STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 26 and 27, 2025 Facility number: 002858 Residential Census: 35 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed August 29, 2025.	R 0000	**1** What corrective action will be accomplished for those residents found to have been affected by the deficient practice? **The DON has updated the health records with health assessments from primary physicians of the residents that were found to be deficient. This was completed by 9/4/2025.** 2 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? **The DON audited all resident health records and updated all health assessments by 9/12/2025. The ED provided education to DON that all health assessments must be updated annually and tracked for**	

			compliance on the spreadsheet. 3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? **The DON will track and update the spreadsheet for annual health assessments. The DON will complete a move in checklist on each new resident to include checking for a current health assessment. Resident's name will be added to spreadsheet to ensure the health assessment is obtained annually. The spreadsheet will be reviewed monthly by DON and ED during the monthly Quality Assurance meeting.** 4 How will the corrective action be monitored to ensure the deficient practice will not recur? **The DON and ED will monitor the health assessment spreadsheet weekly for 3 months. Moving forward, the DON and ED will monitor the**	

			spreadsheet monthly in the Quality Assurance meeting to ensure the compliance and safety of each resident. This will be an ongoing tool reviewed monthly in QA meetings. 5 By what date will the systemic changes be completed? **9/12/2025**	
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure that annual health statements were documented for 5 of 7 residents reviewed. (Resident 203, Resident 229, Resident 233, Resident 256, Resident 257) Findings Include: 1. On 8/26/25 at 8:40 a.m., the clinical record for Resident 203 was reviewed. The diagnosis	R 0409	**1** What corrective action will be accomplished for those residents found to have been affected by the deficient practice? **The DON has updated the health records with health assessments from primary physicians of the residents that were found to be deficient. This was completed by 9/4/2025.** 2 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? **The DON audited all resident health records and updated all health assessments by 9/12/2025.**	09/12/2025

included, but was not limited to, hypertension (high blood pressure). Resident 203's clinical record lacked documentation of an annual health statement.

2. On 8/26/25 at 8:50 a.m., the clinical record for Resident 229 was reviewed. The diagnosis included, but was not limited to, hypertension. Resident 229's clinical record lacked documentation of an annual health statement.

3. On 8/26/25 at 9:00 a.m., the clinical record for Resident 233 was reviewed. The diagnosis included, but was not limited to, essential tremor. Resident 233's clinical record lacked documentation of an annual health statement.

4. On 8/26/25 at 9:10 a.m., the clinical record for Resident 256 was reviewed. The diagnosis included, but was not limited to, hypertension. Resident 256's clinical record lacked documentation of an annual health statement.

5. On 8/26/25 at 9:20 a.m., the clinical record for Resident 257 was reviewed. The diagnosis included, but was not limited to, Alzheimer's disease. Resident 257's clinical record lacked documentation of an annual health statement.

During an interview on 8/27/25

The ED provided education to DON that all health assessments must be updated annually and tracked for compliance on the spreadsheet.

3
What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? **The DON will track and update the spreadsheet for annual health assessments. The DON will complete a move in checklist on each new resident to include checking for a current health assessment. Resident's name will be added to spreadsheet to ensure the health assessment is obtained annually. The spreadsheet will be reviewed monthly by DON and ED during the monthly Quality Assurance meeting.**

4
How will the corrective action be monitored to ensure the deficient practice will not recur? **The DON and ED will monitor**

	at 10:45 a.m., the RDON (Regional Director of Nursing) indicated the facility lacked a specific policy for annual health statements and it was the practice of the facility to obtain an annual health statement upon admission and annually. Based on record review and interview, the facility failed to ensure that annual health statements were documented for 5 of 7 residents reviewed. (Resident 203, Resident 229, Resident 233, Resident 256, Resident 257) Findings Include: 1. On 8/26/25 at 8:40 a.m., the clinical record for Resident 203 was reviewed. The diagnosis included, but was not limited to, hypertension (high blood pressure). Resident 203's clinical record lacked documentation of an annual health statement. 2. On 8/26/25 at 8:50 a.m., the clinical record for Resident 229 was reviewed. The diagnosis included, but was not limited to, hypertension. Resident 229's clinical record lacked documentation of an annual health statement. 3. On 8/26/25 at 9:00 a.m., the clinical record for Resident 233 was reviewed. The diagnosis included, but was not limited to, essential tremor. Resident 233's		**the health assessment spreadsheet weekly for 3 months. Moving forward, the DON and ED will monitor the spreadsheet monthly in the Quality Assurance meeting to ensure the compliance and safety of each resident. This will be an ongoing tool reviewed monthly in QA meetings.** 5 By what date will the systemic changes be completed? **9/12/2025**	

	clinical record lacked documentation of an annual health statement. 4. On 8/26/25 at 9:10 a.m., the clinical record for Resident 256 was reviewed. The diagnosis included, but was not limited to, hypertension. Resident 256's clinical record lacked documentation of an annual health statement. 5. On 8/26/25 at 9:20 a.m., the clinical record for Resident 257 was reviewed. The diagnosis included, but was not limited to, Alzheimer's disease. Resident 257's clinical record lacked documentation of an annual health statement. During an interview on 8/27/25 at 10:45 a.m., the RDON (Regional Director of Nursing) indicated the facility lacked a specific policy for annual health statements and it was the practice of the facility to obtain an annual health statement upon admission and annually.				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE