STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	COMPLETED	
			B. WI	NG		07/31	07/31/2019	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R			ORTH NILES AVENUE			
MORNIN	G VIEW NI IRSING	AND REHABILITATION CENTER			BEND, IN 46617			
WORTH	O VIEW NOROME	THE REINBIETT TION CENTER		00011	1 BEND, IIV 40017			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0000								
Dida 00								
Bldg. 00	This visit was for a	State Residential Licensure	D 00	200				
		State Residential Licensure	R 00)00				
	Survey.							
	Survey dates: July	20.8, 21. 2010						
	Survey dates. July	30 & 31, 2019						
	Facility number: 0	13149						
	racinty named:							
	Residential Census	: 49						
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5.							
	Quality Review wa	s completed on August 7, 2019.						
R 0042	410 IAC 16.2-5-1	The state of the s						
		- Noncompliance						
Bldg. 00	(p) Residents have	_						
		e results of the most recent						
	-	the facility conducted by the						
		any plan of correction in						
	subsequent surve	t to the facility, and any						
	•	on and interview, the facility	R 00	142	R0042		09/21/2010	
		e most recent annual survey	K 00	J4 <i>Z</i>	This plan of Correction is the		08/31/2019	
	•	This deficiency had the			facility's credible allegation of			
		all residents in the facility.			compliance.			
	potential to affect t	in residents in the identity.			Preparation and/or execution	of		
	Finding includes:				this plan of correction does no			
	8				constitute admission or agree			
	During an observat	tion, on 7/30/19 at 2:50 P.M., a			by the provider of the truth of t			
	sign at the entry of	the facility indicated survey			facts alleged or conclusions se			
	results were availal	ble at the reception desk for the			forth in the statement of			
	past 2 years. Upon	request to review the survey			deficiencies. The plan of			
	results for the past	year, the facility was not able			correction is prepared and/or			
	to produce the surv	vey results.			executed solely because it is			
					required by the provisions of			
	During an interview	w, on 7/30/19 at 2:52 P.M., the			federal and state law.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 1 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019
	PROVIDER OR SUPPLIEI IG VIEW NURSING	R AND REHABILITATION CENTE	475 N	ADDRESS, CITY, STATE, ZIP COD ORTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE
	results are supposed reception desk at all A request for a poli	d to be available at the l times. cy related to posting of survey ed, but one was not provided.		This facility respectfully respaper compliance for this what Corrective action(see accomplished for those residents found to have the affected by the deficient practice: It is the intent of this facility provide the most annual set the facility conducted by the Surveyors, any plan of corrin effect with respect to the facility, and any subseque surveys. How other residents having potential to be affected be same deficient practice with identified and what correspond actions(s) will be taken: No residents were effected deficient practice, but has potential to effect all resides. What measures will be pure 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 receptionist desk. The bin will be checked by the receptionist at least week times two months. The Administrator or designed be notified if information missing for immediate replacement of survey.	citation.) will se coeen y to curvey of the State frection to the common to the comm

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 2 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTE	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				material. The Administrator will check monthly for placement on an on-going basis.	
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place: The facility will review the proto with the QAPI Committee for additional recommendation unto 100% compliance has been achieved for 2 consecutive months. Results of the audits be reviewed in QA and plan wadapted or adjusted as needemaintain compliance. By what date the systemic changes will be completed: 08/31/2019	ut ocol til will ill be
R 0090 Bldg. 00	(g) The administration overall management responsibilities of include, but are not (1) Informing the concurrence that diswelfare, safety, or of unusual occurrence telephone, follower a written report on electronic mail to the twenty-four (24) here	d Management - Deficiency ator is responsible for the ent of the facility. The the administrator shall of limited to, the following: division within twenty-four aming aware of an unusual rectly threatens the health of a resident. Notice ence may be made by a written report, or by ally that is faxed or sent by the division within the our time period. Unusual de, but are not limited to:			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 3 of 40

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		07/31/	/2019
				·			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	0.145144.1411001110				PRTH NILES AVENUE		
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER	ł.	SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	(A) epidemic outb	reaks:					
	(B)poisonings;	,					
	(C) fires; or						
	(D) major accider	nts.					
		not be reached, a call shall					
		mergency telephone number					
	published by the	- · ·					
	l ·	nging for or assisting with					
	1	nedical, dental, podiatry, or					
		ther health care services as					
	_	resident or resident's legal					
	representative.	resident of resident's legal					
	1 .	ctor approval prior to the					
	(3) Obtaining director approval prior to the admission of an individual under eighteen (18)						
	years of age to ar	-					
	1 -	acility maintains, on the					
	' '	urate record of actual time					
	worked that indica						
	(A) employee's fu	ir name, and irrame, and irram					
	1 ' '						
	twelve (12) month	sults of the most recent					
	1						
	1	the facility conducted by					
		ny plan of correction in t to the facility, and any					
		eys. The results must be					
		nination in the facility in a					
	1 .	essible to residents and a					
	notice posted of the	•					
	1 ' '	ports of surveys conducted					
	1 -	each facility for a period of					
		making the reports					
		ection to any member of the					
	public upon reque		D O	000			00/21/2010
		on and interview, the facility	R 0	J90	R0090		08/31/2019
		idents had ready access to			This plan of Correction is the		
		dentist, optometrist, podiatrist,			facility's credible allegation of		
	_	his deficient practice had the			compliance.		
	potential to affect 4	9 of 49 residents.			Preparation and/or execution		
					this plan of correction does no	t	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 4 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019	
	ROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER OF THE APPROVIDER		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	Finding Includes: Employee records w 10:00 AM. No provide following service podiatrist, and audic During an interview CHR (Corporate Hu (Executive Director to provide the name to provide services. On 07/31/19, at 2:50	vere reviewed on 07/31/19, at viders were indicated related to es: dentist, optometrist,	TAG	constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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 reque paper compliance for this citat What Corrective action(s) wi 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 potential to be affected by the same deficient practice will I identified and what corrective actions(s) will be taken: All residents have the potential be effected by this alleged deficient practice.	ment the et st tion. II n ient the ee
				What measures will be put in place or what systemic	nto
				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, contract	ctual
				services and has obtained all pertinent required information	
				regarding the noncompliance	of
				410 IAC 16.2-5-1.3(g)(1-6) an received all contractual provide	
			1	I received an contractual provid	010

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 5 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP COD PRTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				information required. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place: The ADON shall audit and kees contractual providers required information up to date. The Elshall review audit and oversees update as personnel changes to departmental changes to realise 100% compliance. Results of audits will be reviewed in QA aplan will be adapted or adjusted needed to maintain compliance. By what date the systemic changes will be completed: 08/31/2019	ut ep all D e and or ze a the and ed as
R 0116 Bldg. 00	screening of prosp Appropriate inquir prospective emplo a personnel policy and any conviction 16-28-13-3.	ompliance nall have specific n and implemented for the pective employees. ies shall be made for pyees. The facility shall have that considers references ns in accordance with IC	D 0116	D0440	00/01/0010
	failed to ensure a preference checks, at completed for 2 of 2 (LPN 2 & DD) Findings Include:	riew and interview, the facility re-employment physical, two and a background check were 2 new employees reviewed.	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 no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions see	t ment the

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 6 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 07/31/	ETED
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP CO DRTH NILES AVENUE H BEND, IN 46617	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION UILD BE PROPRIATE	(X5) COMPLETION DATE
TAG	10:00 AM, for LPN and indicated a hire checks or criminal lacompleted prior to a completed prior to a complete prior t	2 (Licensed Practical Nurse) date of 06/26/19. No reference background check was employment. le was reviewed on 07/31/19. at DD (Dietary Director) and e of 03/25/19. No background r pre-employment physical y, on 07/31/19 at 2:00 PM, the ector) indicated no additional ailable and she would have	TAG	forth in the statement of deficiencies. The plan of correction is prepared at executed solely because required by the provision federal and state law. This facility respectfully paper compliance for the lit is the intent of this factorioride at pre-employment physicals, two references and a background check potential hires for employment to have been affed deficient practice: A criminal background of references were obtained #2. A criminal background references and a physical completed for the Dietar How other residents have	of nd/or e it is ns of request is citation. ility to ent e checks k on oyment. s) will be residents cted by the check and ed on LPN und check, cal was ry Director.	DATE
				potential to be affected I same deficient practice identified and what correactions(s) will be taken: All residents have the p be effected by this deficient practice. What measures will be place or what systemic will be made to ensure the deficient practice does in An audit was completed.	will be ective cotential to ient changes chat the not recur:	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 7 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG		07/31/	2019
			Щ,	CTDPPT :	DDDECC OFF CTATE ZIP COP		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MODAIINI		AND DELIADII ITATION CENTED			RTH NILES AVENUE		
INIORNIN	G VIEW NURSING	AND REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
					HR Director for all present		
					employees to ensure complete	ed	
					background checks, reference		
					and physicals are complete.		
					Those employees identified		
					without completed		
					pre-employment criteria have	been	
					scheduled to have their inform		
					completed. by 08/31/2019.		
					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
					How the corrective action(s) w	ill be	
					monitored to ensure the deficient		
					practice will not recur, i.e., who		
					quality assurance program wil		
					put into place:		
					The HR Director was in-servic	ed	
					by the Clinical Nurse Consulta	nt	
					on the pre-employment screer		
					to be conducted including	Ū	
					background checks and		
					references. The in-service als	6O	
					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 for	ollow	
					up will be reported to QAPI un	til	
					100% compliance has been		
					achieved for 2 consecutive		
					months. Results of the audits	will	
					be reviewed in QA and plan w		
					adapted or adjusted as neede		
					maintain compliance.	0	
					mantain compilatios.		
			I				

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 8 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP COD ORTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				By what date the systemic changes will be completed: 08/31/2019	
R 0117 Bldg. 00	qualifications, and applicable state latwenty-four (24) hourscheduled needs services provided and training of starequired to provide the residents. A mostaff person, with certificates, shall be fifty (50) or more regularly receive ror administration of least one (1) nursi site at all times. Rover one hundred receiving resident administration of rhave at least one person awake and every additional fift shall be assigned they are trained to shall conform with Based on record revialled to ensure a Conform Resuscitation) certification of the shall conform with Based on record revialled to ensure a Conform all shifts in the firesidents on 2 of 7 coverage. (July 28)	ency sufficient in number, training in accordance with ws and rules to meet the our scheduled and its of the residents and The number, qualifications, iff shall depend on skills is for the specific needs of inimum of one (1) awake current CPR and first aid its en on site at all times. If residents of the facility residential nursing services of medication, or both, at ing staff person shall be on residential facilities with (100) residents regularly real nursing services or redication, or both, shall (1) additional nursing staff red on duty at all times for refy (50) residents. Personnel conly those duties for which reperform. Employee duties written job descriptions. The perform was present refered staff member was present accility for a census of 49 days reviewed for CPR	R 0117	R0117 This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of	t ment
	Finding includes:			by the provider of the truth of t	rne

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 9 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	at 2:20 PM, for the certified individual complete night shift shifts on July 31st. During an interview CHR (Corporate Huwere aware of the lawas creating holes in On 07/31/19, at 2:5	le was reviewed, on 07/31/19 week of 07/28/19. No CPR was scheduled on July 28th for t nor for the evening and night 7, on 07/31/19 at 2:35 PM, the timan Resources) indicated they tack of CPR certified individuals in CPR coverage on all shifts. 10 PM, a policy related to CPR quested, but one was not		facts alleged or conclusions forth in the statement of deficiencies. The plan of correction is prepared and/of executed solely because it required by the provisions of federal and state law. This facility respectfully requipaper compliance for this call it is the intent of this facility staff shall be in sufficient numbers, qualifications and training in accordance with Laws including a CPR certification and training in accordance with Laws including a CPR certification and training in accordance with Laws including a CPR certification for those residents member available on each found to have been affected deficient practice: No residents were negative impacted by this alleged depractice. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken: All residents have the potential be effected by this alleged deficient practice. What measures will be put place or what systemic chawill be made to ensure that deficient practice does not a land audit was completed by	or is of uest itation. that State fied each fill be dents if by the ly ficient the he be ve ital to into inges the recur:

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 10 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY PLETED 1/2019
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	475 NO	ADDRESS, CITY, STATE, ZIP CO DRTH NILES AVENUE H BEND, IN 46617	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
D 0110	410 100 46 3 5 4	A(A)(A)(A)(A) EV(2)(A) DV(2)		HR Director on all prese certification completion CPR classes have beer available for current en Additional CPR classes scheduled to ensure the maintains compliance walleged deficient practice. How the corrective action monitored to ensure the practice will not recur, i. quality assurance prograput into place: The HR Director will maaudit of all those staff mandit will be give to the will ensure that one CPR member is scheduled proporting the number of the proport results of the audit QAPI until 100% complibeen achieved for 2 cormonths. Results of the be reviewed in QA and adapted or adjusted as maintain compliance. By what date the system changes will be completed 08/31/2019	in CPR. In made Inployees. In made Inployees. In will be It facility In this It is I	
R 0119 Bldg. 00	Personnel - Nonc	4(d)(1)(A-E)(2)(A-D)(3- ompliance g independently, each				

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 11 of 40

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 N	ADDRESS, CITY, STATE, ZIP COD ORTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	employee shall be facility by the super designee) of the demployee will work employees shall in (1) Instructions on specialized popular (A) aged; (B) developmentar (C) mentally ill; (D) dementia; or (E) children; served in the facility (2) A review of the applicable procedure. (A) organization of (B) personnel policy (C) appearance are employees; and (D) residents' righty (3) Instruction in fi procedures, and fi preparedness, incomprocedures. (4) Review of ethic confidentiality in resident to we providing care. (6) Documentation each resident to we providing care. (6) Documentation employee's person supervising the on Based on interview failed to ensure both orientation were contacted.	given an orientation to the ervisor (or his or her epartment in which the k. Orientation of all include the following: the needs of the ations: Ity disabled; Ity. facility's policy manual and ures, including: nart; cies; and grooming policies for its. Its and disaster luding evacuation in the particular needs of thom the employee will be in of the orientation in the innel record by the person	R 0119	R0119 This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not	08/31/2019

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 12 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 07/31/2019			2019	
			<u> </u>	GED FFE	ADDRESS STEW STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
MODNIN	0.1/15/1/11/150/11/0	AND DELIABILITATION OF STED			PRTH NILES AVENUE		
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.C.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	16	DATE
	1. The employee file was reviewed on 07/31/19, at				constitute admission or agreei	nent	
	10:00 AM, for LPN	V 2 (Licensed Practical Nurse)			by the provider of the truth of t		
		e date of 06/26/19. No general			facts alleged or conclusions se		
		ntation were completed.			forth in the statement of		
		•			deficiencies. The plan of		
	2. The employee fi	ile was reviewed on 07/31/19. at			correction is prepared and/or		
		DD (Dietary Director) and			executed solely because it is		
		e of 03/25/19. No general or			required by the provisions of		
	job specific orienta	tion were completed.			federal and state law.		
		•			This facility respectfully reque	st	
	During an interviev	v, on 07/31/19 at 2:00 PM, the			paper compliance for this citat		
		ector) indicated no additional			ļ , , , , ,		
	documents were available and she would have				Its the intent of this facility to		
	expected them to be	e completed.			ensure that each employee be	,	
	•	•			given an orientation provided		
	On 07/31/19, at 2:5	0 PM, a policy related to			the supervisor prior to working	-	
	orientation was req	uested, but one was not			independently.		
	available.				, ,		
					What Corrective action(s) will	II	
					be accomplished for those		
					residents found to have beer	1	
					affected by the deficient		
					practice:		
					A general orientation and job)	
					specific orientation has been	1	
					completed for LPN #2 and th	е	
					Dietary Director.		
					How other residents having t	he	
					potential to be affected by th	е	
					same deficient practice will b	е	
					identified and what correctiv	е	
					actions(s) will be taken:		
					All resident have the potentia	al	
					to be effected by this alleged	l	
					deficient practice.		
					What measures will be put in	to	
					place or what systemic		
					changes will be made to		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 13 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/31/2019
	ROVIDER OR SUPPLIE	R S AND REHABILITATION CENTE	475 NO	ADDRESS, CITY, STATE, ZIP C DRTH NILES AVENUE H BEND, IN 46617	OD
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE
			TAG	ensure that the deficie practice does not recompleted. An audit was completed employment files to end general orientation or specific orientation are completed. Job specific orientations the missing were identified scheduled for completed for completed for ensuring specific orientations are completed for all new. How the corrective are will be monitored to endeficient practice will recur, i.e., what quality assurance program which include completion of general orientation are specific orientation. The check off sheet for each ire. The check off shinclude completion of general orientation are specific orientation. The completed check off sheets once completed maintained in each endite. The completed check of will be present to QAP until 100% compliance achieved for 2 consecutions. Results of the be reviewed in QA and adapted or adjusted as adapted or adjusted as	ent ur: led by the if insure ijob re ific and hat were ed and etion. Ing job and are hires. Ition(s) Insure the not y rill be put Inve a Inch new Ineet will If the Ind the job The check Ind the job The check Ind will be Inployee In monthly In has been utive In audits will In plan will be

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 14 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 07/31/2019	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTE	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
				maintain compliance. By what date the systemi changes will be complete 08/31/2019	
R 0120	410 IAC 16.2-5-1.4				
Bldg. 00	education and trai advance for all per at least annually. Is not limited to, re and control of infersafety, accident prospecialized popular administration, and appropriate, as fol (1) The frequency education and trai accordance with the facility personne this shall include a inservice per caler of	an organized inservice ning program planned in rsonnel in all departments Fraining shall include, but esidents' rights, prevention ction, fire prevention, revention, the needs of ations served, medication d nursing care, when			
	(3) Inservice recor shall indicate the f (A) The time, date (B) The name of the	, and location.			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 15 of 40

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COI		COMPL	COMPLETED	
			B. WING 07/31/20					
					_			
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD			
					PRTH NILES AVENUE			
MORNING VIEW NURSING AND REHABILITATION CENTER				SOUTH	I BEND, IN 46617			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	(C) The title of the	e instructor.						
	(D) The names of	the participants.						
	(E) The program	content of inservice.						
		I acknowledge attendance						
	by written signatu	re.						
		and record review, the facility	R 0	120	R0120		08/31/2019	
	failed to ensure req	uired in-services (Resident's			This plan of Correction is the			
	Rights, dementia, and abuse) were completed				facility's credible allegation of			
	upon hire and annu	ally for 5 of 5 employee files			compliance.			
	reviewed. (LPN 2,	Maintenance, QMA 3, Dietary			Preparation and/or execution of	of		
	Director, & CNA 4)			this plan of correction does no	t		
					constitute admission or agreei	ment		
	Findings Include:				by the provider of the truth of t	the		
					facts alleged or conclusions se	et		
	1. The employee fi	ile was reviewed on 07/31/19, at			forth in the statement of			
	10:00 AM, for LPN	V 2 (Licensed Practical Nurse)			deficiencies. The plan of			
	and indicated a hire	e date of 06/26/19. No			correction is prepared and/or			
	in-service related to	abuse was completed.			executed solely because it is			
					required by the provisions of			
	2. The employee fi	ile was reviewed on 07/31/19, at			federal and state law.			
	10:05 AM, for the	Dietary Director and indicated a			This facility respectfully reques	st		
	hire date of 03/25/1	9. No in-service related to			paper compliance for this citat	ion.		
	Resident's Rights w	vas completed.						
					It is the intent of this facility to			
	3. The employee fi	ile was reviewed on 07/31/19, at		ensure that required in-servic		ng		
	10:15 AM, for QM	A 3 (Qualified Medication Aide)			upon hire and annually is			
	and indicated a hire	e date of 8/02/16. No			completed for all employees.			
	in-services related	to Resident's Rights or			What Corrective action(s) will	II		
	dementia were com	pleted.			be accomplished for those			
					residents found to have beer	า		
		ile was reviewed on 07/31/19, at			affected by the deficient			
	· · ·	ntenance and indicated a hire			practice:			
		No in-service related to						
	Resident's Rights w	vas completed.			LPN #2 has been in-serviced of			
					abuse. The Dietary Director I	nas		
		ile was reviewed on 07/31/19. at			been in-serviced on Resident			
	-	A 4 (Certified Nurses Aide) and			Rights. The QMA## was in-			
		e of 07/01/17. No in-service			-serviced on Dementia and			
	related to dementia	was completed.			Resident Rights. The			
			1		Maintenance Director was			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 16 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 07/31/2019			
	OF PROVIDER OR SUPPLIE	R S AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617					
MORI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O During an interview ED (Executive Dir documents were av expected them to b On 07/31/19, at 2:5	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION w, on 07/31/19 at 2:00 PM, the ector) indicated no additional vailable and she would have	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY) in-serviced on Resident I CNA #4 has been in-serviced same deficient practice identified and what corrections(s) will be taken: This deficient has the p to effect all residents. What measures will be 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 Clinic Nurse Consultant on the required in-servicing neupon hire and annually. HR completed an audit present employees to a completion of required in-servicing. All employ with incomplete in-servicing. All employ with incomplete in-servicing complete and will also use the check off sheet for active ensure the in-servicing complete and will also use the check off sheet for active ensure are in-services are complete protocol. How the corrective active	Rights. viced on ving the by the will be rective : otential put into ot it : cal e eeded . The on all heck on yees icing on. The a check to is use a ve nnual eed per deed per			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 17 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		'	B. WING 07/31/			2019	
			 -	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	£	1		RTH NILES AVENUE		
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER					
			igspace				
(X4) ID		STATEMENT OF DEFICIENCIE	,	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	íΕ	COMPLETION
TAG	REGULATORY OK	R LSC IDENTIFYING INFORMATION	\vdash	TAG	DATE		
	l			ļ	will be monitored to ensure the	ne	
	l			ļ	deficient practice will not		
	l			ļ	recur, i.e., what quality		
	l			ļ	assurance program will be pu into place:	π	
	l			ļ	The HR Director will provide		
	l			ļ	check off sheets to QA for		
	l			ļ	review and for any additional		
					recommendations.		
					By what date the systemic		
				changes will be completed:			
				08/31/2019			
	l					ļ	
R 0123	410 IAC 16.2-5-1.4						
aa	Personnel - Nonco			ļ			
Bldg. 00	l ' '	all maintain current and					
	1	el records for all employees.					
	<u> </u>	cords for all employees shall		ļ			
	include the following	ng: I address of the employee.		ļ			
	(1) The name and (2) Social Security						
	(3) Date of beginn						
	1 ' '	ent, experience, and					
	education, if applic	· · · · · · · · · · · · · · · · · · ·					
		censure or registration		ļ			
		assistant certificate or letter				ļ	
	of completion, if a					ļ	
		facility and job description.					
		n of orientation to the					
	facility, including r	esidents' rights, and to the		ļ			
	specific job skills.			ļ			
	(8) Signed acknow residents' rights.	wledgement of orientation to					
	_	evaluations in accordance		ļ			
	with facility policy.			ļ			
		son for separation.		,			
		and record review, the facility	R 01	23	R0123		08/31/2019
		gned job description			This plan of Correction is the		00/21/2019
	completed for 2 of 2	2 new employees reviewed.			facility's credible allegation of		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 18 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 07/31/2019	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	10:00 AM, for LPN and indicated a hire job description was 2. The employee fit 10:05 AM, for the I hire date of 03/25/1 was completed. During an interview ED (Executive Dire documents were available expected them to be On 07/31/19, at 2:50	le was reviewed on 07/31/19, at 2 (Licensed Practical Nurse) date of 06/26/19. No signed completed. le was reviewed on 07/31/19 at Dietary Director and indicated a 9. No signed job description y, on 07/31/19 at 2:00 PM, the ctor) indicated no additional ailable and she would have		compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions is 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 reque paper compliance for this cital. 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 been completed and signed. job description for the dietary director has been completed a signed. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken: This deficient has the potent to effect all residents. The HR director has been completed an audit of all pres	ot ment the et st tion. Il n I has The and the ne be re

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 19 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019		
	ROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				employees. Any staff membe with out a job description has been identified. The HR mana or designee has finalized this by completing job descriptions all employees to include employees to include employeing signatures. What measures will be put in 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 Nurse Consultant on the requirement the personnel files and to ensure the files are complete per police. The HR manager will utilize a check off sheet which identified 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 placed in each employee file to the HR manager, to include signature and date, ensuring completeness and accuracy of each personnel file. The HR manager will provided results of the audits to the Executive Director which will be reviewed by QAPI for addition recommendations, until 100% compliance is achieved. By what date the systemic changes will be completed: 8/31/2019	ager audit s for oyee ato sing ts on ure cy. s all et d be oy f the		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 20 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
			B. WING 07/31/2019				2019
	PROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	_	DATE
R 0148 Bldg. 00	(e) The facility sha grounds, and equi in good repair, and adversely affect the residents or the potential of the potential o	fety Standards - Deficiency all maintain buildings, pment in a clean condition, d free of hazards that may be health and welfare of the sublic as follows: hall establish and en program for maintenance inued upkeep of the facility. System, including switches, alternate power hand detection systems, d to guarantee safe simpliance with state hall function properly and plumbing codes. heating and ventilating haspected. on, interview and record failed to maintain a clean from stained and mold covered led to have the heating and hispected, at minimum, yearly. the potential to affect all	R 01	148	R0148 This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreed 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 citate. What Corrective action(s) will be accomplished for those residents found to have been	t ment he et st ion.	08/31/2019

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 21 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. W	B. WING 07/3		07/31/	2019
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R	475 NORTH NILES AVENUE				
MODNIN	IC VIEW NI IDSING	AND REHABILITATION CENTER			BEND, IN 46617		
INIORININ		AND REHABILITATION CENTER		30016			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(Minimum Data Set) Coordinator office; 1 ceiling				affected by the deficient		
	tile adjacent to 3rd floor electrical closet by				practice:		
		tile with lumpy white substance			#1. It is the intent of this facili	ity to	
	-	or exit sign in dining room			maintain a clean environment	free	
		tile (sprinkler head tile) adjacent			from stained and mold covere	ed	
		room back door; 18 ceiling tiles			ceiling tiles and regular		
	in 3rd floor dining room, 1 completely covered in				inspections of the HVAC syste		
	black colored mold by main entry to dining room				All the above mentioned stain	ied	
	and a second tile with black colored mold 1-2				ceiling tile have been replaced	d.	
	inches in diameter in the center of dining room; 6				The inspection of the HVAC h	nas	
	ceiling tiles adjacent to room 315, 2 of the ceiling				been completed.		
	tiles completely covered in black colored mold.				How other residents having	the	
					potential to be affected by the	ne	
	During an interview, on 7/30/19 at 11:54 A.M., the				same deficient practice will	be	
		ector) indicated stained ceiling			identified and what corrective	/e	
	_	aced as soon as they are			actions(s) will be taken:		
	identified.				No residents were effected by		
					deficient practice, but has the		
	_	w, on 7/30/19 at 11:56 A.M., the			potential to effect all resident.		
		er indicated the ceiling tiles					
		15 became stained last week			What measures will be put in	nto	
	after a leak from th	e facility's air conditioner.			place or what systemic		
					changes will be made to		
	_	ce form, undated, indicated,			ensure that the deficient		
	"Interior check-V				practice does not recur:		
		eiling tiles for signs of roof			Ceiling tile inspections have b	een	
	leaks"				added to the preventative		
	A 1: 0 :::				maintenance checks, to be		
		g tile maintenance was			completed weekly. The		
	requested, but none	e was provided.			maintenance director shall ch		
	2 D	7/21/10 - 4 10 27 4 34			for stained tiles on a daily bas		
	-	view, on 7/31/19 at 10:37 A.M.,			utilizing the preventative chec	K list	
		ne facility had not had an			and will schedule weekly		
	_	on the HVAC (heating,			replacement of all stained or		
	ventilation, and air	conditioning) system.			molded tiles.	.:11 15 2	
	A	man and Campa and date 1			The inspection of the HVAC w		
		ntenance form, undated,			completed, at least annually of		
		C Systems Maintenance-Fall			more frequent, if indicated. T		
		ing (March)Complete			inspection will include a comp		
	symptoms check, cleaning, & serviceservice		1		systems check, cleaning, and		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 22 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/31/2019				
	PROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617					
MORNIN (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR performed by local	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION company"		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) serviced, by a local company. The inspection and service documentation will be kept be maintenance director and a cwill be kept by the Executive Director. The executive director met we and inserviced the maintenance director to the updated preventative maintenance or sheet to include the stained or molded tiles, emphasizing the immediate replacement of suctiles, when identified. The an inspection of the HVAC system and all documentation, will be scheduled and checked by the maintenance director per pole A copy of all paperwork to be by the maintenance director copy provided to the Execution Director. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be	y the copy with nace neck or e uch anual em e he licy. e kept and a ve			
				into place: Results of the preventative maintenance of the stained of molded tiles and the results of HVAC checks will be presen QAPI monthly x 2 mos. for additional recommendations By what date the systemic changes will be completed: 08/31/2019	of the ted to			
R 0152	410 IAC 16.2-5-1. Sanitation and Sa	5(i) fety Standards - Deficiency						

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 23 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
			B. WI	B. WING 07/31/2019			
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PRTH NILES AVENUE		
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER			I BEND, IN 46617		
WOTTH	· · · · · · · · · · · · · · · · · · ·	THE REINBIETT THOU GENTER		00011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00 (i) The facility shall handle, store, process,							
	-	an and soiled linen in a safe					
	_	ner that will prevent the					
	spread of infection		D 0	1.50			00/21/2010
		on, interview, and record	R 0	152	R0152		08/31/2019
		failed to properly store clean linen storage rooms observed			This plan of Correction is the		
		Second floor linen room and			facility's credible allegation of		
	Third floor linen ro				compliance. Preparation and/or execution of	of	
	Time noor mich to	om)			I		
	Findings include:				this plan of correction does not constitute admission or agreement		
	i mamga merade.				by the provider of the truth of t		
	During an initial to	ur, on 7/30/19 at 11:35 A.M., the			facts alleged or conclusions se		
	_	e room was observed with one			forth in the statement of	,,	
		x sitting directly on the floor.			deficiencies. The plan of		
		racks were observed to contain			correction is prepared and/or		
		us types. The bottom shelf of			executed solely because it is		
		rved to be 2 inches from the			required by the provisions of		
	floor, had no solid l	bottoms and contained clean			federal and state law.		
	blankets. Both of the	he linen storage racks were			This facility respectfully reque	st	
	observed to have a	zippered cover that was open			paper compliance for this citat	ion.	
	and flipped over the	e top, exposing all linens.			What Corrective action(s) will	iI .	
					be accomplished for those		
	_	ur, on 7/30/19 at 11:49 A.M., the			residents found to have beer	1	
		om was observed with one rack			affected by the deficient		
		ch off of the floor, containing			practice:		
	clean linens and un	covered.			It is the intent of this facility to		
	D	7/20/10 / 11 50 / 25 / 1			handle, store, process and		
	_	v, on 7/30/19 at 11:50 A.M., the			transport clean linen in a safe		
	`	ector) indicated boxes should			sanitary manner that will preve	ent of	
		ly on the floor, the bottom			infection.		
	shelves of linen storage racks should be at least 6 inches from the floor and have a solid bottom to				Usus ather regidents having t	th a	
					How other residents having to potential to be affected by the		
	prevent dust and debris from contaminating clean linen and all linen should be covered while in storage.				same deficient practice will be		
					identified and what correctiv		
					actions(s) will be taken:	C	
	On 7/31/19 at 10:37 A.M., the ED provided the				No residents were effected by this		
					deficient practice, but has the		
"Departmental (Environmental Services)-Laundry and Linen" policy, dated January 2014, and				potential to effect all residents			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 24 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMI	E SURVEY PLETED 1/2019
	PROVIDER OR SUPPLIE	R S AND REHABILITATION CENTE	475 NO	ADDRESS, CITY, STATE, ZIP CO ORTH NILES AVENUE H BEND, IN 46617)D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
	by the facility. The linen will remain h pathogens in suffic illness) through me	the current policy being used be policy indicated, "Clean ygienically clean (free from ient numbers to cause human easures designed to protect it all contamination, such as n carts"		The linen room storage and 3rd floor is now storage and stored directly on the flow what measures will be place or what systemic changes will be made ensure that the deficie practice does not recurate housekeeping/laund manager and the DON been inserviced by the Nurse Consultant and housekeeping/laundry manager and DON have inserviced all departments to the policy of proper storage and transport include linen covers to contamination. How the corrective act will be monitored to endeficient practice will recur, i.e., what quality assurance program with into place: The housekeeping/laund manager and DON will linen storage x 3 weekly noncompliance will be adapted adjusted as needed to recompliance. By what date the systematical systems and syste	ring all storage replaced or d height Nothing is oor. put into c to nt r: ndry have c Clincial both the re ent staff linen to prevent dry monitor y x 2 mos., addressed s of the wed in QA d or maintain	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet

Page 25 of 40

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	R/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG		07/31/2019	
				_			
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MODNINI		AND DELIABILITATION CENTED	475 NORTH NILES AVENUE				
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					changes will be completed:		
					08/31/2019		
R 0214	410 IAC 16.2-5-2(a)					
	Evaluation - Defici	iency					
Bldg. 00	(a) An evaluation	of the individual needs of					
	each resident sha	Il be initiated prior to					
	admission and sha	all be updated at least					
	semiannually and	upon a known substantial					
	change in the resi	dent 's condition, or more					
	often at the reside	nt 's or facility 's request.					
	A licensed nurse s	shall evaluate the nursing					
	needs of the resid	ent.					
	Based on record rev	view and interview, the facility	R 02	214	R0214		08/31/2019
		preadmission evaluation for 2			This plan of Correction is the		
		wed for preadmission			facility's credible allegation of		
	evaluations. (Resid	lents 5 & 7)			compliance.		
					Preparation and/or execution		
	Findings include:				this plan of correction does no	ot	
					constitute admission or agreei		
		ord was reviewed, on 07/31/19 at			by the provider of the truth of t		
		sident 7 and indicated an			facts alleged or conclusions se	et .	
		6/21/19. Resident 7 did not			forth in the statement of		
	-	on evaluation present in the			deficiencies. The plan of		
		al record for Resident 5 was			correction is prepared and/or		
		19 at 1:10 P.M. There was no			executed solely because it is		
	pre-admission evalu	lation available.			required by the provisions of		
	Description of the control of the co	07/21/10 -4 1.15 DM /1			federal and state law.	-4	
	_	y, on 07/31/19 at 1:15 PM, the			This facility respectfully reques		
	· ·	Jursing) indicated she is aware			paper compliance for this citat		
	_	nations are to be completed			What Corrective action(s) will	11	
		to provide documentation of			be accomplished for those	_	
	one being complete	u ioi kesident 3.			residents found to have been	1	
	During an interview	y, on 7/31/19 at 1:23 P.M., the			affected by the deficient		
	-				practice:		
	ED (Executive Dire	uation was not present in			It is the intent of this facility to		
		record and a pre-admission			complete a preadmission		
		ave been performed prior to			evaluation of all residents.		
	admission.	ave been performed prior to			How other residents begins	tha	
	auminssion.		1		How other residents having t	ıı ie	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 26 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019
	PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER	475 NO	ADDRESS, CITY, STATE, ZIP COD ORTH NILES AVENUE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION DATE
	Director) on 07/31/ Needs Assessment indicated this was t the facility. The po	ded by the ED (Executive 19 at 1:15 PM, titled "Level of Policy", dated 12/04/97, and he policy currently used by blicy indicated "Prospective sessed prior to admission"		potential to be affected by same deficient practice wi identified and what correct actions(s) will be taken: No residents were effected deficient practice, but has the potential to effect all newly affected residents. Resident #7 has a complete preassessment and is current DON's file. Resident #5 has completed preassessment by the Completed preassessment by the Clinical Nursing Consultant. Emphasis was placed on completing the preassessment prior to admission for the preadmissions to ensure the facility can meet the needs residents. What measures will be put 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 ass licensed nurse to complete prior to admission. The completed preassessed evaluation, signed and data and will be placed in the D file. How the corrective action(will be monitored to ensure deficient practice will not recur, i.e., what quality	by this he ed ent in as a by the e. The policy he ents, e of all eign a e all ed ON's

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 27 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 NO	ADDRESS, CITY, STATE, ZIP COD PRTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0217 Bldg. 00	facility, using appr			assurance program will be p into place: The DON will log all potentia residents and date when the preadmission assessment w completed, prior to the admission. The DON will report the result the audit to the QAPI committe 2 mos or until compliance. By what date the systemic changes will be completed: 08/31/2019	as s of
	follows: (1) The services or resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or revised as appropriate and facilitic change. Either the request a service particle of the service plan resident upon request. (4) No identification services provided.	ffered shall be reviewed and riate and discussed by the y as needs or desires facility or the resident may blan review. On service plan shall be by the resident, and a copy shall be given to the			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 28 of 40

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SO		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. W	ING		07/31/2019	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE		
MODNIN		AND REHABILITATION CENTER			BEND, IN 46617		
MORININ	G VIEW NURSING	S AND REHABILITATION CENTER		30016	1 BEND, IN 40017		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	no need for a cha	nge in services.					
	(5) If administration	on of medications or the					
	provision of reside	ential nursing services, or					
	both, is needed, a	a licensed nurse shall be					
	involved in identif	ication and documentation of					
	the services to be	provided.					
	Based on record re	view and interview, the facility	R 02	217	R0217		08/31/2019
	failed to develop si	gned services plans on 1 of 7			This plan of Correction is the		
	residents reviewed	for service plans. (Resident 8)			facility's credible allegation of		
					compliance.		
	Finding Includes:				Preparation and/or execution	of	
					this plan of correction does no	ot .	
	The clinical record for Resident 8 was reviewed on				constitute admission or agree	ment	
	07/31/19 at 1:00 P.	M. There was no signed service			by the provider of the truth of		
	plan available.				facts alleged or conclusions s	et	
					forth in the statement of		
	_	v, on 07/31/19 at 2:30 P.M., the			deficiencies. The plan of		
	DON (Director of)	Nursing) indicated all residents			correction is prepared and/or		
	should have signed	service plans.			executed solely because it is		
					required by the provisions of		
		ded by the ED (Executive			federal and state law.		
	· ·	19 at 1:15 PM, titled "Level of			This facility respectfully reque	st	
		Policy", dated 12/04/97, and			paper compliance for this citat		
		the policy currently used by			What Corrective action(s) wi	II	
		olicy indicated "Prospective			be accomplished for those		
		sessed prior to admission and			residents found to have been	n	
	at least semi-annua	lly"			affected by the deficient		
					practice:		
					It is the intent of this facility to		
					have a signed service plan in	•	
					for all residents. Resident #8		
					a completed service plan by the	те	
					DON.		
					How other residents having		
					potential to be affected by the		
					same deficient practice will I		
					identified and what correctiv	е	
					actions(s) will be taken:	. 41-1-	
					No residents were effected by		
			1		deficient practice, but has the		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 29 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTE	475 NC	ADDRESS, CITY, STATE, ZIP COD DRTH NILES AVENUE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				potential to effect all residents The DON has been inserviced the Clinical Nursing Consultar completion of service plans to include signature and date. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The DON designee has comp an audit on all residents to ensure a signed service plan is in plan No other resident has been identified. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place: The DON will present to QAPI mos the results of the complete audit and any recommendatio the system change. By what date the systemic changes will be completed: 08/31/2019	d by Int on Into Ileted sure ce. Ithe It x 2 ted
R 0274 Bldg. 00	410 IAC 16.2-5-5. Food and Nutrition	,			
Diug. Vu	department direct competent in food knowledgeable in handling, food pre	an organized food service ed by a supervisor service management and sanitation standards, food paration, and meal service.			

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 30 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		07/31/2019
			STRE	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R		NORTH NILES AVENUE	
MORNIN	IG VIEW NURSING	AND REHABILITATION CENTE		TH BEND, IN 46617	
WOTATA	· · · · · · · · · · · · · · · · · · ·	THE REINBIETT THOU GENTE	` 1000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	TIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		student enrolled in and			
		ar from completing a division			
		ım ninety (90) hour			
		tion course that provides			
		tion in food service			
	-	nas a minimum of one (1)			
	1 '	e in some aspect of			
		service management.			
	, , ,	a dietetic technician			
	1	d by the American Dietetic			
	Association.				
		an accredited college or			
	1	n one (1) year of graduating			
		d college or university with a			
	-	nd nutrition or food			
		h a minimum of one (1) year			
		some aspect of food service			
	management.	with training and averagings			
		with training and experience			
		pervision and management.			
		or is not a dietitian, a vide consultant services on			
	· ·	eak periods of operation on			
	a regularly sched				
		staff shall be on duty to			
		od preparation, serving, and			
	sanitation.	proparation, our virig, and			
		and record review, the facility	R 0274	R0274	08/31/2019
		ertified dietary manager was	102/4	This plan of Correction is the	
		ficiency had the potential to		facility's credible allegation o	
	affect 49 of 49 resid			compliance.	
				Preparation and/or execution	of
	Finding Includes:			this plan of correction does n	
				constitute admission or agree	
	The employee file	was reviewed on 07/31/19. at		by the provider of the truth of	
		Dietary Director and indicated a		facts alleged or conclusions	
		19. No degree or certification		forth in the statement of	
	was available for re	_		deficiencies. The plan of	
				correction is prepared and/or	
	During an interview	w, on 07/31/19 at 2:00 PM, the		executed solely because it is	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 31 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/31/2019
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTE	475 N	ADDRESS, CITY, STATE, ZIP COI ORTH NILES AVENUE H BEND, IN 46617	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE PROPRIATE COMPLETION DATE
	certification for the On 07/31/19, at 2:5	ector) indicated there was no Dietary Director available. 0 PM, a policy related to dietary nts was requested, but one was		required by the provision federal and state law. This facility respectfully is paper compliance for this What Corrective actions be accomplished for the residents found to have affected by the deficient practice: It is the intent of this facilities ensure that the dietary in has the appropriate qual. How other residents had potential to be affected same deficient practice identified and what conductions(s) will be taken. No residents were effect deficient practice, but had potential to effect all residents are deficient practice, but had potential to effect all residents will be place or what systemic changes will be made to ensure that the deficient practice does not recur. The present dietary man been enrolled into a certiclass. How the corrective actility will be monitored to endeficient practice will in recur, i.e., what quality assurance program will into place: The HR Director and the Administrator will ensure dietary director is competite food service manages.	request s citation. (s) will ose e been it lity to nanager ifications. ving the by the will be rective : ed by this is the dents. put into ont : agger has ification on(s) sure the ot I be put

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 32 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	AT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 07/31/2019
	ROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER	475 NO	ADDRESS, CITY, STATE, ZIP COD RTH NILES AVENUE BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
R 0298 Bldg. 00	(2) A consultant phemployed, or under (A) be responsible in 856 IAC 1-7; (B) review the drug practices in the fact (C) provide consult procedures of order administering, and as medication record (D) report, in writing his or her designed dispensing or admitted (E) review the drug receiving these se sixty (60) days. Based on observation	ervices - Deficiency narmacist shall be er contract, and shall: for the duties as specified g handling and storage cility; tation on methods and ering, storing, disposing of drugs as well ord keeping; gg, to the administrator or e any irregularities in inistration of drugs; and g regimen of each resident rvices at least once every	R 0298	is knowledgeable in sanitary standards, food handling, food prep and meal services. Prior hire the HR Director will review credentials to ensure the dieta manager has the competency knowledge to perform as the manager. The dietary manage will be enrolled into a certificat program and will maintain any certifications required per ISD guidelines. The HR Director shall oversee certifications and will update on proress of all certifications training for review. By what date the systemic changes will be completed: 08/31/2019	to w the ary and er tion H e all QAPI
	failed to ensure 1 of	3 storage areas were free from	-	This plan of Correction is the	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 33 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/31/2019			LETED		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•	
MORNIN	G VIEW NURSING	AND REHABILITATION CENTER	₹		DRTH NILES AVENUE I BEND, IN 46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	d medications. (Second floor			facility's credible allegation of		
	medication cart)				compliance.		
					Preparation and/or execution		
	Findings Include:				this plan of correction does no		
					constitute admission or agree		
	_	on storage observation, on			by the provider of the truth of		
		M., the second floor medication			facts alleged or conclusions s	et	
		o have a Humalog kwikpen			forth in the statement of		
		en date, a Lantus pen opened a bottle of dorozolamide eye			deficiencies. The plan of		
	^	-			correction is prepared and/or		
drops open with no open date, a bottle of					executed solely because it is required by the provisions of		
	levobunolol eye drops open with no open date, a bottle of tobramycin eye drops opened with				federal and state law.		
	instructions to be given for 10 days and the last				This facility respectfully reque	ct	
	_	was given was 7/28/19, a			paper compliance for this citat		
		m bromide nasal spray open			What Corrective action(s) wi		
		ipratropium bromide nebulizer			be accomplished for those		
		package in the drawer. A bin			residents found to have been	1	
		of nyamyc powder, a tube of			affected by the deficient	-	
		n, lotrimin cream, triamcinolone			practice:		
	cream and ketocona	azole cream belonging to			It is the intent of this facility to		
	different residents a	and not bagged individually			ensure storage areas remain	free	
	and a second bin co	ontaining a tube of santyl			of undated and expired		
	-	olone cream, calazine cream and			medications.		
		longing to different residents			How other residents having	the	
		ividually and 2 tubes of			potential to be affected by the		
	l -	am open and with no resident			same deficient practice will I		
	identifiers on them.	•			identified and what corrective	е	
		- /20/40 - 42.05 - 11.5 - 11.5			actions(s) will be taken:		
	_	v, on 7/30/19 at 12:25 P.M., LPN			No residents were effected by	this	
	`	Nurse) 1 indicated the			deficient practice, but has the		
		have labels identifying who			potential to effect all residents		
	and insulin was goo	dates when they are opened			The DON/designee has check		
	and msulin was goo	ou 101 50 days.			the 2nd floor medication cart a		
	During an interview	v, on 7/31/19 at 11:48 A.M., the			labeled all unlabeled, expired	allu	
	_	Nursing) indicated eye drops,			for date medication opened. Medications outdated were		
	,	ould be dated when opened			disposed of per policy. All		
		ointments should not be stored			creams, tubes have been place	ed.	
		lent should have their own			in separate bags. All tubes, e		
	1 5 . ,		1		1		1

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 34 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2019		
	ROVIDER OR SUPPLIER G VIEW NURSING	AND REHABILITATION CENTER		475 NO	ADDRESS, CITY, STATE, ZIP COD RTH NILES AVENUE BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF space. A policy was provid 1:18 P.M., titled, "S revised April 2007, that was currently b indicated "The fad discontinued, outdat biologicals. All suc the dispensing phar resident's medicatio individual cubicle, of	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ded by the DON, on 731/19 at Storage of Medications", and indicated it was the policy being used. The policy cility shall not use ted, or deteriorated drugs or th drugs shall be returned to macy or destroyedEach ons shall be assigned to an drawer, or other holding area to ity of mixing medications of		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) were checked for resident identifiers. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff were inservic by the DON, the policies regar the storage of medications. Inservicing also included the po on medications with shortened expiration dates. Emphasis w placed on placing the date ope sticker and checking the date	ced rding policy d as ened	(X5) COMPLETION DATE
	1:18 P.M., titled, "M Expiration Dates", the policy that was policy indicated " opened, they must be timeframe to avoid and potentially, red medications should	ded by the DON, on 731/19 at Medications with Shortened no date, and indicated it was currently being used. The Once these products are be used within a specific reduces stability and sterility uces efficacy. All of these be labeled in such a way that ate" is securely attached to a"			ensure medication date have a been utilized by expired. The night nurse will check weekly an ongoing basis, for all outdate medications, date medication opened, and individually bagg 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 printo place: The DON/designee will check weekly x 2 mos for full compliance. The DON will repute the results to the QAPI commit x 2 mos. or until 100% compliance. By what date the systemic changes will be completed: 08/31/2019	on ted ed he ut	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 35 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/31/2019			
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	475 1	ET ADDRESS, CITY, STATE, ZIP COD NORTH NILES AVENUE ITH BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R 0300 Bldg. 00	410 IAC 16.2-5-60 Pharmaceutical Se (4) Over-the-count drugs, and biologic must be labeled in accepted profession the appropriate accepted profession the appropriate accepted profession the appropriate accepted profession failed to ensure tube required identification to be servation observed. (Second of Finding Includes: During a medication 7/30/19 at 12:05 P.N. cart was observed to hydrocortisone creat identification. During an interview (Licensed Practical hydrocortisone creat name on it. A policy was provided 1:18 P.M., titled, "L. Containers", revised was the policy that the policy indicated "	c)(4) ervices - Deficiency ter medications, prescription cals used in the facility accordance with currently conal principles and include cessory and cautionary te expiration date. on and interview the facility es of medication had the on labeled during a medication for 1 of 3 medication carts floor medication cart)	R 0300	R0300 This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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 reques paper compliance for this cital What Corrective action(s) where the deficient practice: It is the intent of this facility to ensure tubes of medication had the appropriate identification labels. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken:	of of ottement the set ation. iill en of ave the he be ve
I				No residents were effected by	y this

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 36 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2019			
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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			
				deficient practice, but has the potential to effect all residents. The indentified tubes of hydrocortisone cream that we not labeled or has a resident identification were destroyed policy. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: he DON completed an audit or medication carts for all tubes to ensure all were appropriately labeled with the resident's nand The DON inserviced the licensistaff of the appropriately labeling and resident identifications per policy. The nourse will check for appropriately labeling and resident identification of over the counter drugs. The audit will be completed weekly an ongoing basis. The DON/designee will audit all 3 medication carts weekly x 2 medication carts weekly x 2 medication carts weekly x 2 medication carts 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	f all oo ne. sed ed ight ee stion is or on oos. the ut		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 37 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/31/2019	
	NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 475 NORTH NILES AVENUE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
R 0378 Bldg. 00	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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)		R 03	CROSS-REFERENCED TO THE APPROPRIATE		t	08/31/2019
	10:30 A.M., for Res 7 had a Medicaid w	was reviewed, on 07/31/19 at sident 7 and indicated Resident raiver and a mental health present in the chart for review.			constitute admission or agreed by the provider of the truth of the facts alleged or conclusions see forth in the statement of deficiencies. The plan of correction is prepared and/or	he	

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 38 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

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	G VIEW NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			executed solely because it required by the provisions federal and state law. This facility respectfully required paper compliance for this complete the mental health for by a licensed nurse of a recipients of Medicaid or Stunds. How other residents having potential to be affected by same deficient practice widentified and what correct actions(s) will be taken: No residents were effected deficient practice, but has the potential to effect all reside Resident #7 is no longer a at this facility. The DON widentified and what correct actions (s) will be taken: No residents were effected deficient practice, but has the potential to effect all reside Resident #7 is no longer a at this facility. The DON widentified or SSI on preadm. The DON has been inserving the Clinical Nursing Consultate policy of mental health screening on preadmission. What measures will be puplace or what systemic changes will be made to ensure that the deficient practice does not recur: The DON designee has coan audit on all current residence of the policy of mental health practice does not recur: The DON designee has coan audit on all current residence of the policy of mental health practice does not recur: The DON designee has coan audit on all current residence accompleted mental ensure a completed mental mental mental mental the policy of mental health practice does not recur:	is of guest citation. will e eeen it to a screen all SI mg the y the ill be citive I by this the ents. residing ill a under mission. ced by Itant on it into		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 39 of 40

PRINTED: 09/03/2019 FORM APPROVED OMB NO. 0938-039

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				screening has been completed and placed on the clinical chal How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: The DON will present to QAPI most he results of the complete audit and any recommendation the system change. By what date the systemic changes will be completed: 08/31/2019	rt. the ut x 2 ted		

State Form Event ID: CF4G11 Facility ID: 013149 If continuation sheet Page 40 of 40