STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00411482, IN00404149, and IN00397254. Complaint IN00404149 - No deficiencies related to the allegations are cited. Complaint IN00397254 - No deficiencies related to the allegations are cited. Complaint IN00411482 - No deficiencies related to the allegations are cited. Survey dates: November 8 & 9, 2023 Facility number: 013149 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 11/16/2023.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance. We respectfully request a desk review and consideration for paper compliance of substantial compliance based on the POC.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy DeMeester	Executive Director	12/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview and record review, the facility failed to have the most recent	R 0090	**What corrective action(s) will be accomplished for those**	12/08/2023

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	annual survey readily accessible for 57 of 57 residents reviewed for access to the current annual survey. Finding includes: An observation of the facility, was completed on 11/8/2023 at 10:22 A.M. The binder containing the current annual survey could not be located without asking the receptionist. The receptionist indicated the binder was under the desk of the receptionist and could not be accessed without requesting it. Durning an interview, on 11/8/2023 at 10:40 A.M., Licensed Practical Nurse (LPN) 1 indicated there are two units, one unit on the second floor and one unit on the third floor. LPN 1 indicated residents don't have the code to exit either units, and residents can't go down to the lobby without staff or family members. LPN 1 indicated the only place the current annual survey was, was in the lobby on the first floor. During an interview, on 11/8/2023 at 2:30 P.M., the Executive Director indicated the current annual survey wasn't accessible to residents but should have been. On 11/9/2023 at 10:30 A.M., the Director of Nursing provided a policy titled, "Survey Results, Examination of", undated, and indicated the policy was the one currently used by the facility. The policy indicated " ...A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with the state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident		**residents (staff) found to have been affected by the deficient practice?** No residents were affected in this alleged deficient practice. **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?** All residents have the potential to be affected by the alleged deficient practice. A Survey binder containing the most recent survey has been placed on the first floor, near the entry with a sign indicating the location. A survey binder has been placed on the second and third floor near the nurse station with a sign indicating the location. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The Executive Director (ED) has been re-educated on having the most recent survey readily accessible for all residents. A survey binder auditing tool was put in place to monitor binder location containing most recent survey. ED or designee will review auditing tool every week for 3 months and then 1 time monthly for 3 months. Any findings will be addressed	

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	activity room ...."		immediately. **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/designee will report findings to the quality assurance and performance improvement (QAPI) committee until 100% compliance is met for 3 months and then quarterly until resolved as determined by the QAPI committee.	
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top.			

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	(C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.			
	Based on interview, observation and record review, the facility failed to provide a means of summoning staff for 57 of 57 residents reviewed for a call system. Finding includes: During an interview, on 11/8/2023 at 2:45 P.M, Resident D indicated there wasn't a call light system, and she either must get up and find help or wait until someone checks on her to request help. During an observation, on 11/8/2023 at 3:10 P.M., no call lights were seen or heard going off.	R 0185	**What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No residents were affected in this alleged deficient practice. **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?** All residents have the potential to	12/15/2023

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	During an observation, on 11/9/2023 at 11:22 A.M., no call lights were seen or heard going off. During an interview, on 11/9/2023 at 2:15 P.M., the Director of Nursing indicated the call system was not working and the residents had no way to call staff, but the residents should have had a system to call staff. On 11/9/2023 at 10:30 A.M., the Director of Nursing provided a policy titled, "Call System, Resident", undated, and indicated the policy was the one currently used by the facility. The policy indicated, " ...Residents are provided with the means to call staff or assistance through a communication system that directly calls a staff member or a centralized workstation ...1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual ....3. The resident call system remains functional at all times ...."		be affected by the alleged deficient practice. The nurse call system required maintenance, the previous company is no longer in service and unable to find a company to repair the system. It is reported obsolete, vendors contacted and on-site awaiting bids and installation plan. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Once the nurse call system is installed, a reoccurring preventative maintenance work order will be scheduled to monitor and ensure proper functioning. **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 Executive Director will audit reoccurring nurse call system work orders each month for 6 months.	
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal			

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	preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, interview, and record review the facility failed to ensure that personal food choice preferences were honored for 1 of 57 residents. Findings include: During an observation, on 11/8/2023 at 12:05 P.M., lunch was served to the third-floor residents which consisted of mostaccioli, mixed vegetables and pears for all residents seated in the dining room. During an interview, on 11/8/2023 at 12:25 P.M., Resident H indicated that there was no selection of foods offered and no menus were provided to select meal choices from. He indicated residents had to eat whatever mush was served to them. During an interview, on 11/8/2023 at 2:20 P.M., Resident D indicated residents did not know what the meal was until the food was served and no menus had been provided. When another meal choice had been asked for, Resident D was told there was no alternative meal, not even a cold sandwich. Meals were served hot. During an interview, on 11/8/2023 at 2:30 P.M., Resident B indicated that there was not much selection for meals, but that food was good. She had not had any other food offered to her and had just eaten what was provided and that the foods were served hot. During an interview, on 11/8/2023 at 3:45 P.M., the Dietary Manager indicated that there was no posting of menus and no posting of alternative	R 0270	**What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** Resident H, D, B and J have been given menus with daily options and alternative choices. **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?** All residents have the potential to be affected by the alleged deficient practice. Menus with daily options and alternate choices have been posted in each dining room and at every dining room table. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The Dietary Manager has been re-educated on posting the menus and honoring resident food choice preferences. An auditing tool was created to monitor compliance. The Dietary Manager or designee will review the auditing tool daily for 1 month, weekly for 3 months and then monthly for 2 months. **How the corrective action(s)**	12/08/2023

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	meal choice and there should have been. During an interview, on 11/9/2023 at 9:15 A.M., Resident J indicated that no choice of foods had been offered to the residents and whatever was brought on a plate is what you had to eat. She indicated that no menus had been available for residents to look at. Resident J indicated that the food was served hot, but there were no substitutions available to residents. A record review was completed on, 11/9/2023 at 1:00 P.M., a Physician order dated 9/1/2020 for Resident H indicated that he was on a general diet with double portions. A record review was completed on, 11/9/2023 at 1:00 P.M., a Physician order, dated 6/1/2023, for Resident J indicated that she was on a general diet. During an interview, on 11/9/2023 at 1:25 P.M., the Dietary Manger indicated that no menus or meal tickets were made available to the residents and that meal tickets used to be given to residents, but she was told these could no longer be provided. She indicated that residents did not know that there was an always available entrée since the menus were not provided to residents and should have been available to them. An undated policy titled "Menus" was provided by the Director of Nursing, on 11/8/2023 at 4:05 P.M., and indicated that this was the current policy used by the facility. The policy indicated that " ...(3) the Resident Council will be included in menu planning ...(9) a copy of menus shall be posted in at least two resident areas. Menus shall be posted low enough and in print large enough for residents to read them ...."		**will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Executive Director will review audit log monthly for 6 months to insure compliance is met.	

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R 0273 Bldg. 00	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.	R 0273	**What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. **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?** All residents have the potential to be affected by the alleged deficient practice. all undated, unlabeled, expired and improperly sealed food has been discarded. The kitchenette cooler has been deep cleaned. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** All dietary staff will be in- serviced about dating, labeling and proper sealing of food and proper cleaning of the coolers. An auditing tool was created to monitor compliance.	12/08/2023

Based on observation, interview and record review, the facility failed to ensure food items in the walkin cooler were sealed securely after opening in 1 of 1 kitchens and 2 of 2 pantries. This potentially effected 57 of 57 residents who received foods from the kitchen.

Findings include:

1. During an observation with the dietary manager in the main kitchen, on 11/8/2023 at 9:50 A.M., the following were observed in the walkin cooler:
Cheese slices covered with a plastic wrap not sealed appropriately.
An opened and undated container of sliced cucumbers.
An opened and undated container of tomato's.
An opened and undated container of bread crumbs.
A turkey breast covered with plastic wrap that was not sealed tightly.
An opened carton of thickened water with an expiration date of 11/6/2023.

In the hallway adjacent to an area of canned goods were 2 refrigerators and a stand up freezer. In the black refrigerator was an opened container of mustard, relish and A 1 sauce all without opened dates.

During an interview, on 11/8/2023 at 10:04 A.M., the Dietary Manager indicated all the foods should have been dated and sealed tightly, the

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	thickened water should have been thrown out, the refrigerators and freezer were not being used and should had been cleaned and the condiments removed. 2. During an observation, on 11/8/2023 at 10:15 A.M., in the kitchenette area, the following was observed: The small metal cooler had a dried red sticky substance on the back edge of the cooler. During an interview, on 11/8/2023 art 10:20 A.M., CNA 2 indicated the cooler should have been cleaned. 3. During an observation on the 3rd floor dining room, on 11/8/2023 at 10:50 A.M., the following was observed: a refrigerator with an opened undated gallon of milk. On 11/9/2023 at 4:17 P.M., the Dietary Manager provided the policy titled, "Date Marking for Food Safety", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared... 8. Note: prepared foods that are delivered to the nursing units shall be discarded within 2 hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified...."		The Dietary Manage or designee will review the auditing tool daily for 1 month, weekly for 3 months and then monthly for 3 months. **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?** Executive Director will review audit log monthly for 6 months to ensure compliance is met.	