

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 08/19/2026
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 471379 and 471452. Intake 471379 - State deficiencies related to the allegations are cited at R0036 and R0052. Intake 417452 - State deficiencies related to the allegations are cited at R0036 and R0052. Survey dates: August 18 and 19, 2026 Facility number: 004442 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on August 25, 2026.	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.		

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

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure the physician was notified, in a timely manner, of a resident's (Resident B) significant change in health status for 1 of 3 residents reviewed for physician notification. Findings include: The clinical record for Resident B was reviewed on 8/18/26 at 9:20 a.m. The resident's diagnoses included, but were not limited to, hyperlipidemia (a medical condition involving an excess of lipids circulating in the blood stream), vascular dementia (a decline in thinking skills caused by conditions that	R 0036	By September 11, 2026, management will conduct documented in-service training meetings with all staff members to review company policy CL04-Change in Resident Status. This policy details the cadence that should be followed in the event of a resident's change in status, including but not limited to notifying emergency services, the resident's physician, the community Director of Nursing, and the resident's legal representative. This policy references the requirements outlined in state regulation 410 IAC 16.25-1.2. All residents have the potential to be affected by this deficiency. One resident was affected in this instance.	09/11/2026
--------	--	--------	---	------------

block or reduce blood flow and oxygen to parts of the brain), atrial fibrillation (common heart problem where the top parts of the heart beat fast and in a wild, mixed up way), left bundle-branch block (a heart condition where the electrical path that sends signals to the left lower chamber of the heart is blocked or slowed) and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a terrifying, shocking, or dangerous event).

The Incident Report, dated 8/1/26 at 7:15 a.m., indicated on 8/1/26 at 2:00 p.m., facility staff entered Resident B's room and found the resident lying in bed with no pulse or respirations. Registered Nurse (RN) 3 was in the building and determined there were no breath sounds or pulse.

A Progress Note, dated 8/1/26 at 3:00 p.m., indicated the Director of Nursing (DON) was called to the building after the nursing staff found Resident B deceased in bed. 911 was immediately called and came to the facility and assessed Resident B. Resident B was pronounced deceased by the paramedics.

The clinical record lacked documentation of physician

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

	notification related to the resident's death on 8/1/26. During an interview, on 8/19/26 at 10:20 a.m., Registered Nurse (RN) 4 indicated when a resident passes away at the facility, the physician or nurse practitioner should be notified immediately. During the exit conference, on 8/19/26 at 11:20 a.m., the Director of Health and Wellness (DHW) indicated Resident B's nurse practitioner was notified of the death the following Monday (8/3/26). On 8/19/26 at 10:55 a.m., the DHW provided a current copy of the document titled "Change in Resident Status" dated 6/10/2024. It included, but was not limited to, "Policy...Community staff have the responsibility to...summon medical attention when the resident has a change in status...The facility must immediately consult the resident's physician...when the facility has noticed...A significant decline in the resident's physical...status..." This citation relates to Intakes 471379 and 471452.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	By September 11, 2026, management will conduct a documented in-service training	09/11/2026

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

(v) Residents have the right to be free from:

- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on interview and record review, the facility failed to initiate CPR (Cardiopulmonary Resuscitation) on a resident (Resident B) with no valid do not resuscitate order and failed to call 911 in a timely manner. This deficient practice resulted in no immediate CPR initiated and a delay in 911 being called for 1 of 3 residents reviewed for neglect.

Findings include:

The clinical record for Resident B was reviewed on 8/18/26 at 9:20 a.m. The resident's diagnoses included, but were not limited to, hyperlipidemia (a medical condition involving an excess of lipids circulating in the blood stream), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow and oxygen to parts of the brain), atrial fibrillation (common heart

session for all staff members to review company policy GP12, titled "Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR), and First Aid Training". This policy includes the guidelines for contacting emergency services and initiating CPR in the event of a potential life-threatening emergency. This policy references the requirements outlined in state regulations 410 IAC 16.2-5-1.3; and 410 IAC 16.2-5-1.4. Additionally, management will review the color-coded designations in our EMAR system which translate to "Full Code" or "DNR". This will be reviewed with all staff members during the in-service meeting. All residents have the potential to be affected by this deficiency. One resident was affected in this instance.

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

FORM APPROVED

OMB NO. 0938-0391

problem where the top parts of the heart beat fast and in a wild, mixed up way), left bundle-branch block (a heart condition where the electrical path that sends signals to the left lower chamber of the heart is blocked or slowed) and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a terrifying, shocking, or dangerous event). Resident B's face sheet indicated no advance directive had been initiated or documented. Resident B's service plan lacked a do not resuscitate order/POST form. Resident B's Task Administration Record (documents of nurse/staff skills to be followed) lacked a do not resuscitate order.

The clinical record lacked documentation of a POST (Physician Orders for Scope of Treatment) form or any other advance directives.

On 8/18/26 at 9:27 a.m., review of Resident B's physician orders lacked documentation of a do not resuscitate order.

The Incident Report, dated 8/1/26 at 7:15 a.m., indicated Resident B had rolled out of bed onto the floor. Resident B reported he had hit his head on a chair next to his bed. Resident B was encouraged to go to the emergency department and

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

refused. Resident B was checked on three times over the next two hours and encouraged by staff to go to the hospital and refused. The resident was checked on multiple times throughout the morning with no complaints of pain or visible injuries. On 8/1/26 at 2:00 p.m., staff entered Resident B's room and found the resident lying in bed with no pulse or respirations. Registered Nurse (RN) 3 was in the building and determined there were no breath sounds or pulse.

A Progress Note, dated 8/1/26 at 7:30 a.m., indicated the resident turned on his call light. The staff found the resident on the floor, covered with a blanket and emesis (vomit) covering the bed. The resident reported he had gotten sick, tried to get up to go to the bathroom and then rolled out of bed. The resident reported he hit his head on the chair next to the bed. The resident refused to go to the hospital. The resident was assessed with no injuries observed. The nurse continued to encourage the resident to allow staff to call emergency services and the resident continued to refuse. The resident's family member was contacted related to the resident's fall and was informed the resident refused to go to the hospital. The family member

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

FORM APPROVED

OMB NO. 0938-0391

was informed the resident had no visible injuries or bruising at that time. The family member indicated it was fine if the resident did not want to go to the hospital.

A Progress Note, dated 8/1/26 at 10:30 a.m., indicated the nursing staff had checked on the resident continuously throughout the day due to his fall earlier in the day. The resident had no complaints of pain or discomfort, and range of motion was within normal limits. No visible injuries were observed, and the resident's vital signs remained stable throughout the shift. The resident had been asked if he felt he needed to go to the emergency department since his fall and he continued to refuse.

During an interview, on 8/18/26 at 11:12 a.m., Resident B's family member indicated the resident did not have a DNR or POST form and the resident/family had wanted CPR to be performed in the event of need.

During an interview, on 8/18/26 at 1:09 p.m., the Director of Health and Wellness (DHW) indicated the note she put in on 8/1/26 at 10:30 a.m. was put in as a late entry. She put the entry in because she was told by the staff that they had been

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

FORM APPROVED

OMB NO. 0938-0391

following up with the resident.

A Progress Note, dated 8/1/26 at 3:00 p.m., indicated the DHW was called to building after the nursing staff found Resident B deceased in bed. 911 was immediately called and came to the facility and assessed Resident B. Resident B was pronounced deceased by the paramedics.

Review of the vital signs' history, for 8/1/26, indicated the resident's vital signs were obtained on 8/1/26 at 7:31 a.m. There were no other vitals documented in the resident's clinical record.

The clinical record lacked documentation of the initiation of CPR or any assessment of the resident at the time the resident was found without a pulse or respirations.

During a telephone interview, on 8/18/26 at 10:32 a.m., RN 3 indicated she was called to Resident B's room by the staff. When she went in Resident B's room, he was not breathing. She listened with a stethoscope and there were no heartbeat or respirations. Resident B's skin was cool, but not cold and his body was not stiff. She did not initiate CPR as she was new and did not know what the protocol was. RN 3 called the Executive Director who told her

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

to call 911.

During an interview, on 8/18/26 at 10:52 a.m., Certified Nurse Aide (CNA) 5 indicated on 8/1/26, she had taken Resident B's lunch to his room between 12:25 p.m. and 1:00 p.m., at which time, he was awake. At around 2:00 p.m., after CNA 6 had come to work, CNA 5 and CNA 6 entered Resident B's room to check on him. CNA 5 stayed with Resident B and CNA 6 went to find RN 3. The nurse checked him for respirations and a heartbeat. CPR was not started on Resident B. The Executive Director directed RN 3 to call 911.

During an interview, on 8/18/26 at 11:32 a.m., the DHW indicated the resident did not have a post form or any other advance directives on file.

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

During an interview, on 8/18/26 at 1:09 p.m., the DHW indicated RN 3 told her that she did not initiate CPR because she was unaware of what the policy was. RN 3 should have initiated CPR. RN 3 was educated that when a resident was found unresponsive and a full code, CPR should be initiated and 911 called. On the day of the incident, RN 3 did not call 911 but, instead, called the local sheriff's department. The sheriff's department called 911.

The Emergency Medical Services (EMS) report, dated 8/1/26 at 2:39 p.m., indicated the EMS was dispatched emergent to the nursing facility, per the ED (Executive Director) for verification of death. The EMS arrived on scene at 2:46 p.m. At 2:48 p.m., the EMS met with the sheriff officer who was with Resident B. Resident B was lying in bed with no active pulse or respiratory effort. Resident B's skin was warm and pale. Resident B had dried vomitus on the right shoulder and the resident's pupils were fixed and non-reactive. The nurse (RN 3) advised that she had just recently taken Resident B's vital signs approximately 15 minutes prior to calling 911.

On 8/18/26 at 1:13 p.m., the Executive Director provided a current copy of the document

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

titled "Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR) and First Aid Training" dated 6/10/24. It included, but was not limited to, "If a resident is experiencing respiratory to cardiac arrest, Emergency Medical Services (911) will be called immediately and ...If the resident does not have a valid "Do Not Resuscitate Order" (DNR), an appropriately trained ...staff member will initiate CPR"

This citation relates to Intakes 471379 and 471452.

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 SIGNATUREJASON KIRBY	TITLEExecutive Director	(X6) DATE09/02/2026
--	-------------------------	---------------------