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	09/30/2019

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BENNETT PLACE	3928 HORNE AVE NEW ALBANY, IN 47150

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: September 30, 2019 Facility number: 004442 Residential Census: 37 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 5, 2019.	R 0000	Submission of this response and Plan or 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 response or 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.	
R 0117 Bldg. 00	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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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. Based on record review and interview, the facility failed to ensure a scheduled staff member was certified in First Aid while working on each shift. This deficient practice had the potential to affect 37 of 37 residents who reside in the facility. Findings include: During the review on 9/30/19 from 1:45 p.m. to 2:35 p.m., of the CPR (Cardiopulmonary Resuscitation) and First Aid certifications for the staff no staff had a current First Aid certification. The staff schedule was reviewed from 9/29/19 through 10/5/19. The as worked schedule indicated none of the 20 staff members scheduled to work on the 6:00 a.m. to 6:00 p.m. shifts, the 2:00 p.m. to 10:00 p.m. shifts, the 6:00 p.m. to 6:00 a.m. shifts, or the 6:00 a.m. to 2:00 p.m. shifts, had a current First Aid certification. During an interview on 9/30/19 at 2:37 p.m., the Administrator indicated he was told the Basic Life Support (BLS) CPR and Automated External Defibrillator (AED) Program training included First Aid training. The employees did not have a First Aid certification card. He did not provide a policy for staff training.	R 0117	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Training class scheduled for First Aide for all staff on 10/29/19.* **How will the facility 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 employees was conducted to identify staff members lacking evidence of First Aid Training by Care Services Manager on 10/01/2019 .* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** *Current Care services Staff trained on 10/29/2019 by an approved trainer regarding First Aid* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.**	11/12/2019

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			The Care Services Manager is responsible for sustained compliance by reviewing schedule to monitor and to ensure at least one staff member on duty, per shift, will be first aid certified. The Executive Director and/or designee will conduct a certification audit on 2 employees weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.	
R 0123 Bldg. 00	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: (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			

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	with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure employees received annual in-servicing for Resident Rights, Dementia, and Abuse, employees had a Specific Job Orientation, and Job Description for 4 of 10 personnel files reviewed. (Community Relations Manager 8, Resident Care Partner 6, Activity Director 9, and Resident Care Partner 10). Findings include: 1. During the review on 9/30/19 at 2:15 p.m., the Personnel files lacked documentation of the following: a. Community Relations Manager 8's employee file lacked A Job Description and Specific Job Orientation. The Community Relations Manager 8 began employment on 09/6/19. b. RCP (Resident Care Partner) 6's employee file lacked a Specific Job Orientation, and In-services for Resident Rights, Dementia, and Abuse. The RCP 6 began employment on 4/26/19. c. Activity Director 9's employee file lacked In-services for Resident Rights, Dementia, and Abuse. The Activity Director 9 began employment on 7/29/13. d. RCP 10's employee file lacked In-services for Resident Rights.	R 0123	**R 123 410 IAC 16.2-5-1.4(h)(1-10) Personnel – Nonconformance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Employee 8 job description and job specific orientation completed and placed in file 10/14/2019, Employee 6 specific job orientation and in-services for resident rights, dementia and abuse completed 10/15/2019. Employee 9 records will be obtained once they return from FMLA. Employee 10 in-service for resident rights completed 10/15/2019* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** *An audit was completed by Executive Director to ensure state required forms and training present on 10/16/2019.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.**	11/12/2019

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	The RCP 10 began employment on 1/11/18. During an interview on 9/30/19 at 2:37 p.m., the Administrator indicated the Activity Director was on leave and he could not access the information on the computer for her in-services. There were no other in-services available for the Community Relations Manager, RCP 6, and RCP 10. The review on 9/30/19 at 3:00 p.m., of the Staff Orientation and Training Policy effective on 09/01/16, indicated "...A standardized Orientation Checklist is completed for new employees and can be found in the personnel files of employees. In addition to general orientation, department specific orientation is completed and documented for our new employees. Competency skills checklists are also completed for individuals responsible for the provision of resident care, health services, or medication assistance or administration. Employee education and re-education are held on a regularly scheduled basis to ensure the provision of high levels of resident care and customer service. Competency reviews, individual goal-setting, testing following education and annual employee performance evaluations are ways staff performance is measured." The current Resident Rights Policy indicated, but was not limited to, "...Employees will receive education and training on state-specific resident rights during initial orientation and as part of their on-going continuing education."		*The administrative staff will be in serviced by the Executive Director on state required forms and training for employees by 10/16/2019* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Executive Director is responsible for sustained compliance. ED and/or designee will complete employee file audit to determine presence of required forms and training on new employees within 1 week of hire, weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 month. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.*	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and			

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	local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food items were labeled and dated after use, a kitchen cabinet was free of sticky debris, and the soap dispenser was readily available for use during 1 of 2 kitchen observations. This deficient practice had the potential to affect 37 of 37 residents who received meals from the kitchen. Findings include: During the initial kitchen observation on 9/30/19 at 8:06 a.m., the following was observed: - The empty soap dispenser bottle was lying in the handwashing sink. - 6 containers of food items not easily distinguished were in the reach in refrigerator without a label or date. - The cabinet above the coffee machine had a sticky powdery substance pink in color on the shelf. - 8 half-empty bags of bread and rolls were sitting on the kitchen window sill - Each bag only contained a few slices of bread or rolls. - 2 bags of noodles were open to air in the dry storage room. An interview, on 9/30/10 at 8:15 a.m., RCP (Resident Care Partner) 6 indicated "I know they are supposed to label and date any container of food they put in the refrigerator." An interview with the Chef on 9/30/19 at 11:45	R 0273	**R 273 410 IAC 16.2-5.1 (f) Food and nutritional Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *All items without dates disposed of on 9/30/19. Soap was made readily available prior to breakfast service day on 9/30/19 and empty bottle disposed of in trash receptacle. Cabinet cleaned on 9/30/2019* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** *An audit was conducted to ensure all items were dated and stored appropriately. Any found missing or out of compliance were immediately disposed.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** *Current Staff were in serviced regarding proper cleaning procedures by Executive Director on 10/16/2019. Current dietary staff in-serviced on safe handling of food to include dating and labeling by Executive Director on 10/16/2019*	11/12/2019

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	a.m., he indicated he had been off for 4 days and could not account for what the other staff did, but the left overs should have been labeled and dated when put into the refrigerator. On 9/30/19 at 2:35 p.m., the Administrator presented a copy of the facility's current policy titled "Leftovers and Prepared Foods". This policy indicated " Policy: Leftovers and prepared foods must be covered and stored appropriately. Process: Prepared foods must be stored in an appropriate container with an airtight lid or cellophane, and labeled with the type of food and date..." A second policy titled "Storage of Products" was also presented by the Administrator at 2:35 p.m. This policy indicated "...Process:...Once opened, items should be dated and sealed/covered appropriately for storage."		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Dietary Manager is responsible for sustained compliance. The Executive Director and/or designee with monitor kitchen sanitation 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.*	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation and interview, the facility failed to ensure medications were secured for resident safety during 3 of 3 observations of medication storage. Findings include: 1. During an observation on 9/30/19 at 8:10 a.m., LPN (Licensed Practical Nurse) 3 left the medication room leaving the door unlocked and ajar. The LPN pushed her medication cart to the dining room hall. She obtained medication for four	R 0295	R 295 410 IAC 16.2-5-6(a) Pharmaceutical Services –Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *LPN 3 was re-trained on*	11/12/2019

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	residents whom were entering the dining room. During each administration of the four residents' medications, the medication storage room door was out of view, ajar, and unlocked. An interview, on 9/30/19 at 8:10 a.m., the LPN indicated it was hard to unlock the door with her key, so she had left it open. During an observation on 9/30/19 at 8:11 a.m., Residents 9 and 10 were observed walking by the medication room door, while going to the dining room. 2. During an observation on 9/30/19 at 8:29 a.m., LPN 3 obtained Miralax for Resident 11. The LPN left the Miralax container on the top of the medication cart. She had entered the dining room and administered the medication to the resident leaving the medication cart out of site. An interview, on 9/30/10 at 8:31 a.m., LPN returned to the medication cart and noticed the Miralax on the cart. She indicated, "Oops" that she should have not left the Miralax out onto of the cart unsecured. 3. During an observation on 9/30/19 at 12:23 p.m., LPN 3 was serving in the dining room. She then assisted a delivery man out of the facility. Upon a request for a cart review, the LPN walked from the front door, through the dining room area, and opened the medication room door, which was not locked. During an interview on 9/30/19 at 3:04 p.m., the Administrator indicated the medication room door should be locked and the medications in the cart should be secured when a nurse was not present.		*medication handling and storage on 10/11/2019 by Care Service Manager. Door lock serviced by maintenance on 10/01/2019. New keys cut for door lock.* How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *Door lock changed to ensure all licensed staff will have easy access to medication room.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. *Current licensed staff were in serviced to ensuring medications are stored properly per Enlivant Policy on 10/14/2019 by the Care Services Manager* How the corrective action(s) will be monitored to ensure the deficient practice will not recur. *The Care Services Manager (CSM) is responsible for sustained compliance. The CSM and/or Designee will perform a random cart audits for ensuring medications are secure, med room door locked, meds secured*	

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	The review on 9/30/19 at 2:37 p.m., of the Storage of Medications policy dated 9/1/19, included, but was not limited to, "All medications stored by the community must be maintained in a clean, neat, locked container or area. The medication cart, bins, or cabinet(s) and the Wellness Area should be kept locked when not used..."		*in med cart. Audits will be conducted 5 x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.*	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to ensure the labeling and monitoring of an expiration date on medications for 2 of 2 medication carts reviewed. (Residents 4 and 5) Findings include: 1. An observation on 9/30/19 at 12:23 p.m., of the Medication Cart 1 indicated the following: Resident 4's bisacodyl suppository had an expiration date of 8/20/19. During an interview on 9/30/19 at 12: 23 p.m., LPN (Licensed Practical Nurse) 3 indicated "the night shift nurse should check the expiration dates, but she passed away about 3 weeks ago, so we have been trying to do it."	R 0300	R 300 410 IAC 16.2-5-6(c)(4) Pharmaceutical Services -Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *Humalog kwikpen for resident 5 disposed on 9/30/2019. Bisacodyl suppository for resident 4 disposed on 9/30/2019.. LPN 3 was re-trained on insulin expiration dates by the Care Services Manager on 10/11/2019.* How will the facility identify other	11/12/2019

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	The clinical record was reviewed on 9/30/19 at 2:30 p.m. The resident's diagnoses included, but were not limited to, anorexia, gastro-esophageal reflux disease, and gout. The physician's orders indicated the resident received a bisacodyl suppository 10 milligrams once a day as needed for constipation, with a start date of 12/12/17. 2. An observation on 9/30/19 at 12:30 p.m., of the Medication Cart 2 indicated the following: Resident 5's Humalog kwikpen had an open date of 8/24/19. During an interview on 9/30/19 at 12:30 p.m., LPN 3 indicated the printed pharmacy expiration date was still good. The clinical record was reviewed on 9/30/19 at 2:30 p.m. The resident's diagnosis included, but was not limited to, Diabetes Mellitus type 2. The physician's order indicated the resident was to receive Humalog 100 unit/mL (milliliter) kwikpen per sliding scale 3 times a day, with a start date of 12/14/18. The Medication Administration Record for September, 2019, indicated the resident received the following doses of Humalog, after the pen was open for 28 days: - on 9/22/19 - 2 units before lunch and dinner. - on 9/23/19 - 2 units before breakfast and lunch and 4 units before dinner. - on 9/24/19 - 2 units before breakfast and lunch and 4 units before dinner. - on 9/25/19 - 2 units before lunch and 4 units		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *An audit was conducted on Med Cart 1 and Med Cart 2 by the Care Services Manager to ensure no expired medications were present on 10/08/2019* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. *Current licensed staff were in serviced to medication storage including expired medications per Enlivant Policy on 10/14/2019 by the Care Services Manager* How the corrective action(s) will be monitored to ensure the deficient practice will not recur. *The Care Services Manager is responsible for sustained compliance. The Care Services Manager and/or Designee will perform a random cart audits for expired medications. Audits will be conducted 5 x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary*	

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	before dinner. - on 9/26/19 - 2 units before breakfast and lunch and 2 units before dinner. - on 9/27/19 - 8 units before dinner. - on 9/28/19 - 2 units before breakfast and lunch and 2 units before dinner. - on 9/29/19 - 2 units before breakfast and lunch. - on 9/30/19 - 2 units before breakfast and lunch. During an interview with the Administrator, on 9/30/19 at 12:48 p.m., he indicated they just looked at the medications for expiration dates last month. The facility did not have a policy for monitoring for expired medications. The review on 9/30/19 at 2:40 p.m., of the "How Long Should Insulin Be Used Once a Vial Is Started?" at https://care.diabetesjournals.org/content/26/9/2665 included, but was not limited to, "...Opened vials, whether or not refrigerated, must be used within 28 days. They must be discarded if not used within 28 days..."		*based on three consecutive months of compliance. Monitoring will be ongoing*	