STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING 00 B. WING	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

(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 Complaints IN00444788 and IN00444256. Complaint IN00444788 -Federal/State deficiency related to the allegation is cited at F842. Complaint IN00444256 - No deficiencies related to the allegations are cited. Survey dates: October 17 and 18, 2024. Facility number: 011039 Provider number: 155675 AIM number: 200299100 Census Bed Type: SNF: 1 SNF/NF: 47 Residential: 13 Total: 61 Census Payor Type: Medicare: 5 Medicaid: 35 Private: 8 Other: 13 Total: 61 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 23, 2024.	F 0000		
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility	F 0842	Please find our plan of correction	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
April D Hughes	RN	10/30/2024

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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	failed to ensure a resident's medication administration record accurately reflected the administration of narcotic pain medication for 1 of 3 residents reviewed for medication administration. (Resident C). Findings include: The clinical record for Resident C was reviewed on 10/17/24 at 9:35 A.M. An Admission Minimum Data Set (MDS) assessment, dated 09/24/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, hypertension, diabetes, and seizure disorder. A Physician's order, with a start date of 09/20/24, indicated staff were to administer 15 mg (milligrams) of Morphine Sulfate by mouth every three hours as needed for severe pain for 14 days. The September Controlled Drug Receipt/Record/Disposition Form, for the resident's Morphine Sulfate 15 mg medication, indicated the resident's medication was signed out as given on the following dates and times: 09/21/24 at 3:30 A.M., 09/21/24 at 11:45 A.M., 09/21/24 at 9:01 P.M., 09/22/24 at 5:10 A.M., 09/23/24 at 1:45 A.M., 09/23/24 at 5:26 A.M., 09/23/24 at 1:30 P.M., 09/24/24 at 4:30 (no other specification noted), 09/24/24 at 9:00 A.M., and 09/25/24 at 11:00 A.M. The September 2024 Electronic Medication Administration Record (EMAR) lacked documentation that the medication was administered on the following dates and times: 09/21/24 at 11:45 A.M. and 09/24/24 at 4:30 (no other specification noted).		below. This constitutes my written allegation of compliance for the alleged deficiencies cited. This plan is submitted to meet requirements established by State and Federal law. We would like to request, at this time, a desk review of said plan of correction. F 842 Resident Records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; MD was notified of missing medication administration documentation. Unable to complete head to toe assessment due to resident discharged, reviewed pain assessments, no negative outcomes related to pain regimen. All licensed nursing staff and QMA's have been educated on proper medication administration documentation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected by the alleged deficient practice, but no residents were identified to be affected by this alleged deficiency after review. Pain assessments reviewed, no uncontrolled pain noted. All licensed nurses and QMA's were educated on proper documentation of medication administration.	

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	During an interview on 10/17/24 at 3:30 P.M., RN 2 indicated that when staff were administering a resident's narcotic, they were to write it in the narcotic book with the current date and time, then documented it in the electronic system. Anytime anything was signed out on the narcotic sheet, it was also documented in the electronic system. A current facility policy, titled "Documentation of Medication Administration", with a revision date of April 2007, was provided by the Director of Nursing (DON) on 10/17/24 at 3:00 P.M. The policy indicated," ...A nurse ...shall document all medications administered to each resident on the resident's medication administration record (MAR). Administration of medication must be documented immediately after (never before) it is given ...". This citation relates to Complaint IN00444788. 3.1-50(a)(1) 3.1-50(a)(2)		What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses and QMA's were educated by SDC, DON, & ADON on October 28, 2024. The facility will document medications administered. 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; and A Performance Improvement Tool has been developed that will monitor compliance of documentation of medication administration. DON/Designee will complete PI tool daily (Mon-Fri) for one month, then weekly for one month, then monthly for four months, with results being presented at the QAPI committee meeting and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits. By what date the systemic change for each deficiency will be complete. 10/31/24	