

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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	<p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: October 13, 14, 15, & 16, 2015</p> <p>Facility number: 002858 Provider number: 002858 AIM number: N/A</p> <p>Census bed type: Residential: 65 Total: 65</p> <p>Sample: 7</p> <p>These State findings are cited accordance with 410 IAC 16.2-5.</p> <p>QR completed by 14466 on October 25, 2015.</p>	R 0000	The facility will ensure compliance and submits this Plan of Correction as follows with an effective date of 11-6-15.	
R 0029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, record review, and interview, the facility failed to ensure dignity was provided for a resident receiving an insulin injection for 1 of 1 observation. (Resident #57)</p>	R 0029	The facility will ensure dignity will be provided for every resident. The resident who was identified was evaluated by Resident Services Designee to determine any affects regarding her dignity.	11/05/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>Findings include:</p> <p>The clinical record of Resident #57 was reviewed on 10/13/15 at 1:00 p.m. Diagnoses for the resident included, but were not limited, diabetes mellitus.</p> <p>A recapitulated physician's order for October, 2015, with an original date of 8/22/15, indicated the resident was to receive Humalog insulin injections 2 times per day.</p> <p>On 10/15/15 at 9:50 a.m., the resident was observed sitting in the public lounge area of the memory care unit. Licensed Practical Nurse (LPN) #1 approached the resident, pulled up the resident's shirt exposing approximately 6 inches of skin, and injected the insulin into the resident's abdomen. Another resident (#63) and several staff members were also in the lounge area.</p> <p>On 10/15/15 at 11:10 a.m., the Program Director of the memory care unit indicated she had never observed insulin being administered in the lounge area. She indicated LPN #1 was new to the facility and might need, "to be inserviced" regarding residents' dignity.</p>		<p>No negative affects noted. The nurse who gave resident #57 insulin received counseling on 10-15-15 regarding resident rights and ensuring dignity for our residents at all times. This nurse and all staff completed inservice training to ensure review and understanding of resident rights regarding resident dignity. Resident Rights training, inservicing and ongoing monitoring will be the responsibility of each staff member and shall be supervised by the Directors and Administrator. Administrator will ensure all staff understand and uphold resident rights through all staff monitoring, continued inservice and training and or corrective or disciplinary action. Review will be made at each Quality Assurance monthly meeting to ensure compliance. Effective date 11-6-15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician was notified immediately when insulin medication ordered for the resident was unavailable for 1 of 5 residents reviewed physician notification. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record of Resident #57 was reviewed on 10/13/15 at 1:00 p.m. Diagnoses for the resident included, but were not limited, diabetes mellitus. Diabetes is a disease where the body does not produce enough insulin to enable the sugar in the blood to transfer onto the cells of the body.</p> <p>A service plan for the resident, dated 8/14/15, indicated staff would administer all of the resident's medications.</p>	R 0036	<p>The facility will ensure that physician notification will occur for any resident who has unavailable medication. The resident who was identified was reviewed and evaluated related to any affects and to ensure all medication ordered was available and any physician notification was made. Effective date 10-16-15. A review of all residents medications was made to ensure medication availability and proper notification to the physician on 10-29-15. The Resident Services Director and all medication administration staff will monitor for any unavailable medication and notification to the physician on a daily basis. The Resident Services Director or designee will be responsible to review medication availability and physician notification on a weekly audit review beginning 10-29-15. During Quality Assurance Monthly meeting, continued review of appropriate notification to the physician and availability of</p>	11/06/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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>An admission order, dated 8/14/15, indicated the resident was to receive NovoLog mix 70/30 insulin flexpen, 5 units (dosage), 2 times per day.</p> <p>Review of the Medication Administration Record (MAR) for August, 2015, indicated Resident #57 did not receive any NovoLog insulin from 8/14/15 through 8/24/15. Reasons given for lack of administration were, "med[ication] not in from pharmacy...waiting on delivery of med, med @ pharm[acy], waiting on clarification, med not available, on order from pharm[acy]."</p> <p>Review of a "Call Documentation" dated 8/20/15 at 12:49 p.m., indicated the pharmacy had called the facility and informed them the NovoLog mix required an insurance review for determination, but a different brand of insulin mix, Humalog 75/25 could be provided. This change was approved by the physician on 8/20/15 (6 days after the insulin order start date).</p> <p>A nurse's note dated 8/24/15 at 2:35 p.m. indicated, "Found N.O. [new order] dated 8/22/15 to D/C [discontinue] NovoLog 70/30 flexpen due to insurance non-coverage of item. N.O. to start Humalog 75/25 - 5 units sub Q [subcutaneously] BID [2 times per day]."</p>		<p>medications will be monitored. The Resident Services Director and the Administrator will be responsible to monitor. Effective date 11-6-15.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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 0241 Bldg. 00	<p>Order faxed to [name of pharmacy] for delivery..."</p> <p>A review of the MAR for August, 2015, indicated Resident #57 received her first injection of insulin at 5:00 p.m., 8/25/15, 11 days after she was admitted to the facility.</p> <p>On 10/15/15 at 9:30 a.m., the Regional Director of Health Care Operations indicated the resident's son had taken the prescriptions with him at the time of the resident's admission on 8/14/15. The son found out he couldn't afford the medications at the local pharmacy, so he went through a mail order pharmacy instead. The physician was contacted on 8/20/15. The Regional Director indicated she was not able to find any information the physician was contacted before 8/20/15, regarding Resident #57's ordered insulin being unavailable.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and</p>	R 0241	The facility will ensure that medication ordered by the	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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>interview, the facility failed to ensure a resident received insulin medication as ordered by the physician for 1 of 5 residents reviewed for administration of medication, which resulted in the resident not receiving any insulin for 11 days after admission to the facility and receiving insulin with meals as indicated by physician orders. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record of Resident #57 was reviewed on 10/13/15 at 1:00 p.m. Diagnoses for the resident included, but were not limited, diabetes mellitus. Diabetes is a disease where the body does not produce enough insulin to enable the sugar in the blood to transfer onto the cells of the body.</p> <p>A service plan for the resident, dated 8/14/15, indicated staff would administer all of the resident's medications.</p> <p>a. An admission order, dated 8/14/15, indicated the resident was to receive NovoLog mix 70/30 insulin flexpen, 5 units (dosage), 2 times per day.</p> <p>Review of the Medication Administration Record (MAR) for August, 2015, indicated Resident #57 did not receive any NovoLog insulin from 8/14/15</p>		<p>physician for a resident will be available for each medication administration. The resident identified was reviewed by the Resident Services Director designee on 10-16-15 to ensure all ordered medication was available for each medication administration. A review of all residents medications was made to ensure medication availability as ordered by the physician. Effective date 10-29-15. The systemic process to ensure medication availability as ordered by a physician will include at time of admission, the admitting nurse will ensure medications are available as ordered by the physician for a minimum a one week supply, then twice weekly an audit will be completed by the Resident Services Director or designee to ensure medications are available and in the process of being reordered to ensure medication is available for each medication administration. All medication staff will monitor to ensure medication is available per physician order for each administration, and this will continue on a daily basis. In the event a medication is not available, the Resident Services Director or designee and physicaian will be immediately notified, a determination will be made to ensure that the medication will be obtained in the quickest manner possible. The Resident Services Director will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>through 8/24/15. Reasons given for lack of administration were, "med[ication] not in from pharmacy...waiting on delivery of med, med @ pharm[acy], waiting on clarification, med not available, on order from pharm[acy]."</p> <p>Review of a "Call Documentation" dated 8/20/15 at 12:49 p.m., indicated the pharmacy had called the facility and informed them the NovoLog mix required an insurance review for determination, but a different brand of insulin mix, Humalog 75/25 could be provided. This change was approved by the physician on 8/20/15 (6 days after the insulin medication start date).</p> <p>A nurse's note dated 8/24/15 at 2:35 p.m. indicated, "Found N.O. [new order] dated 8/22/15 to D/C [discontinue] NovoLog 70/30 flexpen due to insurance non-coverage of item. N.O. to start Humalog 75/25 - 5 units sub Q [subcutaneously] BID [2 times per day] Order faxed to [name of pharmacy] for delivery..."</p> <p>A review of the MAR for August, 2015, indicated Resident #57 received her first injection of insulin at 5:00 p.m., 8/25/15, 11 days after she was admitted to the facility.</p>		<p>follow this process to include communication with the pharmacy and or responsible party to ensure medication is received and to ensure future availability. The Resident Services Director and the Administrator are responsible to review medication availability on a weekly audit review beginning 10-29-15. During Quality Assurance Monthly meeting, continued review of medication availability will b emonitored. The Resident Services Director or designee and the Administrator will be responsible with effective date of 11-6-15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>On 10/15/15 at 9:30 a.m., the Regional Director of Health Care Operations indicated the resident's son had taken the prescriptions with him at the time of the resident's admission on 8/14/15. The son found out he couldn't afford the medications at the local pharmacy, so he went through a mail order pharmacy instead. The physician was contacted on 8/20/15. The Regional Director indicated she was not able to find any information the physician was contacted before 8/20/15 regarding Resident #57 not receiving her insulin as ordered by the physician due to the insulin not being unavailable.</p> <p>b. A recapitulated order for October, 2015, with an original order date of 8/22/15, indicated Resident #57 was to receive Humalog insulin 75/25, five units, injected subcutaneously, 2 times per day at 8:00 a.m. and 5:00 p.m. Humalog 75/25 is a mixture of short acting and long acting insulins. It helps to increase glucose transport from the blood stream into the muscle and fat cells of the body.</p> <p>Nursing 2014 Drug Handbook (page 745) indicated Humalog 75/25 insulin mix should be given 15 minutes before or after a meal, because it contains a fast acting insulin which could lower the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>blood sugar too rapidly if food is not provided to counteract the effects of the medication.</p> <p>On 10/15/15, Licensed Practical Nurse (LPN) #1 was observed giving Resident #57 her Humalog 75/25 insulin injection at 9:50 a.m.</p> <p>On 10/15/15 at 11:35 a.m. the Program Director of the memory care unit indicated breakfast was served on the memory care unit at 7:00 a.m., and Resident #57 was always up for breakfast, including this day (10/15/15).</p> <p>On 10/15/15 at 2:40 p.m., LPN #1 indicated the resident was not one who lingered over her breakfast. LPN #1 indicated Resident #57 did not her Humalog insulin injection until 9:50 a.m., because Resident #57 went to therapy.</p> <p>On 10/15/15 at 3:40 p.m., the memory care Program Director indicated LPN #1 had started her shift at the facility at 6:00 a.m.</p> <p>On 10/16/15 at 12:05 p.m., the Regional Director of Health Care Operations indicated she had spoken with the therapist who saw Resident #57 and the therapist indicated the resident was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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 0273 Bldg. 00	<p>always seen between 9:00 a.m. and 10:00 a.m.</p> <p>No further information was provided regarding why Resident #57 did not receive her insulin injection 15 minutes before or after breakfast or as ordered by the physician, at 8:00 a.m.</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure food provided to residents in the memory care dining room was served in a sanitary manner for 2 of 2 dining observations.</p> <p>Findings include:</p> <p>1. During an observation of lunch service in the memory care dining room on 10/14/15 at 11:55 a.m., Licensed Practical Nurse (LPN) #1 was observed wearing a pair of gloves, passing beverages to residents, opening and closing the refrigerator door, holding butter directly with her gloved hands while slicing it, passing the sliced butter</p>	R 0273	The facility will ensure that food services provided to each resident will be sanitary. The nurse identified was counseled to identify, correct and ensure understanding of the sanitary food handling policies and procedures for our residents first verbally on 10-16-15 and then verbally on 11-5-15. All staff training and inservice training completed on or before 11-6-15 to include sanitary dining services to include when and how to use gloves for sanitation, when and how to have volunteers assist with dining services. All Directors or monitor designee will be assigned to monitor food handling and dining services for residents on a rotating Meal Manager	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>to residents, and picking up the roll of Resident #61 with her gloved hands to spread butter on it. She removed her gloves at 12:09 p.m.</p> <p>She was observed to not change her gloves or wash her hands between 11:55 a.m. and 12:09 p.m.</p> <p>On 10/14/15 at 12:12 p.m., LPN #1 indicated she wore gloves during meal service, "to be more sanitary."</p> <p>2. During an observation of lunch service on 10/15/15 at 11:43 a.m., Certified Nursing Assistant #2 asked Resident #56 if he would like to help remove plastic silverware from sealed packets. Resident #56 was observed tearing open the packets (occasionally with his teeth), removing the plastic silverware with his fingers, frequently touching the part of the utensil which would go into a resident's mouth. He was not observed washing his hands or applying gloves prior to opening the packets.</p> <p>On 10/15/15 at 11:10 a.m., the Program Director of the memory care unit indicated there were currently 13 residents who resided on the unit and received food served in the unit dining room.</p>		<p>schedule to include monitoring for each meal, three times daily seven days a week. Ongoing training will continue for existing staff and new staff members. Effective date is 11-5-15. Supervision, ongoing training and monitoring will continue by each Director with the Food Service Director and the Administrator being responsible to ensure sanitary food handling practices. Effective date of correction 11-5-15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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 0299 Bldg. 00	<p>On 10/15/15 at 1:35 a.m., the Dietary Manager indicated the staff was not allowed to touch ready to eat food with their bare hands and were expected to change gloves anytime they changed work sites or jobs, such as leaving the food prep site to open and close the refrigerator.</p> <p>On 10/14/15 at 4:00 p.m., the Regional Director of Health Care Operations provided a policy dated 7/1/13, titled, "Dietary Program Policies and Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "Food Safety Purpose "...Provide food that is free from contamination thus risking the health and wellbeing of the residents and staff...1. All staff will be aware of proper food handling and storage procedures..."</p> <p>410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review,</p>	R 0299	The facility will notify the	10/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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>the facility failed to notify a physician of pharmacy reviews recommending changes in medications for 2 of 7 residents reviewed for pharmacy recommendations (Resident #36 and Resident #57).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #36 was completed on 10/13/15 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension and Alzheimer's.</p> <p>A pharmacy recommendation dated 7/15/15, indicated, "...Please consider decreasing thyroid supplementation [levothyroxine] to 112mcq [microgram] qam [every morning]...." (was prescribed at 125mcg)</p> <p>A pharmacy recommendation dated 7/15/15, indicated, "...Please consider increasing memantine to 10mg [milligrams] bid [twice a day]." (was prescribed at 10mg once a day)</p> <p>A pharmacy recommendation dated 9/16/15, indicated, "...Please consider decreasing thyroid supplementation [levothyroxine] to 112mcq [microgram] qam [every morning]...." (was prescribed at 125mcg)</p>		<p>physician of pharmacy review recommendations promptly. Beginning 10-27-15 all pharmacy recommendations had been sent to physcians for their review. On 10-27-15 the recommendations from the pharmacy for the current month had been sent to the physican for review. Beginning on 10-27-15 and ongoing, the Resident Services Director or designee and the Administrator will ensure that pharmacy reviews are sent to the physician. The day the pharmacy recommendations are received, The Resident Services Director, Administrator or designee will fax to the physician, ensure that the fax went through, then keep a daily log of responses from the physician or resend the recommendation until a response is received from the physician regarding the recommendation. All physician responses will be promptly addressed. Monthly during the Quality Assurance Review, the committee will review and ensure that monthly pharmacy review have been sent to the physician. Effective date is 10-27-15.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>A pharmacy recommendation dated 9/16/15, indicated, "...Please consider increasing memantine to 10mg [milligrams] bid [twice a day]." (was prescribed at 10mg once a day)</p> <p>A review of recapitulation of physician's orders for October 2015, indicated Resident #36 is to receive levothyroxine 125 mcg once a day, and memantine 10mg every evening at bedtime.</p> <p>During an interview on 10/16/15 at 10:30 a.m., the Regional Director of Health Care Operations indicated no documentation was found indicating Resident #36's physician was notified regarding the pharmacy recommendations dated 7/15/15 and 9/16/15.</p> <p>2. The clinical record of Resident #57 was reviewed on 10/13/15 at 1:00 p.m. Diagnoses for the resident included, but were not limited, congestive heart failure, anemia, gout, and diabetes mellitus.</p> <p>Review of a pharmacy Consultation Report dated 9/16/15, indicated, "[name of resident] was recently admitted to [name of facility] and taking several medications that require periodic monitoring." The pharmacist recommended:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>1. uric acid test now and annually due to the resident taking gout medication</p> <p>2. BMP (basic metabolic panel which measures electrolytes) now and every six months due to the resident taking furosemide (a diuretic)</p> <p>3. CBC (complete blood count) now and annually due to the resident being anemic and taking iron tablets</p> <p>4. A1C (a blood test which measures how well a person is doing managing their blood sugar over a period of 2 - 3 months) now and every 6 months due to the resident having diabetes and taking oral diabetic medication and receiving insulin injections.</p> <p>No documentation was found in the resident's record which indicated the physician was notified of the pharmacy recommendations made on 9/16/15.</p> <p>On 10/16/15 at 10:15 a.m. the Regional Director of Health Care Operations (RDHCO) indicated the recommendations had been faxed to the physician on 10/15/15.</p> <p>On 10/16/15 at 11:30 a.m. the RDHCO indicated the physician had approved all of the pharmacy recommendations for laboratory blood draws from 9/16/15. She indicated the facility procedure was when</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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 0306 Bldg. 00	<p>the pharmacist made recommendations they were to be immediately faxed to the physician, then placed in a follow up fax folder awaiting response from the physician. The RDHCO indicated this had not been done with Resident #57's pharmacy consultation recommendations from 9/16/15.</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to ensure the dispositions of discharged residents' medications were documented in their clinical records as indicated by the</p>	R 0306	The facility will ensure that dispositions of medications will be documented in the resident clinical record per facility policy. The facility reviewed and made correction to those two records identified. Beginning 10-29-15,	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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>facility policy for 2 of 2 residents reviewed for disposition of medications. (Resident #69 and #68)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #69 was reviewed on 10/14/15 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, dementia, anxiety, high blood pressure and dyslipidemia.</p> <p>The resident was discharged from the facility on 8/14/15.</p> <p>Recapitulated physician's orders for August, 2015, indicated at the time of discharge, the resident was receiving the following medications, administered by the facility:</p> <p>Aspirin 81 milligrams (mg) Donepezil 10 mg (a medication used for Alzheimer's disease) Metamucil capsule (a medication to help prevent constipation) Hydroxyurea 500 mg (a medication used to treat cancer) Levothyroxine 50 micrograms (used to treat thyroid disease) Pravastatin 40 mg (used to help lower cholesterol) Quetiapine 25 mg (an antipsychotic medication used to treat schizophrenia)</p>		<p>with each resident move out, the disposition of resident medications will be documented in the clinical record and according to facility policy. All medication administration staff was inserviced on or before 11-6-15 regarding the proper policy for medication disposition. The Resident Services Director, designee and the Administrator will monitor to ensure compliance appropriate documentation for medication disposition beginning 10-29-15 and ongoing. During monthly Quality Assurance review, the committee will review medication disposition to ensure compliance. Effective compliance date is 11-6-15.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>Trazodone 50 mg (an antidepressant medication)</p> <p>A nurse's note dated 8/14/15 at 3:00 p.m., indicated, "...Medications given to POA [power of attorney] with proper witnessed counting of medications."</p> <p>No documentation was found in the resident's record which indicated the name and strength of these medications, the prescription number, the number of medications, nor the signature of the person receiving the medications.</p> <p>On 10/14/15 at 11:05 a.m., the Regional Director of Health Care Operations indicated the facility has a drug disposition form which the nurses did not fill out for Resident #69's medications at the time of his discharge.2. The clinical record review for Resident #68, was completed on 10/14/15 at 3:45 p.m. Diagnoses included, but were not limited to, dementia and depression.</p> <p>A nurses note dated 9/25/15 at 9:30 a.m., indicated Resident #68 moved to another facility on 9/25/15.</p> <p>No documentation of medication disposition was found for divalproex (medication used to treat seizure disorders), docusate liquid (medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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>used for constipation), Lasix (medication used to treat fluid retention), levothyroxine (medication used to treat hypothyroidism), mirtazapine (medication used to treat depression), sorbitol (medication used to treat constipation), acetaminophen (medication used to relieve pain and fevers), and Robitussin (medication used to relieve coughs).</p> <p>During an interview on 10/14/15 at 1:25 p.m., the Regional Director of Health Care Operations, indicated there were no medication dispositions found for Resident #68's divalproex, docusate liquid, Lasix, levothyroxine, mirtazapine, sorbitol, acetaminophen, and Robitussin. The Regional Director of Health Care Operations also indicated nursing staff are supposed to fill out a medication disposition form, but it was not done for Resident #68 at the time of discharge.</p> <p>On 10/14/15 at 10:32 a.m., the Regional Director of Health Care Operations provided a policy titled Medication Management Policy / Procedure, dated 7/1/13, and indicated the policy was the one currently used by the facility. The policy indicated, "...Medication during Leave of Absence from Community: ... 4. If a resident permanently leaves the community, the resident's medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
--	---	---	---

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

(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 0349 Bldg. 00	<p>containers will be given to the resident or responsible person in accordance with state law, or returned to the pharmacy. 5. The Medication Release Record will be completed, signed by a licensed professional and resident/responsible party for all medications being sent with a resident during an absence from the community or upon discharge...."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure recapitulated physicians' orders were updated for 1 of 7 residents reviewed for accuracy of documentation. (Resident #36).</p> <p>Findings include:</p> <p>The clinical record review for Resident #36 was completed on 10/13/15 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension and Alzheimer '</p>	R 0349	The facility will ensure that recapitulated physician's orders (rewrites) are accurately updated. The facility sent to pharmacy the updated orders to be corrected and received corrected recapitulated physician's orders for resident #36. Updated correction effective date 11-1-15. During the October rewrite process, a two step review method was utilized to ensure accuracy of recapitulated physician's orders for the month of November. Effective completion date 10-31-15. Effective 11-1-15	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015	
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131			
(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>s.</p> <p>A physician's order dated 6/11/15, indicated to discontinue the lab order for vitamin D level every 6 months and basic metabolic panel (BMP) monthly and to start obtaining a BMP every 3 months, lipid profile every 6 months, liver profile every 6 months, thyroid stimulating hormone every 6 months, and vitamin D level annually.</p> <p>Recapitulation of Physician orders for October 2015, indicated Resident #36 was to have a vitamin D level every 6 months and a BMP lab completed every month as dated June 11, 2015.</p> <p>During an interview on 10/14/15 at 10:40 a.m., the Regional Director of Health Care Operations (RDHO) indicated the 6/11/15, lab order was sent directly to the laboratory from the physician and the facility failed to notify the pharmacy of the new order. The RDHO also indicated the recapitulations of physician's orders are checked by facility staff every month and signed indicating the orders are accurate. The RDHO indicated the October 2015, recapitulation of physician's orders had not been accurately documented to include the</p>		<p>and ongoing, the nurse receiving a new physician's order will appropriately document the new order and submit to the pharmacy for updated recapitulated physician's orders. At month end, a two step review of recapitulated physician's orders will be completed to ensure accurate physician orders. The Resident Services Director and or the designee will monitor new orders and supervise the month end rewrite process to ensure accuracy of physician orders. Effective compliance date 11-1-15 and ongoing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2015
NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131		
(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	
	changes dated 6/11/15. On 10/15/15 at 11:33 a.m., the Regional Director of Health Care Operations provided a policy titled Physician Orders, dated 7/1/13, and indicated the policy was the one currently used by the facility. The policy indicated, "...5. All physicians' orders shall be reviewed every thirty (30) days for accuracy by the Resident Services Director/Designee or resident's physician."				