STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETE			ETED	
		155677	B. WING 04/07/2017			2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LL TRACE CIR		
BELL TR	ACE HEALTH AND	LIVING CENTER			IINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 APPROPRIAT	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
			F 00	000			
	This visit was for	r a Recertification and					
	State Licensure S	Survey.				_	
					This plan of correction is to serve as	•	
	Survey dates:				Bell Trace Health and Living Center's credible allegation of		
	April 3, 4, 5, 6, a	and 7, 2017			compliance.		
	April 5, 4, 5, 0, a	mu 7, 2017.			compliance.		
	Facility number:	002574			Submission of this plan of		
	Provider number	:: 155677			correction does not constitute an		
	AIM number: 20	1224380			admission by Bell Trace Health and		
	111111 1141110 61. 20	122 .300			Living Center or its management		
	Communa had terman				company that the allegations		
	Census bed type:	•			contained in the survey report are a true and accurate portrayal of the	1	
	SNF: 50				provision of nursing care and other		
	SNF/NF: 20				services in this facility. Nor does		
	Total: 70				this submission constitute an		
					agreement or admission of the		
	Census payor typ	pe:			survey allegations.		
	Medicare: 25				We are requesting desk review /		
	Medicaid: 15				paper compliance for this survey.		
	Other: 30						
	Total: 70						
	10ta1. /U						
	Thoso deficienci	og roflagt Stata Eindings					
		es reflect State Findings					
		ace with 410 IAC					
	16.2-3.1.						
	Quality Review	completed on April 12,					
	2017.						
			<u> </u>		l .		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155677		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/07/2017	
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER		725 B	T ADDRESS, CITY, STATE, ZIP CODE BELL TRACE CIR DMINGTON, IN 47408	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
F 0242 SS=D Bldg. 00	MAKE CHOICES (f)(1) The resident activities, schedule waking times), health care service her interests, asse and other applicate (f)(2) The resident choices about asp facility that are sig (f)(3) The resident members of the coin community activoutside the facility Based on record the facility failed was able to choot the morning according for 1 of 3 resident (Resident 240) Findings include On 4/4/17 at 3:0' indicated he prefarm,; but staff avat 7:30 a.m. On 4/7/17 at 9:30 Resident 240 preferakfast.	review and interview, I to ensure that a resident se what time to get up in ording to their preference atts reviewed for choices.	F 0242	F242: 483.10 (f)(1)-(3) RESIDENT PREFERENCES I. Resident 240 was interviewed regarding awakening time preference. The resident's plan of care and assignment sheet were updated to reflect resident 240's preference. II. All current residents will be interviewed regarding awakening preferences and a family member will be contacted for resident was time preferences if the resident has a BIMs score of less than 8. In plans / CNA assignment sheets we be updated accordingly. III. All facility staff will be reeducated regarding resident preferences.	g er ke Care

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Event ID:

0A6B11

Facility ID: 002574

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETE			COMPLETED	
		155677	B. W	ING		04/07/2017	
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	₹			LL TRACE CIR		
DELL TD	ACE HEALTH AND	NUMBER OF STREET			IL TRACE CIR IINGTON, IN 47408		
DELL IK	ACE REALTH AND	CIVING CENTER		BLOON	IIINGTON, IN 47408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	PLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		OATE
	the resident pref	ers to wake between			IV. The Social Service Director or		
	8:30-9:00 a.m.				Director of Nursing, and/or		
					designee will interview 4 residents	I	
	On 4/7/17 at 11:	15 a.m., Resident 240			with a BIMs score of 8 or above an		
		s awaken at 7:30 a.m., for			1 family member of a resident with		
	breakfast.	awaiten at 7.30 a.m., 101			a BIMS score of less than 8		
	orcariast.				regarding wake time preferences each week for the next 4 weeks.		
	0 4/5/15 11	51 0014 1			After the initial 4th week of audits		
	On 4/7/17 at 11:				complete, 2 residents with a BIMs	•	
		orning she assisted			score of 8 or more and 1 family		
	resident to sit on	the side of the bed for			member of a resident with a BIMS		
	breakfast at 8:00) a.m.			score of less than 8 will be		
					interviewed each week for an		
	Resident 240's c	linical record was			additional 8 weeks. Any		
		/17 at 11:21 a.m.			inconsistencies will be corrected.		
					Then, 4 residents with a BIMs score		
	•	ded, but were not limited			of 8 or more and 1 family member		
	•	eart failure, and muscle			of a resident with a BIMs of less		
	weakness.				than 8 will be interviewed quarterl	y	
					ongoing regarding preferences		
	A review of Res	ident 240's admission					
	Minimum Data	Set (MDS) assessment,			The results of these reviews will be		
	dated 3/26/17, ir	ndicated a Brief Interview			discussed at the monthly facility		
	-	s (BIMS) total score of			Quality Assurance Committee		
		score of 13 to 15 being			meeting for 3 consecutive months. Frequency and duration of reviews		
	cognitively intac	•			will be adjusted as needed, if		
	cognitively intac	.t.			compliance is below 100%.		
		.1 . 240			compliance is below 100%.		
		ident 240's personal			Compliance Date: May 1st, 2017		
	•	Activities of Daily Living			The Administrator will be		
	(ADL) careplan,	, initiated on 3/15/17,			responsible for ensuring the		
	indicated "Hono	r/Awake resident at			facility is in compliance by the	ne	
	preferred awake	ning time: 8:30am ."			date listed.		
	•				We request a desk review /		
	On 4/7/17 at 11·	39 a.m., Director of			paper compliance for this		
		provided the Preference			citation.		
	• , ,	•					
	Sheet. The Pref	erence Sheet indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	, , , , , , , , , , , , , , , , , , , ,		COMPLETED 04/07/2017			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE LL TRACE CIR		
BELL TR	ACE HEALTH AND	LIVING CENTER			IINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) d to get up at 8:30 a.m.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0278 SS=D Bldg. 00	On 4/7/17 at 4:00 (ADM) provided updated March 1 was the policy or the facility. The pyou have the riginate promote activities, scheduland waking times 3.1-3(u)(3) 483.20(g)-(j) ASSESSMENT ACCURACY/COO (g) Accuracy of As assessment must resident's status. (h) Coordination A registered nurse coordinate each as appropriate participrofessionals. (i) Certification (1) A registered nuttat the assessment that the assessment coordinate and the assessment coordinate a	D p.m., Administrator I the "Residents Rights," 5, 2017, and indicated it arrently being used by policy indicated, " In the to and the facility the right to choose ales (including sleeping s)" RDINATION/CERTIFIED sessments. The accurately reflect the I must conduct or sesessment with the pation of health arrese must sign and certify					

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Event ID:

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Facility ID: 002574

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155677		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/07/2017	
	PROVIDER OR SUPPLIER		725 BE	ADDRESS, CITY, STATE, ZIP CODE ELL TRACE CIR MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	(i) Certifies a material aresident assessment; (ii) Causes another material and false assessment is subpenalty or not morassessment. (2) Clinical disagrea material and false assessment. (2) Clinical disagrea material and false assessment. (2) Clinical disagrea material and false assessment for 2 for accuracy of the Minimum Dates assessment for 2 for accuracy of the Resident 129) Findings include 1.) On 4/4/17 at was observed to teeth). On 4/717 at 10:0 clinical record we resident 129's A	e and Medicaid, an fully and knowingly- erial and false statement in ment is subject to a civil not more than \$1,000 for or er individual to certify a statement in a resident oject to a civil money e than \$5,000 for each ement does not constitute se statement. ation, interview, and he facility failed to ensure the oral/dental status of ata Set (MDS) of 31 residents reviewed the MDS. (Resident 32, : 10:51 a.m., Resident 129 be edentulous (without	F 0278	F 278:483.20(g)-(j) ASSESSMENT ACCURACY COORDINATION/CERTIFIED I. Oral / dental assessments for residents 32 and 129 have been corrected. II. Other in-house residents will be audited to ensure that most recent MDS accurately reflected current oral status. Any inconsistencies identified will be corrected at the time of the audit. III. Systematic changes will include training for MDS nurses regarding accuracy of oral/dental status. IV. The MDS coordinator, or designee, will audit the accuracy of the oral/dental status portion of	

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Event ID:

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î ´		ľ		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED B. WING 04/07/2017				
		155677	B. W.	ING		04/07/2017		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
					LL TRACE CIR			
BELL TR	ACE HEALTH AND	LIVING CENTER		BLOOMINGTON, IN 47408				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE		
	appears: Normal	in appearance"			the MDS on 100% of new admissions for 4 weeks, then 5			
					residents weekly for 8 weeks, then			
		Iinimum Data Set			quarterly ongoing. Any			
	` ′	ent, dated 3/27/17,			inconsistences will be corrected			
	indicated " Or	ral/Dental Status Z.			accordingly.			
	None of the above	ve were present."						
					The results of these reviews will be			
	On 4/7/17 at 3:20	0 p.m., the MDS			discussed at the monthly facility			
	Coordinator indi	cated the MDS was			Quality Assurance Committee meeting and frequency and			
	incorrectly code	d.			duration of reviews will be adjusted	4		
					as needed. Frequency and duration			
	2.) On 4/7/17 at	11:30 A.M., Resident			of reviews will be adjusted as			
	·	ord was reviewed.			needed, if compliance is below			
					100%.			
	Resident 32's Mi	nimum Data Set (MDS)						
		d 3/3/17, indicated			Completion Date: April 26th, 2017			
	·	Status Z. None of the			The Administrator will be			
	above were prese				responsible for ensuring the facility	,		
	above were prese	ont.			is in compliance by the date listed.			
	An Observations	1 Domant dated 2/25/17			We are requesting desk review /			
	indicated "no	al Report, dated 2/25/17,			paper compliance for this tag.			
	indicatedno	teetn						
	0 4/7/17 + 10	15 D.M. D.M.O.: 1: 4 1						
		15 P.M., RN 2 indicated						
	Resident 32 had	no teetn.						
	0 4/7/17 : 00	0 4 MDC						
	On 4/7/17 at 3:20	•						
		cated the MDS was						
	incorrectly.							
	3.1-31(d)							
F 0282	483.21(b)(3)(ii)							
SS=D		JALIFIED PERSONS/PER						

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					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED
	155677		B. WING 04/07/2017			04/07/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					LL TRACE CIR	
BELL TR	ACE HEALTH AND	LIVING CENTER		BLOOM	MINGTON, IN 47408	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
Bldg. 00	CARE PLAN	sina Osaa Disaa				
	(b)(3) Comprehen	ided or arranged by the				
	·	by the comprehensive				
	care plan, must-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	(ii) Be provided by	qualified persons in				
		ach resident's written plan				
	of care.	and the second second plans				
	Based on record	review and interview,	F 02	282	F282: 483.21(b)(3)(ii)	05/01/2017
	the facility failed	l to ensure care plans			SERVICES BY QUALIFIED	
	1	or personal preferences			PERSON/PER CARE PLAN	
		te up time for 1 of 3			I. Resident 240 was interviewed	
	_	ed for ADLs/assistance.			regarding awakening time	
	(Resident 240)	od for fibility dobistation.			preference. The resident's plan of care and assignment sheet were	
	(Resident 240)				updated to reflect resident 240's	
	Findings include				preference.	
	Tindings include	•			II. All current residents and a family	
	On 4/4/17 at 2:0'	7 m m Dogidant 240			member of residents with a BIMs	
		7 p.m., Resident 240			score of less than 8 will be	
	1	Ferred to wake up at 8:30			interviewed regarding awakening	
		vakens him for breakfast			preferences. Care plans / CNA	
	at 7:30 a.m.				assignment sheets will be updated accordingly.	
					III. All facility staff will be reeducated	4
		6 a.m., CNA 1 indicated			regarding resident preferences.	
	1	efers to wake up before			IV. The Social Service Director or	
		dent 240 preference were			Director of Nursing, and/or designed	غ ا
	on her assignmen	nt sheet, which indicated			will interview 4 residents with a	
	resident prefers t	o wake up between			BIMs score above 8 and 1 family	
	8:30-9:00 a.m.				member of a resident with a BIMS	
					score of less than 8 regarding wake time preferences each week for the	
	On 4/7/17 at 11:	15 a.m., Resident 240			next 4 weeks. After the initial 4th	
	indicated he was	awakened at 7:30 a.m.			week of audits is complete, 2	
	for breakfast.				residents with a BIMs score of 8 or	
					more and 1 family member of a	
	On 4/7/17 at 11::	51 a.m., CNA 1			resident with a BIMS score of less	
		n (morning) she assisted			than 8 will be interviewed each	

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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			ETED
		155677	B. WING 04/07/2017				2017
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1			
DELL TD	AOE LIEALTH AND	NAME OF STEED			LL TRACE CIR		
BELL IR	ACE HEALTH AND	LIVING CENTER		BLOOM	IINGTON, IN 47408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	resident to sit on	side of bed for breakfast			week for an additional 8 weeks. An	v İ	
	at 8:00 a.m.	isiae of oca for orealitast			inconsistencies will be corrected.	, l	
	at 6.00 a.iii.				Then, 4 residents with a BIMs score		
					of 8 or more and 1 family member of	of	
	Resident 240's c	linical record was			a resident with a BIMs of less than 8		
	reviewed on 4/6	/17 at 11:21 a.m. The			will be interviewed quarterly		
	Diagnoses includ	ded, but were not limited			ongoing regarding preferences.		
		art failure, and muscle			anguing regulating preferences.		
		art failure, and muscle			The results of these reviews will be		
	weakness.				discussed at the monthly facility		
					Quality Assurance Committee		
	A review of Res	ident 240's admission			meeting for 3 consecutive months.		
	Minimum Data	Set (MDS) assessment			Frequency and duration of reviews		
		ndicated a Brief Interview			will be adjusted as needed, if		
	· · · · · · · · · · · · · · · · · · ·				compliance is below 100%.		
		s (BIMS) total score of			compliance is below 100%.		
	14, with a total s	score of 13 to 15 being			Compliance Date: May 1st, 2017		
	cognitively intac	et.			Compilative Bate. May 13t, 2017		
					The Administrator will be		
	A review of Res	ident 240's personal			responsible for ensuring the facility	,	
		Activities of Daily Living			is in compliance by the date listed.		
	•				We are requesting desk review /		
		initiated on 3/15/17,			paper compliance or this tag.		
	indicated "Hono	r/Awake resident at			paper compliance of this tag.		
	preferred awake	ning time:_8:30am"					
	_						
	3.1-35(g)(2)						
	3.1-33(g)(2)						
F 0465	483.90(h)(5)						
SS=D	, , , ,	IAL/SANITARY/COMFOR					
Bldg. 00	TABLE ENVIRON						
	(h) Other Environi	mental Conditions					
	•						
	The facility must p	provide a safe, functional,					
		fortable environment for					
	residents, staff an	d the public.					
	(h)(5) Establish no	olicies in accordance with	1				

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155677	B. WING 04/07/2017			2017		
				STREET /	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			LL TRACE CIR			
BELL TRACE HEALTH AND LIVING CENTER				MINGTON, IN 47408				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	1 ' '	II, State, and local laws and ding smoking, smoking						
		ng safety that also take into						
	account non-smol	-						
	i	ration, interview, and	F 04	165	F485:483.90(i)(5)		04/26/2017	
		ne facility failed to ensure						
	· ·	elchair was free from			SAFE / FUNCTIONAL / SANITARY /			
		ent 38) and bedroom			COMFORTABLE ENVIRONMENT			
	• •	ly painted for 2 of 20			I. The subselebels are set of			
		ed for environment.			I. The wheelchair arm pads for resident 38 will be repaired or			
	(Resident 22, Re				replaced. The walls in resident 22'	s		
	(Kesideni 22, Ke	esident 200)			and resident 200's rooms have			
	E. 1 1 1				been repaired and painted. Any			
	Findings include) :			unused screws or nails have been			
					removed.			
	· '	at 09:00 a.m., Resident						
		armrests was observed to			II. Wheelchair arm pads will be			
		acks which revealed a			evaluated and any damaged pads			
	yellow foam und	derneath the covering.			will be repaired or replaced for other residents residing at the			
	The resident ind	icated the cracked			facility. Other resident rooms will			
	armrest was unc	omfortable and			be examined. Any rooms needing			
	occasionally sera	atched him.			wall repair, touch-up paint, or nails	;		
					/ screws removed will be put on a			
	On 04/07/17 at 0	9:24 a.m., RN 1			work schedule and repairs will be			
		eelchair armrests were in			made.			
	need of repair.							
					III. Staff will be educated regarding	i		
	On 04/07/17 at 4	1·15 n.m. the			identifying and notifying the appropriate personnel if wheelcha	ir		
		•			armrests are in disrepair or residen			
		ovided a copy of			rooms are in need of repair.			
		s," revised March, 2017,						
		was the current policy						
	1 2	e facility. The policy						
		e facility must provide a			IV. Maintenance Director or			
		fortable, and homelike			designee will audit 10 wheelchairs			
	environment"				monthly to identify any wheelchair	•		
	I		1		arm rests that need repaired /		1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155677		B. WING		04/07/2017	
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	725 BE	ADDRESS, CITY, STATE, ZIP CODE LL TRACE CIR MINGTON, IN 47408	!	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	2a.) On 4/07/17 22's wall was ob uneven paint col nails. The reside like the room prounused nails rem b.) On 4/07/17 a 200's wall was ounused nails. The would like the natched. On 04/07/17 at 4 administrator prounused nails remeated.	at 11:00 a.m., Resident served to have spackle, ors and seven unused and indicated she would operly painted and the noved and patched. t 11:30 a.m., Resident beserved to have multiple e resident indicated he ails removed and		IAG	replaced. Corrective action will be taken at the time of audit for any damaged wheel chair arm rests. Maintenance Director or designee will audit 10 resident rooms monthly to identify walls in need or repair, paint, or needing screws / nails removed. Any needed repair will be placed on a work schedule. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting for 3 consecutive months. Frequency and duration of reviews will be adjusted as needed, if compliance is below 100%. Compliance Date: April 26th, 2017 The Administrator will be responsible for ensuring the facility is in compliance by the date listed. We are requesting desk review / paper compliance for this tag.	of s	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0A6B11

Facility ID: 002574

If continuation sheet

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