

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: April 18 and 19, 2013</p> <p>Facility Number: 004442 Provider Number: 004442 AIM Number: N/A</p> <p>Survey team: Brenda Nunan, RN, TC Gloria Reisert, Medical Surveyor (April 18, 2013) Gwen Pumphrey, RN (April 18, 2013) Debbie Peyton, RN (April 18, 2013)</p> <p>Census bed type: Residential: 27 Total: 27</p> <p>Census payor type: Other: 27 Total: 27</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/24/13 by Suzanne Williams, RN</p>	R000000	<p>Submission of this response and Plan or 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 response or 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.</p>	
---------	--	---------	--	--

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 that other safeguards 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 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000093	<p>410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement. Based on observation, record review and interview, the facility failed to obtain a contract for 1 of 1 resident reviewed for contracted dialysis services (Resident #24) in the sample of 7.</p> <p>Findings include:</p> <p>During observations on 04/18/2013 at 4:00 p.m., Resident #24 was noted to have a port in the upper right chest that was covered with a gauze square.</p> <p>Resident #24's record was reviewed on 04/18/13 at 1:00 p.m. Diagnoses included, but were not limited to, end stage renal disease, renal</p>	R000093	<p>Bennett House would like to respectfully request an Informal Dispute Resolution by way of face to face discussion as to the below referenced citation regarding R 093 410 IAC 16.2-5-1.3 (j)(1-4) Administration and Management. Please see additional information as to reasoning for request along with additional information for your consideration. R 093 410 IAC 16.2-5-1.3 (j) (1-4) Administration and Management What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #24 has contracted services with the dialysis unit for treatments</p>	06/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>insufficiency, depression, and gastroesophageal reflux disease.</p> <p>An "Assessment and Negotiated Service Plan Summary," dated 04/10/13, indicated staff provided assistance with bathing and included instructions, "...do not get port wet...needs early [meal] on dialysis days, M (Monday), W (Wednesday), F (Friday)...."</p> <p>During an interview on 04/18/2013 at 4:25 p.m., Wellness Director (WD) #1 indicated Resident #24 received dialysis through the port three times weekly. The WD indicated the facility did not have a contract with the dialysis center and did not have specific instructions for care of the resident pre and post dialysis.</p>		<p>independently from the community on an outpatient basis. Resident #24 has been deemed independent and capable of monitoring and adherence to pre and post assessment as evidenced by signed acknowledgement from the dialysis unit. The community has not developed a contractual agreement with the dialysis unit because services rendered are independent from the community and were arranged through the resident. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The Wellness Director reviewed current resident records to ensure professional and diagnostic services provided to the community by an outside resource, either individually or institutionally have a written agreement as to the provisions of service in accordance with Indiana State regulation R 093 410 IAC 16.2-5-1.3 (j) (1-4) Administration and Management. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Wellness Director and Residence Director were re-educated to the Indiana state regulation R 093 410 IAC 16.2-5-1.3 (j) (1-4) Administration and Management along with our policy and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>procedure regarding Third Party Providers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Wellness Director and/or Designee will perform a random weekly review of residents who receive services from outside providers to ensure continued compliance with Indiana State regulation R 093 410 IAC 16.2-5-1.3 (j) (1-4) Administration and Management for a period of six months. Findings will be reviewed through the Bennett House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. By what date will the systemic changes be completed? 6/6/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation, record review, and interview, the facility failed to identify care instructions specific to dialysis services for 1 of 7 residents reviewed for service plans (Resident #24).</p> <p>Findings include:</p>	R000217	Bennett House would like to respectfully request an Informal Dispute Resolution by way of face to face discussion as to the below referenced citation regarding R 217 410 IAC 16.2-5-2 € (1-5) Evaluation. Please see additional information as to reasoning for request along with additional information for	06/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During observations on 04/18/2013 at 4:00 p.m., Resident #24 was noted to have a port in the upper right chest that was covered with a gauze square.</p> <p>Resident #24's record was reviewed on 04/18/13 at 1:00 p.m. Diagnoses included, but were not limited to, end stage renal disease, renal insufficiency, depression, and gastroesophageal reflux disease. The record indicated Resident #24 was admitted to the facility on 03/08/2013. "Resident Services Notes," dated 03/08/2013 at 3:00 p.m., indicated the resident was alert and oriented to person, place and time.</p> <p>Physician's recapitulation orders, dated 03/2013, and identified by Wellness Director (WD) #1 as current, did not indicate orders for laboratory tests and monitoring related to dialysis.</p> <p>An "Assessment and Negotiated Service Plan Summary," dated 04/10/13, indicated staff provided assistance with bathing and included instructions, "...do not get port wet...needs early [meal] on dialysis days, M (Monday), W (Wednesday),</p>		<p>your consideration.</p> <p>R 217410 IAC 16.2-5-2 € (1-5)</p> <p>Evaluation</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #24 has contracted services with the dialysis unit for treatments independently from the community on an outpatient basis. Resident #24 has been deemed independent and capable of monitoring and adherence to pre and post assessment as evidenced by signed acknowledgement from the dialysis unit. The community has not developed a contractual agreement with the dialysis unit because services rendered are independent from the community and were arranged through the resident. In accordance to our policy and procedure a resident who experiences a change of condition will warrant an assessment by an appropriately licensed nurse along with notification to the resident/responsible party and primary care physician for further directive.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>The Wellness Director conducted a review of the residents' medical</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>F (Friday)...." The service plan lacked documentation in regard to assessing the resident for potential complications related to dialysis and assessment of the dialysis delivery port.</p> <p>Resident #24's record lacked documentation of dialysis services, including, but not limited to, pre and post dialysis vital signs, problems during dialysis, and new orders, for March 18, 22, 27, and 29, 2013 and did not include documentation of dialysis on April 1, 5, and 15, 2013.</p> <p>The "Resident Services Notes," included documentation of the following dates: 03/08/13 at 3:00 p.m., 03/09/13 at 1:30 p.m. and 7:15 p.m., 03/10/13 at 1:30 p.m. and 04/15/2013 at 3 p.m. and 9:20 p.m. The service notes did not indicate assessment or care of the dialysis port and lacked notations in regard to facility assessment of the resident pre and post dialysis.</p> <p>A dialysis center report, dated 03/11/13, indicated pre dialysis blood pressure (BP) of 109/55 and post dialysis BP of 178/80. The "Resident Services Notes" did not indicate the vital signs were monitored upon return to the facility to determine if the</p>		<p>record to verify residents requiring an assessment by way of physician order or upon a change of condition were completed per policy and procedure.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>The Wellness Director and licensed staff were re-educated to our policy and procedure regarding physician orders, change of condition, and Indiana state regulation R 217410 IAC 16.2-5-2 € (1-5) Evaluation.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The Wellness Director and/or Designee will perform a random weekly review of the resident record, incident reports, and physician orders to ensure continued compliance for a period of six months. Findings will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>BP remained elevated.</p> <p>A dialysis center report, dated 04/05/2013 was obtained by the facility via fax on 04/18/2013 at 5:22 p.m. The summary indicated pre dialysis BP of 145/62 and post dialysis BP of 177/105. The "Resident Services Notes" did not indicate the vital signs were monitored upon return to the facility to determine if the BP remained elevated.</p> <p>During an interview on 04/18/2013 at 4:25 p.m., Wellness Director (WD) #1 indicated Resident #24 received dialysis through the port three times weekly. WD #1 indicated the facility did not assess or provide any care to the dialysis port. WD #1 indicated the dialysis center was responsible for assessing and caring for the dialysis port and monitoring vital signs and weight pre and post dialysis. The WD indicated the facility did not have a contract with the dialysis center and did not have specific instructions for care of the resident pre and post dialysis. WD #1 indicated there was not a policy for pre and post assessments when a resident left the facility for medical services.</p> <p>During an interview on 04/19/2013 at</p>		<p>reviewed through the Bennett House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? 6/6/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>10:15 a.m., WD #1 indicated she contacted the dialysis center to obtain copies of dialysis records that were not in Resident #24's record during review on 04/18/2013. The WD indicated future dialysis service records would be sent via fax to the facility instead of relying on getting the documents from the resident/family. WD #1 indicated the dialysis center reported the instructions for care of the resident post dialysis was "the same as for any resident living at home." The WD indicated the facility had not obtained copies of the instructions provided to the resident in regard to dialysis. WD #1 indicated there was not a protocol for assessing the resident upon return from dialysis services. WD #1 indicated Resident #24 was alert and oriented and the facility relied on the resident to report to staff any changes in her condition following dialysis.</p> <p>During an interview on 4/19/2013 at 10:15 a.m., Regional Wellness Director (RWD) #1 stated the facility "charted by exception," and followed the "change of condition" guidelines.</p> <p>A "Change of Condition" policy, dated 01/01/2013 was reviewed on 04/19/2013 at 10:15 a.m. The policy indicated, "...I. The Wellness</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Director, Healthcare Coordinator, or designee is responsible for responding to a resident's change of condition, making appropriate notifications and putting appropriate interventions in place...II. Staff must report to the Wellness Director any observation that indicates a possible change in condition of a resident and must document their observation in the Resident Service Notes...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (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, interview, and record review, the facility failed to ensure a doctor's order was followed for 1 of 5 residents observed for medication administration (Resident #27).</p> <p>Findings include:</p> <p>During an observation of medication administration on 4/18/13, at 10:45 a.m., QMA #1 was observed to administer Oxycodone/Acetaminophen 10/325 mg (milligrams), one tablet po (by mouth), to Resident #27. The medication packet label indicated Oxycodone/Acetaminophen 10/325 mg, one tablet po, every 6 hours as needed for pain.</p> <p>During an interview on 4/18/13, at 10:45 a.m., QMA #1 indicated that Resident #27 was receiving Oxycodone/Acetaminophen 10/325 mg, one tablet po, every 4 hours while</p>	R000241	<p>R 241 – 410 IAC 16.2-5-4 (e) (1) Health Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #27 had no adverse reaction from the incident. A clarification order was obtained by the Wellness Director with the resident's primary care physician. Family and physician were notified of the new orders prior to the survey exit on 4/19/13. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The Wellness Director conducted a review of the residents' medical record to verify that recent orders had been noted and transcribed appropriately to the Medication Administration Record. No other residents were found to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p>	06/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>awake. She indicated that a change of direction needed to be sent to the pharmacy for labeling to indicate such.</p> <p>Record review on 4/18/13 at 11:00 a.m., indicated diagnoses including, but not limited to, depression, constipation, chronic obstructive pulmonary disease, chronic back pain, hypertension, anxiety, hyperlipidemia, allergies, and spinal stenosis.</p> <p>The physician's recapitulation orders, dated 04/01/2013-04/30/2013, indicated an order for Oxycodone 10/325 mg (milligrams) every 4 hours while awake.</p> <p>A physician's order, dated 04/15/2013, indicated Oxycodone 10/325 mg, 1 tablet orally every 6 hours as needed for pain.</p> <p>The Medication Administration Record, (MAR), dated 04/01/2013-04/30/2013, indicated Resident #27 received Oxycodone 10/325 mg, 1 tablet orally every 4 hours while awake at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., from 4/1/13 through the 10:00 a.m. dose on 4/18/13.</p>		<p>The Wellness Director and licensed staff were re-educated to our policy and procedure regarding physician orders and medication management. Staff will implement a 3 way audit tool when new orders are received to ensure accuracy. The Wellness Director and/or Designee will be responsible for ensuring compliance with the Indiana State regulation R241- 410 IAC 16.2 5-4 (e)(1) Health Services.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Wellness Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an interview on 4/18/13, at 11:45 a.m., Wellness Director #1 indicated that she had been off for the last 3 days, and would need to look at staffing schedules to see if a nurse had been there to view and initiate the new order.</p> <p>During an interview on 4/18/13, at 2:35 p.m., Wellness Director #1 indicated that LPN #1 was on duty 4/15/13, saw the new order for Oxycodone on 4/15/13, sent the order to the pharmacy, but did not change the dosage times on the MAR.</p> <p>A policy and procedure for "Physician's Orders" was provided by Wellness Director #1 on 4/18/13, at 12:10 p.m., and identified as their current policy. The policy indicated, but was not limited to, "The Residence must have proper physician's orders before providing assistance with any medication or treatment... Orders for medications and treatments must be transcribed to the MAR."</p>		<p>and/or Designee will perform a random weekly audits of new orders utilizing the 3 way audit tool.</p> <p>Physician orders will be checked against the transcription in the MAR and cross referenced with the medication label to ensure accuracy. The Wellness Director and/or Designee will perform random weekly audits of resident records to ensure new orders are noted and implemented and transcribed appropriately. Findings will be reviewed through the Bennett</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? 6/6/13</p>		