

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 06/08/2012
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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
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R0000	<p>This visit was for the Investigation of Complaint IN00108333.</p> <p>Complaint IN00108333 - Substantiated. State residential deficiencies related to the allegations are cited at R033, R053, R090, R091, and R214.</p> <p>Unrelated residential deficiencies are cited.</p> <p>Survey dates: June 7 and 8, 2012</p> <p>Facility number: 004442 Provider number: 004442 AIM number: NA</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: Residential: 28 Total: 28</p> <p>Census payor type: Other: 28 Total: 28</p> <p>Sample: 6</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p>	R0000	<p>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.</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.

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	Quality review 6/12/12 by Suzanne Williams, RN				

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R0033	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation, interview and record review, the facility failed to ensure the phone number for the Indiana State Department of Health was posted in an area accessible to residents. The facility also failed to ensure other information required to be posted was accessible to residents. The practice had the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>During confidential resident interview on 6/7/12, the interviewee indicated she was</p>	R0033	<p>Citation #1 R 033 410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights -Noncompliance</p> <p>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 moved signage to wheelchair height regarding the most recently known addresses and contact information for required state agencies as indicated by Indiana State regulation R 033</p>	07/30/2012			

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	<p>wheel-chair bound and unable to see signs with addresses and phone numbers of agencies posted above residents' mailboxes in the living room area of the facility.</p> <p>During confidential resident interview on 6/7/12, the interviewee indicated he did not know how he would contact the Indiana State Department of Health to register a complaint.</p> <p>During observation in the living room area of the facility on 6/7/12 at 12:50 p.m., signs with addresses and phone numbers of various agencies were observed posted above the residents' mailboxes out of the line of vision of residents seated in wheel chairs. The address and phone number of the Indiana State Department of Health was not observed to be posted.</p> <p>During interview on 6/7/12 at 1:00 p.m., the Administrator indicated information about the Indiana State Department of Health, including the Complaint Hotline, was not posted in the facility. The Administrator also indicated the signage with other required information was not posted within view of wheel chair bound residents.</p> <p>This state residential tag is related to</p>		<p>410 IAC 16.2-5-1.2(h) (1-2)Residents' Rights. Residents were re-educated as to the location of signage regarding state agency contact information and Bennett house grievance process during resident council meeting.</p> <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? No other residents were found to be affected.</p> <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? The Residence Director and Wellness were re-educated to IndianaState regulation R 033 410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights. The Residence Director and/or Designee will be responsible to ensure continued compliance with the above citation.</p> <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? The Residence Director and/or Designee will perform random</p>				

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	Complaint IN00108333.		<p>weekly walking rounds of the residence to ensure the community has posted signage of State agency contact information at wheel chair height for a period of six months. Findings will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>	

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R0053	<p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on record review and interview, the facility failed to ensure residents were protected from verbal abuse. An allegation of verbal abuse was not reported for two days. When the allegation of verbal abuse was reported, the Abuse/Neglect/Exploitation policy was not followed. The deficient practice affected 1 of 1 resident reviewed related to verbal abuse in a sample of 6. (Resident C) The deficient practice had the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>During confidential resident interview on 6/8/12 in regard to staff treatment of residents, the interviewee indicated, "I don't want to say." The resident had readily engaged in small talk just prior to this response.</p> <p>During confidential resident interview on 6/8/12, the interviewee indicated, "In the past, some of the staff have not been so nice," but now that is not a problem.</p> <p>The employee file for CNA #6 was reviewed on 6/8/12 at 10:40 a.m. The</p>	R0053	<p>Citation #2 R 053 410 IAC 16.2-5-1.2(w) Residents' Rights- Deficiency 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 C was interviewed and indicates she had not been abused by anyone at community. PSA # 6 no longer is employed at community.</p> <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? No other residents were found to be affected. The Wellness Director interviewed residents considered to be interview able as to potential abuse with no findings.</p> <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? The staff at Bennett House were re-educated to our policy and procedure regarding resident abuse. The Wellness Director</p>	07/30/2012			

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	<p>record included a document entitled "Disciplinary Action Report," dated 4/19/12. The report indicated, "Date(s) of Violation 4/15/12" and "Describe what happened: [Name of CNA #6] was witnessed yelling at a resident and telling same resident she was going to die alone cause old and nasty [sic]" The "Disciplinary action being taken:" indicated "First Notice," and "Supervisor comments on meeting (to be completed before employee signs)" indicated, "[Name of CNA #6] needs to be very aware that she does her job in a manner that will not violate any resident's rights. Every resident must be treated with dignity and respect. Copy of resident's rights given."</p> <p>During interview on 6/8/12 at 11:40 a.m., the Wellness Director indicated the resident mentioned in this Disciplinary Action Report was Resident C.</p> <p>During interview on 6/8/12 at 12:15 p.m., the Corporate Nurse Consultant indicated the incident related to the allegation of verbal abuse had been reviewed with the corporate Human Resources Department, and the decision had been made that since it was "one person's word against another," and only those two staff persons were in the building, this was determined not to be abuse. The Corporate Nurse</p>		<p>and Residence Director were re-educated to reporting of any alleged abuse to the appropriate State agencies within 24 hours of the occurrence. The Residence Director and/or Designee will be responsible to ensure that resident abuse policy and procedure is followed with appropriate reporting to state agencies as defined by Indiana State law.</p> <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? The Residence Director and/or Designee will perform random weekly resident interviews for a period of six months to ensure continued compliance with our abuse policy and procedure. Findings will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>				

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	<p>Consultant indicated the Administrator had investigated the allegation, and the Consultant provided two written statements that he indicated constituted the investigation. The first statement, handwritten and signed by CNA #4, was dated 4/17/12 and indicated, "On Sunday night 4/15/12 I witnessed [name of CNA #6] yelling at [name of Resident C] [room number of Resident C]. [Name of Resident C] was dirty and she ([name of CNA #6]) told [name of Resident C] that she was going to die alone cause old and nasty [sic]. There was another resident sitting outside that overheard this conversation [sic] as well." Handwritten below the statement was "received [sic] 4-18-12 9:30 a.m." Also provided was a statement dated 4/18/12 10:24 a.m., and signed by CNA #6 that described her care of the resident and indicated, "...I would never mistreat anybody ever my heart wouldn't let me be that way. I'm trying to advance in this field and abuse is not in my character." Documentation failed to indicate other aspects of an investigation.</p> <p>The Consultant also provided the facility's Abuse/Neglect/Exploitation Policy at this time. The policy indicated, "Any complaint of abuse...must be reported to your Regional Director of Operations immediately....Abuse may be defined as an act by any individual which injures,</p>			

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	<p>exploits or in any way jeopardizes an individual's health, welfare, or safety, including, but not limited to:...Emotionally damaging verbal behavior and harassment....If abuse...is suspected, act immediately to protect the resident from additional harm....Act quickly to gather pertinent information. If an employee is suspected of the abuse, the employee must be suspended pending the outcome of an investigation....A staff person suspected or accused of abuse...should not have access to any resident until the Residence investigates and takes action to assure resident safety....Complete an Incident Report and make appropriate documentation in the Resident Services Notes....Initiate an investigation. All staff on duty at the time of the alleged abuse occurred must be interviewed prior to leaving their respective shift. This applies to all staff, as well as other residents in the area....Upon instruction from your Regional Director of Operations, contact the appropriate State agency as soon as possible during the required reporting timeframe...Notify the resident's family/significant other(s) of the suspected or alleged abuse...."</p> <p>The resident's clinical record was reviewed on 6/8/12 at 10:00 a.m. The record failed to indicate a note in the</p>			

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	<p>Resident Services Notes related to the allegation of verbal abuse. The record failed to indicate the family was notified of the alleged verbal abuse.</p> <p>During interview on 6/8/12 at 12:45 p.m., the Administrator indicated CNA #6 was suspended, and he indicated no documentation indicated this. He indicated if he were not present for this interview, no one would know CNA #6 was suspended. The Administrator indicated an Incident Report had not been completed related to the allegation. He indicated no other staff was available to interview related to the incident, since only CNA #6 and CNA #4 were on duty at the time of the incident. The Administrator indicated he was sure he had interviewed other residents, and he indicated he had maintained no documentation related to the resident interviews. The Administrator indicated the allegation of abuse had not been reported to the state agency.</p> <p>This state residential tag relates to Complaint IN00108333.</p>				

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the Administrator reported an incident of verbal abuse to the Indiana State Department of Health for 1 of 1 resident reviewed related to verbal abuse in a sample of 6 residents. (Resident C) The deficient practice had the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>The employee file for CNA #6 was reviewed on 6/8/12 at 10:40 a.m. The record included a document entitled "Disciplinary Action Report," dated 4/19/12. The report indicated, "Date(s) of Violation 4/15/12" and "Describe what happened: [Name of CNA #6] was witnessed yelling at a resident and telling same resident she was going to die alone cause old and nasty [sic]" The "Disciplinary action being taken:" indicated "First Notice," and "Supervisor comments on meeting (to be completed before employee signs)" indicated, "[Name of CNA #6] needs to be very</p>	R0090	<p>Citation #3 R 090 410 IAC 16.2-5-1.3(g) (1-6) Administration and Management- Deficiency</p> <p>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 C was interviewed and indicates she had not been abused by anyone at community. PSA # 6 no longer is employed at community.</p> <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? No other residents were found to be affected. The Wellness Director interviewed residents considered to be interview able as to potential abuse with no findings.</p> <p>What measures will be put into place or what systemic</p>	07/30/2012			

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	<p>aware that she does her job in a manner that will not violate any resident's rights. Every resident must be treated with dignity and respect. Copy of resident's rights given."</p> <p>During interview on 6/8/12 at 11:40 a.m., the Wellness Director indicated the resident mentioned in this Disciplinary Action Report was Resident C.</p> <p>During interview on 6/8/15 at 12:15 p.m., the facility's Corporate Nurse Consultant provided the facility's Abuse/Neglect/Exploitation Policy at this time. Review of the policy indicated, "Any complaint of abuse...must be reported to your Regional Director of Operations immediately....Complete an Incident Report.....Upon instruction from your Regional Director of Operations, contact the appropriate State agency as soon as possible during the required reporting timeframe...."</p> <p>During interview on 6/8/12 at 12:45 p.m., the Administrator indicated an Incident Report had not been completed, and the allegation of abuse had not been reported to a state agency.</p> <p>This state residential tag relates to Complaint IN00108333.</p>		<p>changes will the facility make to ensure that the deficient practice does not recur? The staff at Bennett House were re-educated to our policy and procedure regarding resident abuse. The Wellness Director and Residence Director were re-educated to reporting of any alleged abuse to the appropriate State agencies within 24 hours of the occurrence. The Residence Director and/or Designee will be responsible to ensure that resident abuse policy and procedure is followed with appropriate reporting to state agencies as defined by Indiana State law.</p> <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? The Residence Director and/or Designee will perform random weekly resident interviews for a period of six months to ensure continued compliance with our abuse policy and procedure. Findings will be reviewed through our Bennett House QA process after six months in order 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</p>				

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R0091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on record review and interview, the facility failed to ensure policy related to allegations of abuse were implemented for 1 of 1 resident reviewed related to allegation of abuse in a sample of 6. (Resident C) The facility failed to ensure: an allegation was reported immediately, an Incident Report was completed, the allegation was investigated completely, an employee was suspended during investigation, documentation was made in the resident's record, the family was notified, and that the allegation was reported to the state agency. The deficient practice had the potential to affect all residents in the facility.</p> <p>Findings include: On 6/8/12 at 12:15 p.m., the Corporate Nurse Consultant provided the facility's Abuse/Neglect/Exploitation Policy. Review of the policy indicated, "Any</p>	R0091	<p>Citation #4 R 091 IAC 16.2-5-1.3(h)(1-4) Administration and Management – Noncompliance</p> <p>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 C was interviewed and indicates she had not been abused by anyone at community. PSA # 6 no longer is employed at community.</p> <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? No other residents were found to be affected. The Wellness Director interviewed residents considered to be interview able as to potential abuse with no</p>	07/30/2012			

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	complaint of abuse...must be reported to your Regional Director of Operations immediately....Abuse may be defined as an act by any individual which injures, exploits or in any way jeopardizes an individual's health, welfare, or safety, including, but not limited to:...Emotionally damaging verbal behavior and harassment....If abuse...is suspected, act immediately to protect the resident from additional harm....Act quickly to gather pertinent information. If an employee is suspected of the abuse, the employee must be suspended pending the outcome of an investigation....A staff person suspected or accused of abuse...should not have access to any resident until the Residence investigates and takes action to assure resident safety....Complete an Incident Report and make appropriate documentation in the resident's Service Notes....Initiate an investigation. All staff on duty at the time of the alleged abuse occurred must be interviewed prior to leaving their respective shift. This applies to all staff, as well as other residents in the area....Upon instruction from your Regional Director of Operations, contact the appropriate State agency as soon as possible during the required reporting timeframe...Notify the resident's family/significant other(s) of the suspected or alleged abuse...."		findings. 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 staff at Bennett House were re-educated to our policy and procedure regarding resident abuse. The Wellness Director and Residence Director were re-educated to reporting of any alleged abuse to the appropriate State agencies within 24 hours of the occurrence. The Residence Director and/or Designee will be responsible to ensure that resident abuse policy and procedure is followed with appropriate reporting to state agencies as defined by Indiana State law. 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 resident interviews for a period of six months to ensure continued compliance with our abuse policy and procedure. Findings will be reviewed through our Bennett House QA process after six months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will				

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	<p>On 6/7/12 at 1:05 p.m., files of state reportable incidents provided by the Administrator were reviewed. The files failed to indicate any reports related to allegations of verbal abuse.</p> <p>The employee file for CNA #6 was reviewed on 6/8/12 at 10:40 a.m. The record included a document entitled "Disciplinary Action Report," dated 4/19/12. The report indicated, "Date(s) of Violation 4/15/12" and "Describe what happened: [Name of CNA #6] was witnessed yelling at a resident and telling same resident she was going to die alone cause old and nasty [sic]" The "Disciplinary action being taken:" indicated, "First Notice," and "Supervisor comments on meeting (to be completed before employee signs)" indicated, "[Name of CNA #6] needs to be very aware that she does her job in a manner that will not violate any resident's rights. Every resident must be treated with dignity and respect. Copy of resident's rights given."</p> <p>During interview on 6/8/12 at 11:40 a.m., the Wellness Director indicated the resident mentioned in this Disciplinary Action Report was Resident C.</p> <p>During interview on 6/8/12 at 12:15 p.m.,</p>		<p>result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? July 30, 2012</p>	

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	<p>the Corporate Nurse Consultant indicated the incident related to the allegation of verbal abuse had been reviewed with the corporate Human Resources Department, and the decision had been made that since it was "one person's word against another," and only two staff persons were in the building, this was determined not to be abuse. The Corporate Nurse Consultant indicated the Administrator had investigated the allegation, and the Consultant provided two written statements that he indicated constituted the investigation. The first statement, handwritten and signed by CNA #4, was dated 4/17/12 and indicated, "On Sunday night 4/15/12 I witnessed [name of CNA #6] yelling at [name of Resident C] [room number of Resident C]. [Name of Resident C] was dirty and she ([name of CNA #6]) told [name of Resident C] that she was going to die alone cause old and nasty [sic]. There was another resident sitting outside that overheard this conversation [sic] as well." Handwritten below the statement was "received [sic] 4-18-12 9:30 a.m." Also provided was a statement dated 4/18/12 10:24 a.m., and signed by CNA #6 that described her care of the resident and indicated, "...I would never mistreat anybody ever my heart wouldn't let me be that way. I'm trying to advance in this field and abuse is not in my character." Documentation failed to</p>			

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	<p>indicate other aspects of an investigation.</p> <p>The resident's clinical record was reviewed on 6/8/12 at 10:00 a.m. The record failed to indicate a note in the Resident Services Notes related to the allegation of verbal abuse. The record failed to indicate the family was notified of the alleged verbal abuse.</p> <p>During interview on 6/8/12 at 12:45 p.m., the Administrator indicated CNA #6 was suspended, and he indicated no documentation verified this. He indicated if he were not present for this interview, no one would know CNA #6 was suspended. The Administrator indicated an Incident Report had not been completed related to the allegation. He indicated no other staff was available to interview related to the incident, since only CNA #6 and CNA #4 were on duty at the time of the incident. The Administrator indicated he was sure he had interviewed other residents, and he indicated he had maintained no documentation related to the resident interviews. The Administrator indicated the allegation of abuse had not been reported to a state agency.</p> <p>This state residential tag relates to Complaint IN00108333.</p>			

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure staff with first aid training were on site at all times. The deficient practice had the potential to affect all residents at the facility.</p> <p>Findings include:</p> <p>On 6/8/12 at 10:40 a.m., employee files were reviewed.</p>	R0117	<p>Citation #5 R 117 410 IAC 16.2-5-1.4(b) Personnel- Deficiency 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 Wellness Director scheduled a class for CPR/First Aid certification for Bennett House staff to ensure we have at least one awake staff member on</p>	07/30/2012			

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	<p>The file for CNA #6 indicated the employee was hired on 4/3/12. The file did not include record of certification in CPR and first aid.</p> <p>The file for CNA #4 indicated the employee was hired on 11/28/11. The filed did not include record of certification in first aid.</p> <p>During interview on 6/8/12 at 12:45 p.m., the Administrator indicated CNA #6 and CNA #4 did not have first aid certification.</p> <p>During interview on 6/8/12 at 3:35 p.m., the Administrator indicated CNAs #6 and #4 were the only staff on site during night shift on 4/28-4/29 and 4/29-4/30/12, and did not have first aid certification. During interview on 6/8/12 at 3:50 p.m., the Administrator indicated CNAs #6 and #4 were also the only staff on site for night shift on 4/15/12.</p>		<p>site with current CPR/First Aid certification on site at all times.</p> <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? No other residents were found to be affected.</p> <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? The Wellness Director and Residence Director were re-educated to the Indiana state ruling R 117 410 IAC 16.2-5-1.4(b)Personnel. The Wellness Director will be responsible to ensure Bennett House has at least one awake staff member with current certification on site at all times.</p> <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? The Wellness Director and/or Designee will perform a random weekly review of staff schedule and employee files for a period of six months to ensure continued compliance with R 117 410 IAC 16.2-5-1.4(b)Personnel. Findings</p>				

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			<p>will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>		

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R0123	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <ol style="list-style-type: none"> (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. <p>Based on record review and interview, the facility failed to ensure personnel files included current certification for 1 of 2 personnel files reviewed for Certified Nursing Assistants formerly employed by the facility. The deficient practice had the potential to affect all residents at the facility. (CNA # 6)</p> <p>Findings include:</p> <p>The employee file for CNA #6 was reviewed on 6/8/12 at 10:40 a.m.</p> <p>Documentation in the file failed to</p>	R0123	<p>Citation #6 R 123 410 IAC 16.2-5-1.4(h) (1-10) Personnel-nonconformance</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected. Staff #6's record was reviewed with current licensure verification placed within their employee file.</p> <p>How the facility will identify other residents having the</p>	07/30/2012			

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	<p>indicate a certification of the employee as a Certified Nursing Assistant. Documentation indicated the employee completed a Nurse Aide Training Program on 11/23/11 and completed the Indiana State Department of Health Nurse Aide Competency Evaluation on 1/19/12.</p> <p>An Assisted Living Concepts, Inc. Personnel Action Form (PAF) indicated the employee was terminated on 6/4/12 with last day worked of 5/27/12, and she was not eligible for rehire.</p> <p>During interview on 6/8/12 at 11:40 a.m., the Wellness Director indicated the employee was terminated because of "no call, no show."</p> <p>During interview on 6/8/12 at 12:45 p.m., the Administrator indicated he had contacted the Indiana State Department of Health and had been able to locate documentation that indicated CNA #6 had certification as a Certified Nursing Assistant. He indicated she had a name change, and he provided a copy of an on-line print out of a CNA certification, dated as issued on 1/19/12, with the first name but a different last name of CNA #6 as indicated on facility files. He indicated the employee's hire date was 11/28/11. He indicated the file had not included the documentation of CNA certification.</p>		<p>potential to be affected by the same deficient practice and what corrective action will be taken? No resident's were found to be affected. Staff files were reviewed with verification of current licensure placed within their employee record. The Residence Director and/or Designee will be responsible to ensure a copy of staffs' current license is placed within the employee file.</p> <p>What measures will be put in 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 Indiana State regulation R 123 410 IAC 16.2-5-1.4(h) (1-10) Personnel. The Residence Director developed an audit tool to assist with employee file information in effort to maintain future compliance.</p> <p>How the corrective action will be monitored to endure the deficient practice will not recur i.e., what assurance program will be put into place? The Residence Director and/or Designee will conduct a random monthly audit of personnel files to ensure current license and certifications are present for the next six months. Findings will be</p>				

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			<p>reviewed through our Bennett House QA process after six months in order 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 July 30, 2012</p>		

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R0214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure a licensed nurse provided for the nursing needs after falls, and related to health complaints for 3 of 6 residents reviewed related to health care needs in a sample of 6. (Resident C, Resident D, and Resident F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 6/8/12 at 10:00 a.m.</p> <p>Resident Service Notes (RSN) indicated the following:</p> <p>7/3/11 at 5:45 a.m., "Entered resident's room, found resident on floor next to her bed. Said she had been there twenty minutes. Contacted WD [Wellness Director]. B/P [blood pressure] 140/70." The note was signed by a CNA. Documentation failed to indicate further assessment of the resident. The next RSN was dated 7/10/11.</p>	R0214	<p>Citation #7 R 214 410 IAC 16.2-5-2 (a) Evaluation-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected. Residents C, D, and F had there service plans updated to reflect the resident's scheduled/unscheduled needs as well as interventions to minimize the risk for future falls with injury. 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 resident's were found to be affected. Residents What measures will be put in 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 Indiana State regulation R 214 410 IAC 16.2-5-2 (a)Evaluation and our policy and procedure concerning</p>	07/30/2012			

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	<p>9/2/11 4:30 p.m., "Called to resident's room by CNA who reported resident on floor....This writer went to resident's room where I found her in bed lying on her back. Asked resident was anything hurting. Looked over resident extremely well didn't notice anything abnormal, then asked [name of resident] if she could stand up at bedside, she stood up @ bedside then asked if she could take any steps. Upon trying take steps, I noticed resident having trouble and c/o [complained of] pain to [arrow pointing down - lower] R [right] leg...." The note indicated the WD (Wellness Director) was contacted and instructed to send the resident to the hospital for evaluation. The note was signed by QMA #2.</p> <p>12/19/11 1:00 p.m., "Resident found on floor in room at bedside, lying on right side, playing with baseboard. V/S [vital signs] 136/60 [blood pressure] P [pulse] 74 R [respirations] 20 T [temperature] 98.2. Resident stated she fell off bed. Using wheel chair as structure, resident was able to lift herself into chair without assistance. No injuries noted...." The note was signed by QMA #2.</p> <p>1/9/12 at 9:00 a.m., "Staff said resident has loose stool [symbol for with] upset stomach. Notified [name of medical care provider]...." The note indicated an order</p>		<p>resident fall response. The Wellness Director, licensed nurse, or EMT will provide an assessment of residents who experience a change of condition and/or fall. The Wellness Director is available 24/7 for telephonic triage to provide directive during acute situations requiring assessment of an individual to make appropriate arrangements. How the corrective action will be monitored to endure the deficient practice will not recur i.e., what assurance program will be put into place? The Wellness Director and/or Designee will conduct a random weekly audit of incident reports and resident service notes to ensure residents requiring assessments are completed by appropriate licensed medical professionals when deemed necessary based on their clinical situation for the next six months. Findings will be reviewed through our Bennett House QA process after six months in order 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 July 30, 2012</p>				

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	<p>for Immodium and phenergan was sent by the medical care provider. The note was signed by QMA #2. Documentation failed to indicate a nursing or medical assessment of the resident.</p> <p>The next RSN was 1/11/12 (untimed) and signed by QMA #2 and indicated, "Follow-up check on resident. [Symbol for no] c/o loose stools noted. Resident eating and drinking well; has resumed coming back down to dining area."</p> <p>2/27/12 at 9:15 p.m., "Upon doing pre-bed rounds, I entered Room [number of resident's room] and found [name of resident] on the floor asleep. She awoke, told me she fell from the bed and asked me to assist. Did not attempt to move resident, but did ask resident if she could help herself. She said she was unable to do so. Phoned [name of ambulance service] to assist and assess resident." The note was signed by CNA #6. Documentation failed to indicate assessment of the resident. The next note was 2/28/12 at 10:00 a.m. and indicated the Wellness Director notified the family and physician of the fall.</p> <p>3/29/12 at [illegible number]:33 p.m., "Doing shift change from 2nd to 3rd shift staff & myself [sic] found resident on floor along the side of the bed. Phoned</p>						

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	<p>EMS [Emergency Medical Service] for assess and assist." Documentation failed to indicate assessment of the resident.</p> <p>The resident's Assessment and Negotiated Service Plan Summary, dated 11/29/11, indicated, the resident needed assistance with: medication administration, diabetes management, bathing, toileting, including reminders and assistance with protective undergarments, dressing and grooming, mobility, with history of falls, and orientation/behavior/safety.</p> <p>2. The clinical record for Resident D was reviewed on 6/7/12 at 11:40 a.m.</p> <p>Resident Services Notes for 2/14/12 at 10:00 a.m., signed by the Wellness Director, indicated a swallow study was scheduled, and a home health agency was notified for speech therapy evaluation related to mild cough without eating or drinking. The note indicated, "...Sputum clear. Will continue to monitor for s/sx [signs and symptoms] aspiration."</p> <p>RSN for 2/20/12 at 9:00 a.m., indicated, "Resident c/o [complained of] cough & congestion with yellow sputum, runny nose. This writer phoned [name of Nurse Practitioner (NP)]..." The RSN indicated the NP sent orders for an antibiotic. The note was signed by QMA #2.</p>			

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	<p>Documentation failed to indicate the resident was assessed related to the cough, congestion, yellow sputum, and runny nose.</p> <p>3. The clinical record for Resident F was reviewed on 6/7/12 at 1:55 p.m.</p> <p>The record indicated the following Resident Services Notes:</p> <p>The first note after the resident's admission on 3/30/12 was dated 4/13/12 at 10:25 a.m., and indicated, "Resident c/o cough & congestion, faxed [name of resident's physician] with concern waiting for reply." The note was signed by QMA #2. Documentation failed to indicate the resident was assessed related to the cough and congestion.</p> <p>The next RSN was dated 4/14/12 at 10:40 a.m. and indicated the resident's daughter was contacted about her whereabouts, since the facility received a call from the local hospital to verify the resident's current medications. The note indicated the resident was contacted at her husband's apartment phone number, and when contacted indicated that "...she and her husband proceeded to [name of local hospital] at 12:00 a.m. with c/o chronic coughing..." A hospital "Discharge Instructions" sheet, dated 4/14/12,</p>			

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	<p>indicated the resident was to complete her antibiotic for acute bronchitis.</p> <p>Resident Services Notes, dated 4/26/12 at 2:00 p.m., indicated information related to a change in physician's orders for the resident's anticoagulation medication. The note was followed by seven blank lines, followed by a note, dated 4/28/12 at 7:45 a.m., indicating, "Report given to nurse resident found on floor in bedroom. [Symbol for no] complaints of pain noted this a.m. [morning] Some redness noted bilateral lower extremities r/t wheel chair electric flipped on legs. Redness noted to left outer upper arm with +1 edema noted. Resident refused to go to hospital with EMT [Emergency Medical Technicians] when they arrived to get her up off floor...." The next RSN for 4/28/12 (illegible time) indicated the resident left with her husband to have x-rays at the hospital Documentation failed to indicate any information about the resident's being found on the floor between 4/26/12 at 2:00 p.m. and 4/28/12 at 7:45 a.m., or that the resident had been assessed during that time.</p> <p>An Emergency Department report, dated 4/29/12 (sic) indicated, "History of present illness: ...The patient...states she fell out of her bed, off the side of her bed, this morning at around 2:00 o'clock. She</p>			

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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
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	<p>states that around 5 o'clock somebody helped her back up. She states she bumped her left ankle and left forearm in the fall...." A radiology report for x-ray of the left ankle, dated 4/29/12, indicated, "Impression: 1. Diffuse soft tissue swelling and probably small joint effusion..." RSN for 4/29/12 at 10:45 a.m., indicated the resident was in her room with bilateral legs and left arm elevated related to edema. Documentation was lacking related to further assessment of the extremities.</p> <p>The next RSN was for 5/4/12 at 11:30 a.m., indicated, "Resident found in room on floor yelling 'Help' states she slipped off side of bed while trying to put pants on. [Symbol for no] complaints of pain noted. Resident was able to lift herself back onto bed; then in mobile chair....Left arm noted bruising from prior fall." The note was signed by QMA #2. Documentation was lacking related to further assessment after the fall.</p> <p>The next RSN was for 5/10/12 at 9:00 a.m., and indicated, "Resident found on floor in apartment stated she slipped off side of bed and needed 15 minutes until she was able to re-lift herself. [Symbol for no] complaints of injury or pain noted. Resident was finally able to pull herself up from floor to chair." This note was</p>			

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	<p>signed by QMA #2. Documentation was lacking related to further assessment after the fall.</p> <p>The next RSN was for 5/11/12 at 9:40 a.m., and indicated, "Resident found on floor inside apartment lying on left side. She stated her legs became weak and she just couldn't make it over to her mobile chair. [Symbol for no] complaints of pain; R [right] middle toe cut. EMS called for lift and assist [symbol for no] transport; Resident and husband then left facility for meeting." The note was signed by QMA #2. Documentation was lacking related to further assessment after the fall.</p> <p>During interview on 6/7/12 at 3:10 p.m., the Wellness Director indicated if a nurse is not in the facility to assess resident at the time of a fall, 9-1-1 is called so a medical professional would assess the resident. During interview at this same time, the Administrator indicated staff was instructed to call 9-1-1 so that EMTs (Emergency Medical Technicians) could be paid for the trip. The Administrator indicated if the facility just called a non-emergency number to help get the resident up from the floor, the emergency service could not charge for the service.</p> <p>During interview on 6/8/12 at 2:40 p.m.,</p>						

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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
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	<p>the Administrator indicated the Wellness Director is on-call 24 hours a day, seven days a week for triage. He indicated she carries a cell phone, and she can call a LPN who lives close by to assist as needed when non-licensed staff are caring for residents. If the nurse is unavailable, the Wellness Director could call the Corporate Nurse Consultant to assist with finding someone to come in. During interview on 6/8/12 at 3:50 p.m., in regard to assessment information provided by the emergency services, the Administrator indicated the emergency service provides the facility no documentation related to their assessment of a resident after a fall. The Administrator indicated, "They will not give documentation."</p> <p>The facility's policy for Resident Fall Response was provided by the Administrator on 6/7/12 at 4:00 p.m. The policy included, but was not limited to, "ASSESS SITUATION...2. Do not move the resident.... An evaluation of pain or injury is needed first....3. Take vital signs (B/P, pulse, respirations)...4. Perform a brief check of the resident to include feeling elbows, shoulders, back, hips, and knees.... If the situation is a clear medical emergency (e.g. extreme pain, profuse bleeding), call 9-1-1 immediately then proceed with the following until help arrives. PROVIDE NEEDED FIRST</p>			

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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150
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	<p>AID/CPR (IF REQUIRED BY STAT REGULATIONS)...[for not a clear medical emergency] SUMMON ASSISTANCE....2. Call the Wellness Director to notify him/her of the fall and report all observations and information reported by the resident. Based on this information, the Wellness Director will: (three bullet points) -Decide that transporting the resident to the hospital is not necessary. If so, ask for additional instruction; -Direct staff to call 9-1-1...; -Direct staff to arrange non-emergency transportation to the hospital.... 3. If unable to reach the Wellness Director or Residence Director, call 9-1-1 immediately...." The policy failed to indicate 9-1-1 should be called for assessment and assistance if a nurse was not in the building.</p> <p>This state residential tag is related to Complaint IN00108333.</p>			

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R0241	<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 record review and interview, the facility failed to ensure medication was administered as ordered by the physician for 1 of 6 residents whose medications were reviewed in a sample of 6. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 6/7/12 at 1:30 p.m.</p> <p>The Assessment and Negotiated Service Plan Summary, dated 11/29/11, included, but was not limited to: "Notes: Family setting up meds [medications] (1 wk [week] at a time) Resident will be self administering."</p> <p>Resident Services Notes for 4/18/12 at 12 noon, indicated, "Resident c/o [complained of] stomach pain and constipation. This writer gave her laxative and prune juice...." The note was signed by QMA #2.</p>	R0241	<p>Citation #8 R 241 410 IAC 16.2-5-4(e)(1) Health Services Offense 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 B's medications were reviewed and verified with the primary care physician. Residents B's service level assessment was reviewed and updated to reflect the resident's provisions of nursing care and to provide for his/her scheduled/unscheduled needs. 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. The Wellness Director and/or Designee will continue to review resident's service level assessment and physician orders to ensure medications are administered as ordered by the physician. The Wellness Director</p>	07/30/2012			

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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
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	<p>The record lacked documentation of an order for the laxative.</p> <p>During interview on 6/8/12 at 10:50 a.m., the Wellness Director indicated the resident did not have a physician's order for a laxative. She indicated maybe the family had brought in a laxative which the resident had at the bedside and the QMA had administered that to her.</p>		<p>and/or Designee will be responsible to ensure continued compliance with the above citation. 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 licensed staff And QMA's were re-educated by the Wellness Director as to physicians orders, service plans, and scope of practice. The Wellness Director will be responsible to ensure continued compliance with Indiana state regulation R 241 410 IAC 16.2-5-4(e)(1) Health Services. 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 perform a random weekly review of physician orders and service plans for a period of six months to ensure continued compliance. Findings will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>				

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NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN 47150			
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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure the resident's record was complete and accurate for 2 of 6 sampled residents reviewed related to documentation in the clinical record. (Residents E and F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 6/7/12 at 1:55 p.m.</p> <p>Resident Services Notes (RSN), dated 4/26/12 at 2:00 p.m., indicated information related to a change in physician's orders for the resident's anticoagulation medication. The note was followed by seven blank lines, followed by a RSN, dated 4/28/12 at 7:45 a.m., indicating, "Report given to nurse resident found on floor in bedroom. [Symbol for no] complaints of pain noted this a.m. [morning] Some redness noted bilateral lower extremities r/t wheel chair electric</p>	R0349	<p>Citation #9 R 349 410 IAC 16.2-5-8.1 (a)(1-4) Clinical Records-Noncompliance 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 F no longer resides at Bennett House. Resident E was assessed by a licensed medical professional EMT prior to being transported out of the community. Bennett House was unable to obtain records of event however have re-educated staff as to our documentation policy and procedure.</p> <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? No other residents were found to</p>	07/30/2012			

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	<p>flipped on legs. Redness noted to left outer upper arm with +1 edema noted. Resident refused to go to hospital with EMT [Emergency Medical Technicians] when they arrived to get her up off floor...."</p> <p>During interview on 6/7/12 at 3:10 p.m., the Wellness Director indicated documentation in the residents' clinical records was "by exception," but that it was not the facility's policy to leave blank spaces in the notes for staff to go back and fill in.</p> <p>2. The clinical record for discharged Resident E was reviewed on 6/8/12 at 12:00 p.m. The record indicated the following notes, signed by QMA #2: "3/29/12 6:30 p.m."Resident transported to [name of local hospital] via [name of ambulance service]. Resident leaning to the left, tongue deviates slightly to L [left], less strength from L hand grasp, some confusion and L leg slightly weaker than R. Phoned [name of resident's physician] and left message to concern per [name of former Wellness Director] whom was present to assess resident. [Name of resident's physician] phoned back @ 5:15 p.m. and said if family wants resident sent to ER [emergency room] it's o.k. with him. V/S [vital signs] 120/76 [blood pressure] 76 [pulse] 22</p>		<p>be affected.</p> <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? The licensed staff were re-educated by the Wellness Director as to our policy and procedure concerning documentation, scope of practice, and fall response.</p> <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? The Wellness Director and/or Designee will perform a random weekly audit of Incident reports and service notes to ensure continued compliance with the above citation. Findings will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>				

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	<p>[respirations] 98.7 [temperature]."</p> <p>Resident Services Notes failed to indicate the assessment by the Wellness Director whom this note mentioned was present to assess.</p> <p>The facility's policy entitled "Documentation" was provided by the Wellness Director on 6/8/12 at 10:35 a.m. The policy included, but was not limited to, "...The Resident Service Notes (RSN) provide a record of health-related issues for each resident....It is essential that staff document observations and occurrences accurately and as soon as possible after they occur....All staff should use the RSN to document observations and occurrences....Do not leave blank spaces or lines between entries...."</p>				

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R0352	<p>410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the clinical record included documentation of services provided for 1 of 3 residents whose discharge records were reviewed in a sample of 6. (Resident G)</p> <p>Findings include:</p> <p>The clinical record for Resident G was reviewed on 6/7/12 at 2:35 p.m.</p> <p>The record indicated a Service Assessment/Negotiated Service Plan and Admission Orders and Plan of Care, both dated 4/24/12.</p> <p>Resident Services Notes, dated 4/26/12 at 7:45 p.m. and signed by QMA #2, indicated, "Resident arrived to facility with family members via automobile. Bringing the remaining of her belongings. Resident walked in facility using cane. V/S [vital signs] 160/73 [blood pressure] 73 [pulse] 20 [respiration] 97.6 [temperature]."</p>	R0352	<p>Citation #10 R 352 410 IAC 16.2-5-8.1 (a)(1-4) Clinical Records-Noncompliance 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 G no longer resides at Bennett House. Resident G was discharged on 6/2/2012. 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 licensed staff were re-educated by the Wellness Director as to our policy and procedure concerning documentation and discharge process. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</p>	07/30/2012

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 06/08/2012	
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>No other Resident Services Notes were indicated, and no documentation indicated that the resident was discharged from the facility.</p> <p>The Move-out Activity Summary by House, provided by the Administrator on 6/7/12 at 10:25 a.m., indicated the resident was discharged from the facility on 6/2/12.</p> <p>During interview on 6/7/12 at 3:10 p.m., the Wellness Director (WD) indicated she did not know why there were no notes for the resident, including a discharge note. The Wellness Director indicated there were changing family dynamics, such as the resident had changed her Power of Attorney (POA) from her son to her daughter. The WD indicated the facility had not really provided any services for the resident, since she could care for herself and administered her own medications. She indicated the family had simply moved the resident out of the facility. The WD indicated the information about the family dynamics, change in POA and discharge from the facility were not indicated in the record.</p>		<p>assurance program will be put into place? The Wellness Director and/or Designee will perform a random weekly audit of transfer/discharge binder and documentation in the service notes to ensure continued compliance with the above citation. Findings will be reviewed through our Bennett House QA process after six months in order 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? July 30, 2012</p>				