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	05/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 21, 2024 Facility number: 004442 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 23, 2024.	R 0000	Deficiency ID: R116 Completion Date: 8/1/2024 Plan of Correction Text: 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Business Office Assistant (BOA) educated on all items needed in employee files. 2 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: All residents have the potential to be affected. 3 What measures will be put into place or what systemic change the facility will make to ensure that the deficient practice does not reoccur. BOA or designee will routinely audit employee files.**/b>** **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.**	

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

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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			BOA will audit 5 random employee files per week x 3 weeks, then 3 random employee files per week x 3 weeks, then 1 random employee file per week x 3 weeks. **Background checks to be completed on all prospective employees prior to job offer. No job offer will be offered to prospective employees with a criminal background check.** **All employee files will be audited monthly.** **5 By what date the systemic changes will be completed: 8/1/2024** **Deficiency ID: R120** **Completion Date: 8/1/2024** **Plan of Correction Text:** **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** **All staff was inserved on Resident Rights and Dementia Care on 5/22/2024.** **2 How will the facility**	

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			identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: **All residents have the potential to be affected.** **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** **DHW to follow the monthly inserve schedule. BOA to routinely audit completion of employee Relias training.** **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.** **ED will audit that DHW is following the monthly inservice schedule. BOA will audit Relias training weekly until all staff have completed their required training.** **5 By what date the systemic changes will be completed: 8/1/2024**	

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			Deficiency ID: R247 **Completion Date: 8/1/2024** **Plan of Correction Text:** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **All clinical staff will be inserviced on following physician orders, reading the MAR, and rights of medication administration.** **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;** **All residents have the potential to be affected.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The DHW or designee will routinely audit MAR's for compliance and will audit medication passes to ensure accuracy.**	

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			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 DHW will audit orders and medication administration for 5 random residents per week x2 weeks, then 3 random residents per week x2 weeks, then 1 resident per week x2 weeks.** **All resident MARs will be audited monthly.** **5. By what date the systemic changes will be completed. 8/1/2024** **Deficiency ID: R 297** **Completion Date: 8/1/2024** **Plan of correction text:** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	

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			All clinical staff who administer insulin will be in serviced on insulin administration via flex pen per manufacturer guidelines. **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;** **All residents receiving insulin therapy have the potential to be affected.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The DHW or designee with audit insulin administration for residents receiving insulin and will provide continued education regarding insulin administration.** **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 DHW or their designee will**	

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			audit the administration of insulin for 1 random pass 5 days a week for 2 weeks, then 1 pass 3 days a week for 2 weeks, then weekly indefinitely to ensure continued compliance. **Inservicing specific to insulin administration will be provided immediately and then yearly for any clinical staff that administers insulin.** **5. By what date the systemic changes will be completed.** **8/1/2024** **Deficiency ID: R304** **Completion Date: 8/1/2024** **Plan of correction text:** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **All medication storage units**	

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			(closets, refrigerator, carts) will be audited immediately to ensure proper labeling and storage. All expired meds will be destroyed per policy. Clinical staff will be in serviced on storage and labeling of medications. **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;** **All residents have the potential to be affected.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The DHW will immediately audit all medication carts, closets, refrigerators for proper labeling of medications, expired medications, and proper storage.** **All clinical staff will be inserviced on labeling and storing medications and policy on expired/discontinued medication desruction.** **4. How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **The DHW or their designee will audit all medication labeling and medication storage units 5 days per week for 2 weeks, then 3 days a week for 2 weeks, then weekly indefinitely to ensure that medications are being properly stored and labeled.** **5. By what date the systemic changes will be completed.** **8/1/2024**	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees.			

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	Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to implement the screening of prospective employees related to a conviction barring employment (CNA 5) and employee references (LPN 4) for 2 of 5 personnel files reviewed. Findings include: 1. On 5/21/24 at 10:30 a.m., CNA (Certified Nursing Aide) 5's personal file was reviewed. The CNA's hire date was 1/23/24. The review of CNA 5's Universal Background Screening form, dated 1/19/24, indicated, on 8/20/19, the CNA was charged with theft. She was found guilty of a Class A misdemeanor. Review of the facility nursing schedules, dated 5/19/24 to 6/1/24, indicated CNA 5 worked on 5/20/24 from 6:00 p.m. to 6:00 a.m. The CNA was scheduled to work on the following days and times: 5/21/24 to 5/23/24 and 5/27/24 to 5/30/24 on the 6:00 p.m. to 6:00 a.m. shift. During an interview on 5/21/24 at 3:00 p.m., the DON (Director of Nursing) indicated that the ED did the background checks on the employees. He was not aware CNA 5 had a criminal background. He had no idea why she was hired. He would not hire someone if the background check came back with a criminal history. During an interview on 5/21/24 at 3:15 p.m., the ED indicated that she was aware CNA 5 had a criminal history. She informed the corporate Human Resource department and they indicated that they	R 0116	Deficiency ID: R116 Completion Date: 8/1/2024 Plan of Correction Text: 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Business Office Assistant (BOA) educated on all items needed in employee files. 2 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: All residents have the potential to be affected. 3 What measures will be put into place or what systemic change the facility will make to ensure that the deficient practice does not reoccur. BOA or designee will routinely audit employee files. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance	08/01/2024

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	could not hold the CNA's criminal history against her and the ED could hire the CNA. 2023 Indiana Code, Title 16. Health Article 28. Health Facilities, Chapter 13. Criminal History of Nurse Aides and Other Unlicensed Employees 16-28-13-3. Crimes Barring Employment at Certain Health Care Facilities Universal Citation: IN Code § 16-28-13-3 (2023). "...Sec. 3. (a) A health care facility or an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility may not knowingly employ a person as a nurse aide or other unlicensed employee if one (1) or more of the following conditions exist:..(D) Theft (IC 35-43-4), if the person's conviction for theft occurred less than five (5) years before the individual's employment application date, except as provided in IC 16-27-2-5(a)(5). Current as of June 08, 2021 | Updated by FindLaw Staff. 35-43-4 "...Sec. 2. (a) A person who knowingly or intentionally exerts unauthorized control over property of another person, with intent to deprive the other person of any part of its value or use, commits theft, a Class A misdemeanor..." 2. On 5/21/24 at 10:20 a.m., LPN (Licensed Practical Nurse) 4's personnel file was reviewed. The LPN's employee file lacked documentation of employee reference. During an interview on 5/21/24 at 2:00 p.m., the ED (Executive Director) indicated she was unable to locate documentation that LPN 4 had references. The facility did not present an employment policy.		program will be put into place. BOA will audit 5 random employee files per week x 3 weeks, then 3 random employee files per week x 3 weeks, then 1 random employee file per week x 3 weeks. All employee files will be audited monthly. 5 By what date the systemic changes will be completed: 8/1/2024	

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility	R 0120	Deficiency ID: R120	08/01/2024

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	failed to ensure the employee's required training was completed for dementia training (CNA 7) annual in-servicing on resident rights (CNA 5, LPN 6, and CNA 7) for 3 of 5 personnel files reviewed. Findings include: 1. On 5/21/24 at 10:05 a.m., LPN (Licensed Practical Nurse) 6's personnel file was reviewed. The LPN's training records lacked documentation of resident rights in-servicing since the employee's hire date of 2/5/24. 2. On 5/21/24 at 10:15 a.m., CNA 7's personnel file was reviewed. The CNA's training records lacked documentation of resident rights in-servicing since the employee's hire date of 12/15/23. 3. On 5/21/24 at 10:30 a.m., CNA (Certified Nursing Aide) 5's personnel file was reviewed. The CNA's training records lacked documentation of resident rights in-servicing. The facility could only provide documentation for a general orientation quiz of dementia since the employee's hire date of 1/23/24. During an interview on 5/21/24 at 2:05 p.m., the Executive Director indicated there was no in-service information indicating the above employees had completed their resident rights training and dementia training. The facility did not present an in-service policy for employees.		Completion Date: 8/1/2024 Plan of Correction Text: 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: All staff was inserved on Resident Rights and Dementia Care on 5/22/2024. 2 How will the facility identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. DHW to follow the monthly inserve schedule. BOA to routinely audit completion of employee Relias training. 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. ED will audit that DHW is following the monthly inservice schedule. BOA will audit Relias training	

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			weekly until all staff have completed their required training. 5 By what date the systemic changes will be completed: 8/1/2024	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review, and interview, the facility failed to follow the physician's order for the administration of a routine dose of insulin for 1 of 3 residents observed for insulin administration. (Resident 1) Findings include: During an observation, on 5/21/24 at 11:40 a.m., LPN (Licensed Practical Nurse) 8 administered Resident 1's aspart flex pen (insulin). She administered 4 units of aspart per sliding scale. The current physician's order, dated 9/5/23, indicated Resident 1 was to have administered 5 units of aspart flexpen insulin 100 u/mL (units per milliliter) 5 units subcutaneously with meals. The staff were to administer the aspart flexpen within 10 to 15 minutes of mealtime and bedtime snack at 6:30 a.m.,11:30 a.m., and 4:30 p.m. The May MAR (Medication Administration Record) indicated the resident's 5 units of aspart flexpen insulin was not initialed as given on 5/20/24 or 5/21/24 at 11:30 a.m.	R 0247	Deficiency ID: R247 Completion Date: 8/1/2024 Plan of Correction Text: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All clinical staff will be inserviced on following physician orders, reading the MAR, and rights of medication administration. 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; All residents have the potential to be affected. 3. What measures will be put into	08/01/2024

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	During an interview on 5/21/24 at 12:08 p.m., LPN 8 indicated she didn't see the physician's order on the MAR (Medication Administration Record). The facility did not present a policy for following physician orders.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The DHW or designee will routinely audit MAR's for compliance and will audit medication passes to ensure accuracy. 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 DHW will audit orders and medication administration for 5 random residents per week x2 weeks, then 3 random residents per week x2 weeks, then 1 resident per week x2 weeks. All resident MARs will be audited monthly. 5. By what date the systemic changes will be completed. 8/1/2024	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to			

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BENNETT PLACE	3928 HORNE AVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure proper use of the insulin flexpens for 3 of 3 residents observed for pharmacy services. (Residents, 1, 8, and 9) Findings include: 1. During an interview and observation of the administration of insulin on 5/21/24 at 11:18 a.m., LPN (Licensed Practical Nurse) 8 administered 6 units of Resident 8's Lispro (insulin) per sliding scale. LPN 8 failed to prime the needle of the flexpen prior to the administration of the 6 units of Lispro. The LPN indicated she forgot to administer the routine 3 units of Lispro with the sliding scale. She then obtained a new needle and dialed the Lispro flexpen to the 3 units and administered the insulin without priming the needle of the flexpen prior to the administration. 2. During an interview and observation of the administration of insulin on 5/21/24 at 11:40 a.m., LPN 8 administered 4 units of Resident 1's aspart flexpen insulin per sliding scale. The LPN failed to prime the needle of the flexpen prior to the administration of the resident's insulin. During an observation on 5/21/24 at 12:08 p.m., LPN 8 administered Resident 1's additional 5 units of aspart insulin. LPN 8 placed a needle on the aspart flexpen and without priming the needle prior to administration, she administered the additional 5 units of the resident's insulin. 3. During an observation of the administration of insulin on 5/21/24 at 11:45 a.m., LPN 8 administered 8 units of Resident 9's Novolog per	R 0297	Deficiency ID: R 297 Completion Date: 8/1/2024 Plan of correction text: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All clinical staff who administer insulin will be in serviced on insulin administration via flex pen per manufacturer guidelines. 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; All residents receiving insulin therapy have the potential to be affected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The DHW or designee with audit insulin administration for residents receiving insulin and will provide continued education regarding insulin administration.	08/01/2024

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	05/21/2024

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	sliding scale. The LPN failed to prime the needle prior to the administration of the residents insulin. During an interview on 5/21/24 at 12:08 p.m., LPN 8 indicated she never knew about priming the needle of the flexpens. Priming would help to make sure the full dose of insulin was administered if she had primed it. She had never been taught to prime the flexpen needle, but then changed her mind and indicated she may have been taught to prime the needle but had forgotten. The Novolog Flexpen (insulin aspart injection) 100 units/mL administration instructions, revised January 2019, included, but was not limited to, " ... For each injection: 1. Select a dose of 2 units. 2. Take off the outer needle cap (save it) and inner needle cap (throw it away). 3. With the pen pointing up, tap the insulin to move the air bubbles to the top. 4. Press the button all the way in and make sure insulin comes out of the needle ..."		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 DHW or their designee will audit the administration of insulin for 1 random pass 5 days a week for 2 weeks, then 1 pass 3 days a week for 2 weeks, then weekly indefinitely to ensure continued compliance. Inservicing specific to insulin administration will be provided immediately and then yearly for any clinical staff that administers insulin. 5. By what date the systemic changes will be completed. 8/1/2024	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and record review, the facility failed to ensure that narcotics were stored in a double locked medication storage unit, insulin	R 0304	Deficiency ID: R304 Completion Date: 8/1/2024	08/01/2024

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	pens were labeled, and expired medication were removed for 3 of 3 medication carts/rooms observed for pharmaceutical Services. (Medication Blue Cart, Medication Storage Room/Refrigerator and Medication Red Cart) Findings include: 1. During an observation of the medication storage blue medication cart, on 5/21/24 between 12:39 p.m. and 1:15 p.m., Resident 1's Novolog and Lantus pens were laying in the drawer. Both insulin pens lacked pharmacy or physician administrations. 2. a.During an observation with LPN (Licensed Practical Nurse) 8 of the medication storage room refrigerator, on 5/21/24 between 12:39 p.m. and 1:15 p.m., there was an opened box of Novolog insulin pens. There were two unopened pens in the box with no pharmacy label. 2.b. During an interview and observation with LPN (Licensed Practical Nurse) 8 of the medication storage room, on 5/21/24 between 12:39 p.m. and 1:15 p.m., the medication room and refrigerator narcotic box were unlocked. Resident 3's lorazepam box was unlocked. Resident 3's other bottle of lorazepam was in the top drawer of the red medication cart. LPN 8 indicated the bottle of lorazepam was just removed by her that morning at 10:00 a.m. The lorazepam bottle read to keep the medication stored in the refrigerator. The lorazepam was last administered, on 5/20/24 at 1:30 p.m., for the resident's agitation. 3. During an interview and observation with LPN (Licensed Practical Nurse) 8 of the medication storage room, on 5/21/24 between 12:39 p.m. and 1:15 p.m., Resident 10's hydroxychloroquine 200		Plan of correction text: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication storage units (closets, refrigerator, carts) will be audited immediately to ensure proper labeling and storage. All expired meds will be destroyed per policy. Clinical staff will be in serviced on storage and labeling of medications. 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; All residents have the potential to be affected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The DHW will immediately audit all medication carts, closets, refrigerators for proper labeling of medications, expired medications, and proper storage. All clinical staff will be inserviced	

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	mg (milligrams) was in the red medication cart with an expiration date of 1/5/24 on the bottle. LPN 8 indicated the resident now received her medications by individual medication packets and no longer needed the bottle of medication. The current Medication Storage policy, included, but was not limited to, "Medications stored by the community will be stored in a locked area. Medication carts and medication room will be used to store resident meds. Both shall be kept locked when not in use by staff ... Controlled substances will be stored under double lock in a locked cabinet, separate from other medications and with a different key for access ... Medications requiring refrigeration must also be kept in a locked area ..."		on labeling and storing medications and policy on expired/discontinued medication desruction. 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 DHW or their designee will audit all medication labeling and medication storage units 5 days per week for 2 weeks, then 3 days a week for 2 weeks, then weekly indefinitely to ensure that medications are being properly stored and labeled. 5. By what date the systemic changes will be completed. 8/1/2024	