STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	ETED	
			B. WI	B. WING			2023
NAME OF B	DOLUDED OD GUDDU IED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L		4200 W	YNTREE DR		
BELL OA	KS PLACE			NEWBL	JRGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION DD FFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE		ΤE	COMPLETION
R 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DELICIENCE!		DATE
1 0000							
Bldg. 00							
3	This visit was for a	State Residential Licensure	R 00	000	No deficiencies		
	Survey. This visit in	ncluded the Investigation of					
	Complaint IN00412	2132.					
	•	2132 - No deficiencies related to					
	the allegations are c	ited.					
	Survey dates: July 1	7 18 and 10, 2023					
	Survey dates. July 1	7,16,and 19, 2023					
	Facility number: 00	4903					
	Residential Census:	53					
	These State Residen	ntial Findings are cited in					
	accordance with 410	0 IAC 16.2-5.					
	Quality review com	pleted on July 31, 2023.					
R 0117	410 IAC 16.2-5-1.4	, ,					1
DII 00	Personnel - Deficie						
Bldg. 00		sufficient in number,					
		training in accordance with					
		ws and rules to meet the					
		our scheduled and ds of the residents and					
		. The number, qualifications,					
	•	ff shall depend on skills					
	-	e for the specific needs of					
		ninimum of one (1) awake					
		current CPR and first aid					
	•	oe on site at all times. If					
		esidents of the facility					
	• ` '	esidential nursing services					
	or administration of	of medication, or both, at					
	least one (1) nursi	ng staff person shall be on					
		esidential facilities with					
	over one hundred	(100) residents regularly					
			<u> </u>				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

T.J. Bates Executive Director 08/15/2023

Any defiency statement 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 disclodays 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: JJ5211 Facility ID: 004903 If continuation sheet Page 1 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 07/19/2023			
	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 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
	receiving resident administration of rhave at least one person awake and every additional fit shall be assigned they are trained to shall conform with Based on record refailed to ensure at leduty at all times who CPR (Cardiopulmon days reviewed. (7/1) Findings include: On 7/18/23 at 11:30 provided the nursing time period of 7/16/2 On 7/19 at 2:00 P.M. Certifications for R. LPN(Licensed Prace Nursing Assistant), Aide) was provided reviewed. The schedlacked an employee P.M. to 6:00 A.M. of During an interview Administrator indicated the certain members certifications that have been been been been been been certifications that have been been been been been been been be	ial nursing services or nedication, or both, shall (1) additional nursing staff on duty at all times for ity (50) residents. Personnel only those duties for which operform. Employee duties written job descriptions. Firewand interview, the facility east one staff member was on the owas certified in First Aid and the nary Resuscitation) for 2 of 2 (6/23 and 7/19/23) 1) A.M., the Administrator of general schedule as worked for the 23 through 7/22/23. 1) A.M. (Registered Nurses), tical Nurses), CNA (Certified QMA(Qualified Medication by the Administrator and dule indicated that the facility certified in First Aid from 6:00 on 7/16/23 and 7/19/23 1) You of 7/19/23 at 2:20 P.M., the lated he just had learned that is of the nursing staff had and lapsed.	R 0117	R 117 Submission of this response a Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiencies was correctly cite and is also NOT to be construas an admission against interby the residence, or any employees, agents, or other individuals who drafted or madiscussed 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 af 8/19/2023. The facility will ensure this requirement is met through the following corrective measures 1. On 8/9/2023, Director of	os/19/2023 and egal kists ed, led est y be Plan f this samy cy. lests elle in lieu iter e ::

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 2 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 07/19/2023 NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630
NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR NEWBURGH, IN 47630
NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR NEWBURGH, IN 47630
BELL OAKS PLACE NEWBURGH, IN 47630
(VA) ID CHAMADY CTATEMENT OF DEFICIENCIE IS
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS BLANGE CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (CROSS-REFERENCED TO THE APPROPRIATE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE
Administrator indicated the facility followed the Nursing (DON) conducted audit of
State Regulations for CPR and First Aid coverage. 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

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 3 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/19/2023		
	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 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
				ongoing. 5. August 19th, 2023	
R 0144	410 IAC 16.2-5-1.	5(a) fety Standards - Deficiency			
Bldg. 00	(a) The facility sha a state of good rep and shall provide residents.	all be clean, orderly, and in pair, both inside and out, reasonable comfort for all			
	Based on observation failed to provide a composition of cleanliness and order reasonable comfort. Findings include: During observation 7/18/23 at 10:15 A. rings around the insinches apart with specific debris throughout the Around the base of black substance on the back of the toile bathroom were over the back of the toile bathroom were over the lath Aide on 7/18 indicated she had be administrator to get so far been unsucce. During an interview 7/18/23 at 12:37 P.I resident handbook (indicated basic house)	with Resident 5's Home 8/23 at 10:00 A.M., she een talking with the the bathroom cleaned but had ssful. with the administrator on M., he provided a page from the revised May, 2022) that sekeeping services included	R 0144	R 144 Submission of this response a Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiencies was correctly cite and is also NOT to be construated as an admission against interest by 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 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 a conclusions set forth in this allegation by the survey agence This provider respectfully request the 2567 plan of correction be considered the letter of credib allegation and request a desk review for paper compliance in of post survey review on or after 8-19-2023.	gal cists ed, ed est / be Plan f this any cy. ests le n lieu ter
	vacuuming, and cle	n and bathroom floors, aning the bathroom sink, toilet, ver. The housekeeping daily		Resident toilet was clear and trash was taken out on 8/2/2023 by Housekeeping.	lou

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 4 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 07/19/2023			
	PROVIDER OR SUPPLIER		4200 W	STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, 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		
	rooms: Monday - Rooms 10 Tuesday - Rooms 11 Wednesday - Rooms 20 Friday - common ar Deep clean included clean kitchenette (si sink,cabinets,microw and throw out expiramirrors, toilet, show He indicated there is entire building.	s 200-213 214-227 eas areas I dust, sweep, vacuum, mop, nk, wash dishes in wave, wipe out inside of fridge ed food), bathroom sink, rer, mop bathroom floor, trash. s one housekeeper for the		2. An audit of the commun was conducted on 8/3/2023 b Executive Director to identify environmental concerns and ensure sanitations and safety standards were maintained. Identified concerns were correat time of findings. 3. On 8/11/2023, Executive Director provide re-education Housekeeping staff on proper sanitation and safety standard regarding proper procedures cleaning residents bathroom. 4. The Executive Director is responsible for sustained compliance. The ED or design will conduct observational audicommunity for sanitation and safety standards weekly for four weeks, biweekly for four week then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI Committee determine if continued auditin necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. August 19th, 2023.	ected eto ds for s nee dit of our ss, will g is		
R 0216 Bldg. 00	shall be delineated manual, but at a m assessment shall following:	ompliance content of the evaluation I in the facility policy					

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 5 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLET		ETED	
			B. W	B. WING 07/19/2023			/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	R			/YNTREE DR		
BELL O	AKS PLACE				JRGH, IN 47630		
<u> </u>	THE TENDE			IVEVIDO	7		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mental status.						
		s independence in the					
	activities of daily I	-					
		s weight taken on					
		miannually thereafter.					
	(4) If applicable, t	he resident ' s ability to					
	self-administer me	edications.					
	1 ' '	n shall be documented in					
	writing and kept ir						
		view and interview: the facility	R 0	216	R 216		08/19/2023
	failed to ensure that resident weights were				Submission of this response and		
	obtained as ordered for 6 of 8 resident reviewed.				Plan of Correction is NOT a le	gal	
	The weights of 6 of 8 residents lacked weights as				admission that a deficiency ex	rists	
	per MD(Medical D	octor) orders and facility			or, that this Statement of		
	monthly routine. (F	Resident 2, Resident 5, Resident			Deficiencies was correctly cite	ed,	
	7, Resident 10 Resi	ident 12, and Resident 21).			and is also NOT to be construed		
					as an admission against intere	est	
	Findings include:				by the residence, or any		
					employees, agents, or other		
	1. On 7/18/23 at 11	:05 A.M., Resident 10's clinical			individuals who drafted or may	y be	
	record was reviewe	ed. Diagnoses included but			discussed in the response or I	Plan	
	were not limited to	: depression and edema.			of Correction. In addition,		
	Current physician's	orders included but were not			preparation and submission of	f this	
	limited to: Obtain v	weight one time a day once a			Plan of Correction does NOT		
	month dated 6/30/2	2020.			constitute an admission or		
					agreement of any kind by the		
	The Resident Weig	ht Record form indicated			facility of the truth of any facts		
	Resident 10's weigh	hts were last recorded June of			alleged or the correctness of a		
	2022 and lacked an	y further documentation of			conclusions set forth in this	•	
	weights.				allegation by the survey agend	cy.	
					This provider respectfully requ	•	
	2. On 7/17/23 at 1:4	49 P.M., Resident 12's clinical			the 2567 plan of correction be		
		ed. Diagnoses included but			considered the letter of credib		
		: dementia and anxiety.			allegation and request a desk		
		-			review for paper compliance in		
	The Resident Weig	ht Record indicated Resident			of post survey review on or aff		
	_	s recorded in January and			8/19/2023.	=	
	March of 2023.	J			Residents identified were	e	
					weighed by Director of Nursing	-	
	3. On 7/17/23 at 1:	3. On 7/17/23 at 1:20 P.M., Resident 21's clinical			(DON) on 8-7-2023.	J	

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 6 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMP	E SURVEY LETED 0/2023	
	ROVIDER OR SUPPLIER		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	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAG	record was reviewed were not limited to the record was reviewed. The August 2022 throug 2023, and April through July, 5. On 7/19/23 at 11 weight record was reviewed weights from Janua April through July, 6. On 7/19/23 at 11 record was reviewed from July, 2022 to the During an interview (Director of Nursin weights were not up During an interview CNA(Certified Nur residents are weight On 7/17/23 at 3:30 "Weights/Vital Signand indicated" The procedure in place routinely, per Medi	d. Diagnoses included but depression and anxiety. the Record indicated Resident to recorded in 2023.4. On 7/19/23 dident 2's resident weight record record lacked weights from 12 ph December, 2022, February 13 pough July 2023. 130 A.M., Resident 5's resident reviewed. The record lacked 15 ary and February 2023, and 2023. 130 A.M., Resident 7's weight 15 ph. 15 ph. 16 ph. 16 ph. 17 p	TAG	2. An audit of the conwas conducted on 8/8/20 DON to identify resident missing weights. Identific concerns were corrected findings. 3. On 8/11/2023, Exemplication of the concerns were corrected findings. 4. The Executive Directly resident weights. 4. The Executive Directly responsible for sustained compliance. The ED or will conduct observations community for resident weekly for four weeks, befour weeks, then monthly month. Results of the audiscussed during monthly meetings. The QI Community for the Consecutive months of compliance. Monitoring ongoing. 5. August 19th, 2023	nmunity 023 by s with ed d at time of ecutive ation to are of ector is d designee al audit of veights iweekly for y for one adit will be by QI nittee will uditing is ee will be	DATE
R 0269	performed at more 410 IAC 16.2-5-5. Food and Nutrition	1(b)				
Bldg. 00	Noncompliance (b) The menu or s	substitutions, or both, for all				

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 7 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

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	ING		07/19/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
DELL OA	KO DI AOE				YNTREE DR		
BELL OA	KS PLACE			NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	EDIAN 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
	meals shall be approved by a registered						
	dietician.						
	Based on observation	on, interview, and record	R 0	269	R 269		08/19/2023
		failed to insure that menu			Submission of this response a	ınd	
		eals were approved by a			Plan of Correction is NOT a le		
		for 1 of 1 substitutions			admission that a deficiency ex	-	
	observed.				or, that this Statement of		
					Deficiencies was correctly cite	ed.	
	Findings include:				and is also NOT to be constru		
					as an admission against intere		
	During a tour of the	e kitchen on 7/18/23 at 12:00			by the residence, or any		
		erview with the kitchen			employees, agents, or other		
	_	ecking food temperatures, she			individuals who drafted or may	√ be	
		at she indicated was a cream			discussed in the response or I		
		be she "just made up". When			of Correction. In addition,		
		registered dietician approve			preparation and submission of	f this	
		e of the soup, she indicated			Plan of Correction does NOT		
	she did not.	•			constitute an admission or		
					agreement of any kind by the		
	The facility dietary	policy, dated 7/1/21, indicated			facility of the truth of any facts	i	
		ollowed and variations will be			alleged or the correctness of a		
	documented, and w	ill provide a balanced and			conclusions set forth in this	•	
	nutritious diet, such	as recommended by the			allegation by the survey agend	CV.	
	National Food and	Nutrition Board.			This provider respectfully requ	-	
					the 2567 plan of correction be		
					considered the letter of credib		
					allegation and request a desk		
					review for paper compliance in		
					of post survey review on or aff		
					8/19/2023.		
					1. Residents had no advers	se	
					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 t	.0	
					determine menu item substitu		
					for approval by Dietician if nee	eded.	
					3. On 8/11/2023, current		
	1		1		•		

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 8 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 07/19/2023			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR				
BELL OA	KS PLACE			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		
				Kitchen staff will be re-educate by Executive Director on proper procedures of approval by Dietician for menu substitutes. 4. The Executive Director is responsible for sustained compliance. The Dietary Man or designee will conduct audit food preparation and substitut weekly for four weeks, biweek four weeks, then monthly for omonth to approvals are obtain by Dietician. Results of the auwill be discussed during month QI meetings. The QI Committe will determine if continued audis necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. August 19th, 2023.	er ager of es ly for one ed dit nly ee liting		
R 0272 Bldg. 00	(e) All food shall b	nal Services - Deficiency e served at a safe and					
	failed to serve food temperature for 1 of residents reviewed 1 food and 3 random service. (Resident 2 Resident 12, and Re Findings include:	and observation, the facility at a safe and appropriate f 1 meal trays tested, 2 of 4 for appropriate temperature of interviews regarding meal , Resident 7, Resident 10,	R 0272	R 272 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	gal ists id, ed est / be Plan		

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 9 of 23

NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE SUMMARY STATEMENT OF DEFICIENCIE (XA) ID SUMMARY STATEMENT OF DEFICIENCIE (XA) ID SUMMARY STATEMENT OF DEFICIENCIE (XA) ID SUMMARY STATEMENT OF DEFICIENCIE (XA) REPLIX TAG 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 fined is had he is worned about the type of food bought. He does not like what is served. He thinks hat someone from cooperate should come and try the food. He has problems enting food due to a swallowing problem. He indicated that the chicken is really dry and so is the port 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 on that 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—but food is not always hot, cold food is not always and the food is not always and the provided the resident council minutes for the last 6 months. There were anonymous comments: "he food is cold" and "food temperatures were 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: the food is cold? A.M., be indicated the cast 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.,	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/19/2023	
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with clear plastic wrap and transported on an open cart. The temperatures were: tray delivery service weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safe food					•	_
open cart. The temperatures were: weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safe food					_	
then monthly for one month to ensure sanitation and safe food					1 -	
chicken fried steak 116.1 degrees Fahrenheit ensure sanitation and safe food		open cart. The temp	Scientifes were.			
		chicken fried steak	116.1 degrees Fahrenheit		-	
						-

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 10 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 07/19/2023			
	ROVIDER OR SUPPLIER		4200 V	ADDRESS, CITY, STATE, ZIP COD VYNTREE DR URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	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
	cheese cake 64.2 Fa	hrenheit		maintained. Results of the aud will be discussed during month QI meetings. The QI Committed will determine if continued aud is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. August 19th, 2023.	hly ee diting
R 0273 Bldg. 00	(f) All food prepara (excluding areas in maintained in acco	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling			
	Based on observation review, the facility of preparation and published accordance with start safe food handling start observations. Findings include: During an observation	on, interview, and record failed to maintain all food	R 0273	R 273 Submission of this response at Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiencies was correctly cite and is also NOT to be construted as an admission against interest by 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 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 a conclusions set forth in this allegation by the survey agent.	egal cists ed, ed est y be Plan f this
	not have a dishwash	-		the 2567 plan of correction be	

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 11 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	COMPLETED	
			B. WING			07/19/2023		
				CTD FET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
DELL OA	1/0 DI A OE				YNTREE DR			
BELL OAKS PLACE				NEWBO	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE	
	observation, she ch	ecked the titration and found			considered the letter of credible	е		
	it to be 25 ppm(part	ts per million). She indicated			allegation and request a desk			
	she did not know w	that it should be. The			review for paper compliance ir	ı lieu		
		was available online, and page			of post survey review on or aft			
		ne titration should be between			8/19/23.			
		e machine requires adjustment if			1. On 8/3/2023, ED provide	ed		
	it is not correct.	1 3			re-education to Chef 1 on			
					sanitation standards, proper us	se of		
	3. During interview	and observation with QMA 3,			hairnets, and labeling and dati			
	_), the area beneath a set of			open food and beverage items	-		
		vasher room was inspected,			the Kitchen. On 8/3/2023, ED			
		vo white boxes, 1 approximately			provided re-education to Chef	1 on		
	12 inches in length and a smaller white box				how to properly use the test			
	_	ches in length with open ends.			strips.			
	* *	arger box was a rat trap and the			Observational audit was			
	smaller one was an				conducted on 8/7/2023 by ED	of		
		1			kitchen staff to ensure they are			
	4. The kitchen supe	ervisor's hair net was not			properly cleaning kitchen floor			
	-	ound her face, only the hair			proper use of hairnets, and ite			
	-	top of her head. She was			were labeled and dated and w			
		, painted finger nails.			re-educated at time of findings			
	<i>S</i> ,				necessary. An audit was			
	5. The front of the o	condiment cooler was			conducted on 8/7/2023 by ED	of		
		d drippings. Inside, four salad		kitchen staff to ensure chlorine				
	_	e bottles were open not dated.			titration was within range and			
		1			logged. Concerns corrected at			
	6. The drink cooler	for residents had an external			time of findings as necessary.			
		idicated an internal temperature			3. By 8/11/2023, current			
		nrenheit); the internal		S. By 6/11/2023, current Kitchen staff and Nursing staff		will		
	,	ted a temperature of 62 degrees			be re-educated by Executive			
		with kitchen supervisor, she			Director or Care Services Man	ager		
	_	erature of the cooler should be			on proper sanitation standards	-		
	no more than 35 de				chlorine titration procedure, us			
					hairnets and labeling and datir			
	7. In the walk-in co	oler:			kitchen items.	5		
		inside the cooler read 42			The Executive Director is	3		
	degrees F.				responsible for sustained	-		
	-	ty and sticky, with onion skins,			compliance. The Dietary Man	ager		
	other food debris	,, , ee.,			or designee will conduct audit	-		
		e heads was not dated, cabbage			cleaning procedures, labeling	٠,		
	l con or cabbage	mas not dated, editouge	1		ologining procedures, labelling			

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 12 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	LDING	nstruction <u>00</u>	(X3) DATE COMPL 07/19 /	ETED	
	PROVIDER OR SUPPLIEI	₹		4200 W	DDRESS, CITY, STATE, ZIP COD YNTREE DR IRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	had brown spots on 1 pan of jello wa 2 plastic contain container of potato 1 small package open not dated 1 plastic contain 1 plastic contain 1 plastic contain 1 plastic contain was open not dated 1 case each of ap not dated 1 gallon contained ated 1 gallon of whol 1 gallon Baby R dated 2 gallons French dressing, 1 gallon T gallon pickle relish 2 large bowls of open not dated 1 bag of cut up celery stalks are bre 1/2 bag of mozze dated 1 large bag slice dated 1 box of fresh zu dated 2 boxes of fresh 1 box of summer 1 container label instead of basil leav unreadable. 1 open plastic cu supervisor said it's	outer leaves is not dated ers of pasta salad and 1 salad were open not dated of sliced turkey breast was er of ham was open not dated er of shrimp open not dated er of something white and is open not dated er of sliced vegetables in liquid exples and bananas were open er of fresh garlic was open not er of fresh garlic was open not er of fresh garlic was open not salad dressing, 1 gallon Italian chousand Island dressing, 1 were open not dated pudding-like substance were elery was open not dated; own arella cheese was open not dechini open was open not tomatoes were open not dated expussing was open not dated expussing open not dated expussing open not dated expussing was open expussion.			items, use of hairnets, and chlorine titration of the dishwa weekly for four weeks, biweek four weeks, then monthly for or month to ensure sanitation and safe food handling standards a maintained. Results of the audivil be discussed during month QI meetings. The QI Committed will determine if continued audis necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. August 19th, 2023.	ly for ne d are lit nly ee liting	

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 13 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
			B. WIN	B. WING 07/19/2023			/2023
en en r			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	· ·		4200 W	YNTREE DR		
BELL OA	KS PLACE			NEWBU	JRGH, IN 47630		
(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	opened 11/20/2019	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	*	iners lacked open date and/or					
	_	anufacturer, some were sticky					
	I -	additional bag of opened					
		nix was open not dated					
		t had drips around the top like					
	it boiled over, pudd	lle of yellow substance on the					
	cart under the pot.						
		eezer, there was a box of frozen					
		n not dated, and 2 cups of					
	dated or labeled.	overed and dried out, not					
	dated or labeled.						
	9. In the dry storage	e room:					
	- the floor was dir						
		er's sugar was open not dated.					
	- 1 bag pecans ope	-					
	- 4 bags pasta wer	e open not dated					
	- 1 bag buttermilk	biscuit mix was open not dated					
	- chocolate chips v	were in plastic container, the lid					
	was dirty and sticky						
		sulated tray holder - when					
		n overwhelming odor of mold					
		ze bag of flour was open not					
	dated	on the floor and on the abelian					
		on the floor under the shelves,					
	no vermin observed						
	Monthly pest contro	ol reports indicated there was					
		er under exterior kitchen door					
		orted since June 2021 on every					
	_	was observed at that time.					
		d procedures were reviewed on					
	7/18/2023 at 10:45	a.m. as follows:					
	The facility food as	ervice protection from					
		cy and procedure, undated,					
	indicated that	o, and procedure, andatou,					
	marcated that						

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 14 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/19/2023	
PROVIDER OR SUPPLIE	2	4200 W	YNTREE DR		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
- all left over food with a "use-by" dat from the date the form the date the form the discard by the "use - monitor refrigerator 41 degrees F; freez exceed 0 degrees F - Clean the refrige shelves as needed - floors, walls, and areas must be clear spills, splatters, rub - employees will we pulled back and see preparing food. An additional facilic 2/1/22, indicated the refrigerator will be temperatures will be below. Refrigerator and sanitary at all to	s must be labeled and dated e which is no more than 3 days ood was prepared. Use or by" date. tor and freezer temperatures temperatures should not exceed er temperatures should not. rator door handles, doors, and ceilings in the food service and to keep the area free from obish, dust, grease, dirt, etc. vear hairnet or caps with hair cured when handling or ty food service policy, dated at the temperature of the 35-41 degrees F and freezer e maintained at 0 degrees F or and freezers will be kept clean times. Food stored in				
Food and Nutrition Noncompliance (g) There shall be department direct competent in food knowledgeable in handling, food pre (1) The supervisor following: (A) A dietitian. (B) A graduate or	an organized food service ed by a supervisor discriving management and sanitation standards, food eparation, and meal service. It must be one (1) of the				
	PROVIDER OR SUPPLIED AKS PLACE SUMMARY (EACH DEFICIENT REGULATORY OF CACHE OF CACH	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION - 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. 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:	STREET 4200 W NEWBI SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION - 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 a35-41 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. 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	PROVIDER OR SUPPLIER KKS PLACE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR IS CUBENTIFYING INFORMATION - 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 41 degrees F; freezer temperatures should not exceed 0 degrees F. - Clean the refrigerator door handles, doors, and shelves as needed - Ioors, walls, and ceilings in the food service areas must be clamed to keep the area free from spills, splatters, rubbish, dust, grease, dirt, etc. - employees will wear haimet 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 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. 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	

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 15 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/19/2023	
	PROVIDER 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
	classroom instruct supervision who has year of experience institutional food set. (C) A graduate of program approved Association. (D) A graduate of university or within from an accredited degree in foods an administration with of experience in semanagement. (E) An individual with in food service supervised dietitian shall prove the premises at perform a regularly schedu. (3) Food service sensure proper food sanitation. Based on observation review, the facility food service departs competent in food service with the supervisor of	taff shall be on duty to d preparation, serving, and on, interview, and record failed to provide an organized ment directed by a supervisor ervice management and anitation standards, food aration, and meal service for 1 in the facility.	R 0274	R 274 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 constru as an admission against intere by 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	egal ed, ed est y be Plan

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 16 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	_	SURVEY LETED 0/2023	
	PROVIDER OR SUPPLIEF		4200 V	ADDRESS, CITY, STATE, ZIP CO VYNTREE DR URGH, IN 47630	OD	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	technician program Dietetic Association college or university graduating with a defood administration and experience in formanagement. The setaken 3 days on onleaselity that covered budgeting. Upon concept the title of "Exception in February The facility job deserceived and review follows: - a bachelor's degree preferred - a minimum of 5 yin a food service endermoust have successed training. The facility provide agreement dietary of dietary consultant we consulting per quartietary audit, receive from the administration place on 3/10/23. The deficiencies in sanity dietary per mill	cription for the chef was yed on 7/17/23 at 2:30 p.m. as e in culinary arts program was ears of management experience vironment fully completed food safety at a copy of their corporate onsulting, which indicated the yould provide 4 hours of ter. The most recent quarterly red on 7/18/23 at 10:15 A.M., tor indicated the last audit took the results indicated ration, food storage, and tures and chlorine titration ion of chlorine). No increase in g was scheduled with the		agreement of any kind facility of the truth of an alleged or the correctnet conclusions set forth in allegation by the survey. This provider respectful the 2567 plan of correct considered the letter of allegation and request a review for paper complion of post survey review of 8/19/23. 1. No residents were by deficient practice. 2. Observational audiconducted on 8/7/2023 kitchen staff to ensure of education requireme Concerns corrected at a findings as necessary. 3. By 8/19/2023, Exc. Chef will be enrolled in Dietary Management of meet requirements. 4. The Executive Dir responsible for sustained compliance. The Dieta or designee will conduct course completion for folioweekly for four weeks monthly for one month sanitation and safe food standards are maintained of the audit will be discut during monthly QI meet QI Committee will deter continued auditing is not based on three consecution of compliance. Will be ongoing.	ly facts ess of any this y agency. Illy requests tion be credible a desk tance in lieu n or after e harmed dit was by ED of compliance nts. time of ecutive Certified ourse to rector is ed ry Manager et audit of our weeks, s, then to ensure d handling ed. Results ussed tings. The rmine if ecessary utive	

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 17 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COMP			(X3) DATE COMPL 07/19 /	ETED	
	PROVIDER OR SUPPLIEF		•	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	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					5. August 19th, 2023.		
R 0298	410 IAC 16.2-5-6(
Bldg. 00	(2) A consultant p employed, or undo (A) be responsible in 856 IAC 1-7; (B) review the dru practices in the fa (C) provide consultant procedures of ord administering, and as medication rec (D) report, in writing his or her designed dispensing or admit (E) review the dru receiving these sets sixty (60) days.	Itation on methods and ering, storing, didisposing of drugs as well ord keeping; ang, to the administrator or e any irregularities in aninistration of drugs; and g regimen of each resident ervices at least once every					
	failed to employ a contract to perform every 60 days for 6 drug regimen review Resident 7, Resider 21). Findings include: 1. On 7/20/23 at 10 record was reviewed were not limited to, memory loss, renal record lacked a phat performed by a phate 2. On 7/20/23 at 10 record was reviewed was reviewed by a phate 2. On 7/20/23 at 10 record was reviewed to performed by a phate 2. On 7/20/23 at 10 record was reviewed to performe	and record review, the facility consultant pharmacist under a pharmacy regimen review of 6 residents reviewed for w (Resident 2, Resident 5, at 10, Resident 12, and Resident d. Diagnoses included, but fibromyalgia, osteopenia, insufficiency. The clinical rmacy drug regimen review rmacist.	R 02	98	R 298 Submission of this response a Plan of Correction is NOT a legadmission that a deficiency ex or, that this Statement of Deficiencies was correctly cite and is also NOT to be construe as an admission against intere by the residence, or any employees, agents, or other individuals who drafted or may discussed in the response or F of Correction. In addition, preparation 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 conclusions set forth in this	gal ists d, ed est be Plan this	08/19/2023

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 18 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/19/2023	
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD VYNTREE DR	
BELL OA	KS PLACE			URGH, IN 47630	_
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
1110		ed a pharmacy drug regimen		allegation by the survey age	
	review performed b	by a pharmacist.		This provider respectfully receive the 2567 plan of correction by	quests
		:35 A.M., Resident 7's clinical		considered the letter of cred	
		d. Diagnoses included, but		allegation and request a des	
		, history of cardiovascular		review for paper compliance	
		cal record lacked a pharmacy		of post survey review on or a	after
		w performed by a pharmacist.4.		8/19/2023.	
		5 A.M., Resident 10's clinical		1. Residents 2, 5, 7, 10,	
		d. Diagnoses included but		and 21 suffered no negative	
		depression and edema. The		from these findings. Director	
	cimical record lack	ed a pharmacy drug regimen.		Nursing (DON) was re-educate	
	5 On 7/17/22 at 1.	49 P.M., Resident 12's clinical		on 8/3/2023 of pharmacy dru regimen review policy by	ng
		ed. Diagnoses included but		Executive Director (ED).	
		: dementia and anxiety. The		2. An audit was conducte	d on
		ed a pharmacy drug regimen.		8/7/2023 by DON of residen	
	emmear record rack	ed a pharmacy drug regimen.		charts for pharmacy reviews	
	6 On 7/17/23 at 1:3	20 P.M., Resident 21's clinical		were scheduled at time of fir	
		ed. Diagnoses included but		as necessary.	luligo
		depression and anxiety. The		Current Nursing staff was a staff was	vill be
		ed a pharmacy drug regimen.		re-educated on pharmacy dr	
		1 7 2 2		regimen reviews procedures	-
	7. The facility faile	d to have a written contract		DON by 8/11/2023.	
	1	rmacist to perform pharmacy		4. The Executive Director	ris
	regimens every 60	days as required.		responsible for sustained	
				compliance. The DON or de	signee
	During an interview	w with the Administrator and		will review resident medical	charts
	DON on 7/19/23 at	10:15 A.M., both indicated		for pharmacy reviews for fou	ır
	they were not awar	e that pharmacy drug regimen		weeks, biweekly for four wee	eks,
		performed by a pharmacist		then monthly for one month	to
	every 60 days for e	ach resident.		ensure use of. Results of the	
				will be discussed during mor	•
				QI meetings. The QI Commi	
				will determine if continued a	-
				is necessary based on three	
				consecutive months of	
				compliance. Monitoring will b	pe
				ongoing.	
				5. August 19th, 2023	

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 19 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/19/2023	
	ROVIDER OR SUPPLIER		4200 W	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 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	(g) Medications ac shall be disposed appropriate federa disposition of any destroyed medicate the resident 's clir include the following (1) The name of the (2) The name and (3) The prescription (4) The reason for (5) The amount dis (6) The method of (7) The date of the (8) The signature of the disposal of the disposal of the drug Based on observation interview, the facility storage of medication unlabelled pills in the 17 unlabelled pills in the Trindings include:	ervices - Noncompliance dministered by the facility in compliance with al, state, and local laws, and released, returned, or tion shall be documented in nical record and shall ing information: he resident. strength of the drug. on number. disposal. sposed of. disposition. disposal. of the person conducting drug. of a witness, if any, to the lig. on, record review, and ty failed to ensure proper on in 2 of 2 medication carts. (4 he A Hall medication cart and in B Hall medication cart were : with no markings I number 003 capsule number 40 h IP 101	R 0306	R 306 Submission of this response a Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiencies was correctly cite and is also NOT to be construas an admission against intereby the residence, or any employees, agents, or other individuals who drafted or madiscussed in the response or of Correction. In addition, preparation and submission on 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 conclusions set forth in this	egal cists ed, led est y be Plan f this

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 20 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	A. BUILDING <u>00</u>			COMPLETED	
			B. WIN	G		07/19/	/2023	
		<u> </u>	1 1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	8			YNTREE DR			
BELL OA	KS PLACE				JRGH, IN 47630			
(V4) ID	CIDALADA	CTATEMENT OF DEFICIENCIE	<u> </u>	1	·		(V£)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ומ	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
1710	2 large white pills v			1710	allegation by the survey agend	~\/	DATE	
	2 oblong white pills				This provider respectfully requ			
		osule with number 020			the 2567 plan of correction be			
	1 large tan oblong p				considered the letter of credible			
		with number 247 2 ½			allegation and request a desk	-		
	1 blue oblong pill v				review for paper compliance ir	n lieu		
	1 tan/pink capsule 2	ZAP-18 0.4 mg			of post survey review on or aft			
	1 large white 209				8/19/2023.			
	1 blue capsule with	G 231			1. QMA 1 was re-educated	on		
	1 small yellow pill				proper storage of medication b	ру		
	1 pale yellow with				Director of Nursing (DON) on			
	1 small white pill w				8/4/2023.			
	1 small white no ma	_			2. On 8/7/2023 DON			
	1 small white with	ML 35			conducted audit of medication			
					carts to assure medications we			
	_	v on 7/18/23 at 6:56 A.M., the			stored properly and carts were			
		Nursing) indicated the night			cleaned after shifts. Results of	the		
		d clean the medication carts			audit were reviewed by the			
	weekly.				Executive Director.			
	On 7/10/23 at 12:30	P.M., a current nondated			3. By 8/11/2023, current QMA's and Nurses will be			
		Storage" indicated "			re-educated by DON on prope	r		
		be properly stored, accessed			storage of medication.	·I		
		edure only medications			The Executive Director is	3		
	properly labeled	-			responsible for sustained	,		
	1 1 -5100				compliance. The DON or design	gnee		
					will audit medication carts for	•		
					storage and cleanliness weekl	y for		
					four weeks, biweekly for four	-		
					weeks, then monthly for one			
					month. Results of the audit wil	l be		
					discussed during monthly QI			
					meetings. The QI Committee v			
					determine if continued auditing	g is		
					necessary based on three			
					consecutive months of			
					compliance. Monitoring will be			
					ongoing.			
					5. August 19th, 2023.			
	I		I	ı	l		I	

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 21 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
			B. WING 07/19/2023			/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD /YNTREE DR		
DELL OA	KS DI ACE						
BELL OA	KS PLACE			INEVVD	JRGH, IN 47630		
(X4) ID	SUMMARY S	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
R 0409	410 IAC 16.2-5-12	2(d)					
	Infection Control -	Noncompliance					
Bldg. 00	(d) Prior to admiss	sion, each resident shall be					
	required to have a	health assessment,					
	including history o	f significant past or present					
	infectious disease	s and a statement that the					
	resident shows no	evidence of tuberculosis in					
	an infectious stage	e as verified upon					
	admission and yea	arly thereafter.					
	Based on record rev	view and interview, the facility	R 0	409	R 409		08/19/2023
	failed to provide do	ocumentation of the annual			Submission of this response a	ınd	
	health assessment st	tatement of 6 of 6 residents			Plan of Correction is NOT a le	:gal	
	reviewed.(Resident	2, Resident 5, Resident 10,			admission that a deficiency ex	ists	
	Resident 12, Reside	ent 21, and Resident 7)			or, that this Statement of		
					Deficiencies was correctly cite	÷d,	
	Findings include:				and is also NOT to be constru	ed	
					as an admission against intere	est	
		:05 A.M., Resident 10's clinical			by the residence, or any		
		d. Diagnoses included but			employees, agents, or other		
		depression and edema.			individuals who drafted or may	•	
	Current physician's	orders lacked an annual health			discussed in the response or F	Plan	
	assessment statemen	nt.			of Correction. In addition,		
					preparation and submission of	f this	
		49 P.M., Resident 12's clinical			Plan of Correction does NOT		
		d. Diagnoses included but			constitute an admission or		
		: dementia and anxiety. Current			agreement of any kind by the		
		cked an order for an annual			facility of the truth of any facts		
	health assessment st	tatement.			alleged or the correctness of a	any	
					conclusions set forth in this		
		20 P.M., Resident 21's clinical			allegation by the survey agend	-	
		d. Diagnoses included but			This provider respectfully requ		
		depression and anxiety.			the 2567 plan of correction be		
		order lacked an annual health			considered the letter of credib		
		7/20/23 at 10:35 A.M., Resident			allegation and request a desk		
		vas reviewed. Diagnoses			review for paper compliance in		
	· ·	not limited to, fibromyalgia,			of post survey review on or aft	ier	
		y loss, renal insufficiency. The			8/19/2023.		
	clinical record lacke	ed an annual health statement.			1. Residents 2, 5, 7, 10, 12		
					and 21 suffered no negative e		
	5. On 7/20/23 at 10:	:30 A.M., Resident 5's clinical			from these findings. Director of	of	

State Form Event ID: JJ5211 Facility ID: 004903 If continuation sheet Page 22 of 23

PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			07/19/	2023
	ROVIDER OR SUPPLIER	t	STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF record was reviewed were not limited to clinical record lack 6 On 7/20/23 at 10 record was reviewed were not limited to accident. The clinical health statement. During an interviewed the Administrator at they both indicated need for a annual health statement. On 7/18/23 at 1:00 "Physician Orders In Administrator. The for residents health shows that the residence were not limited to accident. The for residents health shows that the residence were not limited to accident. The for residents health shows that the residence were not limited to accident.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION d. Diagnoses included, but history of falls and anemia. The ed an annual health statement. 35 A.M., Resident 7's clinical d. Diagnoses included, but history of cardiovascular eal record lacked an annual of on 7/19/23 at 10:00 A.M., with hind DON (Director of Nursing) that they were unaware of the eath assessment order. P.M., a current policy Policy was provided by the policy lacked a requirement assessment statement that lent is free of infectious sion and annually thereafter.	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF COMPILE APPROPRIATION OF COMPLETE OF THE APPROPRIATION OF COMPILE APPROPRIATION OF COMPLIANCE OF THE APPROPRIATION OF COMPLETE OF THE APPROPRIATION OF COMPLIANCE OF THE APPROPRIATION OF COMPLIANCE OF THE APPROPRIATION OF COMPLETE OF THE APPROPRIATION OF COMPLIANCE OF THE APPROPRIATION OF COMPLETE OF THE APPR	ealth 023 on g ealth ned ry. er s gnee dent ure	(X5) COMPLETION DATE
					ongoing. 5. August 19th, 2023		

State Form Event ID: IJ5211 Facility ID: 004903 If continuation sheet Page 23 of 23