check placement in the stomach and residual gastric contents..." and "...auscultate the abdomen [approximately 3 inches below the sternum while injecting air from the syringe into the tubing, listen for a 'whooshing' sound to check placement of the tube in the stomach." The policy continued and included, "...For all gastric tubes, pull back gently on the syringe to aspirate stomach content, if stomach content can not [sic] be aspirated, pull back slightly on the tube to reposition. If the tube is still not patent, withhold medication and notify the physician... "</p> <p>3.1-44(a)(2)</p>			

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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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 observation, interview, and record review, the facility failed to ensure adequate supervision was provided, and/or effective interventions were implemented, in that, a resident identified as a risk to experience falls was not provided supervision and/or effective interventions were not implemented and the resident experienced 2 falls for 1 of 3 residents who met the criteria for review of falls. (Resident #14)</p> <p>Findings include:</p> <p>On 5/6/15 at 12:12 P.M., Resident #14 was observed sitting in a recliner with eyes closed and feet on the floor.</p> <p>During an interview on 5/7/15 at 9:25 A.M., LPN #12 indicated Resident #14 had recently experienced a fall.</p> <p>The clinical record of Resident #14 was reviewed on 5/7/15 at 3:30 P.M. The record indicated Resident #14 was admitted on 2/17/15. The diagnoses of Resident #14 included, but were not</p>	F 0323	<p>Res #14 has had fall prevention interventions added to the assignment sheet and staff that care for her have been inserviced on current interventions.</p> <p>All residents assignment sheets have been audited to ensure that fall interventions are on assignment sheets.</p> <p>Systemic change will be the assignment sheet updates being done in morning meeting to capture interventions from falls.</p> <p>Nursing staff will be inserviced on fall prevention strategies and new assignment sheet update procedure.</p> <p>DHS/Designee will monitor assignment sheets daily x 30 days, and weekly thereafter to ensure fall intervention updates are added timely.</p>	05/29/2015

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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591
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	<p>limited to, muscle weakness and difficulty walking.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 2/20/15 indicated Resident #14 experienced severe cognitive impairment, required the assistance of one staff for transfers and the assistance of one staff for bathing.</p> <p>A Care Plan for Falls dated 2/17/15 indicated, "...I have a potential for falls related to weakness...Remind me to lock the brakes on my w/c (wheelchair) before transfers. Assist me with transfers..."</p> <p>A Fall Risk Re-Assessment completed on 3/4/15 indicated Resident #14 experienced severe cognitive impairment, had a history of falls, was at risk to experience a further fall, and/or was non-compliant with safety interventions.</p> <p>A Nurses note dated 3/6/15 at 9:20 A.M. indicated, "...Resident in shower on shower chair and leaned forward and shower chair tipped Resident fell forward and ...hit head on shower chair...shoulder on floor...c/o (complains of pain on back of head and bruise red area lt (left) shoulder..."</p> <p>A Fall Circumstance Assessment and</p>		<p>Results of monitoring will be forwarded to QA committee monthly x6 months for review and quarterly thereafter.</p>	

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	<p>Intervention Report dated 3/9/15 indicated Resident #14 experienced a fall in the shower room on 3/6/15 at 9:20 A.M. The report further indicated, "...Sitting in shower chair and leaned forward and shower chair tipped...has cognitive or memory impairment that effects safety and judgement... history of falls...CARE PLAN update...anti tipper on shower chair..."</p> <p>During an observation in the 200 Hall shower room on 5/8/15 at 10:50 A.M., CNA #3 was observed to place Resident #14 onto a shower chair with unlocked wheels and no front anti-tippers (a safety device). CNA #3 stepped out of view of Resident #14 leaving the resident unsupervised three times during the shower, once to obtain gloves, again to obtain shampoo/shower gel, and then to obtain Resident #14's clean clothing.</p> <p>During an interview, at that time, with CNA #3, indicated Resident #14 did not have anti-tippers on her wheelchair and therefore would not need them on her shower chair. CNA #3 reviewed her CNA assignment sheet and she indicated the assignment sheet did not document an anti-tipper shower chair was needed for Resident #14. CNA #3 further indicated the shower chair wheels should have been locked.</p>			

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	<p>During an interview on 5/8/15 at 11:18 A.M., CNA #6 indicated the shower chair wheels should be locked before placing a resident on the chair and that an anti-tipper shower chair should be used for Resident #14.</p> <p>The CNA Assignment sheet was provided by CNA #7 on 5/8/15 at 8:45 A.M. and reviewed at that time. The assignment sheet lacked documentation that Resident #14 needed to be showered in a shower chair with anti-tippers.</p> <p>The Policy and Procedure for Falls Management Program Guidelines provided by the Director of Nursing (DON) on 5/13/15 at 1:45 P.M. indicated, "...Care Plan interventions should be implemented that address the resident's risk factors...9. Discuss risks and interventions...update 24 hour report, nursing assistant assignment worksheet."</p> <p>During an interview on 5/12/15 at :00 A.M., the DON indicated the correct shower chair should have been used during Resident #14's shower and the CNA assignment sheet should have been updated to reflect the intervention.</p> <p>3.1-45(a)(2)</p>			

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation, interview, and record review, the facility failed to ensure opened food packages were dated and/or food items were not stored next to chemicals. This had the potential to affect 59 of 59 residents who resided in the building.</p> <p>Findings include:</p> <p>The following were observed on 5/6/15 at 9:10 A.M.:</p> <ol style="list-style-type: none"> Two large opened bags, of corn flakes lacked any documentation of the opening dates on the packages. One medium opened bag of cornbread mix lacked any documentation of the opening date. One large opened bag of toffee crunch candy lacked any documentation of the opened date. One opened large bag of walnuts was dated 1/28/15. 	F 0371	<p>Food packages that were not dated have been discarded. Portable butane products have been relocated so that they are not stored next to food items.</p> <p>An audit has been conducted and all items are labeled and stored appropriately.</p> <p>Director of Food Services has inserviced all dining staff on food storage and labeling policy & procedure.</p> <p>DFS/designee will monitor that all food is labeled and stored appropriately by rounding 2 random times per day x30 days and daily thereafter. Results of audits will be forwarded to the QA committee</p>	05/29/2015

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R 0000 Bldg. 00	<p>5. One large bag of butterscotch chips lacked documentation of opened date.</p> <p>6. Located in the storage room on a shelf was a box of portable butane products situated next to open cups of artificial sugar packets and sugar packets.</p> <p>The Policy and Procedure for Storage Procedures provided by the Director of Nursing (DON) on 5/13/15 at 10:45 A.M. indicated, "...Chemical...items not stored in food storage area...6. Open packages are labeled, dated..."</p> <p>During an interview on 5/9/15 at 8:40 A.M., the Dietary Manager indicated the open packages needed to be tabled with the dates.</p> <p>3.1-21(i)(3)</p> <p>This visit was for the State Residential Licensure Survey.</p> <p>Residential Census: 22</p>	R 0000	monthly x 12 months.	

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	Sample: 7 Bridgepointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.				