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

FORM APPROVED
OMB NO. 0938-039

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	01/11/2024

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 the Investigation of Complaint IN00423149. Compliant IN00423149 - No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey date: January 11, 2024 Facility number: 004442 Residential Census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on January 21, 2024.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on record review and interview the facility failed to ensure a residents personal property was protected from theft for 1 of 7 residents reviewed for misappropriation. (Resident H) Findings include, The record for Resident H was reviewed on 1/11/24 at 9:37 a.m. The diagnoses included, but were not limited to, hypertension, sleep apnea, arthritis, chronic asthmatic, bronchitis, A-Fib, Type 2 diabetes, depression, GERD (Gastroesophageal Reflux Disease), and hypothyroidism.	R 0064	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident H car keys are locked in lock box in Executive Directors (ED) office. Executive Director (ED) now has list of all residents that have vehicle and vehicle plate numbers. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what	03/11/2024

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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	The review of the incident report dated 12/21/23, indicated the resident's family member reported that the resident's car was missing from the facility parking lot. He reached out to other family members to see if anyone had come and picked the car up. The resident stated she had not loaned her car to anyone. On 12/22/23, all staff were interviewed, and a police report was filed. Staff were educated on the importance of visitors signing the visitor log. During an interview on 1/11/24 at 10:30 a.m., Resident H indicated someone came into her room with a facility key and took the spare keys to her car. She was either asleep or out of the room. A family member had taken her to the dentist and when they returned, she noticed her car was not in the parking lot. She always parked it in the same place. She was one of two residents that had a car at the facility. She believed someone in the building gave her car keys to the guy that took her car. The night her car was taken there was food also taken from the kitchen. Resident H identified CNA (Certified Nursing Aide) 1 as the employee that was in her room and providing care. The CNA was in a relationship with the suspect. During an interview on 1/11/24 at 1:15 p.m., the Administrator indicated that she arrived at the facility on 12/22/23 at 8:00 am. She noticed a car that was always backed in was now facing the other way and running. She did not know the car belonged to the resident. Later on, that day the resident's family member took the resident to a dental appointment and when they returned, he noticed his family member's car was gone. The resident indicated she did not loan her car to anyone. She always kept her keys in her room. When they looked the keys were gone. The same night food items were missing from the kitchen.		corrective action will be taken: An audit of all residents by Executive Director (ED) and Director of Health and Wellness (DHW) was done to ensure that no other resident had any issues, concerns, or personal items missing on 1/12/24. 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: All staff trained on Resident rights and Misappropriation on 1/24/24. Continued training monthly on Residents rights and Misappropriation. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: Effective 1/29/24 The Executive Director or designee will audit 10 residents per week times 6 weeks, and then all residents monthly will be done to ensure that no resident has any issues, concerns, personal items missing. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5 By what date the systemic	

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	The facility made a police report. She reviewed the staff scheduling and indicated 3 employees were working that evening. The resident's car was found a few days later with a man driving it. She did not know who he was but was informed CNA 1 worked the evening shift and was in a relationship with the man arrested. She felt like the CNA 1 took the resident's keys while on shift and came back to get the car on the 22nd. The CNA was removed from the schedule, and she call the agency the CNA 1 was employed with. The agency immediately termed the CNA. The review of the current Abuse policy on 1/11/24 at 2:00 p.m., indicated ..."The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion... [Misappropriation of residents property] means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent"...		changes will be completed: March 11, 2024	