STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/21/2022

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

(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 the Investigation of Complaint IN00384630, IN00376257, IN00374665, and IN00367666. Complaint IN00384630 - Substantiated. State Residential Findings related to the allegations are cited at R0240. Complaint IN00376257 - Substantiated. State Residential Findings related to the allegations are cited at R0147. Complaint IN00374665 - Substantiated. State Residential Findings related to the allegations are cited at R0216 and R0217. Complaint IN00367666 - Substantiated. No State Residential Findings related to the allegations were cited. Survey date: July 18, 19, 20, and 21, 2022 Facility number: 013149	R 0000		

	Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 7/27/22			
R 0147	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(d) (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on interview and record review, the facility failed to ensure fire drills were completed as directed by the facility policy. This deficient practice had the potential to affect 58 of 58 residents who resided in the facility. Finding includes: On 7/20/22 at 11:00 A.M., an interview with the Maintenance Assistant indicated the facility had not included evacuation practices with fire drills for a long time. Maintenance Assistant indicated he could not say when the facility last practiced a fire drill with the evacuation of residents, and indicated there were several	R 0147	**R147** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be**	08/12/2022

	residents who required the use of a wheelchair and were not able to ambulate down the stairs independently. On 7/20/22 at 12:35 P.M., an interview with the Director of Nursing indicated the facility had not conducted a fire drill that included evacuation practices in the building for several months and that fire drills should be completed every month on every floor and on every shift and fire drill should include resident evacuations. The Director of nursing indicated there were 6 residents in the facility living on the second and third floors who were dependent on wheelchairs and could not ambulate down the stairs. On 7/20/22 at 2:00 P.M., the facility the document entitled, "Fire Drill Report," was provided by the Director of Nursing and were reviewed at that time. The Fire Drill Reports indicated there were no occupants evacuated during the drills since a fire drill conducted on 7/26/2021. On 7/20/22 at 2:10 P.M., a policy entitled, "Fire and Life Safety Training and Drills," dated 2001 and revised January 2019 was provided by the Director of Nursing and indicated this was the current policy. The policy indicated, "Policy Statement The facility conducts fie and life safety		**accomplished for those residents found to have been affected** **by the deficient practice**: No residents were identified in this alleged deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective** **action will be taken:** All residents have the potential to be affected by this alleged deficient practice. Maintenance Assistant educated and in-service about the Fire Safety and Training Drills Policy immediately. Copy was provided to the Maintenance Assistant as a reference. All staff in-serviced and demonstrated ability to use the mobimedical emergency stair chair. General Orientation for new hire employees will include ability to demonstrate the proper use of the mobimedical emergency stair chair. **What measures will be put into place or what**	

	training upon orientation. Skill taught during training are practiced during regular drills. Policy Interpretation and Implementation...2. Fire and life safety drills are conducted at least monthly...3. Fire classes will include at least the following:...d. Evacuation procedures...." This State Residential Finding relates to complaint IN00376257. Based on interview and record review, the facility failed to ensure fire drills were completed as directed by the facility policy. This deficient practice had the potential to affect 58 of 58 residents who resided in the facility. Finding includes: On 7/20/22 at 11:00 A.M., an interview with the Maintenance Assistant indicated the facility had not included evacuation practices with fire drills for a long time. Maintenance Assistant indicated he could not say when the facility last practiced a fire drill with the evacuation of residents, and indicated there were several residents who required the use of a wheelchair and were not able to ambulate down the stairs independently. On 7/20/22 at 12:35 P.M., an interview with the Director of		**systemic changes will be made to ensure that the deficient practice does not recur:** Monthly Fire Drill log audit tool was put into place. Maintenance Assistant will provide Executive Director or designee with Fire Drill log audit for review and signature. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED or designee will monitor the Fire Drill logs monthly for 6 months to assure Fire Drills are conducted as per policy.	

	Nursing indicated the facility had not conducted a fire drill that included evacuation practices in the building for several months and that fire drills should be completed every month on every floor and on every shift and fire drill should include resident evacuations. The Director of nursing indicated there were 6 residents in the facility living on the second and third floors who were dependent on wheelchairs and could not ambulate down the stairs. On 7/20/22 at 2:00 P.M., the facility the document entitled, "Fire Drill Report," was provided by the Director of Nursing and were reviewed at that time. The Fire Drill Reports indicated there were no occupants evacuated during the drills since a fire drill conducted on 7/26/2021. On 7/20/22 at 2:10 P.M., a policy entitled, "Fire and Life Safety Training and Drills," dated 2001 and revised January 2019 was provided by the Director of Nursing and indicated this was the current policy. The policy indicated, "Policy Statement The facility conducts fie and life safety training upon orientation. Skill taught during training are practiced during regular drills. Policy Interpretation and Implementation...2. Fire and life safety drills are conducted at least monthly...3. Fire classes			

	will include at least the following:...d. Evacuation procedures...." This State Residential Finding relates to complaint IN00376257.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain weight on admission for 1 of 3 residents reviewed for weights, (Resident C).	R 0216	**R216** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those**	08/12/2022

	Finding includes: On 7/20/22 at 9:48 A.M., Resident C's medical records were provided by the Director of Nursing and reviewed. The "Admission Record," indicated Resident C's original and current admission date was 2/15/22. The resident's diagnoses included, but were not limited to: dementia, legal blindness, hearing loss, hypertension, insomnia, urinary tract infection, and abnormal weight loss. Review of the resident's "VITAL SIGN FLOW SHEET," indicated there were no documented weights upon admission or any other time while in the facility. On 7/19/22 at 4:00 P.M., an interview with the Director of Nursing indicated Resident C did not have an admission weight recorded and the resident should have had an admission weight taken upon admission. On 7/20/22 at 9:46 A.M., an interview with the Executive Director indicated admission weights were required for all residents. An admission assessment policy was requested but not provided by the time of the survey exit.. This State Residential Finding relates to complaint		**residents found to have been affected by the deficient practice**: Resident C is no longer residing in the facility in this alleged deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. All Nursing Staff in-serviced on Nursing Admission Checklist. A copy was provided to all Nursing Staff. Audit completed of residents that have admitted or readmitted to the facility in the last 60 days to ensure admission weight was obtained **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

	IN00374665. Based on record review and interview, the facility failed to obtain weight on admission for 1 of 3 residents reviewed for weights, (Resident C). Finding includes: On 7/20/22 at 9:48 A.M., Resident C's medical records were provided by the Director of Nursing and reviewed. The "Admission Record," indicated Resident C's original and current admission date was 2/15/22. The resident's diagnoses included, but were not limited to: dementia, legal blindness, hearing loss, hypertension, insomnia, urinary tract infection, and abnormal weight loss. Review of the resident's "VITAL SIGN FLOW SHEET," indicated there were no documented weights upon admission or any other time while in the facility. On 7/19/22 at 4:00 P.M., an interview with the Director of Nursing indicated Resident C did not have an admission weight recorded and the resident should have had an admission weight taken upon admission. On 7/20/22 at 9:46 A.M., an interview with the Executive Director indicated admission		Nursing Admission Checklist will be completed by Nursing Staff with signature and submitted to the Director of Nursing for audit within 24 hours of admission. IDT will complete admission review on all admits/readmits the next business day to ensure compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Director of Nursing or log and monitor compliance for all new admissions/readmissions to the facility. Audit will be completed weekly x 4, monthly x 5 will keep a log until 100% compliance is achieved. Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	

	weights were required for all residents. An admission assessment policy was requested but not provided by the time of the survey exit.. This State Residential Finding relates to complaint IN00374665.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service	R 0217	**R217** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective**	08/12/2022

	plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure a Service Plan was completed upon admission for 1 of 5 residents reviewed for Service Plans, (Resident C). Finding includes: On 7/20/22 at 9:48 A.M., Resident C's medical records were provided by the Director of Nursing and reviewed. The "Admission Record," indicated Resident C's admission date was 2/15/22. The resident's diagnoses included, but were not limited to: dementia, legal blindness, hearing loss, hypertension, insomnia, urinary tract infection and abnormal weight loss. On 7/19/22 at 4:00 P.M., an interview with the Director of Nursing indicated Resident C		**action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Resident C is no longer residing in the facility in this alleged deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. All Nursing Staff in-serviced on Admission protocol which includes Admission Service Plan. A copy was provided to all Nursing Staff. An audit of all admissions/ readmissions in last 60 days completed to ensure admission service plan completed **What measures will be put into place or what systemic changes will be made to ensure that the**	

	did not have a Service Plan in place and the resident should have had a Service Plan developed upon admission. On 7/20/22 at 9:46 A.M., an interview with the Executive Director indicated all residents were required to have Service Plans upon admission, but Resident C did not have a Service Plan in her medical records. On 7/18/22 at 1:00 P.M., the Executive Director provided the facility's Admission Agreement effective 3/2015 and indicated this was the current Admission Agreement. The Admission Agreement indicated, ..."Section 6: Community Resources & Family Members' Rights and Responsibilities Service Plan Upon admission, an individualized Service Plan will be developed. This plan will include details on how each of the resident's care needs will be addressed....". This State Residential Finding relates to complaint IN00374665. Based on record review and interview, the facility failed to ensure a Service Plan was completed upon admission for 1 of 5 residents reviewed for Service Plans, (Resident C). Finding includes:		**deficient practice does not recur:** Director of Nursing will complete the Service Plan or will assign a Licensed Nurse to complete upon admission. Nursing Admission Checklist will be completed by Nursing Staff with signature and submitted to the Director of Nursing for audit within 24 hours of admission. IDT will complete admission review the next business day after an admission to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** IDT/DON to log and monitor compliance for all new admissions to the facility. Audit will be completed weekly x 4, monthly x 5	

	On 7/20/22 at 9:48 A.M., Resident C's medical records were provided by the Director of Nursing and reviewed. The "Admission Record," indicated Resident C's admission date was 2/15/22. The resident's diagnoses included, but were not limited to: dementia, legal blindness, hearing loss, hypertension, insomnia, urinary tract infection and abnormal weight loss. On 7/19/22 at 4:00 P.M., an interview with the Director of Nursing indicated Resident C did not have a Service Plan in place and the resident should have had a Service Plan developed upon admission. On 7/20/22 at 9:46 A.M., an interview with the Executive Director indicated all residents were required to have Service Plans upon admission, but Resident C did not have a Service Plan in her medical records. On 7/18/22 at 1:00 P.M., the Executive Director provided the facility's Admission Agreement effective 3/2015 and indicated this was the current Admission Agreement. The Admission Agreement indicated, ..."Section 6: Community Resources & Family Members' Rights and Responsibilities Service Plan Upon admission, an		Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	

	individualized Service Plan will be developed. This plan will include details on how each of the resident's care needs will be addressed....". This State Residential Finding relates to complaint IN00374665.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview and record review, the facility failed to provide assistance with daily denture care for 1 of 3 residents reviewed for Activities of Daily Living (ADLs) which included denture care. (Resident B) Finding includes: On 7/20/22 at 9:15 A.M., the Director of Nursing provided Resident B's medical record. Resident B's medical record was reviewed at that time and indicated the following: Resident B's "Admission Record," dated 4/23/21, indicated Resident B was admitted to the facility on 4/23/21 with diagnoses that included, but were not limited to:	R 0240	**R240** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective**	08/12/2022

dementia.

Resident B's Brief Interview for Mental Status (BIMS) score dated 12/15/21 indicated the resident had a BIMS score 99 indicating the resident had severe cognitive impairment.

On 7/20/22 at 9:53 A.M., the Director of Nursing provided a form titled, "Level of Service Assessment Evaluation," (the resident's Service Plan), dated 6/17/21. The assessment indicated, "...PERSONAL HYGIENE...4. Dependent on others to provide all personal hygiene...."

On 7/19/22 at 11:30 A.M., an interview with Licensed Practical Nurse (LPN) 2, indicated Resident B was totally dependent on staff for all ADLs including oral and denture care.

On 7/19/22 at 11:45 A.M., an interview with Certified Nursing Assistant (CNA)2, indicated Resident B required total assistance with his ADLs including oral and denture care.

On 7/19/22 at 12:15 P.M., an interview with Qualified Medical Assistant (QMA)3, indicated Resident B required total assistance with oral care.

On 7/20/22 at 1:30 P.M., an interview the Director of Nursing indicated there was no documentation showing that

action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Resident B was not identified in this alleged deficient practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents have the potential to be affected by this alleged deficient practice.
All Nursing Staff in-serviced on new ADL sheet which includes oral care.
A copy was provided to all Nursing Staff.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

Documentation of daily ADL's (includes oral care) will be completed and signed by Certified Nurse Aide. Charge Nurse or

	denture and oral care had been performed for Resident B since admission. On 7/20/22 at 11:50 A.M., Resident B was observed in his room wearing dentures. Toothbrush, toothpaste, and denture tablets were observed in the resident's bathroom. On 7/20/22 at 9:50 A.M., the Director of Nursing provided a policy titled "Activities of Daily Living (ADL), Supporting, and indicated this was the facility's current policy. The policy indicated, "...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the Resident and in accordance with the plan of care, including appropriate support and assistance with:... oral care...." On 7/20/22 at 9:53 A.M., a document entitled, "Chart Progress Notes," dated 6/24/22, from Resident B's dentist, was provided by the Director of Nursing and reviewed at that time. The "Chart Progress Note" indicated, "...FOD [Film on Dentures] has built up and food all over the inside and outside of dentures and caused large epulis [an overgrowth of fibrous connective that cause local irritations, dental plaque and calculus all along upper and buccal due to dentures not		Designee will audit ADL sheets daily verifying services provided were completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing will assess or assign a Licensed Nurse to complete a daily visual assessment on 3 residents for 4 weeks, then 10 residents weekly for 4 weeks. Then 10 residents monthly for 4 months. Executive Director or Designee will review, audit and oversee. Adapted or adjusted as needed to maintain compliance.	

being taken out, cleaned or adjusted...."

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This State Residential Finding relates to complaint IN00384630.

Based on observation, interview and record review, the facility failed to provide assistance with daily denture care for 1 of 3 residents reviewed for Activities of Daily Living (ADLs) which included denture care. (Resident B)

Finding includes:

On 7/20/22 at 9:15 A.M., the Director of Nursing provided Resident B's medical record. Resident B's medical record was reviewed at that time and indicated the following:

Resident B's "Admission Record," dated 4/23/21, indicated Resident B was admitted to the facility on 4/23/21 with diagnoses that included, but were not limited to: dementia.

Resident B's Brief Interview for Mental Status (BIMS) score dated 12/15/21 indicated the resident had a BIMS score 99 indicating the resident had severe cognitive impairment.

On 7/20/22 at 9:53 A.M., the Director of Nursing provided a

form titled, "Level of Service Assessment Evaluation," (the resident's Service Plan), dated 6/17/21. The assessment indicated, "...PERSONAL HYGIENE...4. Dependent on others to provide all personal hygiene...."

On 7/19/22 at 11:30 A.M., an interview with Licensed Practical Nurse (LPN) 2, indicated Resident B was totally dependent on staff for all ADLs including oral and denture care.

On 7/19/22 at 11:45 A.M., an interview with Certified Nursing Assistant (CNA)2, indicated Resident B required total assistance with his ADLs including oral and denture care.

On 7/19/22 at 12:15 P.M., an interview with Qualified Medical Assistant (QMA)3, indicated Resident B required total assistance with oral care.

On 7/20/22 at 1:30 P.M., an interview the Director of Nursing indicated there was no documentation showing that denture and oral care had been performed for Resident B since admission.

On 7/20/22 at 11:50 A.M., Resident B was observed in his room wearing dentures. Toothbrush, toothpaste, and denture tablets were observed in the resident's bathroom.

On 7/20/22 at 9:50 A.M., the Director of Nursing provided a policy titled "Activities of Daily Living (ADL), Supporting, and indicated this was the facility's current policy. The policy indicated, "...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the Resident and in accordance with the plan of care, including appropriate support and assistance with:... oral care...."

On 7/20/22 at 9:53 A.M., a document entitled, "Chart Progress Notes," dated 6/24/22, from Resident B's dentist, was provided by the Director of Nursing and reviewed at that time. The "Chart Progress Note" indicated, "...FOD [Film on Dentures] has built up and food all over the inside and outside of dentures and caused large epulis [an overgrowth of fibrous connective that cause local irritations, dental plaque and calculus all along upper and buccal due to dentures not being taken out, cleaned or adjusted...."

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This State Residential Finding relates to complaint IN00384630.

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