

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2024
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NAME OF PROVIDER OR SUPPLIER  BELL OAKS PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN 47630
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>This visit was for the Investigation of Complaint IN00427944.</p> <p>Complaint IN00427944 - State deficiencies related to the allegations are cited at R0241.</p> <p>Survey date: April 25, 2024</p> <p>Facility number: 004903</p> <p>Residential Census: 44</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on May 2, 2024.</p>	R 0000		
R 0241  Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview the facility failed to ensure that medications were administered by a licensed nurse or qualified medication aide for 1 of 3 residents reviewed for medication administration. The resident received medications from an unqualified person. (Resident G)</p> <p>Findings include:</p>	R 0241	<p>R 241 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</p>	05/25/2024

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>During an interview on 4/25/24 at 11:11 A.M., with LPN (Licensed Practical Nurse) 3 indicated an incident involved Resident G actively dying and the staff nurse was reported to have been having been uncomfortable giving medications to a dying resident. There was an HHA (Home Health Aide) on duty that night caring for the resident was instructed by the nurse to give the medications to the resident. The next morning, the HHA self-reported the incident to LPN 3 and was not aware of not being able to give medications to residents because at a previous workplace, they were able to give medications. LPN 3 indicated the staff nurse never came back after the incident and the HHA was not currently working but not due to this incident. LPN 3 indicated there were in-services done regarding not doing things out of the staff's scope of care and this incident was also discussed during morning meetings. LPN 3 also indicated if there was someone practicing outside of their scope of care, they would report the occurrence as was done with this incident.</p> <p>During an interview on 4/25/24 at 1:24 P.M., the Executive Director (ED) indicated the reported incident involved a HHA who gave medications to a hospice patient because the nurse that was assigned to Resident G could not give medications to a dying patient due to personal reasons. The medications were apparently prepared and labeled with resident's room number by the nurse. He indicated that HHA knew that the resident needed the pain medication and gave it to the resident. He went on to say that the HHA had come from a group home and was allowed to do things like that there. The HHA immediately reported this in the morning when the day nurse came on, which was then reported to the DON (Director of Nursing) and ED. The nurse in question worked nights and went home and was</p>		<p>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 5/25/2024.</p> <p>The facility will ensure this requirement is met through the following corrective measures:</p> <ol style="list-style-type: none"> <li>On 5/10/2024, Director of Nursing (DON) conducted an audit of current staffing schedule to ensure at least one qualified person was scheduled for each scheduled medication administration. No concerns identified with current schedule.</li> <li>On 5/10/2024, DON conducted an audit to determine each qualified personnel were current on licensing. No concerns identified with current staffing.</li> <li>All Nursing staff were in-serviced on Medication Administration policy by DON for requirements of proper distribution of prescribed medications. All Staff were in-serviced on Reporting</li> </ol>	

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	<p>attempted to be reached by the facility. That nurse never called back but sent a text indicating that she resigned immediately. The HHA was later terminated on another incident but had been educated about the incident. The ED indicated the resident's daughter was present at the time that the HHA gave the medications and there were no problems noted. When asked if the staff know about the practicing out to their scope of practice. He indicated that it was assumed that the staff knew their scope of practice. He also indicated there was an in-service on 1/11/24 on incident reporting.</p> <p>On 4/25/24 at 1:44 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia.</p> <p>The current service plan indicated the resident was cognitively impaired but was not provided.</p> <p>Current physician orders indicated the resident was on Hospice but lacked a date. Acetaminophen 500 mg (Milligrams) 2 tablets (1000 mg) BID (two times a day) dated 10/31/23</p> <p>On 4/25/24 at 2:15 P.M., the ED provided a current undated policy "Medication Administration". The policy indicated "...if prescription medication is not self-administered by a resident shall be administered by one of the following:... registered nurse...licensed practical nurse... or a medication technician as defined by States Regulations."</p> <p>This citation relates to complaint IN00427944.</p>		<p>Guidelines by DON regarding what to report and who to report to when, and if, a situation occurs.</p> <p>4 The Executive Director is responsible for sustained compliance. The DON, or designee, will review Medication Administration Records (MAR's) for proper medication administration 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.</p> <p>5 May 25th, 2024.</p>	