

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER BENNETT PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE, NEW ALBANY, , 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 470159 and 470784. This visit was in conjunction with the Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 5/15/26. Intake 470159 - State deficiency related to the allegation is cited at R0240. Intake 470784 - State deficiencies related to the allegations are cited at R0240 and R0406. Survey date: July 21 and 22, 2026 Facility number: 004442 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Submission of this Plan of Correction does not constitute an admission of the alleged deficiency or agreement with the findings. The Plan of Correction is submitted to comply with regulatory requirements and outlines the actions the community will take to ensure compliance.		

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	Quality review completed on August 2, 2026.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure residents (Resident B and Resident F) assessment care plans were followed for 2 of 4 residents reviewed for personal care. Findings include: 1. The clinical record for Resident B was reviewed on 7/20/26 at 9:20 a.m. The resident's diagnoses included, but were not limited to, depression, heart disease and dementia with behavioral disturbance. The resident was on hospice services. The resident assessment care plan, updated on 6/11/26, indicated Resident B required physical assistance with dressing and grooming upon rising and at bed time. Review of the June 2026 and July 2026 Task Administration Record (TAR) lacked	R 0240	Out of 34 residents, 2 were affected. All residents have the potential to be affected. Immediate action: Care providers to chart on paper and submit to DHW until all care providers have access to chart in eMar. ED or DHW will create an ECP User Profile for each qualified care team member (CNA/HHA). Each qualified care team member will complete data entry training in ECP by 8-17-26. Starting 8-17-26, each qualified care team member will be responsible for documenting in the resident Task Administration Records (TAR) assigned to them during their shift. ED or DHW will audit the resident Task Administration Records (TAR) daily for completion for 30 calendar days beginning 8-17-26 and then weekly beginning 9-7-26.	08/03/2026

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documentation of the resident
being groomed/dressed on the
following dates and times:

-6/01/26, upon rising and at
bedtime

-6/02/26, at bedtime

-6/06/26 - 6/07/26, upon rising

-6/08/26, upon rising and at
bedtime

-6/09/26 - 6/11/26, at bedtime

-6/12/26, upon rising and at
bedtime

-6/13/26 - 6/14/26, upon rising

-6/15/26, upon rising and at
bedtime

-6/16/26, at bedtime

-6/17/26 - 6/18/26, upon rising
and at bedtime

-6/19/26 - 6/21/26, upon rising

-6/22/26, upon rising and at
bedtime

-6/23/26 - 6/24/26, at bedtime

-6/25/26, upon rising and at
bedtime

-6/26/26 - 6/28/26, upon rising

-6/29/26, upon rising and at
bedtime

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	-6/30/26, at bedtime -7/01/26 at bedtime -7/02/26, upon rising and at bedtime -7/03/26 - 7/05/26, upon rising -7/06/26, upon rising and at bedtime -7/07/26 - 7/08/26, at bedtime The resident assessment care plan, updated on 6/11/26, indicated Resident B required physical assistance with oral care at 7:00 a.m. and at 8:00 p.m. Review of the June 2026 and July 2026 TAR lacked documentation of the resident receiving oral care on the following dates and times: -6/01/26 at 7:00 a.m. -6/02/26 at 8:00 p.m. -6/04/26 - 6/05/26 at 8:00 p.m. -6/06/26 - 6/07/26 at 7:00 a.m. -6/08/26 at 7:00 a.m. and 8:00 p.m. -6/09/26 - 6/11/26 at 7:00 a.m. -6/12/26 at 7:00 a.m. and 8:00 p.m.			
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-6/13/26 - 6/14/26 at 7:00 a.m.			
-6/15/26 at 7:00 a.m. and 8:00 p.m.			
-6/16/26 at 8:00 p.m.			
-6/17/26 - 6/18/26 at 7:00 a.m. and 8:00 p.m.			
-6/19/26 - 6/21/26 at 7:00 a.m.			
-6/22/26 at 7:00 a.m. and 8:00 p.m.			
-6/23/26 - 6/24/26 at 8:00 p.m.			
-6/25/26 at 7:00 a.m. and 8:00 p.m.			
-6/26/26 - 6/28/26 at 7:00 a.m.			
-6/29/26 at 7:00 a.m. and 8:00 p.m.			
-6/30/26 at 8:00 p.m.			
-7/01/26 at 8:00 p.m.			
-7/02/26 at 7:00 a.m. and 8:00 p.m.			
-7/03/26 - 7/05/26 at 7:00 a.m.			
-7/06/26 at 7:00 a.m. and 8:00 p.m.			
-7/07/26 - 7/08/26 at 8:00 p.m.			

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The resident assessment care plan, updated on 6/11/26, indicated Resident B required meal set-up assist at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

Review of the June 2026 and July 2026 TAR lacked documentation of the resident receiving meal set-up assistance on the following dates and times:

-6/01/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

-6/06/26 - 6/08/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

-6/11/26 - 6/15/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

-6/16/26 - 6/22/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

-6/25/26 - 6/29/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

-7/02/26 - 7/06/26 at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

There was not a set time for the breakfast meal

The resident assessment care plan, updated on 6/11/26, indicated Resident B required verbal prompts for meal consumption at 12:00 p.m. and 5:00 p.m.

Review of the June 2026 and July 2026 TAR lacked

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documentation of the resident receiving verbal prompts during meal consumption on the following dates and times:

-6/01/26 at 12:00 p.m. and 5:00 p.m.

-6/06/26 - 6/08/26 at 12:00 p.m. and 5:00 p.m.

-6/11/26 - 6/15/26 at 12:00 p.m. and 5:00 p.m.

-6/17/26 - 6/22/26 at 12:00 p.m. and 5:00 p.m.

-6/25/26 - 6/29/26 at 12:00 p.m. and 5:00 p.m.

-7/02/26 - 7/06/26 at 12:00 p.m. and 5:00 p.m.

There was not a set time for the breakfast meal

During an interview, on 7/22/26 at 10:55 a.m., Certified Nurse Aide (CNA) 6 indicated the aides do not have a way to document in the residents records.

During an interview on 7/22/26 at 11:03 a.m., Registered Nurse (RN) 4 indicated the nurses sign of on the TAR and pop-up reminders.

2. The clinical record for Resident F was reviewed on 7/21/26 at 7:24 p.m. The resident's diagnoses included,

but were not limited to, arthritis and congestive heart failure. The resident is currently on hospice.

The resident assessment care plan, updated on 6/9/26, indicated Resident F required physical assistance with dressing and grooming upon rising and at bed time.

Review of the June 2026 Task Administration Record (TAR) lacked documentation of the resident receiving groomingdressing assistance on the following dates and times:

-6/01/26, upon rising and at bedtime

-6/02/26 - 6/05/26, at bedtime

-6/06/26 - 6/07/26, upon rising

-6/08/26, upon rising and at bedtime

-6/09/26 - 6/11/26, at bedtime

-6/12/26, upon rising and at bedtime

-6/13/26 - 6/14/26, upon rising

-6/15/26, upon rising and at bedtime

-6/16/26 , at bedtime

-6/17/26 - 6/18/26, upon rising and at bedtime

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-6/19/26 - 6/21/26, upon rising

-6/22/26, upon rising and at bedtime

-6/23/26 - 6/24/26 at bedtime

-6/25/26, upon rising and at bedtime

-6/26/26 - 6/28/26, upon rising

-6/29/26, upon rising and at bedtime

-6/30/26, at bedtime

The resident assessment care plan, updated on 6/9/26, indicated Resident F required physical assistance with oral care and at 7:00 a.m. and at 8:00 p.m.

Review of the June 2026 TAR lacked documentation of the resident receiving assistance with oral care on the following dates and times:

-6/01/26 at 7:00 a.m. and 8:00 p.m.

-6/02/26 - 6/05/26 at 8:00 p.m.

-6/06/26 - 6/07/26 at 7:00 a.m.

-6/08/26 at 7:00 a.m. and 8:00 p.m.

-6/09/26 - 6/11/26 at 8:00 p.m.

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	-6/12/26 at 7:00 a.m. and 8:00 p.m. -6/14/26 - 6/14/26 at 7:00 a.m. -6/15/26 at 7:00 a.m. and 8:00 p.m. -6/16/26 at 8:00 p.m. -6/17/26 - 6/18/26 at 7:00 a.m. and 8:00 p.m. -6/19/26 - 6/21/26 at 7:00 a.m. -6/22/26 at 7:00 a.m. and 8:00 p.m. -6/23/26 - 6/24/26 at 8:00 p.m. -6/25/26 at 7:00 a.m. and 8:00 p.m. -6/26/26 - 6/28/26 at 7:00 a.m. -6/29/26 at 7:00 a.m. and 8:00 p.m. -6/30/26 at 8:00 p.m. This State citation relates to Intakes 470159 and 470784			
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission	R 0406	Out of 34 residents, 1 was affected. All residents have the potential to be affected. An audit was conducted to determine any outstanding physician notifications. None were identified.	08/03/2026

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	of diseases and infection. Based on interview and record review, the facility failed to ensure a treatment was implented, in a timely manner, for resident to prevent signs and symptoms of infection; failed to ensure a resident's family was notified of a wound timely; and failed to ensure home health services was implemented timely for the management of wound care for 1 of 3 residents reviewed for infection control. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/21/26 at 10:47 a.m. The resident's diagnoses included, but were not limited to, left sided hemiparesis (weakness or partial paralysis affecting one side of the body) and dementia (loss of memory, language, and other thinking abilities that interfere with daily life).		ED or DHW will conduct an all staff in-service training for all employees on the topic of the Notification Policy for Resident Injuries. Topic will include notification of the resident's responsible party, resident's primary care physician, and community management. This in-service will be conducted by 8-31-2026. ED or DHW will conduct an all staff in-service training for all employees on the topic of Infection Control Policy and the employee's role in infection control. This all staff in-service will be conducted by 8-31-2026. DHW will conduct ongoing weekly chart audits to ensure all notifications are completed and documented.	
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A progress note, dated 6/21/26 at 9:00 p.m., indicated the resident was being transferred to bed with the mechanical lift. The resident's left leg bumped into the mechanical lift and scratched the resident's leg. The wound was treated, bandaid place and notification was made to the Director of Nursing (DON).

A progress note, dated 7/2/26 at 5:15 p.m., indicated the resident's bilateral shins had open areas with foul smelling drainage. The wound was cleaned with wound cleanser and a dressing applied. The Nurse Practitioner (NP) was notified and no orders were given.

A progress note, dated 7/8/26 at 2:15 p.m., indicated the resident's information was sent to home health for wound evaluation.

The physician's order, dated 7/9/26, indicated the resident was to receive Cephalexin (antibiotic to treat bacterial infections), 500 mg (milligrams) three times a day for 7 days.

The NP note, dated 7/9/26 at 8:15 a.m., indicated the resident was seen for new open areas to her bilateral shins. Nursing had started treatment but the resident needed home health to manage the wounds. Nursing

had notice a foul odor from the left shin wound.

The home health initial assessment, dated 7/10/26 at 11:11 a.m., indicated the resident had a traumatic wound to her left lower extremity which measured 2 cm (centimeters) in length, 1 cm in width with a depth of 0.3 cm. The wound was red around the edges.

The clinical record lacked documentation of family notification of the foul odor drainage on 7/2/26, any treatments completed on the wound between 7/3/26 through 7/9/26, or implementation for home health services prior to 7/8/26.

During an interview, on 7/22/26 at 11:05 a.m., the DON indicated although the facility could not treat wounds, the staff were cleaning and dressing the wound.

During an interview on 7/22/26 at 11:19 a.m., the NP indicated that she first heard of the resident's wounds on 7/8/26 when the DON sent her a message. She had the DON send her pictures of the wound. She then gave orders for an antibiotic and a home health evaluation. The NP checked her phone during the interview and indicated she had received a text message on 7/2/26 at 6:00

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OMB NO. 0938-0391

p.m. from the Registered Nurse (RN) 5. The text message indicated the resident had opened wounds on her shins. RN 5 cleansed the wounds, applied calcium alginate to the wound and covered the wound with a bandaid. The NP indicated she was not on-call at 5:00 p.m., did not respond to the message at that time, and the facility should have called the on-call NP after 5:00 p.m. or should have followed up with her the next day. She did not hear anything related to the text sent to her for 6 days, on 7/8/26, which was when the DON messaged her.

On 7/22/26 at 11:45 a.m., the Executive Director provided a current copy of the document titled "Wound and Skin Care" dated 6/10/24. It included, but was not limited to, "The Community promotes good skin integrity and wound healing practices...Procedure...Respond appropriately to wound or skin integrity issues...notify...family immediately...Request home health or wound care services from the physician...treatments...will be documented in the resident's record...Seek emergency medical attention if there are signs and symptoms of the wound becoming infected...Signs and symptoms may include, but are not limited

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to...Redness...Purulent drainage...Odor...."			
This citation relates to Intake 3070990			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAllison Catron	TITLERDRC	(X6) DATE08/12/2026
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