| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155850 | A. BUILDING 00<br>B. WING | 07/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BELLTOWER HEALTH & REHABILITATION CENTER | 5805 NORTH FIR ROAD<br>GRANGER, IN 46530 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00438379.<br><br>Complaint: IN00438379 - No deficiencies related to the allegations are cited.<br><br>Survey dates: July 22, 23, 24, 25, 26 and 29, 2024<br><br>Facility number: 013644<br>Provider number: 155850<br>AIM number: 201381180<br><br>Census Bed Type:<br>SNF/NF: 76<br>Total: 76<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 50<br>Other: 18<br>Total: 76<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed on 8/9/2024 | F 0000 | | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Marti Carmean | Administrator | 08/20/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and | | | |

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| | trauma-informed.<br><br>Based on interview and record review, the facility failed to develop a care plan regarding communication needs for 1 of 1 residents reviewed for Communication and Sensory Needs (Resident 39) and accident hazards for 1 of 1 residents reviewed for Accidents. (Resident 56)<br><br>Findings include:<br><br>1. A record review for Resident 39 was completed on 7/24/2024 at 9:53 A.M. Diagnoses included, but were not limited to, cerebral infarction, neoplasm of the lower jaw bone, and occlusion and stenosis of the right carotid artery.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 7/5/2024, indicated Resident 39 was moderately cognitively impaired, his vision and hearing were adequate, his speech was sometimes understood and he sometimes understood others and he required substantial to maximal assistance from staff for bed mobility needs.<br><br>The Progress Notes, since he was admitted, indicated Resident 39 was unable to use the call light and staff anticipated his needs.<br><br>The care plan lacked a problem, goal, or interventions related to the resident's inability to use the call light or the provision of an alternate method to communicate his needs.<br><br>During an interview on 7/24/2024 at 1:27 P.M., CNA 6 indicated Resident 39 was sometimes able to use the call light. He was able to verbally communicate and called out if he needed anything | F 0656 | 1 Resident 39 was immediately provided a soft touch call light upon the notification of need. There was no negative outcome related to the alleged deficient practice. Resident 56 has had the care plan modified to include non-compliance of using an air fryer in the room.<br>1.Residents residing at the facility that need a soft touch call light have the potential to be affected to be affected by the alleged deficient practice.<br>1.Facility staff have been educated on the requirement as it relates to the development of care plans for residents requiring specialty call lights. This education will be completed by 8/9/24.<br>Nursing administration and/or designee will inform the interdisciplinary team on specialty equipment needed for residents.<br>Care plans will be reviewed weekly during the long-term care coordination meeting that is in conjunction with the MDS schedule.<br>1.Care Plan audits will be forwarded to QAPI for review, results of those audits will be reviewed monthly for a period of 6-months or until compliance is achieved.<br>2.Date of Compliance 8/12/24 | 08/12/2024 |

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but if he was angry and yelling, he was hard to understand. She checked on him throughout the shift.

During an interview on 7/23/2024 at 11:52 A.M., the resident was not able to answer the surveyor's questions.

During an interview on 7/24/2024 at 2:09 P.M., Resident 39 was able to speak. He indicated he was able to push the call button for help but was unable to activate the call button when he attempted to demonstrate his ability to utilize the call light.He indicated he called out for help when he needed it and he was confident if he called out, someone would come.

During an interview on 7/25/2024 at 1:53 P.M., Unit Manager 2 indicated the facility had not thought of using a touchpad type of call light. The resident's inability to use the call light should have been on the care plan.

During an interview on 7/26/2024 at 2:45 P.M., the Executive Director (ED) indicated the facility did not have a policy that addressed accommodation of needs.
2. During an interview on 7/22/2024 at 10:04 A.M., Resident 56 indicated she cooked all of her own meals in her air fryer in her room and doesn't eat the facility's food. Her brother took her to the store to buy food once a week.

During an observation on 7/22/2024 at 10:10 A.M., Resident 56 had an air fryer on a table in her room, plugged in to the electric outlet. There was a spatula hanging from the wall above the air fryer.

Resident 56's record review was completed on 7/22/2024 at 10:50 A.M. Her diagnoses included,

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| | but were not limited to: type 2 diabetes mellitus and hypertension.<br><br>A Quarterly Minimum Data Set Assessment (MDS) dated, 6/25/2024, indicated the resident had moderate cognitive impairment.<br><br>Resident 56's record lacked the documentation she had regarding a Care Plan to address her ability to cook in her room with an air fryer or a Care Plan regarding she had refused to follow the facility's rules about cooking in her room. There were no notes documented in her record referring to education or noncompliance related to using an air fryer in her room.<br><br>During an interview on 7/24/2024 at 11:10 A.M., CNA 4 indicated she knew Resident 56 cooked in her room and was not aware the resident should not cook in her room.<br><br>During an interview on 7/24/2024 at 11:30 A.M., CNA 5 indicated staff knew when Resident 56 was cooking because they could smell her food. CNA 5 had never been told Resident 56 should not cook in her room. CNA 5 indicated she did not help Resident 56 cook or clean up after cooking.<br><br>Duringm an interview with the Unit Manager (UM) 3, completed on 7/24/2024 at 12:11 P.M., she indicated Resident 56 was not allowed to use an air fryer in her room. In the past, Resident 56 had been educated on not cooking in her room, but the resident was not compliant with cooking in her room.  There was not a Care Plan regarding using an air fryer or for refusing to follow the facility's policy on cooking in resident rooms.<br><br>On 7/26/2024 at 2:45 P.M., the Executive Director provided a policy dated, 5/5/2023 and titled, "Care | | | |

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|---|---|---|---|---|
| | Plan Process, Person-Centered Care", and identified it as the policy currently used by the facility. The policy indicated, "...The facility will develop and implement a baseline and comprehensive care plan for each resident includes the instructions needed to provide effective and person-centered care of the resident... 11. The person-centered care plan includes:... B. Problem... E. Interventions, discipline specific services and frequency F. Refusal of services and/or treatments 1) Evaluation of resident's decision-making capacity 2) Educational attempts 3) Attempts to find alternative means to address the identified risk/need...."<br><br>3.1-35(a) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on interview, observation and record review, the facility failed to keep ensure Resident 56's environment was free of potential hazards for 1 of 1 resident reviewed for environmental hazards. (Resident 56)<br><br>Finding includes:<br><br>During an interview on 7/22/2024 at 10:04 A.M., Resident 56 indicated she cooked all of her own | F 0689 | 1.Resident 56's family has been contacted to remove the air fryer from the residents' room. There was no negative outcome related to the alleged deficient practice.<br>2.Residents' residing at the facility have the potential to be affected by the alleged deficient practice.<br>3.Facility staff have been | 08/12/2024 |

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| | meals and does not eat the facility's food. Her brother takes her to the store to buy food once a week.<br><br>An observation was completed on 7/22/2024 at 10:10 A.M. Resident 56 had an air fryer on a table, plugged in to the electric outlet. There was a spatula hanging on the wall above the air fryer.<br><br>Resident 56's record review was completed on 7/22/2024 at 10:50 A.M. Her diagnoses included, but were not limited to: type 2 diabetes mellitus and hypertension.<br><br>A Quarterly Minimum Data Set Assessment (MDS) dated, 6/25/2024, indicated the resident had moderate cognitive impairment.<br><br>Resident 56's record lacked the documentation she had a Care Plan to address her ability to cook in her room or a Care Plan indicating she had refused to follow the facility's policy regarding cooking in her room.<br><br>During an interview on 7/24/2024 at 11:10 A.M., CNA 4 indicated she knew Resident 56 cooked in her room and was not aware the resident should not cook in her room.<br><br>During an interview on 7/24/2024 at 11:30 A.M., CNA 5 indicated staff knew when Resident 56 was cooking because they could smell her food. CNA 5 had never been told Resident 56 should not cook in her room. CNA 5 indicated she did not help Resident 56 cook or clean up after cooking.<br><br>During an interview with the Unit Manager (UM) 3, completed on 7/24/2024 at 12:11 P.M., she indicated Resident 56 was not allowed to use an air fryer in her room. In the past, Resident 56 had | | educated on the requirement as it relates to air fryer use and the potential safety hazards pertaining to the use. This education will be completed by 8/9/24.<br>Environmental Director will perform weekly rounds to ensure no unsafe cooking devices are in resident rooms.<br>1.Environmental round results will be forwarded to QAPI for review, results of those rounds will be reviewed monthly for a period of 6-months or until compliance is achieved.<br>2.Date of Compliance 8/12/24 | |

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| | been educated on not cooking in her room but the resident was not compliant with facility's policy on cooking in her room.<br><br>During an interview on 7/24/2024 at 1:20 P.M., the Corporate Regulation Specialist indicated all electric devices brought into the facility should be tested by the Maintenance Department remove and and add .  She was unsure if the air fryer had been inspected. She indicated Resident 56 should not cook in her room.<br><br>During an interview on 7/29/2024 at 11:10 A.M., the Maintenance Director indicated he had not inspected  the air fryer for safety and Resident 56 should not cook in her room.<br><br>On 7/24/2024 at 2:30 P.M., the Executive Director provided a policy dated, 3/2006 and titled, "Maintenance/Housekeeping policies and procedures" and identified it as the policy currently used by the facility. The policy indicated, "...Written Criteria, which include equipment for life support, infection control, environmental support and equipment support elements are used to identify inclusion in the program...All equipment shall be evaluated for inclusion into the program prior to use...."<br><br>3.1-45(a) | | | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | | | |

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| | (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview and record review, the facility failed to store and prepare food in a sanitary manner related to expired leftovers, open and undated food in the walk-in cooler and skillets with missing Teflon for 1 of 1 kitchens reviewed. This had the potential to affect 69 of 69 residents who received their meals from the kitchen.<br><br>Findings include:<br><br>During the initial kitchen tour on 7/22/2024 at 9:00 A.M with the Certified Dietary Manager (CDM), the following was observed in the walk-in cooler:<br><br>-A plastic container with pasta noodles dated, 7/11/2024.<br>-An opened jar of jalapenos with no opened on or use by dates.<br>-An opened jar of enchilada sauce with no opened on or use by dates.<br>-An opened bag of whipped topping with no opened on or use by dates.<br>-3 cups of mixed berries with no made on or use | F 0812 | 1 1. The undated food items were immediately discarded upon initial notification. The chipped Teflon pan was discarded upon notification. There were no residents directly affected by the alleged deficient practice.<br>2 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.<br>1.Dietary Staff has been educated on the requirement as it relates to proper dating and disposal of expired foods, that includes ensuring Teflon pans are in solid working order. Education will be completed by 8/9/24<br>Sanitation audits will be completed weekly by the administrator and/or designee any findings will be corrected as identified.<br>1.Sanitation audits will be | 08/12/2024 |

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| | by dates.<br>-3 cups of yogurt with no made on or use by dates.<br><br>During the initial kitchen tour with the CDM on 7/22/2024 at 9:20 A.M., three skillets utilized by the facility for preparing meals were found to be scratched and missing some of the Teflon coating.<br><br>During an interview on 7/22/2024 at 9:25 A.M., the CDM indicated all food that was prepared should have been labeled with a made on date and an expiration date. All jars and containers should be labeled with opened on and expiration dates once opened and left overs should have been disposed of after three days. Skillets with scratches and missing Teflon should not be used and should have been thrown away. The facility does not have a policy related to the condition of the cookware used by the facility.<br><br>On 7/22/2024 at 10:40 A.M., the CDM provided a policy, dated, 6/20/2023, and titled, "Nutrition Policies and Procedures" and identified it as the policy currently used by the facility. The policy indicated, "...Temperature Control for Safety leftovers are discarded after 3 days unless otherwise indicated...All foods removed from the original packaging are stored in a closed container or tightly wrapped package and labeled with the common name of the item and the date it was opened...."<br><br>3.1-21(i)(3) | | forwarded to QAPI for review, these will be presented monthly for a period of 6- months or until compliance is achieved.<br>5 Date of Compliance: 8/12/24 | |