STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0000	This visit was for a State Residential Licensure Survey. Survey dates: July 16, 17, 18, & 19, 2012 Facility number: 002858 Provider number: 002858 AIM number: N/A Survey team: Dinah Jones, RN-TC Marcy Smith, RN Leia Alley, RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 8 These state residential state findings are cited in accordance with 410 IAC 16.2. Quality review completed 7/24/12 Cathy Emswiller RN	R0000		

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to report an allegation of abuse. This involved 1 of 7 residents reviewed for abuse allegations, Resident #7. Findings Include: During clinical record review for Resident #7, on 7/17/12 at 12:30 p.m. a nurses note indicated that Resident #7 stated a Resident Assistant was "mean" to her, leaving on her bra at night time and pulling her shoes off without un-tying them first, and reported the information to a receptionist in the building who then reported it to LPN #1 (Licensed Practical Nurse). LPN #1 then wrote a note in the nurses note and spoke to Resident #7 to make sure she was "ok". During an interview on 7/18/12 at 9:30 a.m. with the Executive Director and Regional Vice President, they indicated that LPN #1 did not report the allegation to the Executive Director nor was its reported to the appropriate state agency.	R0090	----------THIS TAG IS BEING DISPUTED---------- ---------- AN IDR REQUEST HAS BEEN SUBMITTED This facility will ensure that any known allegation of abuse and/or unusual occurrence is reported, and compliance with this regulation will consistently be maintained. CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1. Administrator became aware of this allegation on 7/18/12, discussed with surveyor that the LPN had documented and addressed the resident concern but had not reported it. Adminstrator discussed with surveyor that a full investigation was under way including: Interview and assessment of the resident, interview LPN who worked on 7/1/12 and documented the allegation without reporting it to her supervisor or Administrator, 1:1 corrective action meeting with LPN regarding proper reporting procedures, interviews of 6 employees regarding	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	During a review of a facility policy titled "Resident Abuse Policy/Procedure", dated 9/1/2006 on 7/18/12 at 10:00 a.m., it indicated that employees are to "immediately report" any allegations of abuse to the facility administrator.		the incident in question, interview with 6 residents to determine any concern regarding resident care and ability to file a grievance, discussion with IDT to review correct reporting procedures. (NOTE: Based on the Investigation it was determined abuse was not substantiated.) 2. Adminstrator reported incident on 7/19/12, which was within the twenty four hours of becoming aware of this occurrence. 3. Nursing assessment and care plan of resident (including review of resident current medications for appropriate pain management, and coordination with her hospice provider) led to consult with physician and new order for pain medication. FACILITY EFFORTS TO IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 1. On 7/26/12, the facility RN Consultant reviewed all 2012 Nurses Notes, for each facility resident. No other similar documentation was found in any other resident records. 2. By 8/31/12, the facility Administrator and/or the Resident Services Director will conduct one-on-one interviews with each facility resident and will ask open-ended questions regarding their care and treatment. (EXAMPLE: Please share with me your experiences with our staff and how they interact with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			you.) The facility's greivance report form and where blank forms are located will also be reviewed. Blank greivance report forms are located in the Resident Sign In/Sign Out Book in the front lobby area. MEASURES OR SYSTEMATIC CHANGES PUT INTO PLACE TO ENSURE THAT THIS DEFICIENT PRACTICE DOES NOT RECUR: 1. Staff inservice training, conducted by the Administrator, on 7/23/12 at 2:00pm included abuse prevention and reporting procedure. 2. Effective 8/1/12 all Nurse Note documentation will be revewed on a daily basis by Administrator, Resident Services Director or Designee. Beginning on 8/1/12, nurses will flag all newly written Nurse Notes. The Administrator, Resident Services Director or Desginee will check for new Nurse Notes on a daily basis and will read, initial and return the flagged Nurse Note to it's proper position or location. 3. On 8/3/12, LPN # 1 was counseled and re-trained, by the Administrator. This training / counseling included a review of the state regulations regarding supervisory notifications when reprts of any resident greivance is received (complaints, concerns, allegations, etc.). 4. By 8/7/12 all facility personnel will be trained by the Administrator on reporting and documenting resident complaints, greivances	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			or allegations of abuse. Chain of command, who to call, when to call, facility policies and the laws or regulations concerning abuse will be covered during this inservice. This training will be included and documented during the iitial training of all newly hired personnel. To ensure ongoing compliance, annual review of this training will be provided for all staff. 5. By 8/9/12, the Administrator will attend a resident council meeting and conduct a group review of how to report greivances, concerns or problems. Residents will be reminded that blank greivance forms are maintained in the Resident Sign In/Sign Out Book located in the front lobby. This information will be reviewed annually with residents during routine Resident Council Meetings. DESCRIPTION OF MONITORING THE CORRECTIVE ACTION TO ENSUE THE DEFICIENT PRACTICE WILL NOT RECUR (QUALITY ASSURANCE PROGRAM, ETC.) 1. Daily monitoring of Nurse Notes by the Administrator, Resident Services Director or Designee. Problems or concerns noted will be addressed by the facility management team during Daily Stand-Up Meetings. 2. On an ongoing basis, daily handling, investigation and follow up of all known resident concerns, complaints or greivances will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			the responsibility of the Administrator. When a resident concern, complaint or greivance rises to the level of abuse, or if abuse is suspected or alleged, the Administrator will promptly notify the Regional Vice President and file a timely report with the division. 2. Monthly interdisciplinary review of Resident Greivance Reports along with all relevant investiagtion &/or follow up during routine monthly Safety / Quality Assurance Committee meetings. 3. Quarterly spot checks of at least 4 resident records, to include review of Nurse Notes, by the Regional Vice President. 4. Quarterly spot checks of least 4 resident records, in include review of Nurse notes, by the Regional Resident Services Director, RN. 5. Administrator will be make herself available to attend Resident Council Meetings when requested by the Resident Council President. DATE THAT SYSTEMIC CHANGES WILL BE COMPLETED: 7/23/12: Staff in-service training on abuse prevention and reporting procedures 8/1/12: Daily flagging of new Nurse Notes by nurses and review of these by the Administrator, Resident Service Director or Desginee. (This will continue on an ongoing basis.) 8/3/12: One-on-one training and counseling of LPN # 1, on state regulations,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			supervisory notifications regarding resident greivances, complaints, allegations, etc. 8/7/12: In-service for all current personnel conducted by facility Administrator on reporting and documenting resident complaints, greivances, allegations of abuse, chain of command (who to call, when to call), facility policies and laws or regulations on abuse. This training will occur annually in January and will be included in the initial training for new personnel. 8/9/12: Administrator attendance at resident council meeting to review, with residents, reporting of greivances, concerns, problems, where greviance report forms can be found (in the Resident Sign in/Sign Out Book).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Based on record review and interview, the facility failed to ensure pre-employment physicals were provided by a physician for 6 of 6 employees in a sample of 6 employee files reviewed. The employee files reviewed were CNA [Certified Nursing Assistant] #2, LPN [Licensed Practical Nurse] #3, LPN #4, Life Enrichment Director #5, CNA #6 and CNA #7. Findings include: On 7/18/12 at 2:45 p.m., a record review of 6 of 6 employee files, CNA #2 hired 4/3/2012, LPN #3, hired 2/1/2012, LPN #4, hired 5/21/2012, Life Enrichment Director #5, hired 2/12/2007, CNA #6, hired 3/14/2012 and CNA #7, hired 6/11/2012, indicated the facility did not have a pre-employment health screening form signed by a physician included in the employee's files. During an interview with the Executive Director and Regional Vice President on 7/19/12 at 9:30 a.m., they indicated a physician had not signed the pre-employment health screenings of the 6 employees whose files were reviewed.	R0121	----------THIS TAG IS BEING DISPUTED---------- AN IDR REQUEST HAS BEEN SUBMITTED Depending upon the outcome of the IDR, the facility will ensure that pre-employment physicals are provided by a physician. CORRECTIVE ACTIONS(S) THAT WILL BE ACCOMPLISHED FOR THOSE REISDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Not Applicable: No residents were found to have been affected by this practice. 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: Not Applicable: No residents were found to have been affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: 1. The facility Administrator will implement a "double-check" system to ensure that a physician signature is present on each new employee physical. Effective 8/15/12, the Business Office Manager will receive the prospective employees physical and verify that it has been signed by a	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			physician before processing the new employee. He/she will then forward the physical form to the departmental supervisor for a second verification of the physician signature on the pre-employment physical before placing the new employee on the work schedule. The departmental supervisor will route the pre-employment physical to the Business office manager for inclusion in the employee health file. 2. The Admiminstrator will train the Business office manager and each of the departmental supervisors on the "double-check" process by 8/15/12. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: 1. The Administrator will conduct a monthly audit of all new pre-employment physical forms to ensure they have been signed by a physician. These audits will begin by August 31, 2012. 2. Results from the Administrator audits of new pre-employment physical forms will be reviewd on a monthly basis by the multi-disciplinary Safety / Qualtiy Auusrance Team, during routine monthly meetings, effective 8/31/12. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED. 8/15/12: Business Office Manager and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			departmental supervisor training on the "double-check" system to ensure pre-employment physicals are signed by a physician. 8/15/12: Implementation of the "double-check" system for pre-employment physicals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0273	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 local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure food was stored properly for 2 of 2 observations and the dishwasher chemical sanitization level was checked regularly for 1 of 1 observations. These practices had the potential to affect 31 of 31 residents receiving food from the kitchen. Findings include: During a tour of the kitchen on 7/16/12 at 10:20 a.m. with the Dietary Manager, 26 bowls of lemon pudding parfait topped with whipped cream were observed stored uncovered in the prep refrigerator. During an interview with the Dietary Manager on this date at 10:40 a.m. she indicated she did not know food stored in the refrigerator had to be covered if it was going to be served "right away." She indicated the lunch meal service would begin at 12:00 p.m. She indicated "If I cover them it will ruin the whipped cream." The uncovered bowls of lemon pudding parfait were observed removed from the refrigerator at 12:25 p.m. to be given to the residents for dessert. During a tour of the kitchen on 7/16/12 at 2:00 p.m. with the Dietary Manager, a bottle of lemon juice and a bottle of lime juice were observed sitting on a shelf above the vegetable sink. The lemon juice had an opened date of 2/18/12 and the lime juice had an opened date of 7/20/11. Both	R0273	The facility dietary department will follow food handling and sanitation guidelines to ensure that refrigerated food is covered and that food items which require refrigeration aer properly stored under refrigeration. Dishmachine sanitation logs will be completed daily by dietary personnel. CORRECTIVE ACTIONS(S) THAT WILL BE ACCOMPLISHED FOR THOSE REISDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Not Applicable: No residents were found to have been affected by this practice. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVINGTHE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Not Applicable: No residents were found to have been affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: 1. The consulting Registered Dietitian conducted a thorough	08/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	bottles were labeled with instructions to "Refrigerate after opening." During an interview with the Dietary Manager at this time she indicated "I wasn't aware they were supposed to be refrigerated." During a tour of the kitchen on 7/16/12 at 10:20 a.m. with the Dietary Manager, she indicated they used a Quaternary Ammonium product in the dishwasher and manually to sanitize the dishes after use. She indicated the manufacturer's instructions were 200 ppm (parts per million) for manual washing and 50-100 ppm for the dishwasher. She indicated the strength (ppm) of the solutions was to be checked and recorded every day. Review of a "Daily Sanitizer Checklist" hanging on the wall by the dishwasher indicated the ppm of the sanitizing solution for the dishwasher and the manual dish sink was checked on April 9,10, 12 and 24, 2012, May 8,14,19 and 28, 2012, July 16, 2012. The Dietary Manager indicated at this time "They should have been checked every day." During an interview with the Dietary Manager on 7/19/12 at 10:00 a.m. she indicated all 31 residents residing in the facility eat meals prepared in the facility kitchen.		inspection of the kitchen on 7/30/12 to ensure there are no other food storage issues and that dish washing sanitation temps and chemical sanitation records are being documented each day. 2. On July 17th and again on July 27th, the Dietary Manager in-serviced all dietary personnel on storing and properly covering food items in the refrigerator. The instructor stressed the importance of checking and documenting chemical sanitation strength, storage of opened food items such as lemon or lime juice. 3. By 8 13/12, all dietary personnel (including the Dietary Manager) will be in-serviced by the Consulting Dietitian on storing and properly covering food items in the refrigerator. The instructor will emphasize the importance of checking and documenting chemical sanitation strength, storage of opened food items such as lemon or lime juice. 4. Effective 8/1/12 the Dietary manager will bring the daily dishwashing sanitation records to the daily Stand-Up Meeting for review by the facility management team and the Administrator. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			PLACE: 1. The Registered Dietitian will visit the facility each month, beginning on 7/30/12. Visits will vary in focus and will include (but will not be limited to) sanitation inspections, staff education, food preparation and storage. Written reports of findings will be provided to the Dietary Manager and to the Administrator. 2. The Administrator will review monthly Registered Dietitian reports and address all negative findings with the Dietary Manager, Effective 7/30/12. 3. Beginning on 7/30/12, the Administrator will make unannounced kitchen inspections. Results of these inspections will addressed with the Dietary Manager and dietary personnel. In addition, results will be reviewed with Consulting Dietitian for further staff education and follow up. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED. 7/30/12: Consulting Dietitian kitchen inspection completed. 7/27/12: All dietary personnel in-serviced by the Dietary Manager on storage of food items and documenting chemical sanitation strength. 8 13/12: All dietary personnel (including the Dietary Manager) will be in-serviced by the Consulting Dietitian on storing food items, documenting chemical sanitation strength. 8/1/12: the Dietary Manager will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			bring the daily dishwashing sanitation records to the daily Stand-Up Meeting for review by the facility management team and the Administrator.	