	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	ONSTRUCTION 00	(X3) DATE S COMPL	ETED
			B. WI	NG		11/26/	2024
	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	Survey dates: Nove		R 00	000			
	Facility number: 00	04903					
	Residential Census	: 48					
	These State Resider accordance with 41	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	apleted on December 1, 2024.					
R 0092	410 IAC 16.2-5-1. Administration and						'
Bldg. 00	Noncompliance	u Management -					
	failed to attempt to conjunction with the every six months.  Finding includes:  On 11/25/24 at 10:3 reviewed. The most the fire department The fire department The policy did not idepartment should indicated facility policy.	and record review, the facility told a fire and disaster drill in e local fire department at least 30 A.M., facility fire drills were at recent fire drill that indicated was notified was on 4/18/24. It did attend that fire drill.  46 P.M., the Administrator non-dated Fire Drill policy, indicate how often the fire be invited to fire drills, but olicy was to notify the fire y (in the second quarter) and	R 00	092	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts		12/26/2024
		ne policy did indicate the			alleged or the correctness of a		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	I IGNATURI	3	ITITLE		(X6) DATE

T.J. Bates **Executive Director** 12/12/2024

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.

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 1 of 19

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
			B. WIN	IG		11/26/	2024
		1	<del>-                                    </del>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	3			YNTREE DR		
BELL OA	KS PLACE				JRGH, IN 47630		
	T		<u> </u>		,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		oly with regulations which			conclusions set forth in this		
	I -	e fire department at least every			allegation by the survey agend	-	
	six months.				This provider respectfully requ		
					the 2567 plan of correction be considered the letter of credib		
						ie	
					allegation and request a desk review for paper compliance in	م انویر	
					of post survey review on or aft		
					12/26/2024.	.01	
					The facility will ensure this		
					requirement is met through the	<del>.</del>	
					following corrective measures		
					1 On 12/6/2024, Executive		
					Director (ED) conducted an au		
					of fire drills. No concerns		
					identified.		
					2 On 12/6/2024, ED		
					conducted an audit for inviting	the	
					local fire department to facility	fire	
					drills semi-annually. Identified		
					concerns were corrected at tin	ne of	
					findings.		
					3 ED provide in-service to	staff	
					on policy of fire drills and		
					regulation including inviting the	e fire	
					department at least every six		
					months.		
					4 The Executive Director is	S	
					responsible for sustained		
					compliance. The ED, or design		
					will review Fire Drills for prope		
					regulatory requirements week	ly lor	
					four weeks, biweekly for four weeks, then monthly for one		
					month. Results of the audit wil	l ha	
					discussed during monthly QI	ı De	
					meetings. The QI committee v	vill	
					determine if continued auditing		
					necessary based on three	ی ای	
					consecutive months of		

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 2 of 19

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
			B. W	ING		11/26	/2024
		<u> </u>		CTDEET	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP COD /YNTREE DR		
DELL OA	KS DI ACE						
DELL UA	KS PLACE		NEWBURG		URGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					compliance. Monitoring will be	•	
					ongoing.		
					5 December 26th, 2024.		
D 0404							
R 0121	410 IAC 16.2-5-1.						
DI-I 00	Personnel - Nonco	ompliance					
Bldg. 00	D 1 '	1 1 2 4 6 92		101	D 404		10/06/2021
		and record review, the facility	R 0	121	R 121	1	12/26/2024
		ewly hired employee was			Submission of this response a		
	· ·	berculosis) prior to resident ewly hired employees. A new			Plan of Correction is NOT a le	-	
					admission that a deficiency ex	ISIS	
		get the TB skin test due to an			or, that this Statement of	لم.	
	allergy, did not get a chest x-ray prior to having contact with the residents. (Care Manager 7)				Deficiencies was correctly cite		
	contact with the res	idents. (Care Manager /)			and is also NOT to be constru		
	Finding includes:				as an admission against intere	est	
	Tiliding includes.				by the residence, or any employees, agents, or other		
	On 11/26/24 at 8:34	A.M., the employee records			individuals who drafted or may	, he	
		indicated Care Manager 7 was			discussed in the response or F		
		he file lacked documentation of			of Correction. In addition,	iaii	
		t or chest x-ray being			preparation and submission of	f this	
	completed prior to o				Plan of Correction does NOT	1 1110	
	gempresed prior to	or upon ming.			constitute an admission or		
	During an interview	on 11/26/24 at 11:53 A.M., the			agreement of any kind by the		
	_	ated Care Manager 7 required			facility of the truth of any facts		
		ould not have a skin test done			alleged or the correctness of a		
	1	y to the skin test procedure.			conclusions set forth in this	,	
	_	icated Care Manager 7 had			allegation by the survey agend	CV.	
	been in contact with				This provider respectfully requ	-	
					the 2567 plan of correction be		
	On 11/26/24 at 1:16	P.M., a current Staff TB Policy,			considered the letter of credible	le	
	dated 6/10/24, was	provided by the Director of			allegation and request a desk		
	Nursing (DON) and	l indicated " Each newly			review for paper compliance ir		
	hired care staff men	nber will be screened regarding			of post survey review on or aft		
		otoms of TB after an			12/26/2024.		
	employment offer h	as been made and prior to the			The facility will ensure this		
		signments. TB test must be			requirement is met through the	е	
		ne of employment or within one			following corrective measures:	:	
		mployment All employees			1 On 12/2/2024, Executive	)	
	who have a positive	reaction to the skin test shall			Director (ED) conducted an		

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 3 of 19

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING  B. WING	00	COMPLETED  11/26/2024	
	ROVIDER OR SUPPLIER		4200 W	ADDRESS, CITY, STATE, ZIP COD YNTREE DR JRGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
P 0246	physical and laborat complete a diagnosi			observational audit of employed TB screenings. Staff member identified was sent for chest x-on 12/4/24. No residents were affected.  2 On 12/6/2024, ED conducted an observational at of all employee TB screenings concerns were identified.  3 ED provide in-service to DHW and Nursing staff on TB policy for each newly hired car staff member to be screened regarding exposure to or symptoms of TB after an employment offer has been m and prior to the employee's duassignments.  4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will review new hire screenings weekly for four weeks, then monthly for one month. Result the audit will be discussed dur monthly QI meetings. The QI committee will determine if continued auditing is necessar based on three consecutive months of compliance. Monito will be ongoing.  5 December 26th, 2024.	adit No staff re ade atty s TB eks, s of ing
R 0246 Bldg. 00	410 IAC 16.2-5-4( Health Services -	, ,			
3. 23	failed to ensure as n	and record review, the facility eeded (prn) medications were qualified Medication Aide	R 0246	R 246 Submission of this response a Plan of Correction is NOT a le	

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 4 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  11/26/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	(QMA) only upon a	uthorization by a licensed		admission that a deficiency e	xists		
	nurse for 2 of 7 resi	dent records reviewed.		or, that this Statement of			
	(Resident 5, Reside	nt 7)		Deficiencies was correctly cit	ed,		
				and is also NOT to be constru	ued		
	Findings include:			as an admission against inter	rest		
				by the residence, or any			
	1. On 11/25/24 at 1	0:00 A.M., Resident 5's clinical		employees, agents, or other			
	record was reviewe	d. Diagnosis included, but		individuals who drafted or ma	ay be		
	were not limited to,	Parkinson's Disease.		discussed in the response or	Plan		
				of Correction. In addition,			
	Current physician o	rders included, but were not		preparation and submission of	of this		
	limited to:			Plan of Correction does NOT			
	acetaminophen 325mg (milligrams) every six hours			constitute an admission or			
	as needed.			agreement of any kind by the			
				facility of the truth of any fact	s		
	hydroxyzine 25mg	every six hours as needed.		alleged or the correctness of	any		
				conclusions set forth in this			
	ondansetron 4mg th	ree times a day as needed.		allegation by the survey ager	псу.		
				This provider respectfully req	uests		
	loperamide 2mg ev	ery six hours as needed.		the 2567 plan of correction be	e		
				considered the letter of credil	ole		
	Resident 5's MAR (	Medication Administration		allegation and request a desk	(		
	Record) for Octobe	r and November 2024 included,		review for paper compliance	in lieu		
	but were not limited	l to, the following prn		of post survey review on or a	fter		
	medications admini	stered by a QMA without prior		12/26/2024.			
	authorization from	a licensed nurse:		The facility will ensure this			
		mg given on 10/2/24 at 9:59		requirement is met through the	ne		
	A.M., 10/15/24 at 1	2:10 P.M., and 10/18/24 at 10:36		following corrective measure:	s:		
	A.M.			1 Resident 5 and Resider	nt 7		
				suffered no negative effects r	elated		
	hydroxyzine 25mg	given on 10/2/24 at 10:00 A.M.,		to these findings. QMA's and			
	and 10/18/24 at 10:	36 A.M.		Nurses to be in-serviced on			
				obtaining appropriate authori			
	ondansetron 4mg gi	ven on 10/15/24 at 12:10 P.M.		for each PRN administration	and		
				proper documentation of PRI	N		
	loperamide 2mg giv	ven on 11/17/24 at 12:51 P.M.		administration in the nursing	notes		
				indicating the time and date of	on		
		0:00 A.M., Resident 7's closed		12/13/24			
		reviewed. Diagnosis included,		2 On 12/10/2024, Directo	r of		
	but were not limited	l to, osteoporosis.		Health and Wellness (DHW)			

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 5 of 19

PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		11/26/	2024
		l .	<del></del>	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2			YNTREE DR		
BELL OA	KS PLACE						
BELL UA	INO FLACE			NEWBC	JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					conducted an audit on Medica	tion	
	-	cluded, but were not limited to:			Administration Records of curi	rent	
	_	0mg every eight hours as			residents receiving PRN		
	needed.				medications in past 60 days to	)	
					ensure PRN medication was		
		from April 2024 through July			administered by a QMA after		
		following dates/times			receiving appropriate authoriz		
	•	eeded was administered by a	1		and properly documenting in t		
	QMA without prior	authorization from a licensed			residents' nurses' notes. Resu		
	nurse:		1		of the audit were reviewed by	the	
	4/19/24 at 8:00 P.M				ED.		
	4/22/24 at 8:00 P.M				3 By 12/19/2024, current		
	4/28/24 at 8:00 P.M				QMA's will be re-educated by		
	5/12/24 at 8:00 P.M				DHW on receiving appropriate	;	
	5/26/24 at 8:00 P.M				authorization for each		
	6/4/24 at 8:00 P.M.				administration of a PRN		
	6/7/24 at 8:00 P.M.				medication and documenting i		
	6/8/24 at 8:00 P.M.				the nursing notes indicating th	е	
	6/9/24 at 8:00 P.M.				time and date of the contact.		
	6/18/24 at 8:00 P.M				4 The Executive Director is	S	
	6/23/24 at 8:00 P.M				responsible for sustained		
	6/25/24 at 8:00 P.M				compliance. The DHW, or		
	7/2/24 at 8:00 P.M.				designee, will audit 5 resident		
	7/5/24 at 8:00 P.M.				records receiving PRN medica		
	7/6/24 at 8:00 P.M.				to ensure appropriate authoriz		
	7/7/24 at 8:00 P.M.				was obtained and documented		
	7/12/24 at 8:00 P.M		1		the nurses notes weekly for fo		
	7/15/24 at 8:00 P.M		1		weeks, biweekly for four week	s,	
	7/18/24 at 8:00 P.M		1		then monthly for one month.		
	7/25/24 at 8:00 P.M	l.			Results of the audit will be		
	On 11/26/24 + 12 2	25 D.M. OMA 2 : 4: 4 1 1			discussed during monthly QI	.:11	
		35 P.M., QMA 3 indicated when	1		meetings. The QI committee w		
	~ .	medication, QMAs should zation from a licensed nurse	1		determine if continued auditing	y is	
	•	zation from a licensed nurse authorization in the MAR.	1		necessary based on three		
	and document that a	aumonzauon in me MAK.	1		consecutive months of		
	On 11/26/24 at 1:04	DM the Administrator	1		compliance. Monitoring will be	;	
		P.M., the Administrator			ongoing.		
	-	Qualified Medication Aide	1		5 December 26th, 2024.		
		24, that indicated "PRN	1				
	medications can be	administered by a QMA only	1				

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 6 of 19

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		11/26/	2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			YNTREE DR		
REII ∩Δ	KS PLACE				JRGH, IN 47630		
DELE ON	INOT LAUL		_	INLVID			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		by a licensed nurse of					
		MA must receive appropriate					
		ch administration of a PRN					
	medication"						
D 0070	44044040055	4.60					
R 0273	410 IAC 16.2-5-5.						
Dida 00	Food and Nutrition	nal Services - Deficiency					
Bldg. 00	Događ an absamietic	on, interview, and record	D O	272	R 273		10/26/2024
		failed to maintain all food	R 0	2/3		nd	12/26/2024
	preparation and pub				Submission of this response a		
		te and local sanitation and			Plan of Correction is NOT a leg	-	
		standards for 3 of 3 kitchen			admission that a deficiency ex	1515	
		of 2 dining observations.			or, that this Statement of Deficiencies was correctly cited		
	ooservations, and r	of 2 diffing observations.			and is also NOT to be construct		
	Findings include:				as an admission against interest		
	i manigs metade.				by the residence, or any	,51	
	1. During an observ	ration of the kitchen on			employees, agents, or other		
	_	M., the following were			individuals who drafted or may	/ be	
	observed:	,			discussed in the response or F		
					of Correction. In addition,		
	An open gallon of n	nilk was not dated in the drink			preparation and submission of	this	
	cooler.				Plan of Correction does NOT		
					constitute an admission or		
	The lid to the sugar	bin was off and lying on top			agreement of any kind by the		
	of the flour bin in th				facility of the truth of any facts		
					alleged or the correctness of a	iny	
	A dented can of piz	za sauce			conclusions set forth in this	-	
					allegation by the survey agend	cy.	
	Three cans of peach	nes with dents, two of of which			This provider respectfully requ	ests	
	had dents along the	rim of the can.			the 2567 plan of correction be		
					considered the letter of credibl	е	
	During an observati	ion on 11/25/24 at 12:34 P.M.,			allegation and request a desk		
	the lid to the flour b	oin was off and lying on the			review for paper compliance in	ı lieu	
	sugar bin. At that tin	me, the Executive Chef			of post survey review on or aft	er	
	indicated all the bin	s should have been covered at			12/26/2024.		
		er indicated she was unaware of			The facility will ensure this		
		s for dented cans. Since the			requirement is met through the	e	
		ng she would have used them			following corrective measures:		
	unless the food look	xed or smelled bad, at which			1 On 11/29/24, ED and Ch	ef	

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 7 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		11/26/	2024
			<del></del>	CTD FFT A	DDDFGG CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DELL OA	WO DLAGE				YNTREE DR		
BELL OF	AKS PLACE			NEWBC	JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	time she would hav	re disposed of them.			discarded identified opened		
		•			unlabeled and/or undated food	d.	
	During an observation on 11/26/24 at 12:24 P.M., an open gallon of milk was not dated in the drink				Storage bins were closed and		
					sealed appropriately. All dente		
		, the Executive Chef indicated			cans were pulled from storage		
	she was unaware th	at the milk needed to be dated			racks to be sent back to food		
	when opened.				supplier. On 12/6/24 ice scoop	,	
					holder was ordered for drink c		
	2. During an intervi	iew on 11/25/24 at 10:47 A.M.,			the dining room. On 12/5/24 s		
		indicated she was not familiar			were educated to not were		
		running the dishwasher since			open-toed shoes in the kitcher	n.	
	_	ones who ran the dishwasher.			On 12/10/24 staff were educat		
	At that time, she took a strip from a bottle of				on proper hand hygiene.		
		and dipped it into the water in			2 Observational audit was		
		e strip did not turn colors. She			conducted on 12/11/24 by ED		
		nsure why the strip did not			current staff to ensure any iter		
		that time, there were no			shipped were not damaged, o		
	-	ertified Nurse Aides) to run the			they were, that they were pulle		
	dishwasher.	,			be sent back. Checked for		
					properly sealed storage bins,		
	During an interview	v on 11/25/24 at 12:25 P.M., the			labeling and dating, and that id	ce	
	_	icated the chlorine test strips			scoop containers were being		
		50 to 100 ppm (parts per			used. Also, that no open-toed		
	million).				shoes were being worn. DHW		
	,				completed audit on 12/12/24 f		
	On 11/25/24 at 1:01	P.M., the Administrator was			appropriate hand hygiene.		
	observed to test the	dishwasher with a Hydrion			3 By 12/9/24, current staff	will	
	QT-40 pH test strip	. He placed the strip in the			be re-educated by ED on		
	water in the dishwa	sher and it tested 400. At that			labeling/dating, food storage		
	time, he indicated in	t should test between 400-500.			policy, dented can policy, ope	n	
	He indicated they c	ould use either the chlorine or			toed shoes, ice scoop policy a		
	Hydrion test strips	for the dishwasher since they			hand hygiene.		
	were both provided	by the company that serviced			4 The Executive Director is	s	
		that time, a large plastic			responsible for sustained		
		ne was observed under the			compliance. The Dietary Mana	ager,	
	counter next to the	dishwasher.			or designee, will conduct an a	-	
					of labeled/dated food, dented		
	During an interview	v on 11/25/24 at 1:01 P.M., the	1		cans, food storage, proper ice	,	
		icated she believed the chlorine			scoop storage and open toed		
	test strips were outo	dated and lacked an expiration	1		shoes weekly for four weeks,		
	1	1	1		1		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	ING		11/26/	/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			YNTREE DR		
DELL OA	KS PLACE						
DELL UA	ING FLACE			INEVVBC	JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	date on the bottle.				biweekly for four weeks, then		
					monthly for one month. Result	ts of	
	On 11/26/24 at 11:4	48 A.M., Cook 17 provided a			the audit will be discussed dur	ing	
	copy of the Novem	ber Low Temperature Dish			monthly QI meetings. The QI		
	Washer log with the	e following bleach readings:			committee will determine if		
					continued auditing is necessal	ry	
		Bleach 55, Lunch Bleach 53,			based on three consecutive		
	Dinner Bleach 55				months of compliance. Monito	ring	
	Day 18 Breakfast B	Bleach 51, Lunch Bleach 52,			will be ongoing.		
	Dinner Bleach 51				DHW will conduct an audit of I	hand	
	1 -	Bleach 51, Lunch Bleach 50,			hygiene weekly for four weeks	S,	
	Dinner Bleach 51				biweekly for four weeks, then		
		sleach 50, Lunch Bleach 51,			monthly for one month. Result	ts of	
	Dinner Bleach 51				the audit will be discussed dur	ing	
	Day 21 Breakfast B	Bleach 53, Lunch Bleach 53,			monthly QI meetings. The QI		
	Dinner Bleach 53				committee will determine if		
	1 -	Bleach 51, Lunch Bleach 50,			continued auditing is necessal	ry	
	Dinner Bleach 52				based on three consecutive		
	1 -	Bleach 50, Lunch Bleach 51,			months of compliance. Monito	ring	
	Dinner Bleach 51				will be ongoing.		
	Day 24 Breakfast B	Bleach 53, Lunch Bleach 55			5 December 26th, 2024.		
	At that time, the ch	lorine test trip bottle was					
		llowing key for result readings:					
		million), 50 p.p.m., 100 p.p.m.,					
	200 p.p.m.	// II / II - 9					
	During an interview	on 11/26/24 at 12:01 P.M., the					
	_	icated the company that					
	serviced the dishwa	sher came on 11/25/24. A					
	report from that vis	it was requested and not					
	received.						
	_	vation on 11/26/24 at 1:13 P.M.,					
	CNA 11 was observ	ved coming out of the kitchen					
	carrying a plate wea	aring soft shoes with several					
	holes in the top and	going back into the kitchen.					
	4. On 11/25/24 from	n 12:00 P.M. through 12:15 P.M.,					
	lunch service was o	bserved in the main dining					
	room.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00		LETED S/2024	
	PROVIDER OR SUPPLIER	t.	4200 W	ADDRESS, CITY, STATE, ZIP COD YNTREE DR JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	on a rolling cart by scoop sticking out of 7 was observed to us from the container then place the ice so container.  Care Manager 7 was	were observed filled with ice the kitchen door with an ice of one of them. Care Manager use the ice scoop to scoop ice to serve drinks to residents, toop back into the ice s observed to wash hands in				
	second lather, and to	ys to residents with a two he rest of the hand wash was hands under the water.				
	observed to wash hat to residents with a t	edication Aide) 9 was ands in between passing trays hree second lather, and the sh was performed with her ter.				
	was a separate conta	5 P.M., QMA 9 indicated there ainer for the ice scoop in the the rolling cart in the dining				
	indicated hands sho water during meal s	24 P.M., the Kitchen Manager uld be washed with soap and ervice lathering hands long Happy Birthday song twice				
	provided a current r	B P.M., the Administrator non-dated Ice Scoop policy ice scoop is stored in a clean as water to drain"				
	provided a current I 6/10/24, that indicate	A.M., the Administrator Hand Hygiene policy, dated ted "Wet hand with water and lands together for at least				

State Form Event ID: D2JJ11 Facility ID: 004903 If continuation sheet Page 10 of 19

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		11/26/2024
	ROVIDER OR SUPPLIER		4200 W	ADDRESS, CITY, STATE, ZIP COD /YNTREE DR URGH, IN 47630	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINED'S DI ANI OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	twenty (20) seconds	s Rinse"			
	Administrator indic for the dishwasher.	on 11/25/24 at 1:11 P.M., the ated he did not have a policy			
		d Food Storage Guidelines			
	_	ted "All food items must be			
		oods must be stored in an			
	appropriated container with an airtight lid." On				
	11/26/24 10:37 A.M., the Administrator indicated the same was true for bins of sugar and flour.				
	the same was true for	or bins of sugar and flour.			
	provided an undated policy which indica Orders:Reject if:.	I P.M., the Administrator d Food Storage Guidelines ted " 2. Receiving Foodpackaging is damaged." At nistrator indicated this was the as.			
	On 11/26/24 at 2:14	P.M., the Administrator			
		d Personal Appearance policy			
		andals, flip flops or any type of			
	open toed shoes is r	not allowed with the uniform."			
R 0304 Bldg. 00	410 IAC 16.2-5-6( Pharmaceutical So	ervices - Deficiency			
		on and interview the facility	R 0304	R 304	12/26/2024
		edule II (narcotic) medication		Submission of this response a	
		for 1 of 5 medication ident's narcotic medication		Plan of Correction is NOT a le admission that a deficiency ex	·
		cine cup in the top drawer of		or, that this Statement of	uoto
	the medication cart.			Deficiencies was correctly cite	ed,
Finding includes:				and is also NOT to be constru as an admission against intere by the residence, or any	ed
	During an observati			employees, agents, or other	. [
	administration 11/2.	5/24 at 12:15 P.M., LPN		individuals who drafted or may	/ be

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/26/2024	
	PROVIDER OR SUPPLIER		4200 V	ADDRESS, CITY, STATE, ZIP COD VYNTREE DR URGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	(Licensed Practical drawer of a medicate unlabeled medicate that time, LPN 28 in her medication prior sodium chloride 1 gracetaminophen 7.5 was placed in the to Resident 14 finished During an interview DON (Director of Norefused to take a nate medication should be obtained the time of administrated by the state of t	Nurse) 28 opened the top tion cart and obtained a clear, on cup with 3 tablets in it. At indicated Resident 14 refused in to eating lunch so the 2 gram tablets and 1 oxycodoneming (milligrams/ 325mg tablet in of the medication cart until indicated if a resident reotic medication, the object of the double locked box at		discussed in the response or of Correction. In addition, preparation and submission or Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of conclusions set forth in this allegation by the survey agen This provider respectfully require the 2567 plan of correction be considered the letter of credit allegation and request a desk review for paper compliance in of post survey review on or at 12/26/2024.  The facility will ensure this requirement is met through the following corrective measures 1 Resident 14 suffered not negative effects related to find LPN 28 educated on proper labeling and storage of narcommedication. 12/5/24  2 Director of Health and Wellness (DHW) conducted conducted on the discretion of the discretion	Plan  f this  gany  cy. uests ele n lieu tter  e s: dings. tic  n  ked of rses d	

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PRINTED: 12/17/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COMPLETED		COMPLETED 11/26/2024			
	ROVIDER OR SUPPLIER KS PLACE		STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
R 0306 Bldg. 00	410 IAC 16.2-5-6(9) Pharmaceutical Set Based on observation failed to ensure the production in 1 of facility failed to door medications in 1 of facility failed to door medication refrigerator's. Nume packets and multiple the medication room Findings include: On 11/25/24 at 9:00 was observed. A blue overflowed with cle numerous to count a medications, and the	g)(1-9) ervices - Noncompliance on and interview, the facility proper disposal of 1 medication rooms, and the tument the temperature of the tor for 1 of 1 medication erous medications in clear to pill bottles were observed in the the disposal of the disp	R 0306	designee, will conduct an audi medication carts to make sure narcotic medications are labele properly and stored in double locked drawers weekly for four weeks, biweekly for four weeks, biweekly for four weeks, biweekly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee weetermine if continued auditing necessary based on three consecutive months of compliance. Monitoring will be ongoing.  5 December 26th, 2024.  R 306 Submission of this response and Plan of Correction is NOT a lead admission that a deficiency extor, that this Statement of Deficiencies was correctly cite and is also NOT to be construct as an admission against interestly the residence, or any employees, agents, or other individuals who drafted or may discussed in the response or Formation and submission of Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of a submission or t	t of all ed		
	terazosin 10mg (mil	ingranis) i ootile		conclusions set forth in this			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			11/26/2024	
		l .	<u> </u>	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				YNTREE DR		
DELL CAKO DI ACE							
BELL OAKS PLACE				INCAAR	JRGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mirtazapine 15mg	· 1 bottle			allegation by the survey agend	cy.	
	simvastatin 40mg	1 bottle			This provider respectfully requ	ests	
	quetiapine 50mg	l bottle			the 2567 plan of correction be		
	carbidopa / levodop	oa 25mg/100mg 2 bottles			considered the letter of credib	le	
					allegation and request a desk		
	Resident 10:				review for paper compliance ir	n lieu	
	metformin 850mg				of post survey review on or aft	er	
	trazodone 100mg	1 bottle			12/26/2024.		
	montelukast 10mg-	- 1 bottle			The facility will ensure this		
	isosorbide mononit	rate 30mg 1 bottle			requirement is met through the	Э	
	pentoxifylline 400n	ng 1 bottle			following corrective measures	:	
	warfarin 5mg 1 bo	ottle			1 All medications identified	d	
	nortriptyline 25mg-	- 1 bottle			were destroyed on 11/28/24.		
	atorvastatin 10mg	1 bottle			2 On 11/29/24 an audit of	the	
	metoprolol 25mg	1 bottle	medication room was completed				
					for all medications to be		
	Resident 11:				destroyed. Any identified		
	levothyroxine 100n	ncg (micrograms) 1 bottle			medications were destroyed.	<b>∖</b> n	
	Myrbetriq ER (exte	nded release) 50mg 1 bottle			audit of the fridge log was also	)	
	esomeprazole 40mg	g1 bottle			completed, and staff were		
	metoprolol 25mg	1 bottle			educated on 12/2/24 of the po	licy	
	lamotrigine 100mg-	2 bottles			of Daily Refrigerator Temp Co	ntrol	
	trazodone 150mg	1 bottle			Log.		
	atorvastatin 20mcg-	1 bottle			3 By 12/19/24, current Nur	ses	
					and QMA's will be re-educated	b	
	Resident 12:				proper destruction of medication	on	
	stimulant laxative 8				policy and refrigerator temp co	ontrol	
	Aspirin 81mg 1 be				log.		
	sulfamethoxazole tr	rimethoprim 800/160mg 1			4 The Executive Director is	S	
	bottle				responsible for sustained		
					compliance. The DHW, or		
		vember temperature log lacked			designee, will conduct an audi		
	a temperature recorded for the AM and PM on the				medication fridge log for temp		
	medication refrigera	ator:			and medication destruction log	3	
	November 1				and any medications to be		
	November 45				destroyed weekly for four wee	ks,	
	November 7				biweekly for four weeks, then		
	November 910				monthly for one month. Result		
	November 1315				the audit will be discussed dur	ing	
	November 1819				monthly QI meetings. The QI		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPLETED		
			B. W	ING		11/26/	2024	
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		NOVEDERIC N. AV OF CONDUCTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
R 0349	During an interview DON (Director of Medications in the bashould have been dowere brought into the time, she further increfrigerator should have been dowere brought into the time, she further increfrigerator should have been dowere brought into the time, she further increfrigerator should have been downed at 8:31 Storage Centrally dated 6/10/24 indicastored in a manner to the medication's residents residing in refrigerator temperator documented on the Temperature Control	November 2324  During an interview on 11/25/24 at 9:10 A.M., the DON (Director of Nursing) indicated all months of cor medications in the blue bin and on the counter should have been destroyed as the medications were brought into the medication room. At that time, she further indicated the temperature of the refrigerator should be documented daily.  On 11/26/24 at 8:31 A.M., a current Medication Storage Centrally Stored Medications will be stored in a manner that ensures the maintenance of the medication's integrity and safety of all residents residing in the CommunityThe refrigerator temperature is checked daily and documented on the Daily Refrigerator Temperature Control Log"  committee will continued auc based on thre months of cor will be ongoin 5 December 15 De		committee will determine if continued auditing is necessal based on three consecutive months of compliance. Monito will be ongoing.  5 December 26th, 2024.				
Bldg. 00	interview, the facili document in the res residents reviewed. annual health staten provide a Tuberculi Assessment. (Resid Resident 5, Resident 5, Resident 1. On 11/25/24 at 9 record was reviewed was not limited to, 1	on, record review, and ty failed to accurately ident's clinical record for 5 of 7 Resident's had an order for an ment, but the facility failed to in (TB) skin test or Risk ent 2, Resident 3, Resident 4, it 8)  250 A.M., Resident 4's clinical d. Diagnoses included, but high blood and diabetes was admitted to the facility on	R 0	349	R 349 Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of Deficiencies was correctly cite and is also NOT to be construas an admission against interesty the residence, or any employees, agents, or other individuals who drafted or may discussed in the response or of Correction. In addition, preparation and submission of Plan of Correction does NOT constitute an admission or agreement of any kind by the	gal ists d, ed est be	12/26/2024	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPL	ETED
			B. WING 11/26/2024			2024	
				TDEET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					YNTREE DR		
BELL OAKS PLACE					IRGH, IN 47630		
BELL Office Live			<u> </u>	121100		,	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG			DATE
		ealth statement that indicated			facility of the truth of any facts		
		e of communicable diseases			alleged or the correctness of a	any	
	_	infectious state was dated,			conclusions set forth in this		
	2/29/24 .				allegation by the survey agend	-	
	D 11 (4) 11 1	1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			This provider respectfully requ		
		l record lacked an annual TB			the 2567 plan of correction be		
	_	er test to support the health			considered the letter of credible	le	
	statement.				allegation and request a desk		
	2 0: 11/26/24 -+ 9	.50 A.M. Davidant 81- alinia-1			review for paper compliance in		
		:50 A.M., Resident 8's clinical d. Diagnosis included, but was			of post survey review on or aft	er	
					12/26/2024.		
	not limited to, woundcare and mobility. Resident 8 was admitted to the facility on 2/28/2020.				The facility will ensure this		
	was admitted to the	: facility on 2/28/2020.		requirement is met through the			
	A augment annual ha	ealth statement that indicated			following corrective measures:  1 Resident 4 was correcte		
		e of communicable diseases			11/26/24. Resident 2 and 3	u on	
		infectious state was dated,			corrected on 12/9/24. No resident	lonte	
	8/3/23 .	infectious state was dated,			were harmed during this finding		
	0/3/23.				2 On 12/11/24 Director of	ıy.	
	Resident 8's clinica	l record lacked documentation			Health and Wellness (DHW)		
		or Risk Assessment support			completed an observational au	ıdit	
	the health statemen				of the resident TB's for accura		
	3. On 11/25/24 at 8	:45 A.M., Resident 3's clinical			of completion. Any identified	-,	
	record was reviewe	d. Diagnosis included, but			issues were corrected.		
		hypertension, status post			3 By 12/19/24, current Nur	ses	
	CVA (cerebrovascı	ılar accident), and prediabetic.			will be re-educated proper		
	Admission date wa	s 2/3/24.			Resident Record policy and		
					documenting clinical records of	n	
		ealth statement that indicated			each resident.		
		e of communicable diseases			4 The Executive Director is	S	
		infectious state was dated		responsible for sustained			
	2/3/24.				compliance. The DHW, or		
					designee, will conduct an audi		
	_	l record lacked an admission			resident records to make sure		
		other test to support the			documentation is completed a		
	health statement.				admission and annually for ea		
		:30 A.M., Resident 2's clinical			resident weekly for four weeks	S,	
		d. Diagnosis included, but			biweekly for four weeks, then		
		dementia and atrial fibrillation.			monthly for one month. Result		
	Admission date was 1/27/23.				the audit will be discussed dur	ing	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY LETED 6/2024				
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE			4200 V	STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	(X5) COMPLETION DATE			
	the resident was fre including TB in the 4/2/24.  Resident 2's clinica	sident 2's clinical record lacked an annual TB n test or any other test to support the health		monthly QI meetings. To committee will determine continued auditing is not based on three consect months of compliance. will be ongoing.  5 December 26th, 2	ne if ecessary utive Monitoring				
	5. On 11/25/24 at 10:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. Admission date was 11/4/23.  A current annual health statement that indicated the resident was free of communicable diseases including TB in the infectious state was dated 3/2/24.								
		l record lacked an annual TB er test to support the health							
	DON indicated the results for Resident 5, and Rescompleted on admi Assessment or a TF annually. At that tin health statement sh	v on 11/26/24 at 10:30 A.M., the facility was unable to find TB 2, Resident 3, Resident 4, sident 8 and TB tests should be ssion and then a Risk 3 test should be done me, she indicated the annual ould be updated for the TB tests or Risk Assessments							
	provided a current l 6/10/24, that indica	5 P.M., the Administrator Resident Record policy, dated ted the facility must maintain nted clinical records on each							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
			B. W	NG		11/26/	11/26/2024	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			YNTREE DR			
REII ∩Δ	KS DI ACE				JRGH, IN 47630			
BELL OAKS PLACE				NEVVDC				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0410	410 IAC 16.2-5-12	2(e)(f)(g)						
	Infection Control -	. , . ,						
Bldg. 00		·						
-	Based on interview,	, observation, and record	R 04	410	R 410		12/26/2024	
	review, the facility	failed to ensure a tuberculin			Submission of this response a	nd		
	(TB) skin test or ris	k assessment was completed			Plan of Correction is NOT a le			
	for 5 of 7 residents	reviewed. Residents lacked			admission that a deficiency ex	ists		
	admission and yearl	ly TB test and/or risk			or, that this Statement of			
	assessment. (Reside	ent 2, Resident 3, Resident 4,			Deficiencies was correctly cite	d,		
	Resident 5, Residen	nt 8)			and is also NOT to be constru	ed		
					as an admission against intere	est		
	Findings include: by the residence, or any							
					employees, agents, or other			
	1. On 11/25/24 at 9:50 A.M., Resident 4's clinical				individuals who drafted or may	be be		
	record was reviewed	d. Diagnoses included, but			discussed in the response or F	Plan		
	was not limited to, l	high blood and diabetes			of Correction. In addition,			
	mellitus. Resident 4	was admitted to the facility on			preparation and submission of	this		
	12/20/23. Plan of Correction does NOT							
					constitute an admission or			
		l record lacked an annual TB			agreement of any kind by the			
	skin test or any other	er test to indicate active TB.			facility of the truth of any facts			
					alleged or the correctness of a	iny		
		:50 A.M., Resident 8's clinical			conclusions set forth in this			
		d. Diagnosis included, but was			allegation by the survey agend	-		
		ndcare and mobility. Resident 8			This provider respectfully requ	ests		
	was admitted to the	facility on 2/28/2020.			the 2567 plan of correction be			
					considered the letter of credible	е		
		l record lacked documentation			allegation and request a desk			
	of a yearly TB test of				review for paper compliance in			
		:45 A.M., Resident 3's clinical			of post survey review on or aft	er		
		d. Diagnosis included, but			12/26/2024.			
		, hypertension, status post		The facility will ensure this				
		ular accident), and prediabetic.			requirement is met through the			
	Admission date was	8 2/3/24.			following corrective measures:			
	Dogidant 21a alimi1	I record looked on a designion			1 Resident 4 was corrected	u on		
		l record lacked an admission			11/26/24. Resident 2, 3 and 5	lonto		
	TB.	other test to indicate active			corrected on 12/9/24. No resid			
		:30 A.M., Resident 2's clinical			were harmed during this findin  On 12/11/24 Director of	y.		
	record was reviewed	d. Diagnosis included, but			Health and Wellness (DHW)			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		11/26/2	2024
NAME OF PROVIDER OR SUPPLIER  BELL OAKS PLACE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  were not limited to, dementia and atrial fibrillation.		STREET A 4200 W	ADDRESS, CITY, STATE, ZIP COD  YNTREE DR  JRGH, IN 47630  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  completed an observational au	TE	(X5) COMPLETION DATE	
	skin test, risk assess indicate active TB.  5. On 11/25/24 at 10 record was reviewed were not limited to, dementia. Admission Resident 2's clinical skin test, risk assess indicate active TB.  During an interview DON indicated the results for Resident Resident 8 and TB to admission and then test should be done  On 11/26/24 at 10:1 provided a current Edated 6/10/24, that is screen all residents upon admission or residents.	record lacked an annual TB ament, or any other test to 0:00 A.M., Resident 5's clinical d. Diagnosis included, but Parkinson's Disease and on date was 11/4/23.  I record lacked an annual TB ament, or any other test to any other test to a resident 4, Resident 5, and tests should be completed on a Risk Assessment or a TB		of the resident TB's for accura of completion. Any identified issues were corrected.  3 By 12/19/24, current Nur will be re-educated resident TI upon admission and annual screening.  4 The Executive Director is responsible for sustained compliance. The DHW, or designee, will conduct an audi resident records to make sure resident TB's are completed a admission and annually for ea resident weekly for four weeks biweekly for four weeks, then monthly for one month. Result the audit will be discussed dur monthly QI meetings. The QI committee will determine if continued auditing is necessar based on three consecutive months of compliance. Monito will be ongoing.  5 December 26th, 2024.	rses B's s s t of all t ch s, rs of ing	

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