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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. This visit included the Investigation of Complaints IN00172946, IN00173432, IN00173793 and IN00174569. Complaint IN00172946 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00173432 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00173793 - Substantiated. State Residential deficiencies related to the allegations are cited at R-326. Complaint IN00174569 - Substantiated. State Residential deficiencies related to the allegations are cited at R-269, R-272 and R-273. Survey dates: June 8, 9, 10 and 11, 2015 Facility number: 013149 Provider number: 013149 AIM number: N/A Residential Census: 29 Total: 29	R 0000		

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Sample: 8 These State Residential findings are cited in accordance with 410 IAC 16.2-5.			
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. 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 interview and record review, the facility failed to ensure a policy related to the screening of prospective employees was written and implemented for 1 of 10 employee files reviewed. (CNA #9) Finding includes: On 6-10-15 at 9:15 A.M., the employee record for CNA (Certified Nursing Assistant) #9 was reviewed. There was 1 reference check completed.	R 0116	1 A second reference check on employee #9 was completed on 6-26-2015. However, she is no longer employed. 2. All employee files were checked on by 6/29/2015 to assure that two reference checks were available. 3.An employee new hire check list will be completed prior to hiring by the business office manager to assure that a minimum of two references are available in each employee file. 4. The administrator will monitor by reviewing a monthly check off list of all new hires for each month.	06/26/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	On 6-11-15 at 8:58 A.M., an interview was conducted with the DON (Director of Nursing). The DON indicated it is her expectation that 2 reference checks be completed prior to hire of a new employee. On 6-11-15 at 11:32 A.M., an interview was conducted with the DON. The DON indicated they did not have a facility policy related to reference checks for new employees.			
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			

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 interview and record review, the facility failed to ensure an annual inservice for Resident Rights was completed for 3 of 10 employees and an annual inservice for Abuse was completed for 1 of 10 employees. (CNA #9, LPN #8, and the Director of Nursing) Finding includes: On 6-10-15 at 9:15 A.M., the employee records for CNA (Certified Nursing Assistant) #9, LPN (Licensed Practical Nurse) #8 and the DON (Director of Nursing) were reviewed. The record for CNA #9, LPN #8, and the DON had no documentation that an annual inservice on Resident Right's had been completed.	R 0120	1. Nursing Assistant #9 and LPN#8 are no longer employees of Morning View. DON participated in annual resident rights inservices conducted 1 on 1 with Human Resources on 6/26/2015. 2. All employee files were reviewed on 6/29/2015 for documentation regarding annual inservice training on abuse and resident rights. 3. An inservice on resident rights and abuse reporting will be conducted on July 16, 2015 by the local ombudsman. Training will be conducted upon hire and annually in July thereafter. Human resources to maintain all training certification in employee records. DON to maintain binder with sign in sheets and inservice materials. 4. Humans resources will monitor	06/26/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The record for LPN #8 had no documentation that an annual inservice on Abuse had been completed. On 6-11-15 at 9:55 A.M., an interview with the DON was conducted. The DON indicated she could not find any record that these inservices had been completed. On 6-11-15 at 11:25 A.M., review of the undated "Mandatory Training Requirement for Indiana Residential Care Facilities," received from the DON at this time, indicated "...1. At least eight (8) hours per calendar year for nursing personnel; 2. At least four (4) hours per calendar year for non-nursing personnel; 3. Mandatory topics: a) Residents' Rights...." Review of the undated "Abuse Prevention and Reporting Policy," received from the DON at this time, indicated "...7. All facility staff will be trained during initial orientation and quarterly in-services regarding prevention of abuse, neglect, punishment and seclusion and their responsibilities to report suspected abuse. Training will include interventions for residents who have aggressive or catastrophic reactions and the methods for providing care and treatment to residents as well as resident to staff abuse...."		with assistance of the Director of Nursing biannually (July & January)	

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a clean environment related to stained ceiling tiles in the third floor dining room, the third floor common television area, and 2 of 3 resident rooms. (Room 319 and Room 320). This had the potential of affecting 11 out of 11 residents who utilized the dining and common areas. Finding includes: On 6-08-2015 at 9:00 A.M., a tour of the facility was conducted during which the following were observed: At 9:00 A.M., in Room 319, one ceiling tile above the vanity was observed to have a brown spot on a white colored tile. At 9:05 A.M., in Room 320, one ceiling tile above the bed had a large brown spot. An adjoining tile had three brown spots. The adjoining tile on the other side had one brown spot. Two ceiling tiles along	R 0144	1.Discolored ceiling tiles in rooms 319 and 320 have been replaced. On the third floor along the Northeast wall ceiling tiles with multiple brown spots of various sizes have been replaced. In addition one tile above the doorway inside the third floor common television room with a brown spot has also been replaced. This was completed on 6/11/2015. 2. The entire building as of 6/11/2015 has been checked for discolored or missing ceiling tiles. 3. Housekeeping staff on daily cleaning of rooms will note any missing or stained ceiling tiles and report to maintenance staff daily. Staff will be made aware of the need to enter maintenance issues in the maintenance log book located at each nurses station by the maintenance supervisor. 4. Maintenance supervisor will montor weekly and report findings to administrator.	06/11/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	the Northeast wall had small brown spots of varying sizes. At 9:18 A.M., in the third floor dining area tiles along the Northeast wall were observed with multiple brown spots of various sizes. At 9:27 A.M., one tile above the doorway inside the third floor common television room was observed with a brown spot. During an interview on 6-10-2015 at 10:00 A.M., maintenance employee #11, indicated there was currently a work order in to replace the stained tiles and they would be changed this day. He indicated stained tiles are changed as needed and there is no routine assessment to check for stained tiles.			
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance			

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation, interview and record review, the facility failed to obtain approval by the Registered Dietician for menu substitutions. This had the potential to affect 29 of 29 residents who received meals from 1 of 1 kitchens. Finding includes: During an interview on 6/8/15 at 5:15 P.M., Cook #2 indicated, "...we were supposed to have Coney dogs and mandarin oranges...but we are out of Coney sauce and mandarin oranges...so we are just having hotdogs and mixed tropical fruit...the Administrator told us to make the changes...." On 6/8/15 at 5:28 P.M., the following dinner was observed being served in the second floor dining room. Hot dog on a bun, waffle fries, mixed tropical fruit and coleslaw. On 6/9/15 at 11:46 A.M., Cook #3 indicated, "I have never met the dietician...no one approves the menus...we use menus from [name of food service]...." During an interview on 6/9/15 at 3:00	R 0269	1.The dietician will inservice Cook #2 and #3 regarding approval requirements by a registered dietitian regarding menus or substitutions, or both, for all meals. 2. All residents were found to be affected the deficient practice. 3. A dietary manager will be hired and supervised by a registered dietician . A registered dietician will be contracted for a minimum of 4 hours monthly to offer consultation to ensure compliance with Food and Nutritional Services. Dietary staff will receive in-service training related to compliance with written menus and proper use of menu substitutions , when necessary. In the future, a meal substitution log will be maintained regarding changes to the menu. 4. The Dietary Manager will monitor for compliance daily for two weeks and then weekly for four weeks.	07/15/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	P.M., Cook #3 indicated, "we were out of pot roast so I changed it to corned beef ... I made the change on my own...." During an interview on 6/9/25 at 3:10 P.M., the Administrator indicated, "...our corporate nurse authorized the menu changes...." This State residential tag relates to complaint IN00174569.			
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to maintain safe and appropriate food temperatures in 1 of 1 kitchens. This had the potential to effect 29 of 29 residents. Findings include: On 6/8/25 at 2:40 P.M., review of the forms "[Name] Diet Spread Sheet" which Cook #2 indicated " ...this is what we put our food temperatures on...there are no temperature logs for the month of June the DM (Dietary Manager) hasn't	R 0272	1.Cook # 2 and 3 will be inserviced by the registered dietician regarding the importance of temperature logs to ensure that all food is served at safe and appropriate temperatures. During the survey, the log sheets were put in place and are currently being used. 2. All residents were affected by the deficient practice. 3. Dietary staff members will be inserviced by the registered dietician by 7/15/2015 on temperature log sheets completed daily to ensure food temperature logs are completed prior to food being served. The	07/15/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	given us the logs yet...the DM dates the forms sometimes...." On 6/8/15 at 3:30 P.M., review of the undated "[Name] Diet Spread Sheets" provided by Cook #2 indicated that milk temperatures were not present on the forms and 15 out of 64 days of food temperature logs were missing partial food temperatures or had no food temperatures documented for the day. During an interview on 6/9/15 at 11:50 A.M., Cook #3 indicated, "...I don't temp milk...." During an interview on 6/10/15 at 2:00 P.M., the Administrator indicated " ...I expect that the food and milk to be temped before each meal and the food temperature logs to be filled out for each meal... the food temperature logs should be dated...." On 6/10/15 at 3:41 P.M., review of the Policy "Monitoring Food Temperatures for Meal Service" dated 2011, provided by the DON (Director of Nursing) indicated "...Guideline: Food Temperatures will be monitored daily...1. Prior to serving a meal, food temperatures will be taken and documented for all hot and cold foods to ensure proper serving temperatures...2.		facility shall ensure that all food is served at safe and appropriate temperatures. The policy and procedure for monitoring food temperatures for meal service will be reviewed with all dietary personnel by the Food Service Director. 4. A qualified dietary manager will monitor compliance daily that temperature logs are completed and validated and that temperatures are timely and accurate.	

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The temperature for each food item will be recorded on the food temperature log...." This State Residential tag relates to Compliant IN00174569.			
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 local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to to store and serve food under sanitary conditions, regarding dating of food, expiration of stored foods, hairnet use and handwashing in 1 of 1 kitchens. This had the potential to effect 29 of 29 residents. Findings include: On 6/8/15 between 2:20 P.M., and 2:45 P.M., a kitchen tour was conducted with Cook #2 during this time the following was observed: At 2:21 P.M., in the ice cream freezer: A	R 0273	1.The facility shall ensure all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards. All of the issues regarding open, undated containers were addressed immediately by dietary staff with daily monitoring follow-up 2. All residents were affected by the deficient practice. 3..The dietary staff will be inserviced on 7/10/2015 on dating and labeling opened food, handleing of leftovers, hairnet policy and handwashing policy. The Director of nursing will provide a hand-washing demonstration to dietary employees. Policy and Procedure for "Personnel Standards" and "Preventing Foodborne Illness	07/30/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	one 3 gallon container of vanilla ice cream and a one 3- gallon container of mint chip ice cream open and undated. Cook #2 indicated, "... yes those should have an open date...." At 2:25 P.M., in the reach in cooler: a plastic container of sliced, cooked carrots dated 6-4-15. A plastic container of cooked corn, dated 6-3-15. Cook #2 indicated, "...we only keep left overs for three days...." At 2:29 P.M., in the walk in cooler: an uncovered, undated, slice of pie. An open, undated, plastic container of tomato sauce. 7 individual bowls of fruit covered with plastic wrap indicating 3rd floor but undated. Cook #2 indicated, "...labeling it third floor does not help, it should be dated...." At 2:34 P.M., in the dry storage: an open, undated, container containing 4 cups of brown sugar. An open, undated, 0.4 gal (gallon) bottle of apple juice. The Cook #2 indicated, "...these should have open dates on them...." At 2:38 P.M., in the walk in freezer: An open, undated, box of Belgian waffles. An open, undated, bag of whole strawberries. Cook #2 indicated, "...those should have a open date on them...."		Hand Hygiene" and "Food Ordering, Receiving and Storage" will be reviewed by 7/10/2015. The kitchen will be enclosed by limiting access through two entrance doors to ensure that anyone entering the kitchen area will be wearing a hair net. The Dietary manager will monitor for compliance daily.	

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	On 6/9/15 at 11:35 A.M., CNA (Certified Nursing Assistant) #4 was observed in the kitchen, at the prep table, without a hairnet on. On 6/9/15 at 11:45 A.M., Cook #3 was observed to wash her hands for 12 seconds, turn off faucet with wet hands, then dry hands with a paper towel before continuing to prepare food. During an interview on 6/9/15 at 3:15 P.M., the Administrator indicated "...handwashing should be done per our policy...hairnets should be worn at all times and non dietary personal should not be in the kitchen...." On 6/9/15 at 3:54 P.M., review of the current, undated, policy titled "Personnel Standards" provided by the Administrator at this time, indicated "...2... a. Hair nets, covering all of the hair, must be worn at all times...." On 6/10/15 at 9:00 A.M., review of the current, undated, policy titled "Preventing Foodborne Illness-Hand Hygiene" and "Food Ordering, Receiving and Storage" provided by the Administrator, indicated "... 2. Vigorously lather hands with soap and rug them together, creating friction to all surfaces for at least fifteen (15)			

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	seconds ... 4. Dry hands thoroughly with paper towels and then turn of faucets with a clean, dry paper towel... 6. All perishable food will be stored in the refrigerator or freezer in covered, labeled and dated... 13. b. Food must be dated and sealed when removed from original containers...." On 6/10/15 at 11:30 A.M., Employee # 6 was observed in the kitchen without a hairnet on past the sign that read "Hairnets must be worn beyond this point in the kitchen." This State Residential tag relates to Complaint IN00174569.			
R 0326 Bldg. 00	410 IAC 16.2-5-7.1(a) Activities Programs - Deficiency (a) The facility shall provide activities programs appropriate to the abilities and interests of the residents being served. Based on observation, record review and interview, the facility failed to provide an ongoing activity program for 3 of 3 residents on the first floor. (Residents B, C and E)	R 0326	The activity program for residents B, C , and E have been reevaluated regarding appropriateness of scheduled activity and residents level of participation. Resident E has a current updated calendar.2. All resident will be evaluated for	07/02/2015

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Finding includes: On 6-8-2015 at 10:35 A.M., during an interview, the Ombudsman indicated, "...there are no activities on the first floor...sitting the residents in front of the TV [Television] is not an activity...sometimes the TV isn't even on...one of the residents plays with her shoe strings for entertainment and has fallen out of her wheelchair and bruised herself...." On 6-9-2015 at 10:05 A.M. to 10:36 A.M., an observation was made of Resident #B, #C and #E sitting in the common area on the first floor with the TV on in the corner of the room. None of residents appeared to be watching the TV Resident #C had his eyes closed most of the observation period On 6-10-2015 at 2:15 P.M., during an interview, the Activity Director indicated that a calendar was color coded for each resident for the activities that they participated in and the person running the activity is responsible for charting that information. On 6-10-2015 at 3:45 P.M., a record review of the activity calendars indicated that Resident #B had participated in 2 out of 160 activities in April 2015 and 4 out		activities scheduled and level of participation by July 15, 2015. Each resident will be re-evaluated to ensure that their likes, dislikes, hobbies, past and present interests including past occupation are considered when offering activities.3.Residents B, C, and E will be involved with more group activities with more stimulation through music and outside entertainment. There will be more 1 on 1 participation with this residents that have a severe dementia. Family involvement will be encouraged.4. Administrator will monitor through daily rounds.	

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 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	of 162 activities in May 2015. Resident #C had participated in 4 out of 160 activities in April 2015 and 4 out of 162 activities in May 2015. Resident #E had participated in 1 out of 162 activities in May 2015. The April 2015 calendar was not available for Resident #E. On 6-11-15 at 11:00 A.M., the Administrator indicated that some of the activities offered would not be appropriate for the residents on the first floor. This State Residential tag relates to Complaint IN00173793.			