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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155677 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/01/2015 |
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| NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 725 BELL TRACE CIR BLOOMINGTON, IN 47408 |
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| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00187155 and IN00185496.</p> <p>Complaint IN00187155-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00185496-Substantiated. Federal/State deficiencies related to the allegation are cited at F-282.</p> <p>Survey date: December 1, 2015.</p> <p>Facility number: 002574 Provided number: 155677 AIM number: 201224380</p> <p>Census bed type: SNF: 48 SNF/NF: 18 Total: 66</p> <p>Census Payor type: Medicare: 28 Medicaid: 6 Other: 32 Total: 66</p> <p>Sample: 03</p> <p>This deficiency reflects State findings</p> | F 0000 | <p>This plan of correction is to serve as Bell Trace Health and Living Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace Health and Living Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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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| F 0282 SS=D Bldg. 00 | <p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14466 on December 07, 2015.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure medications were administered as indicated by physician orders and facility policy for 1 of 3 resident reviewed for medication administration (Resident #B) and care plans were followed for keeping the call light in reach for residents with a history of falls for 2 of 3 residents reviewed for falls (Resident #A, Resident #C).</p> <p>Findings include:</p> <p>1.) On 12/1/2015 at 3:30 p.m., Resident #B's closed clinical record was reviewed. Diagnosis included, but were not limited to: cerebral vascular accident (CV).</p> <p>Physician's order dated July 1, 2015 thru</p> | F 0282 | <p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PERCARE PLAN Resident #B no longer resides at this facility. Resident #A& C's care plans are being followed for keeping the call light in reach. All residents have their medication administration completed as indicated by physician orders and facility policy. All residents with a history of falls have been reviewed and their call light is kept in reach. The systemic change includes: ·Charge Nurses will round at least twice a shift to review for residents with a history of falls having their call lights in reach while in their rooms. ·The Facility's Caring Hearts Program, which involves administration visiting with each resident at least weekly, will also incorporate a check of the</p> | 12/18/2015 |

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| | <p>July 31, 2015, indicated Resident #B's medications included but, were not limited to:</p> <p>NovoLog flexpen (insulin) 100 unit/ml (milliliter) per sliding scale.</p> <p>Acidophilus-pectin capsule twice a day.</p> <p>Atenolol 50 mg (milligrams) 1 tablet twice a day.</p> <p>Hydralazine 50 mg 1 tablet three times a day.</p> <p>Oster shell calcium 500 mg 1 tablet twice a day.</p> <p>Pantoprazole 40 mg 1 tablet once a day.</p> <p>Senna with docusate sodium 8.6-50 mg 1 tablet twice a day.</p> <p>Sertraline 100 mg 1 tablet once a day.</p> <p>Tamsulosin 0.4 mg 1 capsule at bedtime.</p> <p>Vancomycin liquid 125 mg/5ml administer 5 ml four times a day with a start date of 7/6/2015 and a discontinue date of 7/19/2015.</p> <p>Vancomycin liquid 125 mg/5 ml administer 5 ml twice a day with a start</p> | | <p>call light in reach during their visits.</p> <p>·Nursing Administration will run the computerized Medication Administration Compliance report daily at the clinical meeting (5days a week), and review for late administrations at the morning clinicalmeeting. All late administeredmedications will be investigated for the reason and if not documented, thenurse will be notified and interviewed for the reason for late administrationand this will be documented in the medical record.</p> <p>Education will be provided to licensed nurses regarding thefacility policy for Medication Administration and the need to document in theMedical Record if any medication is administered late and notify the physiciansas needed. The Facility's Caring HeartsRepresentatives will be provided with education regarding a check of the calllight in reach during their visits. Nursing Administration will be provided with education regarding thesystemic changes. Nursing Administration or designee will complete a QA toolmonitoring for reviewing that call lights are in reach in the resident roomsfor residents with a history of falls. This tool will be completed twice a day, on varying shifts, 7 days aweek for 4 weeks, then 5 days a week on varying shifts for 4 weeks, then weeklyon varying shifts for duration of 12 months of</p> | |

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| | <p>date of 7/20/15 and discontinue date of 7/26/15.</p> <p>Vimpat tablet 50 mg 1 tablet every 12 hours.</p> <p>Vitamin C 500 mg 1 tablet three times a day.</p> <p>Review of the July, 2015 Medication Administration Record (MAR) indicated the following for Resident #B's medications.</p> <p>The NovoLog flexpen was administered late on 7/1/2015 and 7/22/2015. Scheduled for 11:00 a.m., 12:00 p.m. and 5:00 p.m.</p> <p>The acidophilus-pectin capsule was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m.</p> <p>The atenolol tablet was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m.</p> <p>The hydralazine tablet was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m., 1:00 p.m. and 8:00 p.m.</p> | | <p>monitoring. Any concerns will be addressed. In addition, Nursing Administration will runthe computerized Medication Administration Compliance report daily, 7 days aweek to review for any medication administered late. This audit will continue for 4 weeks, andthen 5 days a week for duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at themonthly facility Quality Assurance Committee meeting monthly for 3 months andthen quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%. Compliance date 12/18/15</p> | |

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| | <p>The Oster shell calcium tablet was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m.</p> <p>The pantoprazole tablet was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m.</p> <p>The senna with docusate sodium was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m.</p> <p>The sertraline was administered late on 7/1/2015. Scheduled for 8:00 a.m.</p> <p>The tamsulosin capsule was administered late on 7/8/2015 and 7/22/2015. Scheduled for 8:00 p.m.</p> <p>The vancomycin was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m. from 7/20/2015 thru 7/26/2015 and at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. from 7/6/2015 thru 7/19/2015.</p> <p>The Vimpat was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m. and 8:00 p.m.</p> | | | |

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| | <p>The Vitamin C tablet was administered late on 7/1/2015, 7/8/2015, 7/15/2015 and 7/22/2015. Scheduled for 8:00 a.m., 1:00 p.m. and 8:00 p.m.</p> <p>On 12/1/2015 at 3:30 p.m., an interview with the Corporate Clinical Nurse indicated the nurses should chart in the progress notes when a medication is not given in a timely manner. The corporate clinical nurse looked through the progress notes for July, 2015, but was unable to locate in the progress notes where the nurses had been charting why medication was late.</p> <p>On 12/1/2015 at 4:45 p.m., the Administrator provided the policy "Medication Administration General Policies and Procedures" undated, and indicated it was the one currently being used by the facility. The Policy indicated, " ... The facility has sufficient staff to allow administering of medications without unnecessary interruptions ... Medications are to be administered 60 minutes before or after the prescribed time for administration ..."</p> <p>2a). Resident #A's clinical record was reviewed on 12/2/15 at 9:45 a.m. Diagnoses included, but were not limited to: difficulty walking, muscle weakness, fractured left hip, abnormal posture, and fracture femur neck.</p> | | | |

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| | <p>On 12/1/15 at 9:45 a.m., Resident #A was observed sitting in a recliner chair by the window in her room with her walker being observed to the left of her recliner out of reach. The call light was observed to be attached to a sheet on the bed underneath the covers and under a pillow. Resident #A indicated, "I wish it was closer to me [call light]. It's over there [pointing to the bed]." Resident #A was observed to unsuccessfully reach for her walker. Resident #A stood to her feet, turned to the side and walker over to bring her walker close to her. Resident #A was observed to use the walker and walk over and sit on the bed. Resident #A was observed to be looking for the call light. "Oh, it's under here [pillow]."</p> <p>The current care plan "Falls" dated 12/3/14 through 12/24/15, indicated, "Resident at risk for falling and fall related injuries related to dementia, hx [history] fx [fracture] hip...Goal: Will minimize risk for fall and fall related injuries. ...Approach: ... call light to seek assist ...Keep call light within reach."</p> <p>The current Quarterly Minimum Data Set (MDS) assessment dated 8/27/15, indicated Resident #A needed supervision of 1 staff person for transfer.</p> | | | |

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| | <p>On 12/1/15 at 2:45 p.m., interview with Certified Nursing Assistant (CNA) #1 indicated Resident #A was aware of how to use a call light.</p> <p>On 12/1/15 at 3:00 p.m., Resident #A was observed in bed and her call light was lying across the bedside table which was located away from the bed and next to the recliner by the window.</p> <p>On 12/1/15 at 3:30 p.m., the Director of Nursing (DON) indicated Resident #A was aware of the use of a call light and the call light should be within reach at all times.</p> <p>On 12/1/15 at 4:45 p.m., the Administrator provided policy "Care Plans-Comprehensive" dated 10/2009, and indicated the policy was the one currently used by the facility. The policy lacked documentation on following the careplan for resident care.</p> <p>b). Resident #C's clinical record was reviewed on 12/1/15 at 9:50 a.m. Diagnoses included, but were not limited to: Parkinson, difficulty walking, restless leg, paralysis agitans (loss or impairment of motor function) and pain.</p> <p>On 12/1/15 at 10:00 a.m., Resident #A was observed sitting in a wheelchair at</p> | | | |

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| | <p>the side of her bed. The call light was observed to be over the foot of the bed out of reach for Resident #C. Registered Nurse (RN) #1 indicated Resident #C probably could not reach the call light from where she was sitting. RN #1 was observed to retrieve the call light and attach the call light to Resident #C's pants.</p> <p>The current Quarterly Minimum Data Set (MDS) assessment dated 10/20/15, indicated Resident #C needed extensive assistance of 2 staff persons for transfer.</p> <p>The current care plan "at risk for falling and fall elated injuries related to Parkinson" dated 5/19/15 through 1/20/16, indicated, "Goal: ...minimize risk for fall and fall related injuries, Approach:...utilize call light to seek assist as needed. Keep call light within reach. ..."</p> <p>On 12/1/15 at 2:45 p.m., interview with Certified Nursing Assistant (CNA) #1 indicated Resident #C was aware of how to use a call light.</p> <p>On 12/1/15 at 3:50 p.m., interview with CNA #2 indicated Resident #C was aware of how to use a call light. "Resident #C used the call light this morning and I toileted her. I can't say</p> | | | |

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| | <p>she'll use the call light all the time, but Resident #C knows what the call light is for."</p> <p>On 12/1/15 at 4:45 p.m., the Administrator provided policy "Care Plans-Comprehensive" dated 10/2009, and indicated the policy was the one currently used by the facility. The policy lacked documentation on following the careplan for resident care.</p> <p>This Federal tag relates to complaint IN00185496.</p> <p>3.1-35(g)(2)</p> | | | | |