STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGCREST NURSING AND MEMORY CARE CENTER	915 S 27 ST SOUTH BEND, IN 46615

(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
F000000	This survey was for the Investigation of Complaint IN00135601. Complaint IN00135601-Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F312, and F323. Survey dates: December 8-10, 2013 Facility number: 012199 Provider number: 155781 AIM number: 200989880 Survey team: Honey Kuhn, RN Census bed type: SNF: 4 Total: 4 Census payor type: Other: 4 Total: 4 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on December 16, 2013, by Brenda	F000000		

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.

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	Meredith, R.N.			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record reviews and	F000225	1. What corrective action will be	12/20/2013

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	interviews, the facility failed to thoroughly investigate and report to ISDH (Indiana State Department of Health) the elopement of a resident with dementia who exited the facility unobserved, while pushing a housekeeping cart and was out of the facility for an undetermined amount of time, for 1 of 4 residents reviewed for behaviors in a sample of 4. (Resident "F") Findings include: The closed record of Resident "F" was reviewed on 12/10/13 at 10:00 a.m. Resident "F" was admitted to the facility on 01/10/13, with diagnoses including, but not limited to, encephalopathy, adult FTT (Failure To Thrive), and dementia with behaviors. Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in planning resident care), dated 09/05/13, indicated the resident was not cognitive for interview and had a history of wandering daily. The resident was able to ambulate without assistance. Resident "F" was transferred to another facility on 11/13/13. Review of the "Nurse's Notes" indicated:		accomplished for those residents found to affected by the deficient practice; Resident F was transferred to another facility prior to this survey .2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken; All other residents have the potential to be affected by this deficient practice. On 12/20/13. All staff was in-serviced on the Policy and Procedure relating to Elopement, Investigation and Reporting of unusual Occurrence's as defined by Indiana State Department of Health Guidelines3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A Policy titled Building Security was updated to include the addition of monthly Elopement Drills for alternating shifts and times. All staff was in-serviced on this update on 12/20/13.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality measures will be put into place and what date the systemic changes will be completed.Any elopement, investigation and reportable occurrence's will be reviewed after each occurrence by the DON and Administrator All occurrences will be reviewed for 6 months, monthly, at our clinical quality meeting. The QA will	

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	"08/18/13 3:00 p.m. Resident cont [continues] exit seeking. Found resident outside on side door sidewalk pushing housekeeping cart. Res [resident] returned to facility H/T [Head/Toe] assessment 0 [no] injuries. Administrator, MD [Medical Doctor], wife notified." Interview with the Administrator, DOH (Date Of Hire) 10/21/13, on 12/09/13 at 10:00 a.m., indicated there was no evidence the elopement was reported to ISDH. The Administrator provided a copy of an internal "INCIDENT REPORT," dated 08/18/13, which was initiated by the nurse who recorded the incident in the nursing notes. The Administrator indicated there was no further evidence of an investigation or reporting. On 12/10/13 at 12:45 p.m., The DNS (Director Nursing Services) of an affiliate facility provided a copy of the Policy & Procedure: "INDIANA STATE DEPARTMENT OF HEALTH: Division of Long Term Care: 06/30/2011", titled, "REPORTABLE UNUSUAL OCCURRENCES" and indicated the facility is to follow the directive. The Policy & Procedure indicated:		review to assure that all steps in our policy were initiated and followed. If no elopements are reported after the 6 month period, the QA will be discontinued.	

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	"PURPOSE: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws." "POLICY: All unusual occurrences reported to the Indiana State department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services." "PROCEDURE: 1. Occurrences to be reported. Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division... (7) RESIDENT ELOPEMENT A) A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown...." This Federal tag relates to Complaint IN000135601. 3.1-28(c) 3.1-28(d)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record reviews and interviews, the facility failed to follow their Policy & Procedure in regards to investigation and reporting an elopement of a resident with dementia who exited the facility unobserved, and while pushing a housekeeping cart, for 1 of 4 residents reviewed in a sample of 4. (Resident "F") Findings include: The closed record of Resident "F" was reviewed on 12/10/13 at 10:00 a.m. Resident "F" was admitted to the facility on 01/10/13, with diagnoses including, but not limited to, encephalopathy, adult FTT (Failure To Thrive), and dementia with behaviors. Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in planning resident care), dated 09/05/13, indicated the resident was not cognitive for interview and had a history of wandering daily. The resident was able to ambulate without	F000226	See F 225 for response	12/20/2013

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	assistance. Resident "F" was transferred to another facility on 11/13/13. Review of the "Nurse's Notes" indicated: "08/18/13 3:00 p.m. Resident cont [continues] exit seeking. Found resident outside on side door sidewalk pushing housekeeping cart. Res [resident] returned to facility H/T [Head/Toe] assessment 0 [no] injuries. Administrator, MD [Medical Doctor], wife notified." Interview with the Administrator, DOH (Date Of Hire) 10/21/13, on 12/09/13 at 10:00 a.m., indicated there was no evidence the elopement was reported to ISDH (Indiana State Department of Health). The Administrator provided a copy of an internal "INCIDENT REPORT", dated 08/18/13, which was initiated by the nurse who recorded the incident in the nursing notes. The Administrator indicated there was no further evidence of an investigation or reporting. On 12/10/13 at 12:45 p.m., The DNS (Director Nursing Services) of an affiliate facility provided a copy of the Policy & Procedure: "INDIANA STATE DEPARTMENT OF HEALTH: Division of Long Term Care:			

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	06/30/2011", titled, "REPORTABLE UNUSUAL OCCURRENCES" and indicated the facility is to follow the directive. The Policy & Procedure indicated: "PURPOSE: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws." "POLICY: All unusual occurrences reported to the Indiana State department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services." "PROCEDURE: 1. Occurrences to be reported. Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division... (7) RESIDENT ELOPEMENT A) A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown...." This Federal tag relates to Complaint IN00135601. 3.1-28(a)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			
	Based on record review and interviews, the facility failed to ensure a resident was shaved without incident for 1 of 4 residents reviewed who were dependent for ADL's (Activities of Daily Living: bathing, dressing, grooming, etc.) (Resident "D") Findings include: The closed record of Resident "D" was reviewed on 12/10/.13 at 1:00 p.m. Resident "D" was admitted to the facility on 10/06/11 with diagnoses including, but not limited to, dementia with behaviors, PVD (Peripheral Vascular Disease) and chronic anemia. Review of an Annual MDS (Minimum Data Set: a tool used to assess residents needs for care), dated 07/25/13, indicated the resident was cognitively diminished and required extensive assistance of 1 for hygiene and was totally dependent with assistance of 1 for bathing. The resident was transferred to another facility on 11/05/13.	F000312	F 312 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D was transferred to another facility prior to this survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;All residents have the potential to be affected by this deficient practice.Residents have been assessed to determine if they would benefit from the use of an electric razor. The facility has purchased and electric razor and if a resident is deemed to have problem skin an electric razor shall be used. All C.N.A. have been in- serviced on the appropriate way to shave a resident without an electric razor with a return demonstration. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; C.N.A. were in-serviced on how to shave a resident with and electric razor as well as a safety razor with a return demonstration completed4. How the corrective	12/20/2013

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	Confidential interviews were done throughout the survey with both current and former staff, including, but no limited to, CNA's (Certified Nursing Assistants), LPN's and RN's. A confidential interview indicated an unnamed CNA had caused Resident "D" to bleed during a facial shave. The interviewee indicated the incident was reported but no investigation was done. Review of "Nurse's Notes" indicated: "08/14/13 Late entry for 08/13/13. Resident observed c [with] dried blood to face, mouth, neck, and shirt. Resident stated skin cut to lip and mole [arrow up: above] right skin between nose & [and] lips from shaving [sic] by staff during shower. Washed skin, change clothes. 0 [no] active bleeding at this time." Interview with the current DNS (Director Nursing Services), DOH (Date Of Hire)09/03/13, indicated no knowledge of the incident. Interview with the Administrator, DOH 10/21/13, indicated no knowledge of the incident. This Federal tag relates to Complaint IN00135601.		action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place and what date systemic changes will be made. Any shaving incident where a resident is nicked or has major cut will be investigated and the C.N. A. will re in-serviced and/or counseled up to and including termination. All shaving incident will reviewed by the DON and Administrator. All occurrences will be reviewed for 6 months, monthly, at our Clinical quality meeting. The QA will review to assure that all steps in our policy were initiated and followed. If no shaving incidents are reported the QA will be discontinued.	

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	3.1-38 (a)(3)(D)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record reviews and interviews, the facility failed to provide adequate supervision to prevent the elopement of a resident with dementia who exited the facility unobserved, while pushing a housekeeping cart and was out of the facility for an undetermined amount of time, for 1 of 4 residents reviewed for behaviors in a sample of 4. (Resident "F") Findings include: The closed record of Resident "F" was reviewed on 12/10/13 at 10:00 a.m. Resident "F" was admitted to the facility on 01/10/13, with diagnoses including, but not limited to, encephalopathy, adult FTT (Failure To Thrive), and dementia with behaviors. Review of the most recent quarterly MDS (Minimum Data Set: a tool to assist in planning resident care), dated 09/05/13, indicated the resident was not cognitive for interview and had a history of wandering daily. The	F000323	F-323 What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice;Resident F was transferred to another facility prior to this survey.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all residents have the potential to be affected by this deficient practice. Current residents have been reassessed by social services for their potential to wander. The elopement book has been update to include current photo of the resident with identifying information ie. photo ,age, height ,weight, birth mark tattoos, diagnosis, and responsible party phone number. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A policy titled Building Security was updated and all staff was in- serviced . Nurse on duty are required to check operation and functionality of all exit doors every shift and document on the	12/20/2013

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	resident was able to ambulate without assistance. Resident "F" was transferred to another facility on 11/13/13. Review of "WANDER DATA COLLECTION TOOL" forms indicated the resident was evaluated quarterly, with the Resident "F" most recently assessed prior to the elopement on 06/20/13. The assessment evaluated for wandering and contributing factors and indicated the resident had a history of wandering prior to admission, was cognitively impaired, and was at significant risk of getting to a "potentially dangerous place (stairs, outside the facility)." The facility had a capacity of 19 beds and consisted of 1 hallway, running North and South, where resident's rooms were located and an alarmed door on each end. The hallway had a short connecting hallway, approximately 30 foot, to the West connecting the main hall to the dining room with the Nurses Station located within the area. Another short hallway, approximate same length and to the East, provided access to the main entrance and included the Receptionist's Station. The main entrance door was also alarmed. The facility is located a short distance		approved form. Maintenance or designee will check the functionality of the doors weekly and document their finding on the approved log. Elopement drills will be conducted monthly on alternating shifts and times. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and what date the systemic changes will be completed;Any breach in the facility security program will be reviewed on each occurrence by the administrator, maintenance and DON. All breaches of security will be reviewed for 6 months at our monthly clinical quality meeting. The QA will review findings to assess why and how the breach occurred. The review will also assure that all steps in our policy were initiated and followed. If no breaches of security have been reported after 6 months the QA will be discontinued.	

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NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615	

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	from the corner of a main thoroughfare for Mishawaka. Review of the "Nurse's Notes" from 08/2013 onward indicated: "08/12/13 ...Resident walking quickly [arrow up & arrow down] halls, muttering to himself. Escape attempt X [times] 4 employee entrance by kitchen. Escape attempt 5-6 times North, South doors, with same # [number] front entrance...." "08/14/13 Late entry for 8/13/13. Resident walking halls c [with] 4 escape attempts...." "08/18/13 3 p.m. Resident escape attempt [arrow up: increased] 15 x c [arrow up: increased] agitation for redirection...." "08/18/13 3:00 p.m. Resident cont [continues] exit seeking. Found resident outside on side door sidewalk pushing housekeeping cart. Res [resident] returned to facility H/T [Head/Toe] assessment 0 [no] injuries. Administrator, MD [Medical Doctor], wife notified." Interview with the Administrator, DOH (Date Of Hire) 10/21/13, on 12/09/13 at 10:00 a.m., indicated there was no evidence the elopement was reported			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2013
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	to ISDH (Indiana State Department of Health). The Administrator provided a copy of an internal "INCIDENT REPORT," dated 08/18/13, which was initiated by the nurse who recorded the incident in the nursing notes. The Administrator indicated there was no further evidence of an investigation or reporting. Review of the "SOCIAL SERVICE PROGRESS NOTES" INDICATED: "08/20/13 SS [Social Service] informed this AM via overhearing conversation @ [at] the nurses station that [resident's name] eloped from the facility on 8/18/13. Upon talking further with nursing staff and reading nurses notes, [resident's name] eloped out the North hallway end door and was found outside pushing a laundry cart. He was escorted back into the building by staff. No injuries noted. SSD spoke with [resident's name] today and he has no recollection of the event...[resident's name] does wander about the facility thru out [sic] the day & evening and does push on exit doors. He is not always easily redirected...." The SSD (Social Service Director) was interviewed on 12/10/13 at 11:00 a.m. The SSD indicated being made aware of the elopement on 08/20/13,			

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	during a conversation overheard at Nurse's Station. The SSD indicated the resident was found outside the facility pushing a cart and the alarmed door did not sound. alarm. The SSD indicated the elopement was discussed at a morning "standup" (a meeting to discuss events which have occurred which effect the residents) and was unaware the former Administrator and former DNS had not investigated the incident further. A statement, written and provided on 12/10/13, from the Maintenance person, indicated the alarm was checked following the incident and was in working order. It was believed the door had been exited prior to the elopement and the alarm had not been reset. This Federal tag relates to Complaint IN00135601. 3.1-45(2)			