STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00242271 and IN00237424. Complaint IN00242271 - Substantiated. Federal/state deficiencies related to the allegations are cited at 609 and 842. Complaint IN00237424 - Substantiated. Federal/state deficiencies related to the allegations are cited at 686. Survey dates: December 27 and 28, 2017 Facility number: 004732 Provider number: 155752 AIM number: 200808300 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 1 Medicaid: 18 Other: 10 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	Quality Review was completed on January 5, 2017.			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of resident to resident abuse on 1 of 1 residents reviewed for abuse. (Resident B) Findings include: A medical record review was conducted on 12/28/17 at 9:53 A.M., for Resident B and indicated he was admitted on 12/16/16. His diagnoses included but were not limited to dementia, hypertension, depression, seizures, anemia, heart failure, esophageal obstruction. A progress note, dated 5/12/17 at 10:23 A.M., indicated Resident B hit another resident in the chest and indicated the staff removed the other resident from the situation. No documentation indicated the Administrator or DON (Director of Nursing) were notified. During an interview, on 12/28/17 at 10:30 A.M., the MDS (Minimum Data Set) Assessment Coordinator indicated the incident got missed and was not reported. During an interview, on 12/28/17 at 10:40 A.M. the Administrator indicated the incident on 5/12/17 should had been	F 0609	All residents were evacuated due to a water pipe break. We request a desk review because we do not have residents in the facility.	01/11/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	reported. During an interview, on 12/28/17 at 11:20 A.M., the DON indicated resident to resident altercations should be reported to the DON and the Administrator. A policy was provided by the MDS Coordinator on 12/28/17 at 11:14 A.M., titled, "Reporting Abuse to Facility Management", revised December 2013, and indicated it was the current policy being used by the facility. The policy indicated "...8. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident...." 3.1-28(c)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, observation and interview, the facility failed to prevent a resident admitted with intact skin from developing a Stage 3 pressure ulcer to his left heel. (Resident C) Finding includes: The clinical record was reviewed on 12/27/17 at 12:00 P.M. The diagnoses included, but were not limited to, hypertension, Alzheimer's disease, and seizure disorder. The significant change MDS (Minimum Data Set) assessment, dated 9/25/17, indicated Resident C was admitted on 7/9/13, did not have any current pressure areas, and required extensive assist with transfers and bed mobility. No care plan for skin risk was available.	F 0686	All residents were evacuated due to a water pipe break. We request a desk review because we do not have residents in the facility.	01/11/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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

A care plan for blisters to right and left heel, dated 8/30/17, included intervention to float heels and keep heel protectors on at all times.

The Progress Notes, dated 8/30/17 at 9:58 P.M., indicated that Resident C had fluid filled blisters to both heels measuring 2 x 2 cm (centimeters) and some redness surrounding to the outer area of the tissue.

The Progress Notes, dated 8/30/17 at 11:58 P.M., indicated Resident C had heel protective boots on both feet, flow air mattress and evaluation for chair had been ordered.

The Progress Notes, dated 9/5/17 at 10:54 P.M., indicated fluid filled blister to left heel measured 2.2 cm x 2.1 cm.

The Progress Notes, dated 9/6/17 at 3:38 P.M., indicated the blister to heel had opened and new order for bactracin with dry dressing twice daily was ordered.

No updates were noted to care plan for blisters.

The Progress Notes, dated 9/7/17 at 4:27 P.M., indicated Resident C's blister to left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	heel was a Stage 2 pressure area that measured 15 cm x 9.5 cm with undetermined depth with no signs of infection. No updates noted to the care plan for blisters. . The Progress Notes, dated 9/14/17 at 5:16 P.M., indicated Stage 2 pressure area to left heel measured 15 cm x 9.5 cm with undetermined depth and wound bed was beefy red. The Progress Notes, dated 9/20/17 at 1:49 P.M., left heel pressure ulcer had black eschar in center of wound. The Progress Notes, dated 9/21/17 at 4:49 P.M., the left heel wound was noted to have serous drainage and odor and the foot was swollen with wound bed necrotic at heel. A new order was received for Keflex 250 mg (milligrams) x 7 days. No updates noted to the care plan for blisters. The Physician Progress Notes, dated 9/26/17, indicated Resident C had unstageable pressure areas to the left and right heel.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	No updates noted the care plan for blisters. During an observation, on 12/28/17 at 10:30 A.M., the DON (Director of Nursing) was observed completing the dressing change to the left heel. The pressure area to left heel was present and showed signs of healing. There was no air flow mattress on bed. During an interview, on 12/28/17 at 10:30 A.M., the DON indicated the pressure area to left heel was considered a healing Stage 3 pressure ulcer and measured 1 cm x 3.1 cm, no depth. She indicated the wound bed was covered with epithelial tissue. During an interview, on 12/28/17 at 11:13 A.M., the MDS coordinator indicated no air flow mattress was placed on bed at time of order on 8/30/17 and no new requests were made at the time when the pressure areas were noted to be worsening. During an interview, on 12/28/17 at 11:15 A.M., the DON indicated the care plan should have been updated with changes in the pressure areas on the left and right heels to decrease likelihood of worsening and Resident C should of had a skin risk care plan in place.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	On 12/28/17 at 11:14 A.M., the MDS Coordinator provided the Prevention of Pressure Ulcers, dated 9/2013, and indicated this was the policy currently being used by the facility. The policy indicated the purpose of the procedure was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The care process should include efforts to stabilize, reduce or remove underlying risk factors, to monitor the impact of the interventions, and to modify the interventions as appropriate. 3.1-40(a)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review and interview, the facility failed to ensure that medication administration was documented on 3 of 3 residents reviewed for medication administration. (Resident B, E and G) Finding includes: 1. On 12/27/17 at 2:03 P.M., the MAR (medication administration record) for Resident G was observed to have missing initials on 12/19/17. A form, titled, Medication Administration Record, dated 12/1/17 thru 12/31/17, indicated pantoprazole was not signed at 6:00 A.M., clonazepam, donepezil, quetiapine, simvastatin, lithium, magnesium oxide was not signed off at 9:00 P.M., mi-acid suspension not signed off at 5:00 P.M., carbidopa/levodopa not signed off at 4:00 P.M. and 8:00 P.M.	F 0842	All residents were evacuated due to a water pipe break. We request a desk review because we do not have residents in the facility.	01/11/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	2. On 12/27/17 at 3:08 P.M., the MAR for Resident E was observed to have missing initials on 12/21/17. A form, titled, Medication Administration Record, dated 12/1/17 thru 12/31/17, indicated amlodipine, ezetimibe, lisinopril, loratadine, peg 3350 powder packet, vitamin D3, carvedilol, ferrous sulfate, memantine and omega-3 fish oil was not signed at 9:00 A.M. 3. A medical record review was conducted on 12/27/17 at 3:41 P.M., for Resident B and indicated he was admitted on 12/16/16. His diagnoses included but were not limited to dementia, hypertension, depression, seizures, anemia, heart failure, esophageal obstruction. His physician's orders indicated an order, dated 9/16/17, for potassium 10 meq (milliequivalent) 1 tablet daily and a order, dated 9/26/17, for sinemet 25/100 mg (milligrams) 1 tablet 3 times daily. The MAR was observed to have missing initials on 9/16, 9/17, 9/18 and 9/19/17 at 9:00 A.M. for potassium and missing initials for sinemet on 9/29/17 at 2:00 P.M. During an interview, on 12/28/17 at 10:02			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	12/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(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
	A.M., the MDS (Minimum Data Set) assessment Coordinator indicated if there is no initials in the box on the MAR, no medication was given. During an interview, on 12/28/17 at 10:30 A.M., the MDS Coordinator indicated there were no orders to hold the potassium and it should have been given. During an interview, on 12/28/17 at 11:14 A.M., the MDS Coordinator and DON (Director of Nursing) indicated he should have had his 2:00 P.M. sinemet prior to his discharge on 9/29/17. A policy was provided by the MDS Coordinator on 12/28/17 at 11:14 A.M., titled, "Administrating Medications", revised December 2012, and indicated the policy was the one currently used by the facility. The policy indicated "...19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next one...." 3.1-50(a)(1)			