STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0000	This visit was for a State Residential Licensure survey. Survey dates: February 8, 9, and 10, 2011 Facility Number: 004442 Provider Number: 004442 Aim Number: NA Survey Team: Gloria J. Reisert, MSW/TC Avona Connell, RN Donna Groan, RN (2/9 and 2/10/2011) Census Bed Type: Residential: 36 Total: 36 Census Payor Type: Other: 36 Total: 36 Sample: 07 Supplemental sample: 21 These State Residential Findings are in accordance with 410 IAC 16.2 Quality review completed 2-15-11 Cathy Emswiller RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0036	Based on record review and interview the facility failed to ensure the physician was notified when a medication was not available for 1 of 7 sampled residents reviewed for availability of medication. (Resident #2) [R#2] Findings include: The clinical record for R#2 was reviewed on 2/9/11 at 9:20 a.m. The resident's diagnoses included, but were not limited to dementia with psychotic disorder and depression. The resident was admitted on 8/3/10. Physician Orders included, but were not limited to: Exelon (to treat Dementia) Patch 4.6 mg (milligram) daily at 7 a.m. Review of the Medication Administration Record for August 2010 indicated from August 3 through the 31st the nurse/QMA (qualified medical assistant) initials for the time provided were circled as not given. Documentation in the Resident Service Notes, on 2/9/11 at 9:20 a.m., lacked physician notification as to why the medication was not given as ordered. A Prescription dated 8/26/10 was in the record which indicated "Rx (Prescription) D/C (discontinue) Exelon Patch not covered on insurance."	R0036	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 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. **Citation #1** **R 036** **410 IAC 16.2-5-1.2 (k) (1-2)** **Resident Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes**	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	On 2/9/11 at 2:45 p.m., the Wellness Director provided the policy and procedure for "F. COMMUNICATING WITH RESIDENT'S PHYSICIANS" which included, but was not limited to: "1. When staff report changes in a resident's condition, the Wellness Director must make a determination as to what action should be taken, such as: square 1 Assistance with a PRN (as needed) and/or other medication for the resident. square 4 Informing the resident's physician of the situation, and following any instructions...2. If contacting the resident's physician for further instructions, complete information about the resident and his/her current status should be readily accessible, including: square 2 the resident's current medication record(s)....3. When calling the physician's office for guidance on a particular resident situation: square 1 Ask to speak directly to the physician's nurse. square 2 Briefly inform the individual answering the phone of the resident's status (he/she will typically refer you to the physician's nurse). 4. Typically, the nurse will then ask for all pertinent information about the resident's current status, and either: square 1 Make a recommendation (e.g. have the resident come in for an appointment) square 2 Pass		**will the facility make to ensure that the deficient practice does not recur?** The Residence Director, Wellness Director, and licensed staff were re-educated to our policy and procedure regarding resident change of condition, physician notification, and documentation. The Wellness Director and/or Designee will ensure continued compliance with physician notification per our policy through an ongoing weekly review of resident's medication administration record, incident reports, and service notes. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will ensure continued compliance with physician notification per our policy through an ongoing weekly review of resident's medication administration record, incident reports, and service notes. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 information on to the physician. In this case, either the nurse and/or the physician will call back with recommendations..." On 2/9/11 at 11:15 a.m., in interview with the Wellness Director, she indicated the physician should be notified "right away" when medication was not available.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0144	Based on observation, record review, and interview the facility failed to ensure dining room furniture, sinks, and lighting and chairs in common areas were clean and free of dust on 2 of 2 observations. This deficient practice had the potential to affect 36 of 36 currents residents in the facility. Findings include: 1. During the initial tour on 2/8/2011 at 8:15 a.m., 7 of 7 straight back chairs in the front lounge were observed to have dust on the bottom rails that rolled to the touch. 4 of 4 high back chairs in the corner just outside this lounge by the patio were also observed to have dust on the bottom rails that rolled to the touch. 2. On 02/08/11 between 1:45 p.m. and 1:56 p.m., the following was observed while accompanied by the Regional Director: a. The wood frames of 31 of 31 dining room chairs were soiled with heavy dust that rolled up when swiped with the hand. b. Cob webs were observed between the globes of 5 of 16 ceiling light fixtures. c. The hand sink in the dining room was	R0144	**Citation #2 R144 410 IAC 16.2-5-1.5 (a) Sanitation & Safety Standards What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Items identified were thoroughly cleaned by staff. Third shift staff were re-educated to cleaning tasks as indicated on the third shift cleaning schedule. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director, Wellness Director, and staff were re-educated to the third shift cleaning schedule. Staff will sign and date task sheet to confirm completion and turn into the Residence Director and/ or Designee for review to ensure continued compliance. The Residence Director will conduct ongoing random daily rounds to ensure continued compliance. **How will the corrective action(s) will be monitored to ensure the deficient practice**	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	soiled with food debris and a yellow film on the inner surface. During this observation, the Regional Director indicated the sink was to be cleaned every evening. d. At 2:05 p.m. on 02/08/11, the QMA [Qualified Medication Aide] provided a copy of the third shift task sheet. The sheet indicated the dining room chairs and sink were to be cleaned nightly.		**will not recur, i.e., what quality assurance program will be put into place?** The Residence Director will conduct ongoing random daily rounds to ensure continued compliance with assigned cleaning schedule as designated by third shift task sheet. Findings will be reviewed and corrected through our QA process. .**By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0154	Based on observation and interview the facility failed to ensure equipment was clean and in good repair for 1 of 2 dietary observations. This deficient practice had the potential to affect 36 of 36 currents residents in the facility. Findings include: On 02/08/11 the following was noted: 1. At 8:20 a.m., 2 large pots (5 gallon) stored as clean were marred and pitted on the inner surface and 2 were soiled with dried food debris on the inner surfaces.. 2. At 8:41 a.m., the can opener blade was soiled with dried brown substance. In interview with the cook at this time she indicated she had not used the can opener this morning. 3. At 8:43 a.m., the ice machine was soiled with a slick red colored substance on the inner surface where the ice was made. The cook indicated she did not know when the machine was last cleaned. 4. At 8:45 a.m., a small plastic pitcher stored as clean was heavily stained a brown color. 5. On 02/10/11 at 10:00 a.m., the	R0154	**Citation #3 R154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The Residence Director discarded and replaced the 2 large pots (5 gallon) & plastic pitcher on 2/10/2011. The can opener blade and ice machine was cleaned by staff on 2/10/2011. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director, Dining Service Coordinator, cooking staff, and Maintenance Director were re-educated to our kitchen cleaning schedule. The Residence Director developed and implemented a routine cleaning schedule for the ice machine to be documented and completed by the Maintenance Director on a monthly basis. The Residence Director and/ or Designee will perform random weekly rounds of the Residence	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	maintenance director indicated he had not emptied the ice machine and cleaned it since he was hired. He indicated he had been here almost 6 months. He further indicated he had instructions for cleaning the machine but it was not on a routine cleaning schedule.		on an ongoing basis to ensure continued compliance with safety and sanitation standards. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/ or Designee will perform random weekly rounds of the Residence on an ongoing basis to ensure continued compliance with safety and sanitation standards. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0214	Based on record review and interview the facility failed to ensure a pre-admission assessment was initiated prior to admission for 1 of 3 residents reviewed with recent admission in a sample of 7. (Resident #2) [R2] Findings include: The clinical record for R2 was reviewed on 2/9/11 at 9:20 a.m. The resident diagnoses included, but were not limited to dementia with psychotic disorder and depression. The resident was admitted on 8/3/10. Move-in 8/3/10. The Nursing Comprehensive Evaluation was dated 08/04/2010. The Wellness Director provided the policy and procedure for "ASSESSMENT PROCESS OVERVIEW" DATED 12/2008 on 2/9/11 at 2:45 p.m., which included, but was not limited to: "1. A formal service assessment process must be completed prior to move in on all applicants to determine what services are needed/preferred and if they can be provided/arranged by the Residence. The assessment process includes: square 1 Service Assessment/Negotiated Service Plan; square 2 Elopement risk Assessment, including the Mini Mental Status Exam (MMSE); square 3 Mobility	R0214	Citation #4 <o:p></o:p> R214 <o:p></o:p> 410 IAC 16.2-5-2 (a) <o:p></o:p> Evaluation <o:p></o:p> <font	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Management Tool; square 4 In some states, the Nursing Comprehensive Evaluation must be completed prior to move-in. Refer to you state regulations. Note: With the exception of the Nursing Comprehensive Evaluation, these assessments can and should be completed by other team members - (Residence Director, Sales Professional, Assistant Residence Director or Management Assistant) in most instances. The Wellness Director should be consulted for all items marked NURSE ALERT and may need to conduct the nursing assessment prior to accepting the resident..." On 2/9/11 at 9:20 a.m., in interview with the Wellness Director, she indicated she had "no answer for the assessment not being done prior to move-in."		face="Times New Roman">What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? <o:p></o:p> No residents were found to be affected. Resident #2 was assessed by the Wellness Director on 8-4-2010. <o:p></o:p> <o:p> </o:p> How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <o:p></o:p></span	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			> No other residents were found to be affected. <o:p></o:p> <o:p> </o:p></s pan> What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? <o:p></o:p> The Wellness Director was re-educated to our policy and procedure regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			our policy and procedure regarding the assessment process. The Wellness Director and/ or Designee will be responsible to ensure residents are assessed as indicated within our policy going forward. <o:p></o:p> <o:p> </o:p> How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? <o:p></o:p> The Wellness Director will perform a random weekly review of resident admissions to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			assessments are completed per our policy to ensure continued compliance on an ongoing basis. Findings will be reviewed and corrected through our QA process. <o:p></o:p> <o:p> </o:p> By what date will the systemic changes be completed? <o:p></o:p> Compliance Date: 3/20/11 <o:p></o:p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0217	Based on record review and interview the facility failed to ensure the service plans were reviewed/updated semi- annually and signed by the resident or the resident's responsible party for 1 of 5 residents in a sample of 7 and 1 of 2 closed records reviewed. (Resident [R] #R3 and #R6) Findings include: 1. Resident R#3's record was reviewed on 02/9/11 at 10:00 a.m.. The resident had diagnoses including but not limited to: Alzheimer's Dementia, with depression, osteoarthritis and hypertension. The last service plan was dated 05/01/2010 and lacked a signature of the resident or responsible party. On 02/09/11 at 12:15 p.m., the Wellness Director indicated the facility had not updated the care plan since 05/01/10. 2. Resident #R6's record was reviewed on 02/08/11 at 10:10 a.m. The resident had diagnoses including but not limited to: congestive heart failure, hypothyroidism, Alzheimer's dementia. The last service plan was dated 04/16/10 and lacked a signature of the resident or responsible party. The service plan indicated the next review was due 07/15/10. No further service plan was	R0217	**Citation #5** **R217** **410 IAC 16.2-5-2 (e) (1-5)** **Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #3's service plan was reviewed and signed with the resident and responsible party. Resident #6 no longer resides at Bennett House. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding our service plans and assessment process. The Wellness Director and/ or Designee will perform a random ongoing weekly review of resident records to ensure service level assessments are signed and reviewed with residents and/ or responsible parties prior to implementation.	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	available for review. The resident was transferred to the hospital on 01/11/11, and did not return to the facility.		**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and/ or Designee will perform a random ongoing weekly review of resident records to ensure service level assessments are signed and reviewed with residents and/ or responsible parties prior to implementation. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0272	Based on observation , record review and interview the facility failed to ensure food temperatures were taken to ensure food was served at a safe temperature on 1 of 2 dietary observations. This deficient practice had the potential to affect 36 current residents. Findings include: Upon entrance to the kitchen on 02/08/11 at 8:10 a.m., breakfast service was in progress. The residents were being served scrambled and fried eggs, tator tots, bacon, and cereal. When asked for the location of the temperatures taken prior to service, the cook indicated she did not take the breakfast temperatures. Upon request she measured the temperature of the fried eggs. The eggs measured less than 130/140 degrees Fahrenheit. The eggs measured 90 degrees Fahrenheit. Review of the temperature logs for the dates of February 3, and 4, at 9:15 a.m. on 02/08/11, temperatures were lacking for breakfast, lunch and dinner for all items served.	R0272	Citation #6 <o:p></o:p> R272 <o:p></o:p> 410 IAC 16.2-5-5.1 (e) <o:p></o:p> Food and Nutritional Services <o:p></o:p> <font	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			face="Times New Roman">What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? <o:p></o:p> No residents were found to be affected. <o:p></o:p> <o:p></o:p> How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <o:p></o:p></span	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			> No other residents were found to be affected. <o:p></o:p> <o:p> </o:p></s pan> What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? <o:p></o:p> The Residence Director, Dining Service Coordinator, and the cooking staff were re-educated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			our policy and procedure regarding obtaining food temperatures along with appropriate documentation to ensure food is served at a safe temperature. The Residence Director and/or Designee will conduct ongoing random weekly reviews of meal service and the food temperature Log to ensure continued compliance. <o:p></o:p> <o:p> </o:p> What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? <o:p></o:p> <span style="mso-spacerun:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			yes"> The Residence Director and/or Designee will conduct ongoing random weekly reviews of meal service and the food temperature Log to ensure continued compliance. Findings will be reviewed and corrected through our QA process. <o:p></o:p> <o:p> </o:p> By what date will the systemic changes be completed? <o:p></o:p> Compliance Date: 3/20/11 <o:p></o:p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0299	Based on interview and record review the facility failed to ensure Consultant Pharmacy recommendations were followed-up with the physician in a timely manner for 2 of 7 sampled residents. (Resident #2 and #4) [R2, R4] Findings include: 1. The clinical record for R2 was reviewed on 2/9/11 at 9:20 a.m. The resident diagnoses included, but were not limited to dementia with psychotic disorder and depression. A Consultation Report from Pharmacy dated 8/27/2010 included, but was not limited to: "Comment: R2 takes Zolpidem (sleeping medication) 10 mg (milligram) HS (hour of sleep). The recommended maximum daily dose threshold for this medication when used to treat insomnia in the elderly is: zolpidem (Ambien) 5 mg. Recommendation: Please re-evaluate continued use of Zolpidem at this dose, perhaps decreasing to 5 mg HS. Rationale for Recommendation - There is a risk in elderly and/or debilitated persons towards the development of over sedation, dizziness, confusion, and/or ataxia when sedative/hypnotic agents are used at greater than the recommended maximum safe dose. The recommendation was faxed to the physician on 9/21/2010. The	R0299	**Citation #7** **R299** **410 IAC 16.2-5-6 (c) (3)** **Pharmaceutical Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #2 and #4 had there pharmacy recommends reviewed with the physician for orders by the Wellness Director. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director was re-educated to our policy and procedure concerning pharmacy recommendations. The Wellness Director shall provide pharmacy recommendations to the resident's primary care physician per our policy. The Wellness Director will perform an ongoing monthly review to ensure pharmacy recommendations are addressed by the physician in a timely manor. **What measures will be put into**	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	physician signed and dated the report on 9/22/10. A Physician's Response was lacking from 9/21/2010 through 2/9/11. Physician's Orders for 11/10 included, but was not limited to Zolpidem Tartrate 10 mg tablet - IE Ambien 10 mg tablet give 1 tablet orally daily at bedtime for insomnia with a start date of 8/04/10. 2. The clinical record for R4 was reviewed on 2/9/11 at 8:35 a.m. The resident diagnoses included, but were not limited to: heart disease and chronic obstructive pulmonary disease. A Consultation Report from Pharmacy dated 8/27/2010 included, but was not limited to: "Comment: R4 takes Zoloft which is being administered at bedtime. He also takes Trazodone (anti-depressant) 50 mg HS. Recommendation: Please consider obtaining a physician's order to administer Zoloft in the morning. Rationale for Recommendation - Insomnia is a potential therapy-limiting adverse affect which is reported with use of second generation antidepressants such as the selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). Altering administration to the morning may minimize the risk for insomnia." The recommendation was faxed to the		**place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director shall provide pharmacy recommendations to the resident's primary care physician per our policy. The Wellness Director will perform an ongoing monthly review to ensure pharmacy recommendations are addressed by the physician in a timely manor. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	physician on 9/21/2010. A hand written note on the same form indicated "OK Agree" and signed by the physician. Review of the September 2010 Routine Medication sheet included, but was not limited to "Sertraline HCL (hydrochloride) 100 mg tablet IE - Zoloft 100 mg tablet Give 1 tablet orally daily at bedtime" Review of the February 2011 Routine Medication sheet included, but was not limited to "Sertraline HCL 100mg tablet IE - Zoloft 100mg tablet Give 1 tablet orally daily at bedtime." Documentation was lacking the facility followed up on the Pharmacy Recommendations from 8/21/10 through 2/9/11. On 2/10/11 at 11:30 a.m., the Wellness Director indicated "once the recommendation is received she wants them sent to the physician within a week and follows-up within a few days."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0302	Based on observation and interview the facility failed to ensure over the counter medications were labeled with the resident name and/or physician name for 5 residents in a supplemental sample of 21. (Residents #9, 16, 26, 27, 28) Findings include: During observation of the medication cart on 02/08/11 at 11:00 a.m., with the Qualified Medication Aide passing medications, the following over the counter medications failed to include residents' name or physician name. 1. Resident #9 had a bottle of Mature Multivitamins. The vitamins lacked the resident or physician name. 2. Resident #16 had a bottle of Aspirin 81 milligram. The bottle lacked the resident name or physician name. 3. Resident #26 had 1 bottle of Mens formula Multi Vitamin, 1 bottle of Tylenol Extra Strength, and 1 box of Alka Seltzer. The medications lacked the physician name. 4. Resident #27 had a bottle of Aleve. The bottle lacked the physician name.	R0302	**Citation #8** **R302** **410 IAC 16.2-5-6 (c) (6)** **Pharmaceutical Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #9,#16, #26, #27, and #28 had there over the counter medications labeled with the appropriate information as indicated under state ruling 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and licensed staff were re-educated to state ruling 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services. The Wellness Director will perform an ongoing random weekly review of the medication cart to ensure residents receiving over the counter medications are labeled with the following information: (1) resident name (2) Physician name (3)	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	5. Resident # 28 had a bottle of My Tab for Gas. The container lacked the resident and physician name. In interview with the QMA at this time she indicated she was unaware the medications had to be labeled with the resident and physician name.		expiration date (4) name of drug (5) strength of drug. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director will perform an ongoing random weekly review of the medication cart to ensure residents receiving over the counter medications are labeled with the following information: (1) resident name (2) Physician name (3) expiration date (4) name of drug (5) strength. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0349	Based on record review and interview the facility failed to ensure the clinical records were complete and accurately documented for an assessment for depression for 1 of 5 residents with a diagnosis of depression in a sample of 7 (Resident #4) [R4] . Findings include: 1. The clinical record for R4 was reviewed on 2/9/11 at 8:35 a.m. The resident diagnoses included, but were not limited to: heart disease, depression and chronic obstructive pulmonary disease. A Physician Order dated 1/28/11 included "arrow pointing up Celexa (antidepressant) to 40 mg (milligram) po (by mouth) daily" Review of the Resident Services Notes lacked any documentation of an assessment for depression s/s (signs/symptoms) such as, crying, sad expression, withdrawn, fatigue. On 2/10/11 at 8:30 a.m., the Wellness Director provided a hospice Plan of Care Review dated 1/12/11 and faxed on 2/9/11 at 16:59 (4:59 p.m.) which included, but was not limited to "Feelings of depression." Documentation was lacking of an assessment or documentation related to s/s of depression. In interview with the Wellness Director, at this time, she could	R0349	**Citation #9** **R349** **410 IAC 16.2-5-8.1 (a) (1-4)** **Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #4 was assessed by the Wellness Director regarding feeling of depression prior to medication utilization and documented regarding improved mood at present time. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director was re-educated to our policy and procedure regarding documentation, change of condition, and our assessment process. The Wellness Director will ensure residents are assessed upon notification of a resident's change of condition as indicated within our policy. **What measures will be put into**	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	find no documentation for an increase in signs and symptoms of depression in the Resident Service Notes.		**place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director will conduct a random weekly ongoing review of resident's service notes to ensure residents are assessed when experiencing a change of condition. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0354	Based on record review and interview the facility failed to send a transfer form with the resident when transported to the hospital for 2 of 3 residents reviewed requiring a transfer sheet in a sample of 7. (Resident #2 and #4) [R2, R4] Findings include: 1. The clinical record for R2 was reviewed on 2/9/11 at 9:20 a.m. The resident diagnoses included, but were not limited to dementia with psychotic disorder and depression. The resident was admitted on 8/3/10. Resident Services Notes included, but was not limited to: 10/12/10 9:30 p "Found resident on floor near sink; called res. daughter & patient reported intolerable pain transferred to [named] hospital via [named] EMS (emergency medical service)." The next entry dated 10/19/10 "Resident had a fall in hall c/o (complains of) back pain. Dtr (daughter) notified; MD notified. EMS called for Transport to [named] hospital for Eval (evaluation)." Documentation was lacking of a transfer form in the record. Documentation was lacking the hospital personnel had been called and given transfer information via phone. 2. The clinical record for R4 was	R0354	Citation #10 <o:p></o:p> R354 <o:p></o:p> 410 IAC 16.2-5-8.1 (g) (1-7) <o:p></o:p> Clinical Records <o:p></o:p> <font	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	reviewed on 2/9/11 at 8:35 a.m. The resident diagnoses included, but were not limited to: heart disease and chronic obstructive pulmonary disease. Resident Service Notes included, but were not limited to: 11/27/10 2:05 pm "resident put light on this writer wen in and he asked me to call daughter and tell her to come and see him. I called daughter she said she was coming as soon as she finished eating." 3:10 pm "[named hospice] nurse is here with resident checking on him came and got this writer to help change him so he can go the [named] hospital." 3:30 pm "res. went to [named] hospital by yellow ambulance per 2 staff..." Documentation was lacking of a facility transfer sheet in the record. Documentation was lacking the hospital personnel had been called and given transfer information via phone. Documentation was lacking in the clinical record of a transfer sheet on phone call to the hospital. A transfer form would include: 1. Identification data, 2. Name of the transferring institution. 3. Name of the receiving institution and date of transfer. 4. Resident's personal property when transferred to an acute care facility. 5. Nurses' notes relating to the resident's:		face="Times New Roman">What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? <o:p></o:p> No residents were found to be affected. <o:p></o:p> <o:p> </o:p></s pan> How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <o:p></o:p> <p class="MsoNormal" style="margin: 0in 0in 0pt; mso-layout-grid-align:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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. functional abilities and physical limitations; B. nursing care; C. medications; D. treatment; and E. current diet and condition on transfer. 6. Diagnosis. 7. Date of chest x-ray and skin test for tuberculosis." On 2/9/11 at 2:45 p.m., the Wellness Director indicated staff had been doing Transfer sheets and then they were dropped." On 2/10/11 at 9:05 a.m., the Wellness Director provided the following policy and procedure dated 1/20/10, "I. EMERGENCY TRANSFER TO OTHER SETTINGS: 4. Staff should always send copies of the following information with a resident to the hospital when being transferred (if possible): square 1 Resident Information and Contacts form; square 2 Insurance information; square 3 Primary care physician and number; square 4 Current medication sheet(s); and square 5 Information regarding current incident; square 6 In addition, in some states, a transfer form is required. DO NOT DELAY DEPARTURE IN AN EMERGENCY TO SECURE THIS INFORMATION!! TELEPHONE OR FAX THE INFORMATION TO THE HOSPITAL."		none">No other residents were found to be affected. <o:p></o:p> <o:p> </o:p></s pan> What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? <o:p></o:p> The Wellness Director and staff were re-educated to our policy and procedure regarding ALC Decision Tree and transfer of residents with appropriate documentation. The Wellness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			Director and/or RD will be notified of residents who are transferred out of community per our ALC Decision Tree to ensure proper documentation has been completed and sent with resident for communication purposes. <o:p></o:p> <o:p> </o:p></s pan> What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? <o:p></o:p> <span style="mso-spacerun:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			yes"> The Wellness Director will perform a weekly ongoing review of incident reports and service notes to ensure appropriate transfer documentation has been completed and sent with resident sent out of the community per our policy and procedure. Findings will be reviewed and corrected through our QA process. <o:p></o:p> <o:p> </o:p> By what date will the systemic changes be completed? <o:p></o:p> Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOUSE	3928 HORNE AVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			<o:p></o:p> <o:p> </o:p> <o:p> </o:p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0356	Based on record review and interview, the facility failed to ensure the emergency file contained all information required (a picture, hospital preference, physician phone number, name of physician, and correct apartment number) for 4 of 7 residents' (R#2, 3, 4, and 5) and 17 of 21 supplemental residents' (R#8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, and 25) Emergency Files reviewed. [Resident] Findings include: Review of the current Emergency Files for the residents on 2/8/2011 at 10:00 a.m., indicated the following residents had items missing in their files: a. Resident #2 - admitted to her apartment on 8/3/2010 and was missing the name and phone number of her physician and had no hospital preference listed. b. Resident #3 - admitted to her apartment on 5/13/2010 and was missing the physician's phone number and had no hospital preference listed. c. Resident #4 - admitted to his apartment on 10/23/2009 and had the wrong apartment number listed. The number	R0356	**Citation #11** **R356** **410 IAC 16.2-5-8.1 (i) (1-8)** **Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Residents #2, #3, #4, #5, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #21, #22, #23, #24, and #25 had there emergency files updated to ensure compliance with state ruling 410 IAC 16.2-5-8.1 (i) (1-8). **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and staff were re-educated as to information to be contained within the emergency binder as indicated within state ruling 410 IAC 16.2-5-8.1 (i) (1-8). The Wellness Director will be responsible for ensuring the emergency binder is in compliance through an ongoing random weekly review.	03/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	listed was #128 when he actually resided in #138. d. Resident #5 - admitted to her apartment on 9/3/2010 and was missing the physician's phone number. e. Resident #8 - admitted to his apartment on 9/22/2010 and was missing the phone number of the physician. f. Resident #9 - admitted to his apartment on 11/18/2010 and was missing a personal photo. g. Resident #10 - admitted to his apartment on 5/2/2008 and was missing the phone number of the physician. h. Resident #11 - admitted to her apartment on 4/8/2009 and was missing the phone number of the physician. i. Resident #12 - admitted to her apartment on 6/29/2009 and was missing the phone number of the physician. j. Resident #13 - admitted to her apartment on 9/27/2010 and was missing a hospital preference and had the wrong apartment number listed. The number listed was #113 when she actually resided in #115.		**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director will conduct a random weekly review of the emergency file to ensure continued compliance with state ruling 410 IAC 16.2-5-8.1 (i) (1-8). Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	k. Resident #14 - admitted to his apartment on 4/25/2010 and was missing a hospital preference. l. Resident #15 - admitted to her apartment on 7/2/2010 and was missing a hospital preference. m. Resident #16 - admitted to her apartment on 2/4/2011 and was missing a personal photo and her apartment number. n. Resident #17 - admitted to his apartment on 6/18/2008 and was missing a hospital preference and an apartment number. o. Resident #18 - admitted to her apartment on 3/1/2009 and was missing an apartment number. p. Resident #19 - admitted to his apartment on 10/18/2010 and had the wrong apartment number listed. The apartment number listed was #124 when he actually resided in #126. q. Resident #21 - admitted to her apartment on 11/25/2007 and had the wrong physician's name listed and no hospital preference.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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. Resident #22 - admitted to his apartment on 11/25/2007 and had the wrong physician's name listed and no hospital preference. s. Resident #23 - admitted to her apartment on 12/3/2009 and the wrong physician listed, no hospital preference was chosen, and had the wrong apartment listed, The apartment listed was #117 when the resident actually resided in #133. t. Resident #24 - admitted to her apartment on 3/26/2009 and was missing the physician's phone number and had no apartment number listed. u. Resident #25 - admitted to her apartment on 5/20/2010 and was missing the physician's phone number and a hospital preference. During an interview with the Wellness Director at 1:15 p.m. on 2/8/2011, she indicated she was not aware the Emergency Files were incorrect and would work on making sure they matched the clinical records.			