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	07/31/2019

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. Survey dates: July 30 & 31, 2019 Facility number: 013149 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on August 7, 2019.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to provide the most recent annual survey results for review. This deficiency had the potential to affect all residents in the facility. Finding includes: During an observation, on 7/30/19 at 2:50 P.M., a sign at the entry of the facility indicated survey results were available at the reception desk for the past 2 years. Upon request to review the survey results for the past year, the facility was not able to produce the survey results. During an interview, on 7/30/19 at 2:52 P.M., the	R 0042	**R0042** *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.*	08/31/2019

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
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	SS (Social Services) designee indicated the survey results are supposed to be available at the reception desk at all times. A request for a policy related to posting of survey results was requested, but one was not provided.		*This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the intent of this facility to provide the most annual survey of the facility conducted by the State Surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all resident. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The facility reproduced the annual survey binder information and placed it at the receptionist desk. The binder will be checked by the receptionist at least weekly times two months. The Administrator or designee will be notified if information is missing for immediate replacement of survey**	

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			material. The Administrator will check monthly for placement on an on-going basis. **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 facility will review the protocol with the QAPI Committee for additional recommendation until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed: 08/31/2019**	
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 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:			

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	(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 and interview, the facility failed to ensure residents had ready access to provider care for a dentist, optometrist, podiatrist, and audiologist. This deficient practice had the potential to affect 49 of 49 residents.	R 0090	**R0090** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/31/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Finding Includes: Employee records were reviewed on 07/31/19, at 10:00 AM. No providers were indicated related to the following services: dentist, optometrist, podiatrist, and audiologist. During an interview, on 07/31/19 at 12:00 PM, the CHR (Corporate Human Resources) and ED (Executive Director) indicated they were not able to provide the names of the providers that come in to provide services. On 07/31/19, at 2:50 PM, a policy related to provider access was requested, but one was not available.		*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 residents found to have been affected by the deficient practice:** No residents were negatively impacted by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be effected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility conducted a full audit of the Podiatry, Dental, Vision, Audiology, Optometry, contractual services and has obtained all pertinent required information regarding the noncompliance of 410 IAC 16.2-5-1.3(g)(1-6) and received all contractual providers	

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			information required. **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 ADON shall audit and keep all contractual providers required information up to date. The ED shall review audit and oversee and update as personnel change or departmental changes to realize a 100% compliance. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed: 08/31/2019**	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure a pre-employment physical, two reference checks, and a background check were completed for 2 of 2 new employees reviewed. (LPN 2 & DD) Findings Include: 1. The employee file was reviewed on 07/31/19, at	R 0116	R0116 *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*	08/31/2019

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	10:00 AM, for LPN 2 (Licensed Practical Nurse) and indicated a hire date of 06/26/19. No reference checks or criminal background check was completed prior to employment. 2. The employee file was reviewed on 07/31/19. at 10:05 AM, for the DD (Dietary Director) and indicated a hire date of 03/25/19. No background check, references, or pre-employment physical were indicated. During an interview, on 07/31/19 at 2:00 PM, the ED (Executive Director) indicated no additional documents were available and she would have expected them to be completed. A policy was provided by the ED on 07/31/19 at 1:15 PM, titled "Background Screening Investigations", dated 11/2015, and indicated this was the policy currently used by the facility. The policy indicated "...conducts employment background screening checks, reference checks and criminal conviction investigations...."		*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.* It is the intent of this facility to provide a pre-employment physicals, two reference checks and a background check on potential hires for employment. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A criminal background check and references were obtained on LPN #2. A criminal background check, references and a physical was completed for the Dietary Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All residents have the potential to be effected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An audit was completed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			HR Director for all present employees to ensure completed background checks, references and physicals are complete. Those employees identified without completed pre-employment criteria have been scheduled to have their information completed. by 08/31/2019. 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 HR Director was in-serviced by the Clinical Nurse Consultant on the pre-employment screening to be conducted including background checks and references. The in-service also included physicals and TB Screening requirements. The HR Director will complete a pre-employment check sheet on all potential hires to ensure the criteria and screening is completed before hiring on an on-going basis. The results of the audits and follow up will be reported to QAPI until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.	

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		A. BUILDING 00 B. WING	07/31/2019

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			By what date the systemic changes will be completed: 08/31/2019	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a CPR (Cardiopulmonary Resuscitation) certified staff member was present on all shifts in the facility for a census of 49 residents on 2 of 7 days reviewed for CPR coverage. (July 28 & 31, 2019) Finding includes:	R 0117	R0117 *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*	08/31/2019

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	The staffing schedule was reviewed, on 07/31/19 at 2:20 PM, for the week of 07/28/19. No CPR certified individual was scheduled on July 28th for complete night shift nor for the evening and night shifts on July 31st. During an interview, on 07/31/19 at 2:35 PM, the CHR (Corporate Human Resources) indicated they were aware of the lack of CPR certified individuals was creating holes in CPR coverage on all shifts. On 07/31/19, at 2:50 PM, a policy related to CPR certification was requested, but one was not available.		*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.* *It is the intent of this facility that staff shall be in sufficient numbers, qualifications and training in accordance with State Laws including a CPR certified staff member available on each shift.* What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively impacted by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All residents have the potential to be effected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An audit was completed by the	

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			HR Director on all present staff for certification completion in CPR. CPR classes have been made available for current employees. Additional CPR classes will be scheduled to ensure the facility maintains compliance with this alleged deficient practice. 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 HR Director will maintain an audit of all those staff members who have CPR certification on an on-going basis. The results of the audit will be give to the DON who will ensure that one CPR staff member is scheduled per shift when completing the nursing schedule. The HR Director and DON will report results of the audits to QAPI until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. By what date the systemic changes will be completed: 08/31/2019	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each			

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	employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on interview and record review, the facility failed to ensure both general and job specific orientation were completed for 2 of 2 new employees reviewed. (LPN 2 & Dietary Director) Findings Include:	R 0119	**R0119** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/31/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	1. The employee file was reviewed on 07/31/19, at 10:00 AM, for LPN 2 (Licensed Practical Nurse) and indicated a hire date of 06/26/19. No general or job specific orientation were completed. 2. The employee file was reviewed on 07/31/19. at 10:05 AM, for the DD (Dietary Director) and indicated a hire date of 03/25/19. No general or job specific orientation were completed. During an interview, on 07/31/19 at 2:00 PM, the ED (Executive Director) indicated no additional documents were available and she would have expected them to be completed. On 07/31/19, at 2:50 PM, a policy related to orientation was requested, but one was not available.		*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.* *Its the intent of this facility to ensure that each employee be given an orientation provided by the supervisor prior to working independently.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** **A general orientation and job specific orientation has been completed for LPN #2 and the Dietary Director.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** **All resident have the potential to be effected by this alleged deficient practice.** **What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur: **An audit was completed by the HR Director of all staff employment files to ensure general orientation or job specific orientation are completed. Job specific and general orientations that were missing were identified and scheduled for completion.** **The HR Director was in-serviced on ensuring job specific orientations and general orientations are completed for all new hires.** **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:** **Th HR Director will have a check off sheet for each new hire. The check off sheet will include completion of the general orientation and the job specific orientation. The check sheets once completed will be maintained in each employee file.** The completed check off sheets will be present to QAPI monthly until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to	

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(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
			maintain compliance. **By what date the systemic changes will be completed: 08/31/2019**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.			

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		A. BUILDING 00 B. WING	07/31/2019

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	(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure required in-services (Resident's Rights, dementia, and abuse) were completed upon hire and annually for 5 of 5 employee files reviewed. (LPN 2, Maintenance, QMA 3, Dietary Director, & CNA 4) Findings Include: 1. The employee file was reviewed on 07/31/19, at 10:00 AM, for LPN 2 (Licensed Practical Nurse) and indicated a hire date of 06/26/19. No in-service related to abuse was completed. 2. The employee file was reviewed on 07/31/19, at 10:05 AM, for the Dietary Director and indicated a hire date of 03/25/19. No in-service related to Resident's Rights was completed. 3. The employee file was reviewed on 07/31/19, at 10:15 AM, for QMA 3 (Qualified Medication Aide) and indicated a hire date of 8/02/16. No in-services related to Resident's Rights or dementia were completed. 4. The employee file was reviewed on 07/31/19, at 10:25 AM, for Maintenance and indicated a hire date of 10/14/14. No in-service related to Resident's Rights was completed. 5. The employee file was reviewed on 07/31/19. at 10:30 AM, for CNA 4 (Certified Nurses Aide) and indicated a hire date of 07/01/17. No in-service related to dementia was completed.	R 0120	**R0120** *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.* *It is the intent of this facility to ensure that required in-servicing upon hire and annually is completed for all employees.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** LPN #2 has been in-serviced on abuse. The Dietary Director has been in-serviced on Resident Rights. The QMA## was in--serviced on Dementia and Resident Rights. The Maintenance Director was	08/31/2019

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	During an interview, on 07/31/19 at 2:00 PM, the ED (Executive Director) indicated no additional documents were available and she would have expected them to be completed. On 07/31/19, at 2:50 PM, a policy related to in-services was requested, but one was not available.		in-serviced on Resident Rights. CNA #4 has been in-serviced on Dementia. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** **This deficient has the potential to effect all residents.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The HR Director was in-serviced by the Clinical Nurse Consultant on the required in-servicing needed upon hire and annually. The HR completed an audit on all present employees to check on completion of required in-servicing. All employees with incomplete in-servicing requirements have been scheduled for completion. The HR Director will utilize a check off sheet for new hires to ensure the in-servicing is complete and will also use a check off sheet for active employees to ensure annual in-services are completed per protocol.** **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: **The HR Director will provide check off sheets to QA for review and for any additional recommendations.** **By what date the systemic changes will be completed:** **08/31/2019**	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure a signed job description completed for 2 of 2 new employees reviewed.	R 0123	**R0123** *This plan of Correction is the facility's credible allegation of*	08/31/2019

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	(LPN 2 & Dietary Director) Findings Include: 1. The employee file was reviewed on 07/31/19, at 10:00 AM, for LPN 2 (Licensed Practical Nurse) and indicated a hire date of 06/26/19. No signed job description was completed. 2. The employee file was reviewed on 07/31/19. at 10:05 AM, for the Dietary Director and indicated a hire date of 03/25/19. No signed job description was completed. During an interview, on 07/31/19 at 2:00 PM, the ED (Executive Director) indicated no additional documents were available and she would have expected them to be completed. On 07/31/19, at 2:50 PM, a policy related to job descriptions was requested, but one was not available.		*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.* *It is the intent of this facility to maintain current and accurate personnel records for all employees.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The job description for LPN#2 has been completed and signed. The job description for the dietary director has been completed and signed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** **This deficient has the potential to effect all residents.** The HR director has been completed an audit of all present	

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			employees. Any staff member with out a job description has been identified. The HR manager or designee has finalized this audit by completing job descriptions for all employees to include employee signatures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The HR manager has been inserviced by the Clinical Nursing Consultant on the requirements on the personnel files and to ensure the files are complete per policy. The HR manager will utilize a check off sheet which identifies all required documentation to be included in the personnel files. This completed check off sheet will be utilized, checked off and signed if applicable, and completed. The check off sheet when finalized completely, will be placed in each employee file by the HR manager, to include signature and date, ensuring completeness and accuracy of each personnel file. The HR manager will provide the results of the audits to the Executive Director which will be reviewed by QAPI for additional recommendations, until 100% compliance is achieved. **By what date the systemic changes will be completed: 8/31/2019**	

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R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, interview and record review, the facility failed to maintain a clean environment, free from stained and mold covered ceiling tiles, and failed to have the heating and ventilation system inspected, at minimum, yearly. This deficiency had the potential to affect all residents in the facility. Findings include: 1. During an initial tour, on 7/30/19 at 11:52 A.M., the following ceiling tiles were observed with brown stains in various sizes: 5 ceiling tiles, 1st floor, adjacent to stairwell by rooms 104 & 105; 1 ceiling tile directly next to wall by room 106; 1 ceiling tile above fire extinguisher by room 107; 1 ceiling tile next to vent by room 101; 1 ceiling tile across from room 223, dining room entrance; 2 ceiling tiles at the main entry to 2nd floor dining room; 2 ceiling tiles adjacent to the MDS	R 0148	**R0148** *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 residents found to have been**	08/31/2019

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		A. BUILDING 00 B. WING	07/31/2019

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	(Minimum Data Set) Coordinator office; 1 ceiling tile adjacent to 3rd floor electrical closet by elevator; 1 ceiling tile with lumpy white substance adjacent to 3rd floor exit sign in dining room hallway; 1 ceiling tile (sprinkler head tile) adjacent to 3rd floor dining room back door; 18 ceiling tiles in 3rd floor dining room, 1 completely covered in black colored mold by main entry to dining room and a second tile with black colored mold 1-2 inches in diameter in the center of dining room; 6 ceiling tiles adjacent to room 315, 2 of the ceiling tiles completely covered in black colored mold. During an interview, on 7/30/19 at 11:54 A.M., the ED (Executive Director) indicated stained ceiling tiles should be replaced as soon as they are identified. During an interview, on 7/30/19 at 11:56 A.M., the maintenance worker indicated the ceiling tiles adjacent to room 315 became stained last week after a leak from the facility's air conditioner. A daily maintenance form, undated, indicated, "...Interior check-Walk interior of building...Inspect ceiling tiles for signs of roof leaks...." A policy for ceiling tile maintenance was requested, but none was provided. 2. During an interview, on 7/31/19 at 10:37 A.M., the ED indicated the facility had not had an annual inspection on the HVAC (heating, ventilation, and air conditioning) system. A semi-annual maintenance form, undated, indicated, "...HVAC Systems Maintenance-Fall (September) & Spring (March)...Complete symptoms check, cleaning, & service...service		**affected by the deficient practice:** #1. It is the intent of this facility to maintain a clean environment free from stained and mold covered ceiling tiles and regular inspections of the HVAC system. All the above mentioned stained ceiling tile have been replaced. The inspection of the HVAC has been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all resident. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Ceiling tile inspections have been added to the preventative maintenance checks, to be completed weekly. The maintenance director shall check for stained tiles on a daily basis utilizing the preventative check list and will schedule weekly replacement of all stained or molded tiles. The inspection of the HVAC will be completed, at least annually or more frequent, if indicated. The inspection will include a complete systems check, cleaning, and	

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	performed by local company...." A policy for HVAC maintenance was requested, but one was not provided.		serviced, by a local company. The inspection and service documentation will be kept by the maintenance director and a copy will be kept by the Executive Director. The executive director met with and inserviced the maintenance director to the updated preventative maintenance check sheet to include the stained or molded tiles, emphasizing the immediate replacement of such tiles, when identified. The annual inspection of the HVAC system and all documentation, will be scheduled and checked by the maintenance director per policy. A copy of all paperwork to be kept by the maintenance director and a copy provided to the Executive Director. **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:** Results of the preventative maintenance of the stained or molded tiles and the results of the HVAC checks will be presented to QAPI monthly x 2 mos. for additional recommendations. **By what date the systemic changes will be completed: 08/31/2019**	
R 0152	410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency			

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		A. BUILDING 00 B. WING	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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Bldg. 00	(i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. Based on observation, interview, and record review, the facility failed to properly store clean linen in 2 of 2 clean linen storage rooms observed for linen storage. (Second floor linen room and Third floor linen room) Findings include: During an initial tour, on 7/30/19 at 11:35 A.M., the second floor storage room was observed with one large cardboard box sitting directly on the floor. Two metal storage racks were observed to contain clean linen of various types. The bottom shelf of each rack was observed to be 2 inches from the floor, had no solid bottoms and contained clean blankets. Both of the linen storage racks were observed to have a zippered cover that was open and flipped over the top, exposing all linens. During an initial tour, on 7/30/19 at 11:49 A.M., the third floor linen room was observed with one rack approximately 1 inch off of the floor, containing clean linens and uncovered. During an interview, on 7/30/19 at 11:50 A.M., the ED (Executive Director) indicated boxes should not be stored directly on the floor, the bottom shelves of linen storage racks should be at least 6 inches from the floor and have a solid bottom to prevent dust and debris from contaminating clean linen and all linen should be covered while in storage. On 7/31/19 at 10:37 A.M., the ED provided the "Departmental (Environmental Services)-Laundry and Linen" policy, dated January 2014, and	R 0152	**R0152** *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 residents found to have been affected by the deficient practice:** It is the intent of this facility to handle, store, process and transport clean linen in a safe and sanitary manner that will prevent of infection. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all residents.	08/31/2019

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		A. BUILDING 00 B. WING	07/31/2019

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	indicated this was the current policy being used by the facility. The policy indicated, "...Clean linen will remain hygienically clean (free from pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts...."		The linen room storage on the 2nd and 3rd floor is now storing all linen properly. All linen storage racks have either been replaced or corrected to the required height per ISDH regulations. Nothing is stored directly on the floor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The housekeeping/laundry manager and the DON have been inserviced by the Clincial Nurse Consultant and both the housekeeping/laundry manager and DON have inserviced all department staff to the policy of proper linen storage and transport to include linen covers to prevent contamination.** **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 housekeeping/laundry manager and DON will monitor linen storage x 3 weekly x 2 mos., noncompliance will be addressed by reeducation. Results of the monitoring will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic**	

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			changes will be completed: 08/31/2019	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete a preadmission evaluation for 2 of 7 residents reviewed for preadmission evaluations. (Residents 5 & 7) Findings include: 1. The clinical record was reviewed, on 07/31/19 at 10:30 A.M., for Resident 7 and indicated an admission date of 06/21/19. Resident 7 did not have a pre-admission evaluation present in the chart. 2. The clinical record for Resident 5 was reviewed on 07/30/19 at 1:10 P.M. There was no pre-admission evaluation available. During an interview, on 07/31/19 at 1:15 PM, the DON (Director of Nursing) indicated she is aware pre-admission evaluations are to be completed and she was unable to provide documentation of one being completed for Resident 5. During an interview, on 7/31/19 at 1:23 P.M., the ED (Executive Director) indicated the pre-admission evaluation was not present in resident 7's clinical record and a pre-admission evaluation should have been performed prior to admission.	R 0214	**R0214** *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 residents found to have been affected by the deficient practice:** It is the intent of this facility to complete a preadmission evaluation of all residents. **How other residents having the**	08/31/2019

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	07/31/2019

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

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	A policy was provided by the ED (Executive Director) on 07/31/19 at 1:15 PM, titled "Level of Needs Assessment Policy", dated 12/04/97, and indicated this was the policy currently used by the facility. The policy indicated "...Prospective residents will be assessed prior to admission...."		**potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all newly affected residents. Resident #7 has a completed preassessment and is current in DON's file. Resident #5 has a completed preassessment by the DON and is in the DON's file. The DON was inserviced on the policy of the preassessments by the Clinical Nursing Consultant. Emphasis was placed on completing the preassessments, prior to admission for the preadmissions to ensure the facility can meet the needs of all residents and all possible residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The DON will complete the preassessment or will assign a licensed nurse to complete all prior to admission. The completed preassessed evaluation, signed and dated and will be placed in the DON's file.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			assurance program will be put into place: **The DON will log all potential residents and date when the preadmission assessment was completed, prior to the admission.** The DON will report the results of the audit to the QAPI committee x 2 mos or until compliance. **By what date the systemic changes will be completed: 08/31/2019**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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 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			

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	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 develop signed services plans on 1 of 7 residents reviewed for service plans. (Resident 8) Finding Includes: The clinical record for Resident 8 was reviewed on 07/31/19 at 1:00 P.M. There was no signed service plan available. During an interview, on 07/31/19 at 2:30 P.M., the DON (Director of Nursing) indicated all residents should have signed service plans. A policy was provided by the ED (Executive Director) on 07/31/19 at 1:15 PM, titled "Level of Needs Assessment Policy", dated 12/04/97, and indicated this was the policy currently used by the facility. The policy indicated "...Prospective residents will be assessed prior to admission and at least semi-annually...."	R 0217	**R0217** *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 residents found to have been affected by the deficient practice:** It is the intent of this facility to have a signed service plan in place for all residents. Resident #8 has a completed service plan by the DON. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the	08/31/2019

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			potential to effect all residents. The DON has been inserviced by the Clinical Nursing Consultant on completion of service plans to include signature and date. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DON designee has completed an audit on all residents to ensure a signed service plan is in place. No other resident has been identified. **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 DON will present to QAPI x 2 mos the results of the completed audit and any recommendation to the system change. **By what date the systemic changes will be completed: 08/31/2019**	
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian.			

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	(B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on interview and record review, the facility failed to ensure a certified dietary manager was employed. This deficiency had the potential to affect 49 of 49 residents. Finding Includes: The employee file was reviewed on 07/31/19. at 10:05 AM, for the Dietary Director and indicated a hire date of 03/25/19. No degree or certification was available for review. During an interview, on 07/31/19 at 2:00 PM, the	R 0274	**R0274** *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*	08/31/2019

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	ED (Executive Director) indicated there was no certification for the Dietary Director available. On 07/31/19, at 2:50 PM, a policy related to dietary manager requirements was requested, but one was not available.		*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 residents found to have been affected by the deficient practice:** It is the intent of this facility to ensure that the dietary manager has the appropriate qualifications. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The present dietary manager has been enrolled into a certification class. **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 HR Director and the Administrator will ensure that dietary director is competent in the food service management, and	

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			is knowledgeable in sanitary standards, food handling, food prep and meal services. Prior to hire the HR Director will review the credentials to ensure the dietary manager has the competency and knowledge to perform as the manager. The dietary manager will be enrolled into a certification program and will maintain any certifications required per ISDH guidelines. The HR Director shall oversee all certifications and will update QAPI on proress of all certifications and training for review. **By what date the systemic changes will be completed: 08/31/2019**	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview the facility failed to ensure 1 of 3 storage areas were free from	R 0298	**R0298** *This plan of Correction is the*	08/31/2019

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	undated and expired medications. (Second floor medication cart) Findings Include: During a medication storage observation, on 7/30/19 at 12:05 P.M., the second floor medication cart was observed to have a Humalog kwikpen opened with no open date, a Lantus pen opened with no open date, a bottle of dorozolamide eye drops open with no open date, a bottle of levobunolol eye drops open with no open date, a bottle of tobramycin eye drops opened with instructions to be given for 10 days and the last day the medication was given was 7/28/19, a bottle of ipratropium bromide nasal spray open with no date and 6 ipratropium bromide nebulizer vials out of the foil package in the drawer. A bin containing a bottle of nyamyc powder, a tube of calmoseptine cream, lotrimin cream, triamcinolone cream and ketoconazole cream belonging to different residents and not bagged individually and a second bin containing a tube of santyl ointment, triamcinolone cream, calazine cream and nystatine cream belonging to different residents and not bagged individually and 2 tubes of hydrocortisone cream open and with no resident identifiers on them. During an interview, on 7/30/19 at 12:25 P.M., LPN (Licensed Practical Nurse) 1 indicated the medications should have labels identifying who the belong to, and dates when they are opened and insulin was good for 30 days. During an interview, on 7/31/19 at 11:48 A.M., the DON (Director of Nursing) indicated eye drops, inhalers, insulin should be dated when opened and all creams and ointments should not be stored together, each resident should have their own		*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 residents found to have been affected by the deficient practice:** It is the intent of this facility to ensure storage areas remain free of undated and expired medications. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all residents. The DON/designee has checked the 2nd floor medication cart and labeled all unlabeled, expired and for date medication opened. Medications outdated were disposed of per policy. All creams, tubes have been placed in separate bags. All tubes, etc.	

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	space. A policy was provided by the DON, on 731/19 at 1:18 P.M., titled, "Storage of Medications", revised April 2007, and indicated it was the policy that was currently being used. The policy indicated "...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed...Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents...." A policy was provided by the DON, on 731/19 at 1:18 P.M., titled, "Medications with Shortened Expiration Dates", no date, and indicated it was the policy that was currently being used. The policy indicated "...Once these products are opened, they must be used within a specific timeframe to avoid reduces stability and sterility and potentially, reduces efficacy. All of these medications should be labeled in such a way that the "Beyond Use Date" is securely attached to a part of the package...."		were checked for resident identifiers. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The nursing staff were inserviced by the DON, the policies regarding the storage of medications. Inservicing also included the policy on medications with shortened expiration dates. Emphasis was placed on placing the date opened sticker and checking the date to ensure medication date have not been utilized by expired. The night nurse will check weekly on an ongoing basis, for all outdated medications, date medication opened, and individually bagged and opened on all medication carts. **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 DON/designee will check weekly x 2 mos for full compliance. The DON will report the results to the QAPI committee x 2 mos. or until 100% compliance. **By what date the systemic changes will be completed: 08/31/2019**	

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		A. BUILDING 00 B. WING	07/31/2019

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R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview the facility failed to ensure tubes of medication had the required identification labeled during a medication storage observation for 1 of 3 medication carts observed. (Second floor medication cart) Finding Includes: During a medication storage observation, on 7/30/19 at 12:05 P.M., the second floor medication cart was observed to have two tubes of hydrocortisone cream with no label or resident identification. During an interview, on 7/30/19 at 12:25 P.M., LPN (Licensed Practical Nurse) 1 indicate the tubes of hydrocortisone cream should have the resident's name on it. A policy was provided by the DON, on 731/19 at 1:18 P.M., titled, "Labeling of Medication Containers", revised April 2007, and indicated it was the policy that was currently being used. The policy indicated "...Labels for over-the-counter drugs shall include all necessary information such as: a. The original label; b. The resident's name...."	R 0300	**R0300** *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 residents found to have been affected by the deficient practice:** It is the intent of this facility to ensure tubes of medication have the appropriate identification labels. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this	08/31/2019

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		A. BUILDING 00 B. WING	07/31/2019

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			deficient practice, but has the potential to effect all residents. The indentified tubes of hydrocortisone cream that were not labeled or has a resident identification were destroyed per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** he DON completed an audit of all medication carts for all tubes to ensure all were appropriately labeled with the resident's name. The DON inserviced the licensed staff of the appropriately labeled medications per policy. The night nurse will check for appropriate labeling and resident identification of over the counter drugs. This audit will be completed weekly on an ongoing basis. The DON/designee will audit all 3 medication carts weekly x 2 mos. **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 results will be submitted to QAPI x 2 mos. for additional recommendations or until 100% compliance.. **By what date the systemic changes will be completed: 08/31/2019**	

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R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on record review and interview, the facility failed to conduct a mental health screening for residents who were recipients of Medicaid for 1 of 3 residents reviewed for mental health screening. (Resident 7) Finding includes: The clinical record was reviewed, on 07/31/19 at 10:30 A.M., for Resident 7 and indicated Resident 7 had a Medicaid waiver and a mental health screening was not present in the chart for review.	R 0378	**R0378** *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*	08/31/2019

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	During an interview, on 7/31/19 at 1:30 P.M., the SS (Social Services) designee indicated the mental health screening was not present in resident 7's clinical record and one should have been done on the date of admission. A policy regarding mental health screening was requested, but one was not provided.		*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 residents found to have been affected by the deficient practice:** It is the intent of this facility to complete the mental health screen for by a licensed nurse of all recipients of Medicaid or SSI funds. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** No residents were effected by this deficient practice, but has the potential to effect all residents. Resident #7 is no longer a residing at this facility. The DON will complete the mental health screening on any resident under Medicaid or SSI on preadmission. The DON has been inserviced by the Clinical Nursing Consultant on the policy of mental health screening on preadmission. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DON designee has completed an audit on all current residents to ensure a completed mental health	

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MORNING VIEW NURSING AND REHABILITATION CENTER	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

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			screening has been completed and placed on the clinical chart. **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 DON will present to QAPI x 2 mos the results of the completed audit and any recommendation to the system change. **By what date the systemic changes will be completed: 08/31/2019**	