STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIRCLE BLOOMINGTON, IN 47408

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442317 and IN00441579. Complaint IN00442317 - No deficiencies related to the allegations are cited. Complaint IN00441579 - No deficiencies related to the allegations are cited. Survey dates: September 9, 10, 11, 12, and 13, 2024 Facility number: 002574 Provider number: 155677 AIM number: 201224380 Census Bed Type: SNF/NF: 40 SNF: 42 Total: 82 Census Payor Type: Medicare: 15 Medicaid: 33 Other: 34 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 18, 2024.	F 0000	=”” p=””> =”” p=””> This plan of correction is to serve as Bell Trace's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations. =”” b=””>	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility	F 0641	I. The corrective actions to be	09/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Haislip	HFA	09/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	failed to ensure an accurate MDS (Minimum Data Set) assessment for 1 of 5 residents reviewed for unnecessary medications. The Admission MDS assessment lacked documentation of an anxiety diagnosis. (Resident 65) Finding includes: On 9/12/24 at 2:00 p.m., Resident 65's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, anxiety disorder, hypertension, and pain. A review of the Admission MDS assessment, dated 7/9/24, anxiety disorder was not marked as an active diagnosis. A Review of Medication Administration Record (MAR), indicated Resident 65 had an active order on 7/8/24 for Ativan (medication used to treat anxiety) 0.5 milligram (mg) half a tablet (0.25 mg) oral (by mouth) three times a day for diagnosis of anxiety disorder. A review of Resident Assessment Instrument (RAI),Version 3.0 User's Manual, 10/2023, for section I5700 of MDS, on 9/12/24 at 2:45 p.m., indicated; a 7-day look-back period. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. An interview with the Director of Nursing (DON) on 9/13/24 at 11:15 a.m., indicated section I5700 on the Admission MDS Assessment, dated 7/9/24, was not marked to indicate a diagnosis of anxiety. The DON indicated Resident 65 had a diagnosis of anxiety on admission. She indicated the facility		accomplished for those residents found to have been affected by the practice. ="" p="">
 ="" p="">
 Resident 65's MDS that the diagnosis of Anxiety was not coded, was corrected. II. The facility will identify other residents that may potentially be affected by the practice. All residents who have had a MDS completed in the last 30 days will be reviewed. Any diagnosis that has not been coded correctly will be corrected. III. The RAI manual was reviewed, and the procedures were reviewed, with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur. The facility MDS Coordinator will receive re-education regarding MDS coding and the RAI manual by 9/26/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will audit 5 resident MDSs per week x 4 weeks, then 3 MDSs per week x 4 weeks, then 2 MDSs per week x 4 weeks, then 5 MDSs monthly x 6 months or as deemed by the Quality Assurance Committee.	

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	does not have an MDS Policy, but follow the RAI manual for MDS completion. An interview with the MDS Coordinator on 9/13/24 at 11:15 a.m., indicated the resident had a diagnosis of anxiety on admission and section I5700 should have been marked to reflect the diagnosis. The MDS Coordinator indicated the facility used the RAI manual to complete MDS assessments. An interview with RN 1 on 9/13/24 at 1:45 p.m., indicated the resident had multiple episodes of anxiousness and restlessness. RN 1 indicated the resident had an order for anxiety medication that did help with these episodes. She indicated the resident has had anxiety and restlessness since admission. 3.1-31(d)		The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 9/30/24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were stored properly for 2 of 3 medication rooms observed. Medications were not labeled with an open date and expired medications were not disposed of. (Skilled 3 Rehabilitation Medication Room, Skilled 1 Medication Room). Findings include: On 9/13/24 at 11:56 a.m., the refrigerator in the Skilled 3 Rehabilitation 1 Medication Room was observed to have a vial of tuberculin PPD (medication used to test for tuberculosis) and a vial of Humalog (insulin) without an open date. The Director of Nursing (DON) could not find an	F 0761	I. The corrective actions to be accomplished for those residents found to have been affected by the practice. The vial of Tuberculin and Humalog that did not have a date opened on the label on Skilled 3 Rehab Medication Room refrigerator and Skilled 1 Rehab Medication Room were discarded and re-ordered if indicated. II. The facility will identify other residents that may potentially be affected by the practice. All medication refrigerators and	09/30/2024

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	open date on the vials. On 9/13/24 at 12:04 p.m., the refrigerator in Skilled 1 Medication Room was observed to have a vial of tuberculin PPD opened and dated 4/16/24. The Unit Manager was unsure when to discard the vial after the vial was opened. On 9/13/24 at 1:46 p.m., the DON provided the facility's policy, "Expiration dates for Certain Drug, Biologicals, and Records," undated and indicated it was the policy being used by the facility. A review of the policy indicated "...Insulin...28 days refrigerated/unrefrigerated after 1st use...Tubersol/Aplisol tuberculin PPD vial...30 days after first use..." 3.1-25(k)(6)		storage areas will be checked for any medications not properly labeled with date opened. Any medication not labeled appropriately will be labeled or discarded accordingly and re-ordered. III. The facility procedure on Medication Labeling and Storage was reviewed with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur. Facility QMAs and Nurses will receive re-education regarding Medication Labeling and Storage by 9/26/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe the Medication Storage Refrigerators and Medication Carts to ensure that medications are labeled with the date opened. The observations will be done 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then weekly x 4 weeks, then monthly x 6 months or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing	

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			process, based upon the results of the audits. V. Plan of Correction completion date: 9/30/24	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 2 of 2 kitchen observations. Food was stored under a water line which had condensed water. Findings include: On 9/10/24 at 10:50 a.m., food was observed in the kitchen walk-in freezer on shelving beneath a condenser line upon which large portions of ice had formed. The ice portions were on and in a large box of packaged brussel sprouts and a large box of packaged mixed vegetables. On 9/13/24 at 1:50 p.m., food was observed in the kitchen walk-in freezer on shelving beneath a condenser line upon which large portions of ice had formed. The ice portions were on and in a large box of packaged brussel sprouts and a large box of packaged mixed vegetables. During an interview on 9/13/24 at 1:58 p.m., the Dietary Manager indicated the food was stored beneath the iced over condenser line and the condenser line was in need of repair. On 9/13/24 at 2:10 p.m., a review of the "Indiana State Department of Health Retail Food Establishment Sanitation Requirements," effective 11/13/04 indicated, "...410 IAC 7-24-177 Food	F 0812	I. The corrective actions to be accomplished for those residents found to have been affected by the practice. No residents were affected. The condenser line was de-thawed, and ice removed. The food items that were affected were discarded. Maintenance did an inspection of the freezer. The freezer was in need of repair, which was completed on 9/24/24. II. The facility will identify other residents that may potentially be affected by the practice. Current residents receiving care have the potential to be affected. All residents were observed, and no residents were affected. III. The facility policy on Food Storage was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. The Dietary Manager will receive re-education regarding the maintenance of the freezer/condenser line and food	09/30/2024

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	storage Sec. 177... food shall be protected from contamination by storing the food as follows:...(5) In packages, covered containers, or wrappings...", and "...410 IAC 7-24-178 Food storage; prohibited areas Sec. 178. (a) Food may not be stored as follows:...(2) Under the following:...under lines on which water has condensed..." 3.1-21(i)(2) 3.1-21(i)(3)		storage by 9/26/24. IV. The facility will monitor the corrective action by implementing the following measures. The Administrator or Designee will monitor the food storage areas including the freezer to ensure food is being stored appropriately per the facility policy. The observations will be done 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then weekly x 4 weeks, then monthly x 6 months or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 9/30/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to implement infection control practices for 1 of 3 residents reviewed for urinary catheters. Urinary catheter tubing was observed on the floor. (Resident 14) Findings include: On the following dates, times, and locations,	F 0880	I. The corrective actions to be accomplished for those residents found to have been affected by the practice. The facility made accommodations to Resident 14's wheelchair to ensure the catheter tubing is higher and not touching the floor. The resident was	09/30/2024

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	Resident 14 was observed in his wheelchair with his urinary catheter tubing beneath the wheelchair and lying on the floor: - On 9/11/24 at 10:55 p.m., in the resident's room. - On 9/12/24 at 1:30 p.m., on the front outside patio. - On 9/12/24 at 2:46 p.m., at the resident common room/puzzle station. On 9/11/24 at 11:15 am, Resident 14's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure and acute kidney failure. A physician's order with a start date of 6/20/24 indicated the resident had a Foley catheter secondary to diagnosis of obstructive and reflux uropathy. A care plan intervention with a start date of 1/14/24 indicated, "...Do not allow tubing or any part of the drainage system to touch the floor..." During an interview on 9/12/24 at 2:48 p.m., the Director Of Nursing indicated the resident's catheter tubing was in contact with the floor and in need of adjustment to stay off of the floor. 3.1-18(b)(1)		re-educated on not self-adjusting his catheter tubing and the risk of doing so. His plan of care was updated to reflect his non-compliance with his catheter maintenance. II. The facility will identify other residents that may potentially be affected by the practice. Current residents receiving care have the potential to be affected. Current residents who have indwelling catheters in the facility were observed to ensure their catheter tubing does not make contact with the floor. There were no other residents affected. III. The facility policy/procedure for Catheter Care was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. The nursing staff will receive re-education regarding care of an indwelling catheter by 9/26/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe residents who have catheters 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then weekly x 4 weeks, then monthly x 6 months or as deemed by the	

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			Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 9/30/24	