STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00412132. Complaint IN00412132 - No deficiencies related to the allegations are cited. Survey dates: July 17,18,and 19, 2023 Facility number: 004903 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 31, 2023.	R 0000	No deficiencies	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T.J. Bates	Executive Director	08/15/2023

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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	receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in First Aid and CPR (Cardiopulmonary Resuscitation) for 2 of 2 days reviewed. (7/16/23 and 7/19/23) Findings include: On 7/18/23 at 11:30 A.M., the Administrator provided the nursing schedule as worked for the time period of 7/16/23 through 7/22/23. On 7/19 at 2:00 P.M., the CPR and First Aid Certifications for RN (Registered Nurses), LPN(Licensed Practical Nurses), CNA (Certified Nursing Assistant), QMA(Qualified Medication Aide) was provided by the Administrator and reviewed. The schedule indicated that the facility lacked an employee certified in First Aid from 6:00 P.M. to 6:00 A.M. on 7/16/23 and 7/19/23 During an interview on 7/19/23 at 2:20 P.M., the Administrator indicated he just had learned that the certain members of the nursing staff had certifications that had lapsed. During the same interview, the Administrator indicated there is to be at least 1 person scheduled per shift that is certified in CPR and First aide. The facility lacked a current policy, the	R 0117	R 117 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. The facility will ensure this requirement is met through the following corrective measures: 1. On 8/9/2023, Director of	08/19/2023

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	Administrator indicated the facility followed the State Regulations for CPR and First Aid coverage.		Nursing (DON) conducted audit of current staffing schedule to ensure at least one staff member is on duty at all times who is certified in First Aid and CPR. No concerns identified with current schedule. 2. On 8/9/2023, DON conducted audit of nursing staff personnel file to determine First Aid and CPR Certification. Identified staff in need of certification were provided with First Aid and CPR certification on 8/19/2023 by DON. 3. The Director of Nursing (DON) and Executive Director (ED) were in-serviced on First Aid and CPR requirements for nursing staff, including the requirement to have at least one staff member on duty at all times who is certified in First Aid and CPR by Regional Director of Care Services (RDCS) on 8/11/2023. 4. The Executive Director is responsible for sustained compliance. The DON or designee will review staffing schedule weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure at least one staff member is on duty at all times who is certified in First Aid and CPR. 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	

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			ongoing. 5. August 19th, 2023	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to provide a clean, orderly, bathroom in good repair for 1 of 5 residents reviewed for cleanliness and orderliness that provides reasonable comfort the the resident. (Resident 5) Findings include: During observation of Resident 5's bathroom on 7/18/23 at 10:15 A.M., there were two dark, black rings around the inside of the toilet bowl about 6 inches apart with specks of black and brown debris throughout the inside of the toilet bowl. Around the base of the toilet, there was a gooey black substance on the floor, which was thicker at the back of the toilet. Two waste baskets in the bathroom were overflowing. During an interview with Resident 5's Home Health Aide on 7/18/23 at 10:00 A.M., she indicated she had been talking with the administrator to get the bathroom cleaned but had so far been unsuccessful. During an interview with the administrator on 7/18/23 at 12:37 P.M., he provided a page from the resident handbook (revised May, 2022) that indicated basic housekeeping services included mopping the kitchen and bathroom floors, vacuuming, and cleaning the bathroom sink, toilet, and bathtub or shower. The housekeeping daily	R 0144	R 144 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8-19-2023. 1. Resident toilet was cleaned and trash was taken out on 8/2/2023 by Housekeeping.	08/19/2023

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	checklist included deep cleaning of resident rooms: Monday - Rooms 100-111 Tuesday - Rooms 112-123 Wednesday - Rooms 200-213 Thursday - Rooms 214-227 Friday - common areas areas Deep clean included dust, sweep, vacuum, mop, clean kitchenette (sink, wash dishes in sink,cabinets,microwave, wipe out inside of fridge and throw out expired food), bathroom sink, mirrors, toilet, shower, mop bathroom floor, trash. He indicated there is one housekeeper for the entire building.		2. An audit of the community was conducted on 8/3/2023 by Executive Director to identify environmental concerns and ensure sanitations and safety standards were maintained. Identified concerns were corrected at time of findings. 3. On 8/11/2023, Executive Director provide re-education to Housekeeping staff on proper sanitation and safety standards regarding proper procedures for cleaning residents bathroom. 4. The Executive Director is responsible for sustained compliance. The ED or designee will conduct observational audit of community for sanitation and safety standards weekly for four weeks, biweekly for four weeks, then monthly for one month. 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. August 19th, 2023.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and			

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	mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview: the facility failed to ensure that resident weights were obtained as ordered for 6 of 8 resident reviewed. The weights of 6 of 8 residents lacked weights as per MD(Medical Doctor) orders and facility monthly routine. (Resident 2, Resident 5, Resident 7, Resident 10 Resident 12, and Resident 21). Findings include: 1. On 7/18/23 at 11:05 A.M., Resident 10's clinical record was reviewed. Diagnoses included but were not limited to: depression and edema. Current physician's orders included but were not limited to: Obtain weight one time a day once a month dated 6/30/2020. The Resident Weight Record form indicated Resident 10's weights were last recorded June of 2022 and lacked any further documentation of weights. 2. On 7/17/23 at 1:49 P.M., Resident 12's clinical record was reviewed. Diagnoses included but were not limited to : dementia and anxiety. The Resident Weight Record indicated Resident 12 had two weights recorded in January and March of 2023. 3. On 7/17/23 at 1:20 P.M., Resident 21's clinical	R 0216	R 216 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. Residents identified were weighed by Director of Nursing (DON) on 8-7-2023.	08/19/2023

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	record was reviewed. Diagnoses included but were not limited to: depression and anxiety. The Resident Weight Record indicated Resident 21's had one weight recorded in 2023.4. On 7/19/23 at 11:30 A.M., Resident 2's resident weight record was reviewed. The record lacked weights from August 2022 through December, 2022, February 2023, and April through July 2023. 5. On 7/19/23 at 11:30 A.M., Resident 5's resident weight record was reviewed. The record lacked weights from January and February 2023, and April through July, 2023. 6. On 7/19/23 at 11:30 A.M., Resident 7's weight record was reviewed. The record lacked weights from July, 2022 to July, 2023. During an interview on 7/17/23 at 1:45 P.M., DON (Director of Nursing) indicated she knew the weights were not up to date. During an interview on 7/18/23 at 1:25 P.M., CNA(Certified Nurse Aide) 8, indicated the residents are weighed monthly. On 7/17/23 at 3:30 P.M. a current policy "Weights/Vital Signs, issued 2/1/22 was provided and indicated " The Community will have procedure in place to obtain weights/vital signs routinely, per Medical Provider order... Procedures.... unless ordered otherwise by the Medical Provider, weights and vital signs will be performed at... monthly..."		2. An audit of the community was conducted on 8/8/2023 by DON to identify residents with missing weights. Identified concerns were corrected at time of findings. 3. On 8/11/2023, Executive Director provide re-education to DON policy and procedure of resident weights. 4. The Executive Director is responsible for sustained compliance. The ED or designee will conduct observational audit of community for resident weights weekly for four weeks, biweekly for four weeks, then monthly for one month. 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. August 19th, 2023.	
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all			

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	meals shall be approved by a registered dietician. Based on observation, interview, and record review, the facility failed to insure that menu substitutions for meals were approved by a registered dietician for 1 of 1 substitutions observed. Findings include: During a tour of the kitchen on 7/18/23 at 12:00 P.M., during an interview with the kitchen supervisor while checking food temperatures, she was stirring soup that she indicated was a cream of turkey soup recipe she "just made up". When asked if she had the registered dietician approve the nutritional value of the soup, she indicated she did not. The facility dietary policy, dated 7/1/21, indicated the menus will be followed and variations will be documented, and will provide a balanced and nutritious diet, such as recommended by the National Food and Nutrition Board.	R 0269	R 269 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. Residents had no adverse effects from substituted food items. Menu substitutes from 7/19/2023 were recorded and approved by Dietician. 2. On 8/9/2023, Executive Director (ED) audited menus to determine menu item substitutes for approval by Dietician if needed. 3. On 8/11/2023, current	08/19/2023

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			Kitchen staff will be re-educated by Executive Director on proper procedures of approval by Dietician for menu substitutes. 4. The Executive Director is responsible for sustained compliance. The Dietary Manager or designee will conduct audit of food preparation and substitutes weekly for four weeks, biweekly for four weeks, then monthly for one month to approvals are obtained by Dietician. 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. August 19th, 2023.	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on interview and observation, the facility failed to serve food at a safe and appropriate temperature for 1 of 1 meal trays tested, 2 of 4 residents reviewed for appropriate temperature of food and 3 random interviews regarding meal service. (Resident 2, Resident 7, Resident 10, Resident 12, and Resident 21) Findings include: 1. During an interview on 7/17/23 at 11:05 A.M., Resident 12 indicated the food is ok but is cold	R 0272	R 272 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	08/19/2023

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	when she gets hers. She indicated breakfast is usually luke warm but the other 2 meals are cold. 2. During an interview on 7/17/23 at 11:26 A.M., Resident 21 indicated food is bad he is worried about the type of food bought. He does not like what is served. He thinks that someone from cooperate should come and try the food. He has problems eating food due to a swallowing problem. He indicated that the chicken is really dry and so is the pork and this is hard for him . Family will bring in food that he can eat and likes. 3. During an interview on 7/17/23 at 11:40 A.M., Resident 10's the food is ok but is also cold when it gets to her.4. During an interview with Resident 2 on 7/17/23 at 11:14 P.M., she indicated "Well, the food's not a pretty story...hot food is not always hot, cold food is not always cold". 5. During an interview with Resident 7 on 7/17/23 at 11:43 A.M., he indicated he eats his meals in his room and that when he gets his food it is often cold. 6. On 7/18/23 at 8:15 A.M., the Administer provided the resident council minutes for the last 6 months. There were anonymous comments: " the food is cold" and "food temperatures vary all the time". 7. On 7/19/23 at 12:45 P.M., food temperatures were measured on a test tray that was being delivered to a resident's room. Food was not in an insulated container, but was on a plate covered with clear plastic wrap and transported on an open cart. The temperatures were: chicken fried steak 116.1 degrees Fahrenheit mashed potatoes 126.8 Fahrenheit		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 any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. On 8/3/2023, Executive Director (ED) provided re-education to Chef and CNA1, and on proper use of food tray covers. 2. Observational audit was conducted on 8/14/2023 by ED of current staff to ensure they are using appropriate tray delivery devices and were re-educated at time of findings as necessary. 3. By 8/11/2023, current Kitchen staff and Nursing staff will be re-educated by Executive Director or Care Services Manager on proper use of tray delivery devices. 4. The Executive Director is responsible for sustained compliance. The Dietary Manager or designee will conduct audit of tray delivery service weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safe food handling standards are	

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	cheese cake 64.2 Fahrenheit		maintained. 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. August 19th, 2023.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain all food preparation and public serving areas in accordance with state and local sanitation and safe food handling standards for 1 of 2 kitchen observations. Findings include: During an observation of the kitchen on 7/17/23 at 8:24 A.M., the following were observed: 1. The kitchen and dishwasher room floors were sticky and soiled with debris. The corner under the dishwasher was covered with black food debris, white scaly covering, and particles of white rice-sized particles stuck to the floor. 2. The kitchen supervisor indicated she checks the chlorine titration of the dishwasher once a week and does not keep a titration log. She does not have a dishwasher manual. During	R 0273	R 273 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be	08/19/2023

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	observation, she checked the titration and found it to be 25 ppm(parts per million). She indicated she did not know what it should be. The dishwasher manual was available online, and page 24 indicated chlorine titration should be between 50-100 ppm and the machine requires adjustment if it is not correct. 3. During interview and observation with QMA 3, CNA 7, and CNA 9, the area beneath a set of shelves in the dishwasher room was inspected, where there were two white boxes, 1 approximately 12 inches in length and a smaller white box approximately 8 inches in length with open ends. She indicated the larger box was a rat trap and the smaller one was an insect trap. 4. The kitchen supervisor's hair net was not covering the hair around her face, only the hair she had braided on top of her head. She was observed with long, painted finger nails. 5. The front of the condiment cooler was splattered with food drippings. Inside, four salad dressings in squeeze bottles were open not dated. 6. The drink cooler for residents had an external thermometer that indicated an internal temperature of 47 degrees F(Fahrenheit); the internal thermometer indicated a temperature of 62 degrees F. During interview with kitchen supervisor, she indicated the temperature of the cooler should be no more than 35 degrees F. 7. In the walk-in cooler: - the thermometer inside the cooler read 42 degrees F. - the floor was dirty and sticky, with onion skins, other food debris - 1 box of cabbage heads was not dated, cabbage		considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/23. 1. On 8/3/2023, ED provided re-education to Chef 1 on sanitation standards, proper use of hairnets, and labeling and dating open food and beverage items of the Kitchen. On 8/3/2023, ED provided re-education to Chef 1 on how to properly use the test strips. 2. Observational audit was conducted on 8/7/2023 by ED of kitchen staff to ensure they are properly cleaning kitchen floors, proper use of hairnets, and items were labeled and dated and were re-educated at time of findings as necessary. An audit was conducted on 8/7/2023 by ED of kitchen staff to ensure chlorine titration was within range and logged. Concerns corrected at time of findings as necessary. 3. By 8/11/2023, current Kitchen staff and Nursing staff will be re-educated by Executive Director or Care Services Manager on proper sanitation standards and chlorine titration procedure, use of hairnets and labeling and dating kitchen items. 4. The Executive Director is responsible for sustained compliance. The Dietary Manager or designee will conduct audit of cleaning procedures, labeling	

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		A. BUILDING 00 B. WING	07/19/2023

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	had brown spots on outer leaves - 1 pan of jello was not dated - 2 plastic containers of pasta salad and 1 container of potato salad were open not dated - 1 small package of sliced turkey breast was open not dated - 1 plastic container of ham was open not dated - 1 plastic container of shrimp open not dated - 1 plastic container of something white and unrecognizable was open not dated - 1 plastic container of sliced vegetables in liquid was open not dated - 1 case each of apples and bananas were open not dated - 1 gallon container of fresh garlic was open not dated - 1 gallon of whole milk was open not dated - 1 gallon Baby Ray's BBQ sauce was open not dated - 2 gallons French salad dressing, 1 gallon Italian dressing, 1 gallon Thousand Island dressing, 1 gallon pickle relish were open not dated - 2 large bowls of pudding-like substance were open not dated -1 bag of cut up celery was open not dated; celery stalks are brown - 1/2 bag of mozzarella cheese was open not dated - 1 large bag sliced pepperoni was open not dated - 1 box of fresh zucchini open was open not dated - 2 boxes of fresh tomatoes were open not dated - 1 box of summer squash was open not dated - 1 container labeled basil leaves contained salt instead of basil leaves. The use-by date was unreadable. - 1 open plastic cup of white substance, kitchen supervisor said it's probably sugar - 1 container ground mustard was very sticky,		items, use of hairnets, and chlorine titration of the dishwasher weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safe food handling standards are maintained. 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. August 19th, 2023.	

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	opened 11/20/2019 - most spice containers lacked open date and/or use-by date from manufacturer, some were sticky - in the kitchen,1 additional bag of opened buttermilk biscuit mix was open not dated - 1 black crock pot had drips around the top like it boiled over, puddle of yellow substance on the cart under the pot. 8. In the walk-in freezer, there was a box of frozen chicken patties open not dated, and 2 cups of orange sherbet uncovered and dried out, not dated or labeled. 9. In the dry storage room: - the floor was dirty and sticky - 1 bag confectioner's sugar was open not dated. - 1 bag pecans open was not dated - 4 bags pasta were open not dated - 1 bag buttermilk biscuit mix was open not dated - chocolate chips were in plastic container, the lid was dirty and sticky - Cambro brand insulated tray holder - when opened there was an overwhelming odor of mold - 1 institutional size bag of flour was open not dated - Vermin trap was on the floor under the shelves, no vermin observed. Monthly pest control reports indicated there was a gap 1/4" or greater under exterior kitchen door which has been reported since June 2021 on every monthly report and was observed at that time. Dietary policies and procedures were reviewed on 7/18/2023 at 10:45 a.m. as follows: The facility food service protection from contamination policy and procedure, undated, indicated that			

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	- all left over foods must be labeled and dated with a "use-by" date which is no more than 3 days from the date the food was prepared. Use or discard by the "use by" date. - monitor refrigerator and freezer temperatures daily. Refrigerator temperatures should not exceed 41 degrees F; freezer temperatures should not exceed 0 degrees F. - Clean the refrigerator door handles, doors, and shelves as needed - floors, walls, and ceilings in the food service areas must be cleaned to keep the area free from spills, splatters, rubbish, dust, grease, dirt, etc. - employees will wear hairnet or caps with hair pulled back and secured when handling or preparing food. An additional facility food service policy, dated 2/1/22, indicated that the temperature of the refrigerator will be 35-41 degrees F and freezer temperatures will be maintained at 0 degrees F or below. Refrigerators and freezers will be kept clean and sanitary at all times. Food stored in refrigerators and freezers will be covered, dated, and labeled.			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour			

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	classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on observation, interview, and record review, the facility failed to provide an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service for 1 of 1 executive chef in the facility. Findings include: During an interview on 7/17/23 at 8:24 A.M. with the supervisor of the kitchen, who has the title of "Executive Chef", she indicated she is not a dietician, is not a graduate or student enrolled in and within one year of completing a division-approved instruction course in food	R 0274	R 274 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	08/19/2023

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	service supervision, a graduate of a dietetic technician program approved by the American Dietetic Association, a graduate of an accredited college or university or within one year of graduating with a degree in foods and nutrition or food administration, or an individual with training and experience in food service supervision and management. The supervisor indicated she had taken 3 days on online courses provided by the facility that covered food safety, ordering, and budgeting. Upon completion, the facility awarded her the title of "Executive Chef". She began the position in February The facility job description for the chef was received and reviewed on 7/17/23 at 2:30 p.m. as follows: - a bachelor's degree in culinary arts program was preferred - a minimum of 5 years of management experience in a food service environment - must have successfully completed food safety training. The facility provided a copy of their corporate agreement dietary consulting, which indicated the dietary consultant would provide 4 hours of consulting per quarter. The most recent quarterly dietary audit, received on 7/18/23 at 10:15 A.M., from the administrator indicated the last audit took place on 3/10/23. The results indicated deficiencies in sanitation, food storage, and dishwasher temperatures and chlorine titration ppm (parts per million of chlorine). No increase in additional consulting was scheduled with the unqualified food service manager.		agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/23. 1. No residents were harmed by deficient practice. 2. Observational audit was conducted on 8/7/2023 by ED of kitchen staff to ensure compliance of education requirements. Concerns corrected at time of findings as necessary. 3. By 8/19/2023, Executive Chef will be enrolled in Certified Dietary Management course to meet requirements. 4. The Executive Director is responsible for sustained compliance. The Dietary Manager or designee will conduct audit of course completion for four weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safe food handling standards are maintained. 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.	

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R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to employ a consultant pharmacist under contract to perform a pharmacy regimen review every 60 days for 6 of 6 residents reviewed for drug regimen review (Resident 2, Resident 5, Resident 7, Resident 10, Resident 12, and Resident 21). Findings include: 1. On 7/20/23 at 10:35 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, fibromyalgia, osteopenia, memory loss, renal insufficiency. The clinical record lacked a pharmacy drug regimen review performed by a pharmacist. 2. On 7/20/23 at 10:30 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to history of falls and anemia. The	R 0298	R 298 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 alleged or the correctness of any conclusions set forth in this	08/19/2023

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	clinical record lacked a pharmacy drug regimen review performed by a pharmacist. 3. On 7/20/23 at 10:35 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, history of cardiovascular accident. The clinical record lacked a pharmacy drug regimen review performed by a pharmacist.4. On 7/18/23 at 11:05 A.M., Resident 10's clinical record was reviewed. Diagnoses included but were not limited to: depression and edema. The clinical record lacked a pharmacy drug regimen . 5. On 7/17/23 at 1:49 P.M., Resident 12's clinical record was reviewed. Diagnoses included but were not limited to : dementia and anxiety. The clinical record lacked a pharmacy drug regimen. 6. On 7/17/23 at 1:20 P.M., Resident 21's clinical record was reviewed. Diagnoses included but were not limited to: depression and anxiety. The clinical record lacked a pharmacy drug regimen. 7. The facility failed to have a written contract with a licensed pharmacist to perform pharmacy regimens every 60 days as required. During an interview with the Administrator and DON on 7/19/23 at 10:15 A.M., both indicated they were not aware that pharmacy drug regimen reviews were to be performed by a pharmacist every 60 days for each resident.		allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. Residents 2, 5, 7, 10, 12, and 21 suffered no negative effects from these findings. Director of Nursing (DON) was re-educated on 8/3/2023 of pharmacy drug regimen review policy by Executive Director (ED). 2. An audit was conducted on 8/7/2023 by DON of resident charts for pharmacy reviews and were scheduled at time of findings as necessary. 3. Current Nursing staff will be re-educated on pharmacy drug regimen reviews procedures by DON by 8/11/2023. 4. The Executive Director is responsible for sustained compliance. The DON or designee will review resident medical charts for pharmacy reviews for four weeks, biweekly for four weeks, then monthly for one month to ensure use of. 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. August 19th, 2023	

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R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
	Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 2 of 2 medication carts. (4 unlabelled pills in the A Hall medication cart and 17 unlabelled pills in B Hall medication cart) Findings include: During a medication pass observation on the 7/18/23 at 6:39 A.M., Medication carts were observed as follows: A Hall cart: 1 oblong white pill with no markings 1 yellow oblong pill number 003 1 small white/beige capsule number 40 1 white capsule with IP 101 B Hall cart: 1 white oblong with ALPO	R 0306	R 306 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 alleged or the correctness of any conclusions set forth in this	08/19/2023

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	2 large white pills with number 54/27 2 oblong white pills with A 33 1 brown and tan capsule with number 020 1 large tan oblong pill with ALT 1 small rectangular with number 247 2 ½ 1 blue oblong pill with JCL 28 1 tan/pink capsule ZAP-18 0.4 mg 1 large white 209 1 blue capsule with G 231 1 small yellow pill with TEL 1 pale yellow with TV-3702 1 small white pill with S 111 1 small white no markings 1 small white with ML 35 During an interview on 7/18/23 at 6:56 A.M., the DON (Director of Nursing) indicated the night shift is to check and clean the medication carts weekly. On 7/19/23 at 12:30 P.M., a current nondated policy "Medication Storage" indicated " Medication .... will be properly stored, accessed and secured....Procedure.... only medications ....properly labeled ....can be stored..."		allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. QMA 1 was re-educated on proper storage of medication by Director of Nursing (DON) on 8/4/2023. 2. On 8/7/2023 DON conducted audit of medication carts to assure medications were stored properly and carts were cleaned after shifts. Results of the audit were reviewed by the Executive Director. 3. By 8/11/2023, current QMA's and Nurses will be re-educated by DON on proper storage of medication. 4. The Executive Director is responsible for sustained compliance. The DON or designee will audit medication carts for storage and cleanliness weekly for four weeks, biweekly for four weeks, then monthly for one month. 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. August 19th, 2023.	

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R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to provide documentation of the annual health assessment statement of 6 of 6 residents reviewed.(Resident 2, Resident 5, Resident 10, Resident 12, Resident 21, and Resident 7) Findings include: 1. On 7/18/23 at 11:05 A.M., Resident 10's clinical record was reviewed. Diagnoses included but were not limited to: depression and edema. Current physician's orders lacked an annual health assessment statement. 2. On 7/17/23 at 1:49 P.M., Resident 12's clinical record was reviewed. Diagnoses included but were not limited to : dementia and anxiety. Current physician's order lacked an order for an annual health assessment statement. 3. On 7/17/23 at 1:20 P.M., Resident 21's clinical record was reviewed. Diagnoses included but were not limited to: depression and anxiety. Current physician's order lacked an annual health assessment.4. On 7/20/23 at 10:35 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, fibromyalgia, osteopenia, memory loss, renal insufficiency. The clinical record lacked an annual health statement. 5. On 7/20/23 at 10:30 A.M., Resident 5's clinical	R 0409	R 409 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 alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 8/19/2023. 1. Residents 2, 5, 7, 10, 12 and 21 suffered no negative effects from these findings. Director of	08/19/2023

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BELL OAKS PLACE	4200 WYNTREE DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record was reviewed. Diagnoses included, but were not limited to history of falls and anemia. The clinical record lacked an annual health statement. 6 On 7/20/23 at 10:35 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, history of cardiovascular accident. The clinical record lacked an annual health statement. During an interview on 7/19/23 at 10:00 A.M., with the Administrator and DON (Director of Nursing) they both indicated that they were unaware of the need for a annual heath assessment order. On 7/18/23 at 1:00 P.M., a current policy "Physician Orders Policy was provided by the Administrator. The policy lacked a requirement for residents health assessment statement that shows that the resident is free of infectious disease upon admission and annually thereafter.		Nursing was re-educated on obtaining orders for resident health assessments regarding TB on admission and yearly on 8/4/2023 by Executive Director (ED). 2. An audit was conducted on 8/7/2023 by Director of Nursing (DON) of resident charts for health assessments and orders obtained at time of findings as necessary. 3. Sales Counselor will be re-educated on required health assessment for admission order by Executive Director by 8/11/2023. 4. The Executive Director is responsible for sustained compliance. The DON or designee will review new admission resident records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure orders obtained for health assessments regarding TB. 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. August 19th, 2023	