

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/08/2024	
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints IN00433049, IN00432841 and IN00431360. Complaint IN00433049 - No deficiencies related to the allegations are cited. Complaint IN00432841 - No deficiencies related to the allegations are cited. Complaint IN00431360 - State deficiency related to the allegations is cited at R0297. Survey dates: May 5, 6 and 8, 2024 Facility number: 013149 Residential Census: 55 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on 5/9/2024	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review				

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R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were administered for 2 of 3 residents reviewed for medication administration. (Resident H and Resident G) Findings include: 1. On 5/6/24 at 2:03 P.M., a review of the clinical record for Resident H was conducted. The resident's diagnoses included, but were not limited to: diabetes and dementia A Physician's Order dated, 9/18/23, indicated the resident was to be administered Lantus 18 units by subcutaneous injection every morning (9:00 A.M.) and at bedtime (9:00 P.M.). Another order for Lispro (insulin), dated 9/18/23, indicated the resident was to	R 0297	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 5/8/24 for resident H, the DON notified the MD that the MAR was not signed and that the residents may have not been administered their prescribed insulin on 3/16 & 3/17 at bedtime. On 5/8/24 the DON notified the MD that the MAR was not signed and that the residents may have not been administered their prescribed insulin on 3/16, 3/17, & oral a.m. medication on 3/22. How will the facility identify other residents having the potential to be affected by the same deficient practices?	05/30/2024
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have her blood sugar checked, before meals and at bedtime, and the dosage of Lispro was to be determined by the results of the blood sugar test.

The Medication Administration Record (MAR) indicated the resident had not been administered her Lantus nor had her blood sugar checked to determine her Lispro unit amount, on 3/16/24 and 3/17/24, at bedtime.

2. On 5/8/24 at 1:12 P.M., a review of the clinical record for Resident G was conducted. The resident's diagnoses included, but were not limited to: heart disease, reflux disease, vitamin D deficiency and diabetes.

A Physician's Order, dated 10/15/23, indicated the resident was to be administered Lantus (insulin) 15 units by subcutaneous injection at bedtime. The resident had orders for the following medications to be administered, orally, at 6:00 A.M.; vitamin D 1000 units, vitamin B-12 100 mcg (micrograms), ferrous sulfate 325 mg (milligrams), Tylenol 650 mg and Reglan 10 mg.

The Medication Administration Record (MAR) indicated the resident had not been administered her bedtime Lantus, on 3/16/24, 3/17/24 and

Weekly audits of medication administration will be completed by the Director of Nursing or designee. If any discrepancy is noted, it will be addressed at the time found and the Executive Director will then reevaluate if more frequent monitoring is needed.

What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?

The facility will provide re-education to all Licensed nurses and Qualified medication aides by 5.24.24 in the form of in-servicing, including: following MD/NP orders, Documentation guidelines and facility policy on medication administration, in-servicing will also include re-education on documentation of the eMAR and eTAR, including documentation once administered and checking the MARs/ TARs prior to leaving shift for missed documentation and notification to the Director of Nursing for any medication not available from pharmacy at scheduled time for administration. Re-education will

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OMB NO. 0938-0391

3/22/24. The MAR indicated, on 3/26/24, the resident had not been administered her 6:00 A.M. doses of vitamin D, vitamin B-12, ferrous sulfate, Tylenol, and Reglan.

During an interview, on 5/8/24 at 2:17 P.M., the Director of Nursing (DON) indicated she had no explanation as to why, on 3/16/24 and 3/17/24, Resident H had not been administered her 9:00 P.M. dose of insulin. In addition Resident H's blood sugar had not been checked to determine if the sliding scale insulin was needed, prior to bedtime. The DON had no explanation as to why Resident G had not been administered her insulin, on 3/16/24, 3/17/24 and 3/22/24, nor her oral medication on 3/26/24 at 6:00 A.M. The DON indicated if a Qualified Medication Aide (QMA) was working the evening shift, the nurse was to administer the bedtime insulin, prior to leaving the building. She indicated an agency QMA had worked the night of the 25th-morning of the 26th of March and either forgot to document the administration of those 6:00 A.M. medications for Resident G or forgot to provide them.

On 5/8/24 at 11:37 A.M., the DON provided a policy titled, "Assisted Living Medication Services", undated and

also include the documentation on the eMAR/eTAR and reporting to the nurse for documentation and reasoning for non-administered of Medications/Treatments.

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?

Beginning 5/13/24 the DON or designee will perform audits of MAR/TAR weekly X4, then bi-weekly X4, then monthly X3 months. The results of the audits will be reviewed at the clinical meeting. The DON and or ADON will ensure corrective action is initiated if indicated.

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indicated the policy was the one currently used by the facility. The policy indicated "...Guidelines: Residents will take medications appropriately, according to physician recommendations...2. There shall be a licensed/qualified staff person available who is responsible for the administration of the medications...."

This State Residential finding relates to complaint IN00431360.

Based on interview and record review, the facility failed to ensure medications were administered for 2 of 3 residents reviewed for medication administration. (Resident H and Resident G)

Findings include:

1. On 5/6/24 at 2:03 P.M., a review of the clinical record for Resident H was conducted. The resident's diagnoses included, but were not limited to: diabetes and dementia

A Physician's Order dated, 9/18/23, indicated the resident was to be administered Lantus 18 units by subcutaneous injection every morning (9:00 A.M.) and at bedtime (9:00 P.M.). Another order for Lispro (insulin), dated 9/18/23, indicated the resident was to have her blood sugar checked,

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before meals and at bedtime, and the dosage of Lispro was to be determined by the results of the blood sugar test.

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2. On 5/8/24 at 1:12 P.M., a review of the clinical record for Resident G was conducted. The resident's diagnoses included, but were not limited to: heart disease, reflux disease, vitamin D deficiency and diabetes.

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The Medication Administration Record (MAR) indicated the resident had not been administered her bedtime Lantus, on 3/16/24, 3/17/24 and 3/22/24. The MAR indicated, on

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3/26/24, the resident had not been administered her 6:00 A.M. doses of vitamin D, vitamin B-12, ferrous sulfate, Tylenol, and Reglan.

During an interview, on 5/8/24 at 2:17 P.M., the Director of Nursing (DON) indicated she had no explanation as to why, on 3/16/24 and 3/17/24, Resident H had not been administered her 9:00 P.M. dose of insulin. In addition Resident H's blood sugar had not been checked to determine if the sliding scale insulin was needed, prior to bedtime. The DON had no explanation as to why Resident G had not been administered her insulin, on 3/16/24, 3/17/24 and 3/22/24, nor her oral medication on 3/26/24 at 6:00 A.M. The DON indicated if a Qualified Medication Aide (QMA) was working the evening shift, the nurse was to administer the bedtime insulin, prior to leaving the building. She indicated an agency QMA had worked the night of the 25th-morning of the 26th of March and either forgot to document the administration of those 6:00 A.M. medications for Resident G or forgot to provide them.

On 5/8/24 at 11:37 A.M., the DON provided a policy titled, "Assisted Living Medication Services", undated and indicated the policy was the one

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currently used by the facility.
The policy indicated
"...Guidelines: Residents will
take medications appropriately,
according to physician
recommendations...2. There
shall be a licensed/qualified staff
person available who is
responsible for the
administration of the
medications...."

This State Residential finding
relates to complaint
IN00431360.

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
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