

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 02/02/2012
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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 a State Residential Licensure Survey.</p> <p>Survey dates: January 31, February 1 and 2, 2012</p> <p>Facility number: 004442 Provider number: 004442 AIM number: NA</p> <p>Survey team: Dottie Navetta, RN-TC Gloria J. Reisert, MSW Donna Groan, RN (1/31, 2/1/2012)</p> <p>Census bed type: Residential: 29 Total: 29</p> <p>Census payor type: Other: 29 Total: 29</p> <p>Sample: 07 Supplemental Sample: 22</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 7, 2012 by Bev Faulkner, RN</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>	
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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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R0045	<p>(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:</p> <p>(A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:</p> <p>(i) The resident.</p> <p>(ii) A family member of the resident if known.</p> <p>(iii) The resident ' s legal representative if known.</p> <p>(iv) The local long term care ombudsman program (for involuntary relocations or discharges only).</p> <p>(v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.</p> <p>(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.</p> <p>(vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).</p> <p>(B) Record the reasons in the resident ' s clinical record.</p> <p>(C) Include in the notice the items described in subdivision (9).</p> <p>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.</p> <p>(8) Notice may be made as soon as practicable before transfer or discharge when:</p> <p>(A) the safety of individuals in the facility</p>			

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	<p>would be endangered;</p> <p>(B) the health of individuals in the facility would be endangered;</p> <p>(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;</p> <p>(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or</p> <p>(E) a resident has not resided in the facility for thirty (30) days.</p> <p>(9) For health facilities, the written notice specified in subdivision (7) must include the following:</p> <p>(A) The reason for transfer or discharge.</p> <p>(B) The effective date of transfer or discharge.</p> <p>(C) The location to which the resident is transferred or discharged.</p> <p>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .</p> <p>(E) The name of the director and the address, telephone number, and hours of</p>			
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	<p>operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.</p> <p>Based on record review and interview, the facility failed to ensure a Transfer/Discharge form was prepared prior to residents leaving the facility, which included the reason for the transfer, the location to where the residents were going, and the date of the transfer. The facility also failed to place a copy of the notice in the residents' clinical records, and ensure the residents were aware of the right to appeal the discharge via an appeal form. This deficient practice affected 2 of 2 discharged residents in a sample of 7 residents. (Residents #6 and 7)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #6 on 1/31/2012 at 12:05 p.m., indicated the resident was admitted to the facility on 10/27/2011 and discharged on 12/2/2011. Diagnoses included, but were not limited to, hypertension, fatigue, and chronic obstructive pulmonary disease.</p>	R0045	<p>Citation #1 R 045 410 IAC 16.2-5-1.2(r) (6-9) 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. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director, Residence Director, and staff were re-educated to our policy and procedure regarding resident transfer/discharge and the Indiana state regulation 410 IAC 16.2-5-1.2(r) (6-9) Resident Rights. The Wellness Director will be responsible to ensure residents requiring a transfer and</p>	03/16/2012			

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	<p>Documentation was lacking of a Transfer/Discharge notice having been completed prior to the resident being transfer to another facility.</p> <p>2. Review of the clinical record for Resident #7 on 1/31/2012 at 12:40 p.m., indicated the resident had diagnoses which included, but were not limited to: hypothyroidism, chronic kidney disease, hypertension and Alzheimer disease and was discharged on 11/4/2011.</p> <p>Documentation was lacking of a Transfer/Discharge notice having been completed prior to the resident being transfer to another facility.</p> <p>During an interview with the Regional Director of Quality and Care Management and the Administrator on 1/31/2012 at 2:30 p.m., they indicated they were not aware a Transfer/Discharge Notice had to be completed when residents were discharged.</p>		<p>or discharge will have the necessary Transfer/Discharge form prepared prior to the residents leaving the community, which includes the reason for transfer/discharge, the location to which the resident is going, and the date of transfer. The Wellness Director and/or Designee will also be responsible to ensure a copy of the notice is placed in the resident record, and ensure the resident was aware of the right to appeal via an appeal form. 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 residents transferred or discharged from the community to ensure the necessary Transfer/Discharge paperwork is completed with a copy placed into the residents record for a period of six months to ensure continued compliance. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>				

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R0153	<p>(j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.</p> <p>Based on observation, record review and interview, the facility failed to ensure that oxygen tanks were secured in a resident's apartment and there was no oxygen in use sign on door. This affected 1 of 2 rooms observed with oxygen in use. (Resident # 3)</p> <p>Findings include:</p> <p>On 1/31/2012 at 9:00 a.m., during initial tour it was observed that Resident # 3's apartment did not have a oxygen in use sign on the outside of the door.</p> <p>During initial tour and in an interview with QMA (Qualified Medication Aide) she indicated, that Resident # 3 uses oxygen when needed.</p> <p>On 2/1/2012 at 8:50 a.m., upon entrance of Resident # 3's apartment room it was observed that 5 oxygen tanks were not secured in a container or crate and were free standing at the end of the kitchen counter.</p>	R0153	<p>Citation #2 R 153 410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards – 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 #3's durable medical company was contacted and delivered appropriate storage crates to ensure the oxygen tanks were secured. Resident #3 also had an "oxygen in use" signage posted outside his/her door. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated to the Indiana State ruling 410 IAC 16.2-5-1.5(j) Sanitation and Safety regarding oxygen storage. The Wellness Director and/or Designee will be responsible to ensure residents</p>	03/16/2012			

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	<p>On 2/1/2012 at 9:40 a.m., record review of the facility's policy and procedure on oxygen storage and safety procedures indicated, but not limited to; "2. Residents using oxygen must have an "Oxygen IN Use" sign posted in a prominent place, preferably on exterior door or wall of apartment". "4. If oxygen cylinders are in use, they must be stored properly and secured in an upright position. They should be maintained in a crate or anti-tip container or should be chained to the wall". "5. Oxygen cylinders not in use must be stored in an area.....or the chance of accidental damage to the stem. Do not leave tanks free standing..... Cylinders must be secured individually".</p> <p>On 2/1/2012 at 1:00 p.m., in an interview with the Administrator he indicated he was not aware that according to the policy and procedure he was responsible for "ensuring proper storage of all flammable and combustible material."</p>		<p>with oxygen therapy have appropriate signage posted outside their rooms with appropriate storage of oxygen tanks in order to maintain compliance with the above residential ruling. 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 random weekly rounds of Resident rooms who are receiving oxygen therapy to ensure continued compliance with safety and sanitation standards regarding oxygen signage and storage for a period of six months. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>				

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R0214	<p>(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>A. Based on record review and interview the facility failed to ensure that after a fall the resident was assessed by the Wellness Director according to facility policy and procedure. This affected 1 of 7 Residential residents reviewed for falls. (Resident # 1)</p> <p>B. Based on record review and interview, the facility failed to ensure a semi-annual assessment was completed for 1 of 7 residents reviewed for semi-annual assessments in a sample of 7 residents. (Resident #7)</p> <p>Findings included:</p> <p>A. On 1/31/2012 at 10:00 a.m., Resident # 1's clinical record was reviewed and included diagnoses, but not limited to; hypertension (high blood pressure), dementia, cerebral vascular accident (stroke).</p> <p>Review of the Resident Services Notes, dated 6/1/2011 [no time], "Late entry:</p>	R0214	<p>Citation#3 R 214 410 IAC 16.2-5(a) Evaluation – 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 #7 no longer resides at the Bennett House. Resident #1 was assessed by the Wellness Director utilizing the Service Level Assessment and Negotiated Service Plan as to this clients licensed and unlicensed needs and updated to reflect interventions to minimize the risk for 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 other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director, Residence Director, and staff were re-educated as to our policy and procedure regarding fall</p>	03/16/2012			

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	<p>Resident put on call light went to check on her and she was on the bathroom floor. Helped her up she had scratched up her elbow. Elbow was bandaged up."</p> <p>On 1/31/2012 at 11:00 a.m., in an interview with Regional Director of Quality and Care Management he identified the signature as a Certified Nursing Aide (CNA) no longer employed.</p> <p>On 1/31/2012 at 12:00 p.m., record review of the policy and procedure related to "RESIDENT FALL RESPONSE ASSESS SITUATION" "2. Do not move the resident.....3. Take vitals signs....Assess residents discomfort. 4. Perform a brief check of the resident to include feeling elbows, shoulders, back, hips, and knees.</p> <p>On 2/1/2012 at 2:30 p.m., record review of the CNA specific tasks if resident falls indicated, but was not limited to; "1. Check for visible signs of injury or illness. 2. Check the resident's vital signs. 3. Ask the resident if they hit their head. 4. Call the Wellness Director and follow his/her directions." "After every incident: 1. Document incident in Resident Service Notes. Document emergency care given, response, outcome, and which individual were notified. 2. Complete incident report and distribute according to policy. 3.</p>		<p>management as well as the Indiana state ruling R 214 410 IAC 16.2-5(a) Evaluation. The Wellness Director and/or Designee will ensure residents are appropriately evaluated as indicated within our policy and procedure. 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 random weekly review of incident reports and resident service notes for a period of six months to ensure continued compliance. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>				

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	<p>Before the end of the shift the incident occurred on, the Wellness Director will notify the Regional Director of Quality and Clinical Services of incident according to policy...."</p> <p>Documentation was lacking that the facility followed their policy and procedures related to falls and taking vitals, response, outcome and follow up and that the Wellness Director had been called or notified.</p> <p>On 1/31/2012 at 10:45 a.m., in an interview with Regional Director of Quality and Care Management he indicated that it was "not a complete assessment after a fall."</p> <p>B. Review of the clinical record for Resident #7 on 1/31/2012 at 12:40 p.m., indicated the resident had diagnoses which included, but were not limited to: hypothyroidism, chronic kidney disease, hypertension and Alzheimer disease.</p> <p>Review of the most recent semi-annual assessment located in the record indicated a date of 1/17/2011.</p> <p>During an interview with the Regional Director of Quality and Care Management on 1/31/2012 at 1:30 p.m., he indicated he was unable to locate the resident's semi-annual assessment that was</p>			
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	<p>supposed to have been completed in July 2011. He indicated the last assessment completed was dated 1/17/2011 and that the assessments were supposed to be done every six months.</p> <p>During an interview with the Corporate Director on 2/2/2012 at 1:30 p.m., at the final exit meeting, she indicated she had contacted the main corporate office and the last semi-annual in the computer system was completed on 2/25/2011.</p>			
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R0273	<p>(f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, record review and interview, the facility failed to ensure that foods outdated in refrigerator were thrown out and that a box of long grain rice was secured after use and that leftovers placed in refrigerator were dated. This had the potential to affect 29 residents currently residing at facility.</p> <p>Findings include:</p> <p>On 1/31/2012 at 9:00 a.m., during the initial tour of the kitchen and pantry there was a blue bag of long grain rice observed open to the air and inside of a 25 lb. (pound) box marked long grain rice.</p> <p>On 1/31/2012 at 9:15 a.m., in an interview with the DM (Dietary Manager) # 1, she indicated, that the rice was used last night at supper and should have been tied back up.</p> <p>1/31/2012 at 9:20 a.m., upon observation of the middle refrigerator in kitchen it was found to have a 5 lb. container of lowfat cottage cheese 1/3 full, dated as opened on 11/16/2011 and with a manufacturer expiration of 12/12/2011; a 5 lb. container</p>	R0273	<p>Citation# 4 R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - 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. All items of concern were discarded upon notification during survey. 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 Dining Service Coordinator and kitchen staff were re-educated to our policy and procedure regarding proper food storage and discarding of outdated food items as referenced by Indiana State regulation R 273} 410 IAC 16.2-5-5.1(f) Food and Nutritional Services. The Dining Service Coordinator, Residence Director and/or Designee will be responsible to ensure continued compliance with this residential</p>	03/16/2012			

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	<p>of lowfat cottage cheese unopened with a manufacturer expiration of 12/12/2011; a 5 lb. container of sour cream 3/4 full, dated as opened on 11/16/2011 and with a manufacturer expiration date of 1/9/2012; a 5 lb. container of sour cream 1/3 full dated as opened on 12/7/2011 and with a manufacturer expiration of 1/23/2012, a 5 lb. container of sour cream 1/2 full, dated as opened on 11/20/2011 and with a manufacturer expiration of 1/23/2012, and three 5 lb. containers of sour cream unopened with a manufactures expiration of 1/9/2012.</p> <p>A 4 quart container of mixed fruit, 3/4 full; a 4 quart container 1/4 full with yellow pudding like substance; a full 4 quart container of corn chowder identified by DM # 1; 5 pieces of yellow cake with white frosting and a small container of soup like substance lacked a date when placed in refrigerator.</p> <p>On 1/31/2012 at 9:30 a.m., in an interview with the DM # 1 she indicated the mixed fruit and pudding like substance was used last night and she did not know when the corn chowder, cake or soup was placed in the refrigerator.</p> <p>On 1/31/2012 at 10:00 a.m., in an interview with the Regional Director of Quality and Care Management he</p>		<p>regulation. 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 daily walking rounds of kitchen for a period of six months to ensure continued compliance with kitchen safety and sanitation standards regarding food storage and discarding of outdated food items. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>				

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	<p>indicated they use ServSafe essentials as their policy and procedure on safe handling of food.</p> <p>On 1/31/2012 at 10:05 a.m., record review of the policy and procedure of ServSafe essentials indicated, but not limited to; under bullet Labeling, "After seven days, you must throw it out to prevent bacteria, so as Listeria monocytogenes, from growing to unsafe levels". "The label....must include the name of the food and the date by which should be sold, eaten, or thrown out".</p> <p>Under bullet rotation it indicated, but not limited to; "Throw away food that has passed its manufacturer's use-by or expiration date".</p> <p>On 2/2/2012 at 1:30 p.m., record review of DM # 1 checklist and workplan, dated 12/6/2011, instructed by Registered Dietitian indicated "Potentially hazardous foods stored appropriately: f. All food in refrigerator and freezer covered and dated." This was checked off as being completed. "Standard food service practices followed appropriately: a. Foods protected from hazardous contamination." This was checked off as being completed.</p>			
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R0354	<p>(g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to send a transfer form which included name of transferring and receiving facilities, date of transfer, current diet and condition on transfer, diagnoses, nursing notes related to the resident, and functional abilities and limitations with 2 residents when they were discharged to another facility. This deficient practice affected 2 of 2 discharged residents in a sample of 7 residents. (Residents #6 and 7)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #6 on 1/31/2012 at 12:05 p.m., indicated the resident was admitted to the facility on 10/27/2011. Diagnoses included, but were not limited to,</p>	R0354	<p>Citation #5 R 354 410 IAC 16.2-5-8.1(8) (1-7) 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. Residents #6 an #7 n longer reside at Bennett House. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director, Residence Director, and staff were</p>	03/16/2012			

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	<p>hypertension, fatigue, and chronic obstructive pulmonary disease.</p> <p>Documentation was lacking of a Transfer form having been completed, which accompanied the resident when he transferred to another facility on 12/2/2011.</p> <p>2. Review of the clinical record for Resident #7 on 1/31/2012 at 12:40 p.m., indicated the resident had diagnoses which included, but were not limited to: hypothyroidism, chronic kidney disease, hypertension and Alzheimer disease.</p> <p>Documentation was lacking of a Transfer form having been completed, which accompanied the resident when she transferred to another facility on 11/4/2011.</p> <p>During an interview with the Regional Director of Quality and Care Management and the Administrator on 1/31/2012 at 2:30 p.m., they indicated they were not aware a Transfer form had to be completed and sent with the residents when they were discharged to another facility.</p> <p>On 2/1/2012 at 9:50 a.m., the Regional</p>		<p>re-educated to our policy and procedure regarding resident transfer/discharge and the Indiana state regulation R 354 410 IAC 16.2-5-8.1(8) (1-7) Clinical Records. The Wellness Director will be responsible to ensure residents requiring a transfer and or discharge will have the necessary Transfer/Discharge paperwork prepared prior to the residents leaving the community, which includes the reason for transfer/discharge, the name of the transferring institution, location to which the resident is going, date of transfer, current diet and condition upon transfer, diagnosis, nursing notes indicating functional abilities and needs. The Wellness Director and/or Designee will also be responsible to ensure a copy of the notice is placed in the resident record, and ensure the resident was aware of the right to appeal via an appeal form. 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 residents transferred or discharged from the community to ensure the necessary Transfer/Discharge paperwork is completed with a copy placed into the residents record for a period of six months</p>				

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	Director of Quality and Care Management presented a copy of the facility's current policy on "F. MOVE-OUT". Review of the policy at this time included, but was not limited to: "...2. Document the move-out in the Resident Service Notes. The move-out note should include statements regarding the resident's condition at move-out, the location to which the resident moved, items, including medications, released to the resident or responsible party, records released, if any, and any other pertinent information. 3. When the resident moves to another location, provide the Resident and/or his/her family/legal representative with copies of the resident's most current physician orders, medication record and Service Assessment/Negotiated Service Plan...Record this in the Resident Service Notes..."		to ensure continued compliance. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.		

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R0356	<p>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on record review and interview, the facility failed to ensure information in the Emergency Files was complete or updated for 25 of 29 resident files in the facility population of 29. Information was not updated related to apartment numbers changes for Resident #11,12, 13,14,16, 17, 19, 23, 24, 25, 26, 27, 28 and 29; hospital preferences not included for Resident #3, 8, 14, 15, 18, 20, 21, 22, and 23; or current physician names or numbers for Resident #2, 4, 5, 6,16 and 29; and no current photograph for Resident #4. This affected of 5 in the sample of 7 and 20 of 22 in the supplemental sample of 22.</p>	R0356	<p>Citation #6 R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records – 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. Residents # 11, 12, 13, 14, 16, 17, 19, 23, 24, 25, 26, 27, 28, and 29 had there room number updated to reflect their current room number. Residents # 3, 8, 14, 15, 18, 20, 21, 22, and 23 had their preferred hospital preference indicated upon their face sheet. Residents 2, 4 5, 6, 16, and 29 had their current physician indicated on their face sheet. A photograph was taken and placed within the resident emergency file for</p>	03/16/2012			

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	<p>Findings include:</p> <p>On 1/31/2012 at 11:15 a.m., the Regional Director of Quality and Care Management presented the 3 binders which he indicated contained all the current emergency information on the residents. He indicated facility staff would grab these binders in case of an emergency. During review of the Resident Emergency Files at this time, the following was observed:</p> <ol style="list-style-type: none"> 1. Resident #11 moved into the facility on 10/26/2011. No apartment number was listed and the name and phone number of the physician who treated the resident when she lived out of town was still listed. The name and phone number of the physician currently treating her was missing. 2. Resident #12 moved into the facility on 11/5/2008. The apartment listed was #117 instead of her current apartment #102. 3. Resident #13 moved into the facility on 1/26/2011. The apartment listed was #121 instead of her current apartment #105. 4. Resident #14 moved into the facility on 8/3/2010. No hospital preference was listed. 		<p>resident #4. 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? Resident face sheets were reviewed with information updated to include all the necessary information as indicated within Indiana state ruling R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records regarding the information to be available and indicated within the Emergency file. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director was re-educated to the Indiana state ruling R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records. The Residence Director and/or Designee will be responsible to ensure the necessary information is obtained and updated to reflect the residents preference in the event of an emergency as specified within Indiana state regulation. 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 a random weekly audit of the residents emergency file to ensure</p>				

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	<p>5. Resident #15 moved into the facility on 5/2/2008. No hospital preference was listed.</p> <p>6. Resident #16 moved into the facility on 11/9/2011. No apartment number or physician phone number was listed.</p> <p>7. Resident #17 moved into the facility on 3/5/2010. No apartment number was listed.</p> <p>8. Resident #18 moved into the facility on 9/1/2010. No hospital preference was listed.</p> <p>9. Resident #19 moved into the facility on 9/27/2010. The apartment listed was #113 instead of her current apartment #115.</p> <p>10. Resident #20 moved into the facility on 6/30/2010. No hospital preference was listed.</p> <p>11. Resident #21 moved into the facility on 9/28/2011. No hospital preference was listed.</p> <p>12. Resident #5 moved into the facility on 8/17/2011. The phone number of the physician currently treating her was missing.</p> <p>13. Resident #22 moved into the facility</p>		<p>continued compliance with Indiana state regulation for a period of six months to ensure continued compliance with R 356 410 IAC 16.2-5-8.1(i)(1-8) Clinical Records. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p>				

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	<p>on 6/16/2008. No hospital preference was listed.</p> <p>14. Resident #2 moved into the facility on 6/15/2002. The name of the physician and phone number currently treating the resident was incorrect.</p> <p>15. Resident #23 moved into the facility on 5/13/2008. No hospital preference was listed and her apartment number was missing.</p> <p>16. Resident #24 moved into the facility on 10/18/2010. The apartment listed was #124 instead of his current apartment #126.</p> <p>17. Resident #25 moved into the facility on 6/24/2011. No apartment number was listed.</p> <p>18. Resident #26 moved into the facility on 7/13/2010. The apartment listed was #127 instead of her current apartment #130.</p> <p>19. Resident #27 moved into the facility on 6/28/2011. No apartment number was listed.</p> <p>20. Resident #28 moved into the facility on 3/23/2007. No apartment number was listed.</p>			

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	<p>21. Resident #29 moved into the facility on 3/18/2009. No apartment number was listed and the phone number of the physician currently treating her was missing.</p> <p>22. Resident #8 moved into the facility on 5/20/2010. No hospital preference was listed.</p> <p>23. Resident #3 moved into the facility on 9/24/2011. No hospital preference was listed.</p> <p>24. Resident #4 moved into the facility on 9/13/2011. A current picture of the resident and the name and phone number of the physician currently treating her was missing.</p> <p>25. Resident #6 was admitted to the facility on 10/27/2011. The phone number of the physician who treated the resident while residing in the facility until 12/2/2011 was missing.</p>			
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R0410	<p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 7 residents in a sample of 7 residents without documentation of a prior negative Tuberculin test within 6 months of move-in received a 2-Step Tuberculin skin test upon admission. (Resident #6).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #6 on 1/31/2012 at 12:05 p.m., indicated the resident was admitted to the facility on 10/27/2011 and discharged on 12/2/2011. Diagnoses included, but were not limited to, hypertension, fatigue, and</p>	R0410	<p>Citation#7 R 410 IAC 16.2-5-12(e) (f) (g) Infection Control - 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 #6 no longer resides at the Bennett House.</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</p>	03/16/2012			

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 02/02/2012	
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>chronic obstructive pulmonary disease.</p> <p>Review of the Immunization Record form failed to indicate the resident had received a first or second step PPD [tuberculosis test] during his stay.</p> <p>During an interview with the Regional Director of Quality and Care Management on 1/31/2012 at 2:00 p.m., he indicated he was unable to locate documentation the resident had a negative TB test prior to admission nor had he received the 2-step Tuberculin skin tests while a resident in the facility.</p> <p>On 2/1/2012 at 9:40 a.m., the Regional Director of Quality and Care Management presented a copy of the facility's current policy on "TB Testing". Review of this policy at this time included, but was not limited to: "The Wellness Director is responsible for conducting (or making arrangement for) 2-step Mantoux method TB tests on all...residents...Resident Guidelines: 1. Upon move-in, all Residents should have a two-step Mantoux method TB skin Test, unless they have a documented positive history of a positive TB test...3. Whenever possible, and as required by State Regulations, step one will be administered, read and recorded prior to move-in. Skin tests must be administered,</p>		<p>taken? Residents records were reviewed to ensure compliance with out policy and procedure regarding mantoux skin testing and Indiana State regulation R 410 IAC 16.2-5-12(e)(f)(g) Infection Control.</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, Wellness Director, and Residence Sales manager was re-educated to our policy and procedure concerning mantoux skin testing and Indiana state ruling R 410 IAC 16.2-5-12(e)(f)(g) Infection Control. The Wellness Director and/or Designee will be responsible to ensure continued compliance with our policy and procedure and Indiana residential ruling.</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 the residents mantoux skin test to ensure continued compliance with our policy and procedure along with the Indiana state ruling R 410 IAC 16.2-5-12(e) (f) (g) Infection Control</p>				

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	read and recorded within the first two weeks of move-in..."		for a period of six months to ensure continued compliance with R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records. Audits will be reviewed through our Bennett House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.		