STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENNETT PLACE	3928 HORNE AVE NEW ALBANY, IN 47150

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00408697, IN00407476, and IN00407482. Complaint IN00407476 - State deficiencies related to the allegations are cited at R0289. Compliant IN00407482 - No deficiencies related to the allegations are cited. Complaint IN00408697 - State deficiencies related to the allegations are cited at R0027. Survey dates: May 30 and 31, 2023 Facility number: 004442 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 2023.	R 0000		
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on record review and interview, the facility failed to ensure a resident received access to an adequate amount of fluids at night per resident request. This deficient practice affected 1 of 9 residents reviewed for adequate hydration.	R 0027	/b> Resident B was assessed for hydration by the Care Services Manager (CSM) on 5-15-2023 with no findings of dehydration.	06/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stefanie Jenkins		07/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	(Resident B) Finding includes: During an interview with the resident on 5/30/23 at 9:25 a.m., he indicated a nurse and a CNA (Certified Nurse Aide) told him he could not have water or a Coke to drink at night because there was a physician's order not to give him anything to drink at night. He indicated after they told him this, they then brought him a small cup of water and said "Here, now don't bother me again" and that this happened for a couple of days. Staff interviews conducted by the facility on 5/15/23, indicated the following: - CNA 1 indicated that although the resident was not denied water at night, they did slow down on the water at night and rationed it by giving him a small medicine cup of water because he urinated so much at night. - LPN (Licensed Practical Nurse) 2 denied she told the resident he could not have water and whenever she entered his room on 5/14/23, he had his Coke and water at his bedside. - CNA 3 indicated that although she made sure throughout her shift on 5/13/23 the resident had access to his Coke and half of a 5 ounce cup of water, it kept disappearing back into the refrigerator after she replaced it. The resident asked her why staff kept giving him this little 5 ounce cup with not much water in it. The CNA also indicated that before she left her second shift for the night, the night nurse told her they did not give him much water after 8:00 p.m., so staff did not have to keep changing his bed.		**2 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:** Current residents were assessed for hydration by the CSM on 5-15-2023 with no findings of dehydration. Current interview able residents were interviewed on 5-15-2023 by CSM and/or Executive Director (ED) to ensure no other fluid restrictions or resident rights violations. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The ED and CSM were re-educated on 6/15/2023 by the Regional Director of Care Services (RDCS) on resident rights per ISDH Attachment 1. Current Staff were re-educated on 6-16-2023 by the CSM on resident rights per ISDH Attachment 2. **4 How 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 CSM or designee will interview 5 appropriate residents weekly for 4 weeks, then 5 appropriate	

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	- LPN 4 indicated that during shift report on 5/15/23, LPN 2 told them she would put the resident's water or soda out of reach due to his extreme bed wetting at night. The record for Resident B was reviewed on 5/30/23 at 11:00 a.m. The diagnoses included, but were not limited to, diabetes, Alzheimer's dementia, chronic obstructive pulmonary disease, chronic kidney disease, and hypertensive heart disease. The Assessment Tool and Negotiated Service Plan, dated 12/2/22, indicated the resident needed one staff member's assistance for baths/showers, dressing and grooming, and getting in or out of bed. The MME (Mini Mental Status Evaluation) indicated he was alert and oriented. Review of the monthly physician's orders, between 9/2022 and 5/2023, indicated there was no order to limit the resident's fluid intake at any time of the day or night. During an interview with the ED on 5/30/23 at 10:20 a.m., she indicated the resident was a heavy wetter which was probably why the nurse would deny the resident something to drink or they would bring him a small 5 ounce cup of water, which she did not think was enough for anyone. He liked to keep a big glass of water and his Coke at bedside to drink. She had the DON do a Hydration Assessment on him to be sure he was not dehydrated and he wasn't. Based on the resident being very alert and oriented, staff interviews, and what the nurse said to another nurse during report, it was determined the issue happened and and the nurse was terminated. There was a CNA who also worked with this nurse that was involved, but after the nurse was		residents biweekly for 4 weeks, then 5 residents monthly for 1 month to ensure no continued resident rights violations occur. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	

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	terminated, there were no further issues with the CNA. The resident indicated there had not been any further problems. On 5/30/23 at 1:00 p.m., the ED presented a copy of the facility's current policy on "Resident Rights" dated effective 3/1/22. Review of this policy at this time included, but was not limited to, "Policy: ...its employees strive to protect and promote the rights of each resident as afforded to them by citizenry and regulation. Procedure: 1) Employees will honor each resident as an individual, treating them with respect and dignity at all times. Each resident has the right to, at minimum:...B) To receive care, treatment and services which are adequate and appropriate..." This State tag relates to Complaint IN00408697.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure pharmacy irregularities were corrected in a timely manner for 1 of 3 residents	R 0298	=”” b=””> /b> Resident K’s physician was	06/30/2023

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	reviewed for pharmacy irregularities. (Resident K) Findings include: During an interview on 5/30/23 at 10:30 a.m., NP (Nurse Practitioner) 6 indicated she had not seen Resident K as a patient since 3/29/21. The last time her practice saw the resident was on 7/19/21. When she ran her reverse inspection report she observed someone at the facility was sending in telephone orders for this resident for gabapentin under her name/DEA (Drug Enforcement Agency) number. She had not been in the building for 2 years and she had not received any faxed telephone orders to be signed for this resident or the gabapentin. She called the pharmacy and the pharmacy informed her the gabapentin telephone order started on 12/30/22 and continued until she found it. She indicated she informed the facility ED (Executive Director), and she was rude about the incident. The ED asked her why it took her so long to report the issue and why was she telling her about it now. NP 6 indicated she asked the ED who oversaw what went on in the facility and the ED indicated she was. NP 6 informed the ED she thought she should know what was going on in her facility. NP 6 informed the cooperate office and their response was that the incident would be investigated. The record for Resident K was reviewed on 5/30/23 at 11:00 a.m. The diagnoses included but were not limited to, bipolar affective disorder, history of falls, depression, hypothyroidism, tremors, dementia, and Parkinson's disease. A review of the MAR (Medication Administration Report) on 5/30/23 at 1:45 p.m., indicated the following:		corrected on the physician order sheet on 4-1-2023 by Care Services Manager (CSM). **2 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:** An audit of current resident physician order sheets from past 30 days was completed on 6-2-2023 by the CSM to ensure the resident's physician was correct. No issues were identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director (ED) and CSM were re-educated on 6/16/2023 by the Regional Director of Care Services (RDCS) on the need to immediately notify pharmacy of a change in resident's physician and ensure said change is made on physician order sheets. Attachment 1. Current nursing staff were re-educated on 6-19-2023 by the CSM on the need to immediately notify pharmacy of a change in resident's physician and ensure said change is made on physician order sheets Attachment 3. **4 How the corrective action(s)**	

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	- On 11/01/22 through 11/30/22 the MAR indicated NP 6 was listed as the provider, but her name was crossed out with ink and NP 7 was listed as the provider. - On 1/1/23 through 1/31/23 the MAR indicated NP 6 was listed as the provider and her name was crossed out in ink. No other provider was listed. - On 2/1/23 through 2/28/23 the MAR indicated NP 6 was listed as the prescriber. - On 3/1/23 through 3/31/23 the MAR indicated NP 6 was listed as the provider, but her name was crossed out and NP 9 was wrote in ink. The record for Resident K lacked documentation the pharmacy regularities were corrected. The record lacked documentation of pharmacy reviews prior to March 2023. The physician's order , dated 11/28/22, indicated the physician's name was NP 6 and crossed out by the nurse and NP 7 was added as the provider. The physicians' order, dated 12/28/22, indicated the resident was prescribed gabapentin 100 mg (milligrams) 1 capsule by mouth two times a day with a start date of 9/26/22. The NP 6 was documented on the MAR as the prescribing physician. During an interview on 5/30/23 at 1:30 p.m., the DON (Director of Nursing) indicated the pharmacy failed to mark off the resident's old NP name and add the new NP name. There were no telephone orders sent to the pharmacy. The MAR wasn't getting carried over with the new provider. The Pharmacy Consultant should be checking for irregularities every 60 days. She indicated a monthly MAR would be sent to the resident's physician for review and signature. The pharmacy did not pick up on the discrepancy. The physician		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The CSM or designee will review physician order sheets for changes in resident's physician and ensure the pharmacy was notified weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly for 1 month. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going	

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	orders were not sent to NP 6 to be signed. The orders were sent to the resident's current physician, and he signed them. The night shift nurse does the end of the month review for changes on the MAR and makes corrections. The corrections would be sent to the proper provider and the MAR would be signed. Pharmacy would receive a copy and made the correction. If the irregularity was not caught by the night shift nurse, then pharmacy should have. The pharmacy was their safety net and there was no communication from the pharmacy. The nurse was marking out NP 6 as the provider and adding NP 7 as the current NP, but pharmacy was not making the correction. A document, dated 5/31/23 at 7:48 a.m., was presented by the ED. The Pharmacy staff 8 indicated when there was a change in the physician, the pharmacy would need to be provided a new prescription from the new provider. This instance was found to be coded incorrectly, so a call to the pharmacy to research the issue would have been sufficient. During an interview on 5/31/23 at 10:30 a.m., the ED indicated the pharmacy reviewed the MARs every 60 days for irregularities by the computer. The pharmacy consultant did not come to the facility. When new orders or changes were made, the facility would fax a copy to the pharmacy for the corrections to be made on the MAR. A review of the Consultant Pharmacist Physician Recommendations, dated 3/3/23, indicated the MAR was reviewed and a recommendation was sent to the physician requesting clarification for hydrocodone 1 or 2 tabs every 6 hours as needed for pain.			

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	The review on 5/31/23 at 11:5 a p.m., of the current Consultant Pharmacist Services included, but was not limited to, ..."The consultant pharmacist reviews and evaluates the pharmaceutical services by helping the facility identify, evaluate, and address medication issues that may affect resident care, medical care, and quality of life. The pharmacist is responsible for helping the facility obtain, and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet state and federal requirements... 1. Consultant Pharmacist will conduct a medication regimen review for Facility residents at least monthly or as outlined per pharmacy services agreement... 3. The consultant pharmacist or designee will periodically review a random sample of medication administration records for timeliness, accuracy, proper documentation and compliance with applicable laws and current medication administration standards..." This State tag relates to Complaint IN00407476			