STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS PLACE	4200 WYNTREE DR, NEWBURGH, , 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00463164, IN00463168, IN00463163, IN00462896 and IN00462907. Complaint IN00463164: State deficiencies related to the allegations are cited at R0245 and R0349. Complaint IN00463168: State deficiencies related to the allegations are cited at R0244. Complaint IN00463163: No deficiencies related to the allegations are cited. Complaint IN00462896: State deficiencies related to the allegations are cited at R0245. Complaint IN00462907: State deficiencies related to the allegations are cited at R0064. Survey dates: July 9, 10, & 11, 2025	R 0000	The submission of this plan of correction does not indicate an admission by Bell Oaks Place that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bell Oaks Place. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for assisted living care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of	

	Facility number: 004903 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 16, 2025.		noncompliance cited during the Complaint Survey conducted July 11th, 2025 through July 13th, 2025. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 1 of 3 residents reviewed for misappropriation. A resident's medication was taken from a cabinet in their room by facility staff. (Resident B) Finding includes: During a review of facility reported incidents on 7/9/25 at 10:10 A.M., an incident, dated 6/14/25, indicated that Resident B reported that Housekeeper 13 had stolen a medication	R 0064	1) Resident B was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Family secured medications under lock and key for all future administration and storage. 2) All residents have the potential to be affected. All staff educated on the abuse and neglect policy and procedures. Executive Director conducted interviews of all residents to educate on resident rights as well as ensure no ongoing or current concerns. 3 As a measure of ongoing compliance, The Executive Director, or designee, will: a Interview 3 residents for abuse and neglect	07/28/2025

	(Tramadol) from her apartment. Housekeeper 13 was seen on a surveillance video taking the medication. Housekeeper 13 was terminated from employment. On 7/9/25 at 11:00 A.M., during a review of the facility's investigation of the misappropriation allegation, an undated, handwritten account of the allegation signed by the Facility Administrator indicated Resident B was asked about the allegation of missing medication. Resident B indicated that she had reported the incident on 5/28/25 regarding a surveillance video that contained footage of Housekeeper 13 taking medication from Resident B's cabinet. Housekeeper 13 refused to make a statement when questioned about the incident. During an interview on 7/10/25 at 11:15 A.M., the Facility Administrator indicated that the misappropriation incident took place on 5/28/25. The Facility Administrator observed the surveillance footage on 6/14/25. The Facility Administrator indicated the incident did not require much further investigation as Housekeeper 13 could be seen in the video taking the resident's medication. During an interview on 7/11/25		concerns three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. b Interview 3 staff members to ensure understanding of abuse and neglect policy three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. 4 Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5 . Date of alleged Compliance on 7/28/2025	

at 9:30 A.M., Resident B indicated she had some medications go missing and that housekeeping staff was caught on her apartment camera taking them. Housekeeper 13 could be seen taking the medication from the resident cabinet and could be seen in the video opening the medication bottle. Resident B indicated that she was prescribed an as needed (PRN) Tramadol (pain medication) following a procedure and that she stored her medications in a cabinet in her room as she was able to administer her own medications.

No facility policy regarding resident misappropriation was received from the facility.

This citation relates to complaint IN00462907.

Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 1 of 3 residents reviewed for misappropriation. A resident's medication was taken from a cabinet in their room by facility staff. (Resident B)

Finding includes:

During a review of facility reported incidents on 7/9/25 at 10:10 A.M., an incident, dated 6/14/25, indicated that Resident B reported that Housekeeper 13 had stolen a medication

	(Tramadol) from her apartment. Housekeeper 13 was seen on a surveillance video taking the medication. Housekeeper 13 was terminated from employment. On 7/9/25 at 11:00 A.M., during a review of the facility's investigation of the misappropriation allegation, an undated, handwritten account of the allegation signed by the Facility Administrator indicated Resident B was asked about the allegation of missing medication. Resident B indicated that she had reported the incident on 5/28/25 regarding a surveillance video that contained footage of Housekeeper 13 taking medication from Resident B's cabinet. Housekeeper 13 refused to make a statement when questioned about the incident. During an interview on 7/10/25 at 11:15 A.M., the Facility Administrator indicated that the misappropriation incident took place on 5/28/25. The Facility Administrator observed the surveillance footage on 6/14/25. The Facility Administrator indicated the incident did not require much further investigation as Housekeeper 13 could be seen in the video taking the resident's medication. During an interview on 7/11/25			

	at 9:30 A.M., Resident B indicated she had some medications go missing and that housekeeping staff was caught on her apartment camera taking them. Housekeeper 13 could be seen taking the medication from the resident cabinet and could be seen in the video opening the medication bottle. Resident B indicated that she was prescribed an as needed (PRN) Tramadol (pain medication) following a procedure and that she stored her medications in a cabinet in her room as she was able to administer her own medications. No facility policy regarding resident misappropriation was received from the facility. This citation relates to complaint IN00462907.			
R 0244	Health Services - Noncompliance 410 IAC 16.2-5-4(e)(4) (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, interview, and record review, the facility failed to ensure the facility policy was followed for administrations of medications. Nursing staff was observed with multiple residents' medications prepared for administration by	R 0244	1) Residents residing on Hall 1 were assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Nursing staff completing preparation of doses for one scheduled administration at a time. 2) All residents have the potential to be affected. All facility nurse and QMA staff educated on	07/28/2025

	presetting the medications in individual cups and then going room to room with the medication cups. (Hall 1) Finding includes: During an observation on 7/11/25 at 9:30 A.M., QMA 5 was walking down Hall 1 with a tray that contained multiple medicine cups, each containing loose pills or tablets. During an interview on 7/11/25 at 9:30 A.M., QMA 5 indicated she was passing resident medications and that she had preset each resident's medication cup at the medication cart and was going room to room with the tray of medications to administer them to the residents on Hall 1. During an interview on 7/11/25 at 10:15 A.M. the Facility Administrator indicated nursing staff should administer one resident's scheduled medications at a time. The Administrator indicated resident medications are delivered from the pharmacy in a roll that is arranged and pre-packaged for each scheduled medication administration. Staff could walk a pre-packaged scheduled medication packet to the resident room, but should not pre-set medication cups for multiple residents. On 7/11/25 at 10:30 A.M., the		facility medication services policy and procedures as well as online medication administration in-servicing. 3) As a measure of ongoing compliance, The Executive Director, or designee, will: Observe medication passes of 3 residents three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. 4) Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5) Date of alleged compliance on 7/28/2025	

	Facility Administrator supplied a copy of a facility policy titled, Medication Services, dated 6/10/24. The policy indicated, "...Preparation of doses for more than one (1) scheduled administration is not permitted." This citation relates to complaint IN00463168. Based on observation, interview, and record review, the facility failed to ensure the facility policy was followed for administrations of medications. Nursing staff was observed with multiple residents' medications prepared for administration by presetting the medications in individual cups and then going room to room with the medication cups. (Hall 1) Finding includes: During an observation on 7/11/25 at 9:30 A.M., QMA 5 was walking down Hall 1 with a tray that contained multiple medicine cups, each containing loose pills or tablets. During an interview on 7/11/25 at 9:30 A.M., QMA 5 indicated she was passing resident medications and that she had preset each resident's medication cup at the medication cart and was going room to room with the tray of medications to administer them to the residents on Hall 1.			

	During an interview on 7/11/25 at 10:15 A.M. the Facility Administrator indicated nursing staff should administer one resident's scheduled medications at a time. The Administrator indicated resident medications are delivered from the pharmacy in a roll that is arranged and pre-packaged for each scheduled medication administration. Staff could walk a pre-packaged scheduled medication packet to the resident room, but should not pre-set medication cups for multiple residents. On 7/11/25 at 10:30 A.M., the Facility Administrator supplied a copy of a facility policy titled, Medication Services, dated 6/10/24. The policy indicated, "...Preparation of doses for more than one (1) scheduled administration is not permitted." This citation relates to complaint IN00463168.			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure injectable medications were administered by licensed staff for 1 of 1 resident reviewed	R 0245	1) Resident D was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. All insulin injections are administered by licensed staff. 2) All residents receiving injections have the potential to be affected. All	07/28/2025

	for insulin. Insulin had been documented and signed as administered by a non-insulin certified Qualified Medication Aide (QMA). (Resident D) Finding includes: On 7/10/25 at 10:00 A.M., the Regional Nurse indicated there was one resident in the facility that received insulin (Resident D) and the resident had already received the insulin that morning. On 7/10/25 at 10:15 A.M., employee records indicated the following QMAs were not certified to administer insulin: QMA 3, QMA 7, and QMA 9. On 7/10/25 at 10:26 A.M., Resident D's clinical record indicated the resident was admitted on 5/27/25 and diagnoses included, but were not limited to, diabetes. Resident D's physician orders included but were not limited to; Lantus 100U (units)/ml (milliliters), 19U every morning, dated 7/9/25 and Basaglar 100U, 19U every morning, dated 6/4/25 through 7/8/25. Resident D's Medication Administration Record (MAR) for June and July 2025 indicated insulin was administered by a non-insulin		nurse and QMA staff educated on administering and assisting with injections policy and procedures. 3) As a measure of ongoing compliance, The Executive Director, or designee, will: monitor documentation of a resident injections three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. 4) Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5) Date of alleged Compliance on 7/28/2025.	

	certified QMA on the following dates and times: 6/16/25 at 8:11 A.M. given by QMA 3 6/17/25 at 8:21 A.M. given by QMA 3 6/21/25 at 7:44 A.M. given by QMA 9 6/22/25 at 7:58 A.M. given by QMA 9 6/23/25 at 10:17 A.M. given by QMA 3 6/24/25 at 7:30 A.M. given by QMA 3 6/30/25 at 7:34 A.M. given by QMA 3 7/9/25 at 10:01 A.M. given by QMA 7 7/10/25 at 9:06 A.M. given by QMA 3 During a confidential interview, staff indicated the facility used to have an insulin certified staff member come in to administer Resident D's insulin, but the resident had been educated to self-administer the insulin recently. Staff indicated the person giving the insulin should be signing off on the MAR that they administered it. On 7/10/25 at 2:30 A.M., the Regional Nurse and			

	Administrator indicated the resident's MAR should be signed by the staff member that administered the medication. If a non-insulin certified QMA is signed in to the electronic record, the staff that administered the insulin should log themselves in and sign under their name. On 7/10/25 at 12:55 P.M., the Administrator provided a facility policy titled, Administering and Assisting with Injections policy, dated 6/10/24. The policy indicated, "...Licensed medical professionals will only administer injectable medications/insulin they have drawn up, or pre-drawn medication by the pharmacy or drug manufacturer..." On 7/10/25 at 12:55 P.M., the Administrator provided a facility policy titled Medication Services, dated 6/10/25. The policy indicated, "...Injectable medications shall be given only by licensed personnel..." This citation relates to complaint IN00463164 and IN00462896. Based on interview and record review, the facility failed to ensure injectable medications were administered by licensed staff for 1 of 1 resident reviewed for insulin. Insulin had been documented and signed as administered by a non-insulin			

certified Qualified Medication Aide (QMA).

(Resident D)

Finding includes:

On 7/10/25 at 10:00 A.M., the Regional Nurse indicated there was one resident in the facility that received insulin (Resident D) and the resident had already received the insulin that morning.

On 7/10/25 at 10:15 A.M., employee records indicated the following QMAs were not certified to administer insulin: QMA 3, QMA 7, and QMA 9.

On 7/10/25 at 10:26 A.M., Resident D's clinical record indicated the resident was admitted on 5/27/25 and diagnoses included, but were not limited to, diabetes.

Resident D's physician orders included but were not limited to; Lantus 100U (units)/ml (milliliters), 19U every morning, dated 7/9/25 and Basaglar 100U, 19U every morning, dated 6/4/25 through 7/8/25.

Resident D's Medication Administration Record (MAR) for June and July 2025 indicated insulin was administered by a non-insulin certified QMA on the following dates and times:

	6/16/25 at 8:11 A.M. given by QMA 3 6/17/25 at 8:21 A.M. given by QMA 3 6/21/25 at 7:44 A.M. given by QMA 9 6/22/25 at 7:58 A.M. given by QMA 9 6/23/25 at 10:17 A.M. given by QMA 3 6/24/25 at 7:30 A.M. given by QMA 3 6/30/25 at 7:34 A.M. given by QMA 3 7/9/25 at 10:01 A.M. given by QMA 7 7/10/25 at 9:06 A.M. given by QMA 3 During a confidential interview, staff indicated the facility used to have an insulin certified staff member come in to administer Resident D's insulin, but the resident had been educated to self-administer the insulin recently. Staff indicated the person giving the insulin should be signing off on the MAR that they administered it. On 7/10/25 at 2:30 A.M., the Regional Nurse and Administrator indicated the resident's MAR should be signed by the staff member that			

	administered the medication. If a non-insulin certified QMA is signed in to the electronic record, the staff that administered the insulin should log themselves in and sign under their name. On 7/10/25 at 12:55 P.M., the Administrator provided a facility policy titled, Administering and Assisting with Injections policy, dated 6/10/24. The policy indicated, "...Licensed medical professionals will only administer injectable medications/insulin they have drawn up, or pre-drawn medication by the pharmacy or drug manufacturer..." On 7/10/25 at 12:55 P.M., the Administrator provided a facility policy titled Medication Services, dated 6/10/25. The policy indicated, "...Injectable medications shall be given only by licensed personnel..." This citation relates to complaint IN00463164 and IN00462896.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:	R 0349	1) Resident B was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Clinical staff is completing a narcotic count at the beginning and conclusion of every shift.	07/28/2025

	(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure complete and accurate records for 2 of 2 medication carts reviewed. Narcotic count sheets were not filled out completely with off-going and on-coming staff signatures. (100 Hall, 200 Hall) Finding includes: On 7/10/25 at 9:00 A.M., the narcotic count binders for 100 and 200 Halls were reviewed. The controlled medication shift change log forms were observed with the following missing information: 100 Hall - 6/26/25 (no time/shift listed) signature for off-going nurse 6/26/25 (no time/shift listed) signature for on-coming nurse (no date) 6a signature for off-going nurse 6/29/25 6am signature for on-coming nurse		2) All residents have the potential to be affected. All nurses and QMAs educated on the controlled substance management policy and procedures. 3) As a measure of ongoing compliance, The Executive Director, or designee, will: monitor controlled substance shift count forms three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. 4) Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5) Date of alleged Compliance on 7/28/2025	

No information for 6/29/25 pm shift

6/30/25 6am signature for off-going nurse

6/30/25 6pm signature for on-coming nurse

7/1/25 6am signature for off-going nurse

7/2/25 6am signature for on-coming nurse

No information for 7/3/25 am shift

7/3/25 6pm signature for off-going nurse

7/8/25 (no time/shift listed) signature for off-going nurse

7/8/25 (no time/shift listed) signature for on-coming nurse

200 Hall -

7/1/25 6am signature for off-going nurse

7/2/25 6am signature for off-going nurse

7/2/25 6am signature for on-coming nurse

7/2/25 7pm signature for off-going nurse

No information for 7/3/25 am shift

7/3/25 6pm signature for

off-going nurse

7/3/25 6pm signature for on-coming nurse

No information for 7/8/25 am shift

During a confidential interview, staff indicated narcotic count sheets should be signed by the off-going and on-coming staff member each shift. Staff indicated administration informed them that the count could be done with a Certified Nurse Aide (CNA) if a QMA or nurse was not available, but due to uncertainty, the CNAs refused to sign the forms when they assisted with the count.

On 7/10/25 at 1:35 P.M., the Administrator provided a facility policy titled, Controlled Substance Management policy, dated 6/10/24. The policy indicated, "...Shift counts are performed at the end of each shift, or when the QMA responsible for medication changes... A complete count will take place by the QMA going-off and the QMA coming on... If the quantity if verified both the on-coming and off-going QMAs will sign the Controlled Substance Shift Count Form..."

This citation relates to complaint IN00463164.

Based on interview and record review, the facility failed to

ensure complete and accurate records for 2 of 2 medication carts reviewed. Narcotic count sheets were not filled out completely with off-going and on-coming staff signatures. (100 Hall, 200 Hall)

Finding includes:

On 7/10/25 at 9:00 A.M., the narcotic count binders for 100 and 200 Halls were reviewed. The controlled medication shift change log forms were observed with the following missing information:

100 Hall -

6/26/25 (no time/shift listed) signature for off-going nurse

6/26/25 (no time/shift listed) signature for on-coming nurse

(no date) 6a signature for off-going nurse

6/29/25 6am signature for on-coming nurse

No information for 6/29/25 pm shift

6/30/25 6am signature for off-going nurse

6/30/25 6pm signature for on-coming nurse

7/1/25 6am signature for off-going nurse

7/2/25 6am signature for on-coming nurse

No information for 7/3/25 am shift

7/3/25 6pm signature for off-going nurse

7/8/25 (no time/shift listed) signature for off-going nurse

7/8/25 (no time/shift listed) signature for on-coming nurse

200 Hall -

7/1/25 6am signature for off-going nurse

7/2/25 6am signature for off-going nurse

7/2/25 6am signature for on-coming nurse

7/2/25 7pm signature for off-going nurse

No information for 7/3/25 am shift

7/3/25 6pm signature for off-going nurse

7/3/25 6pm signature for on-coming nurse

No information for 7/8/25 am shift

During a confidential interview, staff indicated narcotic count sheets should be signed by the off-going and on-coming staff

	member each shift. Staff indicated administration informed them that the count could be done with a Certified Nurse Aide (CNA) if a QMA or nurse was not available, but due to uncertainty, the CNAs refused to sign the forms when they assisted with the count. On 7/10/25 at 1:35 P.M., the Administrator provided a facility policy titled, Controlled Substance Management policy, dated 6/10/24. The policy indicated, "...Shift counts are performed at the end of each shift, or when the QMA responsible for medication changes... A complete count will take place by the QMA going-off and the QMA coming on... If the quantity if verified both the on-coming and off-going QMAs will sign the Controlled Substance Shift Count Form..." This citation relates to complaint IN00463164.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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