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	11/21/2023

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 the Investigation of Complaint IN00418522. Complaint IN00418522 - State deficiencies related to the allegations are cited at R0247. Survey date: November 21, 2023 Facility number: 004903 Residential Census: 48 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on November 27, 2023.	R 0000		
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify the physician of missed medications for 1 of 3 residents reviewed for hospice. (Resident B) Finding includes: On 11/21/23 at 9:35 A.M., Resident B's clinical record was reviewed. Diagnoses included, but was not limited to, vascular dementia without behaviors and depression.	R 0247	=”” p=””>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 of Plan of Correction. In addition,	12/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T.J. Bates	Executive Director	12/12/2023

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.

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	11/21/2023

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
	A current service plan, dated 9/25/23, indicated the resident required employees to administer all medications, required employee assistance to re-order medications, and received hospice services. A physician orders report from September 2023 included, but was not limited to: Sertraline (brand name: Zoloft) (an antidepressant) tab (tablet) 100 mg (milligrams) - 1 tablet by mouth one time a day, dated 8/23/23. The MAR (medication administration record) from September 2023 indicated the resident did not receive sertraline 100 mg from 9/19/23 to 9/25/23. A Nurse's Medication Note, dated 9/25/23, indicated the medication was unavailable and pharmacy was contacted. A medication error care plan, dated 9/27/23, indicated the resident "did not receive Zoloft September 19th through September 25th". Progress Notes included, but were not limited to: On 9/25/23 at 4:00 P.M., "[Name of hospice] visit with resident this day. Hospice nurse notes resident tired and emotional this day. VS (vital signs) WNL (within normal limits). NNO (no new orders) at this time. Refill for sertraline and furosemide refills requested." On 9/27/23 at 8:00 P.M., "Resident noted to have not received her Zoloft medication for 1 week. Re-started on 9/26/23. No adverse reactions noted this shift." On 9/30/23 at 8:15 A.M., "Resident shows improvement in mood. No concerns noted at this time."		does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged of the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction by considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 12/20/23. ="" p=""> The facility will ensure this requirement is met through the following corrective measures: 1. On 12/4/23, Director of Nursing (DON) conducted audit of identified resident MAR to ensure resident received ordered medications, or MD/Hospice was notified if medication was not in facility for resident to receive. 2. On 12/4/23, Director of Nursing (DON) conducted audit of current resident MAR's to ensure all residents received ordered medications, or MD/Hospice was notified if medication was not in facility for resident to receive. 3. Nursing staff re-educated to notify MD/Hospice for unavailable medications. Nursing staff to be educated on medication re-order procedures. Nurses re-educated that charting is to be completed when contacting MD, NP, or Hospice regarding unavailable medications. 4. The Executive	

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	11/21/2023

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
	The clinical record lacked documentation of notification to the physician, hospice, or pharmacy prior to 9/25/23 regarding the resident not receiving sertraline due to unavailability. A facility report, dated 9/27/23, indicated the resident had an order for routine sertraline that ran out and was missed for re-order which caused the resident to have increased anxiety. On 11/21/23 at 11:36 A.M., an in-service log, undated, was provided by the Administrator that indicated staff were educated on proper re-ordering procedures of medications. At that time the Administrator indicated the in-service was completed on 9/27/23. Education included, but was not limited to, "correctly document exceptions and problems observed or reported by resident". On 11/21/23 at 8:15 A.M., the Senior Life Counselor indicated [name of hospice] used [name of pharmacy], and nursing staff notified hospice when medication refills were needed. On 11/21/23 at 10:30 A.M., RN 7 indicated all communication with hospice got documented in the progress notes. On 11/21/23 at 11:35 A.M., the Administrator indicated staff called [name of hospice] on 9/25/23 to report the resident had increased behaviors, and that was how they realized the sertraline had not been refilled. He further indicated staff was aware it was missing as evidenced by the documentation on the MAR, but it had not been communicated properly in order for the medication to be refilled. In an anonymous interview on 11/21/23 at 12:54		Director is responsible for sustained compliance. The DON or designee will audit medication carts 3 days a week for 4 weeks, 2 days a week for 4 weeks, then 1 day a week for 4 weeks. For medications that are not available, charting will be audited that MD, or Hospice notified that medications are unavailable, and pharmacy notified. 5. December 20th, 2023	

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	11/21/2023

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
	P.M., it was indicated the resident could not get out of bed and was "not ok" due to not receiving her Zoloft for a week. On 11/21/23 at 1:41 P.M., a current Medication Management policy, dated 2/1/22, indicated "the community will ... reorder medications as early as pharmacy will allow (of 5-7 days before supply runs out)". This citation relates to Complaint IN00418522			