STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING 00 B. WING	08/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. Survey dates: August 8, 9, 10, 11, and 12, 2022 Facility number: 011039 Provider number: 155675 AIM number: 200299100 Census Bed Type: SNF/NF: 46 SNF: 5 Residential: 12 Total: 63 Census Payor Type: Medicare: 5 Medicaid: 42 Other: 4 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 19, 2022.	F 0000	Please find our POC and audit tools with education materials and employee education list check off. We would like to request a desk review. If there are additional documents I can submit for you please let me know. Thank you, Holly Witkemper	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 1 of 6 residents observed for medication administration (Resident 49) and failed to follow physician's orders related to interventions for a resident with congestive heart failure for 1 of 2 residents reviewed for edema. (Resident 33) Findings include: 1. During an observation on 08/11/22 at 8:05 A.M., LPN (Licensed Practical Nurse) 2 prepared to administer medications to Resident 49. The LPN opened a new, unused Lantus (a long acting insulin) insulin pen and attached a needle to the pen. She held the pen sideways and indicated she was priming the pen, to expel any air bubbles. She continued to hold the pen sideways and dialed up 20 units of insulin. She entered the resident's room and administered the medication. LPN 2 did not cleanse the pen prior to attaching the needle and did not hold the pen upright when she primed the pen. During an observation on 08/11/22 at 8:25 A.M., LPN 2 gathered Resident 49's Novolog (a short acting insulin) insulin pen from the medication cart. LPN 2 attached a needle to the pen, held the pen sideways and primed the pen. She continued to hold the pen sideways and dialed up 30 units of insulin. LPN 2 did not cleanse the pen prior to attaching the needle and did not hold the pen upright when she primed the pen. During an interview on 08/11/22 at 8:28 A.M., LPN 2 indicated she would normally cleanse the top of an insulin pen with alcohol prior to attaching a	F 0684	Please find our plan of correction below. This constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by State and Federal law. We would like to request, at this time, a desk review of said plan of correction. F684 Education was completed on following manufacturers guidelines for insulin administration with all nursing staff. DON observed all nursing staff while administrating insulin to all residents with orders. A Performance Improvement Tool has been developed that will monitor compliance with insulin administration. DON/Designee daily for one month, then weekly for one month, then monthly for four months will complete PI tool with results being forwarded to QAPI committee for any further recommendations and/or resolution. Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Cont. F 684	09/03/2022

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	needle. She did not hold the pens upright when she primed them. The LPN then detached the needle from Resident 49's Novolog pen, cleansed the top of the insulin pen with an alcohol swab, and attached a new needle. The LPN held the pen upright, primed the pen with 2 units of insulin, and dialed up 30 units of insulin to administer to the resident. The current, undated Lantus package insert was provided by the DON (Director of Nursing) on 08/11/22 at 2:55 P.M. The insert indicated, "...ATTACH THE NEEDLE...wipe the pen tip (rubber seal) with an alcohol swab...PERFORM A SAFETY TEST...Dial a test dose of 2 units...Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose...Press the injection button all the way in and check to see that insulin comes out of the needle...Always perform the safety test before each injection..." The current Novolog package insert, with a revised date of 03/2021, was provided by the DON on 08/12/22 at 11:45 A.M. The insert indicated, "...Pull off the pen cap...wipe the rubber stopper with an alcohol swab...To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units. Hold your insulin...Flex Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the bottom all the way in...A drop of insulin should appear at the needle tip..." The current facility policy, titled "Insulin Administration", with a revised date of September 2014, was provided by the Administrator on		Resident #33's physician has been notified of refusal of treatment of compression stockings. An audit has been completed of all resident refusals and MD notification. Licensed Nurses have been re-educated on facility Policy & Procedure related to refusal of treatment and notification of MD. A Performance Improvement Tool has been developed that will monitor compliance with insulin administration. DON/Designee daily for one month, then weekly for one month, then monthly for four months will complete PI tool with results being forwarded to QAPI committee for any further recommendations and/or resolution. Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Compliance Date September 1, 2022	

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	08/11/22 at 2:50 P.M. The policy indicated, "...Disinfect the top of the vial with an alcohol wipe..." 2. During an observation and interview on 08/08/22 at 2:05 P.M., Resident 33 was sitting in a chair in her room. Her left ankle was visible and swollen. She indicated she had worn "those tight socks" once and she was not going to wear them again. During an observation and interview on 08/10/22 at 1:45 P.M., the resident was sitting in a chair in her room. Both of her ankles were swollen and her short socks were making indentations on her ankles. She indicated she was taking a medication for the swelling in her legs, but they continued to swell. The resident was not wearing long compression stockings. During an observation on 08/11/22 at 10:50 A.M., the resident was sitting in her room in a recliner with her feet elevated. She was not wearing compression stockings. Both of her legs were visibly swollen. She was wearing shoes and socks and her socks were making indentations on her ankles. During an interview on 08/11/22 at 2:25 P.M., CNA (Certified Nurse Aide) 3 and CNA 4, indicated if a resident had refused to wear their compression stockings they would report to the nurse and the nurse would go and try to assist the resident with putting them on. The CNAs educated the residents on the need for the compression stockings. During an interview on 08/11/22 02:31 PM., LPN 2, indicated if a resident had refused to wear their compression stockings the CNAs would report it to the nurse. The nurse would re-approach and			

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	educate the resident. If the resident continued to refuse, they would notify the physician and see if they wanted to order something else or discontinue the order. If the physician was notified it would be documented in the progress notes. Sometimes the resident would allow putting the compression stockings on then took them off. The physician should have been notified of the resident's refusals. The clinical record was reviewed on 08/11/22 at 2:47 P.M.. A Quarterly MDS (Minimum Data Set) assessment, dated 08/01/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Parkinson's Disease, congestive heart failure, and muscle wasting. A physician's order, with a start date of 10/08/21, was provided by LPN 2 on 08/11/22 at 3:03 P.M. The order indicated the resident was to wear compression stockings during the day and to remove them at bedtime. Staff were to assist the resident with putting them on in the morning. The progress notes for July and August 2022, were provided by LPN 2 on 08/11/22 at 3:03 P.M. The progress notes lacked documentation the physician had been notified of the resident's refusals to wear the compression stockings. The current Requesting, Refusing and/or Discontinuing Care or Treatment policy, with a revised date of February 2021, was provided by the ADON (Assistant Director of Nursing) on 08/11/22 at 3:24 P.M. The policy indicated, "...Documentation pertaining to a resident's...refusal of treatment includes at least the following:...The date and time the practitioner was notified as well as the practitioner's			

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	response...The healthcare practitioner must be notified of refusal of treatment..." 3.1-37(a) 3.1-5(a)(3)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents' safety related to unauthorized medications at the bedside for 2 of 24 residents observed (Residents 49 and 54) and failed to implement appropriate interventions for a resident with an altered mental status prior to a fall for 1 of 4 residents reviewed for falls. (Resident 6) Findings include: 1. During an observation and interview on 08/08/22 at 10:46 A.M., Resident 49 was sitting in her room in her wheelchair. A full cup of medications were on the resident's over the bed table. The resident indicated the staff trusted her. She had been down to the therapy gym for therapy, then gone to the exercise activity so the staff had left them in her room for her. When she left for therapy and the group exercise activity her medications were not in her room. When she returned to her room the medications had been left	F 0689	F689 Education was completed with all licensed nursing staff regarding the policy for self-administering medications. All residents had the opportunity to be effected. Walking observations with nursing staff was completed to ensure proper supervised medication administration. Education was provided to residents that request meds left at bedside related to regulations. A Performance Improvement Tool has been developed that will monitor compliance with medication administration. DON/Designee daily for one month, then weekly for one month, then monthly for four months will complete PI tool with results being	09/03/2022

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	on her table. There were 13 whole pills and one half of a pill visible in the medication cup. During an interview on 08/12/22 at 9:39 A.M., the DON (Director of Nursing) indicated if a resident was permitted to self-administer medications they would have a lock box and a self-administration of medication evaluation completed. They would also be care planned to self-administer medications. The August 2022, EMAR (Electronic Medication Administration Record) was provided by the DON on 08/12/22 at 11:45 A.M. The record indicated the resident had not received narcotics during the morning medication administration. The record lacked an order for the resident to self-administer medications. The resident's prescribed medications ordered by the physician, for 6:00 A.M. on 08/08/22, included, but were not limited to: - a cranberry capsule 400 mg (milligrams), - isosorbide monitrate 30 mg for edema, - montelukast 10 mg for cough, - potassium chloride 20 MEQ (Milliequivalents) for hypokalemia, - torsemide 20 mg, two tablets for congestive heart failure, - Trintellix 20 mg for depression, - buspirone 7.5 mg for anxiety, - Cefdinir 300 mg for urinary tract infection, - Eliquis 2.5 mg for atrial fibrillation, and - Gabapentin 300 mg for polyarthritis. The complete care plan record was provided by the DON on 08/12/22 at 11:45 A.M. The record lacked a care plan and an intervention to permit the resident to self-administer her medications.		forwarded to QAPI committee for any further recommendations and/or resolution. Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. F689 cont. All residents with alcohol consumption had the opportunity to be effected. An audit of Care plans r/t alcohol use was completed. All residents audited for need of alcohol careplan and completed as appropriate. MDS coordinators and licensed nurses reeducated on Facility Policy & Procedure related to comprehensive Care Plans. A Performance Improvement Tool has been developed that will monitor compliance with Comprehensive Care Plans. PI tool be completed daily by DON/Designee for one month, then weekly for one month, then monthly for four months with results being forwarded to QAPI committee for any further recommendations and/or resolution Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Compliance Date September 1,	

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	The clinical record was reviewed on 08/09/22 at 1:08 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/21/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), heart failure, and neurogenic bladder. The resident required extensive assistance of two or more staff members for bed mobility, transfers, personal hygiene, dressing, toilet use, and locomotion on and off the unit. 2. Resident 54 was observed in her room on 08/09/22 at 9:44 A.M. The resident was sitting in her wheelchair at her overbed table. She was holding a cup of unidentified medications. The resident was actively taking the medications unsupervised and drinking milk to wash them down. The resident indicated the cup of medications had been left in her room for a little while that morning. Sometimes the nurses stood over her while she took her medicine and sometimes they did not. She could take her medications by herself. The resident's clinical record was reviewed on 08/11/22 at 1:56 P.M. An Admission MDS assessment, dated 07/02/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, heart failure, diabetes, and end stage renal disease. The resident's current medication orders were as followed: clonidine patch 0.3 mg, carvedilol 25 mg BID, Sevelamer Carbonate Tab 800 mg 3 tab by mouth before meals, ondansetron hcl 4 mg, insulin glargine hydrocodone 5/325, eliquis 2.5 mg, melatonin 5 mg, allopurinol 100 mg give 200 mg, hydroxyzine 25 mg, trazodone 50 mg, prednisone 1 mg daily for chf x 90 days, trulicity inject 1.5 mg every evening on Fridays, humalog 18 units		2022	

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	before meals, and renal-vite 0.8 mg. The August 2022, EMAR was provided by the DON on 08/12/22 at 11:45 A.M. The record indicated the resident had not received narcotics during the morning medication administration. The record lacked an order for the resident to self-administer medications. The complete care plan record was provided by the DON on 08/12/22 at 11:45 A.M. The record lacked a care plan and an intervention to permit the resident to self-administer her medications. During an interview on 08/11/22 10:53 A.M. the Administrator indicated there were no residents that self administered their medications. During an interview on 08/12/22 09:48 A.M., QMA (Qualified Medication Aide) 5 indicated there were no residents in the facility that self administered medications. Nursing staff were never to leave a resident's medications at bedside. The current facility policy, titled "Self-Administration of Medications", with a revision date of February 2021, was provided by the Administrator on 08/12/22 at 11:28 A.M. The policy indicated, "...Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so...If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan. The decision...is reassessed periodically..." The current facility policy, titled "Administering Oral Medications", with a revision date of October 2010, was provided by the Administrator on			

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	08/12/22 at 11"28 A.M. The policy indicated, "...Remain with the resident until all medications have been taken..." 3. The clinical record for Resident 6 was reviewed on 08/09/22 at 2:44 P.M. An Annual MDS assessment, dated 05/26/22, indicated, the resident was cognitively intact. The diagnoses, included but were not limited to, stroke, hypertension, diabetes, anxiety, and depression. The resident had a fall with injury since the last assessment. A Progress Note, dated 05/22/22 at 5:30 P.M., indicated the resident had returned from being out of the facility with family. The resident and family had stated the resident had consumed alcohol and upon the assessment the resident was inebriated (intoxicated). A Progress Note, dated 05/22/22 at 7:45 P.M., indicated the resident was attempting to transfer himself from a chair to the bed. The resident had lost his balance and fell to the floor. He suffered a 2 centimeter by 0.1 centimeter laceration to the forehead with steri-strips applied and neurological assessments were initiated. The family and physician were notified. A Progress Note, dated 05/22/22 at 9:00 P.M., indicated the resident had a fall while ambulating himself to the bathroom. The resident had no injuries from the fall. Neurological assessments were reinitiated and all appropriate notifications were made. A Progress Note, dated 05/23/22 at 9:40 A.M., indicated the IDT (Interdisciplinary Team) had reviewed the falls and indicated the root cause was determined to be lack of safety awareness and impaired balance. A new intervention was			

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	implemented for education on using the call light during periods of time when the cognition was altered. The clinical record lacked a care plan for alcohol use or any documentation that the resident was placed on any increased monitoring after his return to the facility intoxicated. During an interview on 08/11/22 at 9:32 P.M., LPN (Licensed Practical Nurse) 8 indicated Resident 6 had weakness on one side of the body due to a stroke. During an interview on 08/11/22 at 11:01 A.M., the DON indicated the resident had a couple of falls on a weekend shift. She was the nurse on duty when the resident had gone of the facility with family and consumed some alcohol while out. He had decreased safety awareness and imbalance upon returning to the facility. After returning he had two falls. Assessments were completed on each fall and the family was educated to not allow the resident to consume alcohol while out on visits. The resident had obtained a laceration to his head on one of the falls that did not require him to be sent to the hospital. Increased safety checks were not documented in the clinical record. The IDT had reviewed the falls and education was provided to use the call light when cognition was altered. She would determine the intervention was appropriate by verbal and demonstration reinforcement. The current facility policy titled, "Falls and Fall Risk, Managing", with a revised date of March 2018, was provided by the DON on 08/11/22 at 12:02 P.M. The policy indicated, "...Based on previous evaluations and current data, the staff will identify interventions related to the resident's			

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	specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...Fall Risk Factors:...2. Resident conditions that may contribute to the risk of falls include:...c.delirium and other cognitive impairment..." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal			

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	155675	A. BUILDING 00 B. WING	08/12/2022

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MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines to prevent UTIs (Urinary Tract Infections) for residents with indwelling urinary catheters for 1 of 1 resident reviewed for catheter care with a UTI. (Resident 49) Findings include: During an observation and interview on 08/08/22 at 10:39 A.M., Resident 49 was sitting in her wheelchair in her room. Her indwelling urinary catheter tubing was on the floor under her foot. She was wearing tennis shoes. She indicated she had the urinary catheter because her urine was not draining well enough and she'd had a lot UTIs. She'd had the catheter for about a year. The drainage bag was emptied two to three times a day. She could not remember how often the staff cleaned around the insertion site. During an observation on 08/09/22 at 12:52 P.M., the resident was sitting in her wheelchair at the door to the therapy gym. Part of her indwelling urinary catheter bag was resting against the floor along with approximately three inches of her catheter tubing. During an observation on 08/09/22 at 2:45 P.M., the resident was in the main dining room in a group activity. Her urinary catheter bag was hanging on the back of her wheelchair at the middle of her back above her bladder.	F 0690	F690 All residents with Foley catheter had the opportunity to be effected. An audit completed to ensure all Foley Catheter tubing is secure and not touching the floor. Staff reeducated on facility policy and procedure on catheter care to include facility infection control practices. A Performance Improvement Tool has been developed that will monitor compliance with proper placement of Foley catheter and tubing. PI tool be completed daily by DON/Designee for one month, then weekly for one month, then monthly for four months with results being forwarded to QAPI committee for any further recommendations and/or resolution Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria.	09/03/2022

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	During an observation and interview with LPN (Licensed Practical Nurse) 2 on 08/12/22 at 9:00 A.M., the resident was in her room in her wheelchair with one to two inches of her urinary catheter tubing touching the floor. LPN 2 indicated the tubing should not be touching the floor and went into the resident's room to adjust the catheter tubing. The clinical record was reviewed on 08/09/22 at 1:08 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/21/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), heart failure, and neurogenic bladder. The resident required extensive assistance of two or more staff members for bed mobility, transfers, personal hygiene, dressing, toilet use, and locomotion on and off the unit. A physician's order, with a start date of 08/01/22, was provided by the DON (Director of Nursing) on 08/12/22 at 10:10 A.M. The order indicated the resident received Cefdinir (an antibiotic) 300 milligrams, two times a day for a UTI until 08/09/22. The current "Catheter Care, Urinary" policy, with a revised date of September 2014, was provided by the DON on 08/12/22 at 10:10 A.M. The policy indicated, "...purpose...to prevent catheter-associated urinary tract infections...The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...Be sure the catheter tubing and drainage bag are kept off the floor..."			

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	3.1-41(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility failed to develop a resident-center care plan related to dementia for 1 of 2 residents reviewed for dementia care. (Resident 28) Findings include: The clinical record for Resident 28 was reviewed on 08/09/22 at 3:06 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/20/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia without behavioral disturbances, hypertension, non-Alzheimer's dementia, anxiety, depression, and respiratory failure. The Complete Care Plan, was provided by the ADON (Assistant Director of Nursing) on 08/11/22 at 10:00 A.M. and lacked a care plan related to dementia. During an interview on 08/11/22 at 9:34 A.M., LPN (Licensed Practical Nurse) 8 indicated the resident would wander the building and yell out for her kids. The resident loved to drink coke. The staff all knew the resident liked to drink coke. If it was a new staff member, they would just let them know. During an observation on 08/11/22 at 1:01 p.m.,	F 0744	F744 Resident #28 care plan was immediately updated. An audit of Care plans r/t resident centered care of dementia. All residents audited for need of dementia care, care plan and completed as appropriate. All residents with dementia have the opportunity to be effected. MDS coordinators and licensed nurses reeducated on Facility Policy & Procedure related to comprehensive Care Plans. A Performance Improvement Tool has been developed that will monitor compliance with Comprehensive Care Plans. PI tool be completed daily by DON/Designee for one month, then weekly for one month, then monthly for four months with results being forwarded to QAPI committee for any further recommendations and/or resolution Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate	09/03/2022

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	the resident was sitting in her wheelchair in the common area outside the nurses station. She was observing other residents and staff while staff were attempting to engage the resident in an activity. During an interview on 08/12/22 at 1:07 P.M., TNA (Temporary Nurse Aide) 9 indicated if she needed to see resident interventions, she would look at the care plan in the clinical record. This resident should have a care plan for dementia care but she had never looked at it before. She knew to help calm the resident would be distractions, talking with the resident, and getting her drinks. She was unable to locate a dementia care plan for the resident. During an interview on 08/12/22 at 1:14 P.M., the ADON indicated all staff were made aware of resident centered interventions for dementia by report and looking at the care plan. This resident's non-pharmalogical interventions included one on one, food, drinks, and expressing selves. The resident was lacking a care plan for dementia and should have had one in place. The current facility policy titled, "Dementia-Clinical Protocol" with a revised date of November 2018, was provided by the ADON on 08/12/22 at 1:26 P.M. The policy indicated, "...Treatment/Management...1. For the individual with confirmed dementia, the IDT [Interdisciplinary Team] will identify a resident-centered care plan to maximize remaining function and quality of life..." 3.1-37(a)		further monitoring criteria.	
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary			

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Bldg. 00	Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to monitor residents blood pressure and heart rate before administering medications for 2 of 5 residents reviewed for unnecessary medications. (Residents 28 and 45) Findings include: 1. The clinical record for Resident 28 was reviewed on 08/09/22 at 3:06 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/20/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia without behavioral disturbances, hypertension, non-Alzheimer's dementia, anxiety, depression, and respiratory	F 0757	F757 All residents had the opportunity to be effected. All residents with medication parameters were audited for unnecessary meds. Resident #28 MD notified of medication administration and all vitals. Nursing educated completed on medication administration and MD notification. A Performance Improvement Tool has been developed that will monitor compliance with medication parameters and	09/03/2022

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	failure. An open ended physician's order, with a start date of 02/01/22, indicated the staff were to administer Labetalol (a hypertension medication) 100 mg (milligrams) once a day for hypertension, and to hold the medication for a heart rate less than 80 or a systolic blood pressure less than 120. The July and August 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was reviewed and indicated the resident had received the hypertension medication the following day when the blood pressure was less than 120 or the heart rate was less than 80: - 07/01/22 with a heart rate of 65, - 07/04/22 with a heart rate of 59, - 07/05/22 with a heart rate of 79, - 07/06/22 with a heart rate of 63, - 07/07/22 with a heart rate of 58, - 07/09/22 with a heart rate of 68, - 07/10/22 with a heart rate of 61, - 07/11/22 with a heart rate of 72, - 07/12/22 with a heart rate of 77, - 07/15/22 with a heart rate of 68, - 07/18/22 with a heart rate of 70, - 07/20/22 with a heart rate of 68, - 07/24/22 with a heart rate of 74, - 07/25/22 with a heart rate of 76, - 07/26/22 with a heart rate of 70, - 07/27/22 with a heart rate of 68, - 07/28/22 with a heart rate of 64, - 07/29/22 with a heart rate of 76, - 07/30/22 with a heart rate of 67, - 08/03/22 with a heart rate of 78, - 08/08/22 with heart rate of 68, and - 08/10/22 with a heart rate of 55 and a blood pressure of 103/76.		administration. PI tool be completed daily by DON/Designee for one month, then weekly for one month, then monthly for four months with results being forwarded to QAPI committee for any further recommendations and/or resolution Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Compliance Date September 1, 2022	

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	The July and August 2022 clinical record lacked indication the medication had been held. During an interview on 08/11/22 at 9:22 A.M., LPN (Licensed Practical Nurse) 8 indicated residents' medications would be signed on the EMAR. If a medication had hold parameters and was out of the parameters, she would hold the medication and document it on the EMAR why it wasn't given. If she had to hold the medication continuously then she would document in the clinical record and notify the physician. During an interview on 08/11/22 at 10:39 A.M., the ADON (Assistant Director of Nursing) indicated if a resident's medication had hold parameters and the medication was out of the parameters the nurse should have not administered the medication and document in the EMAR that the medication was held. If there was a check on the EMAR then it meant the mediation was administered. 2. The clinical record for Resident 48 was reviewed on 08/09/22 at 3:15 P.M. A Quarterly MDS assessment, dated 07/30/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, acute respiratory failure, hypertension, dementia, and psychotic disorder. An open ended physician's order, with a start date of 06/22/22, indicated the nursing staff were to give diltiazem (a blood pressure medication) 120 mg (milligrams), twice a day for hypertension, and hold if the systolic blood pressure was less than 100. The July and August 2022 EMAR/ETAR			

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	indicated the resident had received the diltiazem the following days when the systolic blood pressure was less than 100 or was not obtained: - 07/14/22 at 6:00 P.M. with no blood pressure noted, - 07/19/22 at 6:00 P.M. with no blood pressure noted, - 07/20/22 at 6:00 A.M. with a blood pressure of 72/42 and 6:00 P.M. with no blood pressure noted, - 07/22/22 at 6:00 A.M. with a blood pressure of 83/53 and 6:00 P.M. with no blood pressure noted, - 07/23/22 through 07/30/22 at 6:00 P.M. with no blood pressure noted, - 08/01/22 through 08/05/22 at 6:00 P.M., with no blood pressure noted, - 08/07/22 through 08/10/22 at 6:00 P.M. with no blood pressure noted, - 08/08/22 at 6:00 A.M. with a blood pressure of 98/43, and - 08/09/22 at 6:00 A.M. with a blood pressure of 88/43. The clinical record lacked indication that the medication had been held. A Care Plan, initiated on 07/12/22, indicated the resident had hypertension. Interventions included, but were not limited to, give antihypertensive medications as ordered. During an interview on 08/12/22 at 1:14 P.M., the ADON indicated Resident 28 and 45 suffered no ill effects from receiving the medications outside of the parameters. The current facility policy, titled "Administering Medications', with a revised date of April 2019 was provided by the ADON on 08/11/22 at 10:00 A.M. The policy indicated, "...Medications are administered in a safe and timely manner, and as			

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	prescribed..." 3.1-48(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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 when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medication appropriately related to unlabeled insulin pens for 1 of 3 medication carts observed (Team 1 Medication Cart). Findings include:	F 0761	F761 All residents medication audit was completed immediately. Unlabeled medication disposed of and replaced and labeled appropriately. All residents had the opportunity	09/03/2022

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	1. During an observation on 08/11/22 at 8:05 A.M. LPN (Licensed Practical Nurse) 2 prepared to administer medications to Resident 49. The LPN opened the Team 1 Medication Cart and gathered a used Lantus insulin pen with 200 of 300 units remaining, labeled with the resident's name. The pen lacked an opened on date. 2. During an observation of the Team 1 Medication Cart with QMA (Qualified Medication Aide) 5 on 08/12/22 at 09:30 A.M. the following items were improperly labeled: - Resident 48's used Levemir insulin pen with 195 of 300 units remaining. The pharmacy label indicated the pen was received from the pharmacy on 07/12/22. The pen was not labeled with an opened on date, and - Resident 54's used Lantus insulin pen with 100 of 300 units remaining. The pharmacy label indicated the pen was received from the pharmacy on 07/28/22. The pen was not labeled with an opened on date. During an interview on 08/12/22 at 09:35 A.M., QMA 5 indicated she was unsure how long the insulin pens were good for after they were opened. The pens should be labeled with an opened on date. The current facility policy titled "Storage of Medications", with a revised date of November 2020 was provided by the Director of Nursing on 08/12/22 at 11:45 A.M. The policy indicated, "...The facility stores all drugs and biologicals in a safe, secure, and orderly manner..." 3.1-25(k)(6)		to be effected. Education provided to all licensed nursing staff on storage of medication policy. A Performance Improvement Tool has been developed that will monitor compliance with storage of medication including proper labeling of name and open date. DON/Designee daily for one month, then weekly for one month then monthly for four months will complete PI tool with results being forwarded to QAPI committee for any further recommendations and/or resolution. Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Compliance Date September 1, 2022	

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to document resident information related to discharge for 1 of 15 residents reviewed for identifiable information. (Resident 26) Findings include: During an interview on 08/11/22 at 9:17 A.M., LPN (Licensed Practical Nurse) 8 indicated Resident 26 had complaints of chest pain one evening and she	F 0842	F842 Discharge note was completed for resident #26 at time of notification of lack of documentation. All resident discharges for previous 90 days reviewed for lack of discharge documentation. Education provided to all nursing staff on Policy of Charting and Documentation.	09/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING 00 B. WING	08/12/2022

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

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	had received orders to send her to the emergency room. When she would receive the orders to send someone to the hospital she would complete her assessment on paper, prepare the appropriate paperwork, call report to the hospital, notify the family and emergency transport. She would send all the paperwork with the resident and did not keep any copies and would document in a progress note the situation with the resident and where they went. The clinical record for Resident 26 was reviewed on 08/09/22 at 2:06 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/18/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, heart failure and schizophrenia. The census report for Resident 26 indicated she was discharged to the hospital on 08/06/22. The clinical record lacked documentation or an assessment indicating the resident had been sent to the hospital on 08/06/22 until a late entry note was entered on 08/11/22 at 1:42 P.M. after the concern was brought to the attention of DON during the survey process. During an interview on 08/12/22 at 9:46 A.M., the DON (Director of Nursing) indicated the resident's clinical record should have had a progress note prior to the late entry note indicating she was sent to the hospital. The management team usually discuss in morning meeting and those notes would be reviewed at that time. The current facility policy titled, "Charting and Documentation", was revised July 2017 was provided by the DON on 08/11/22 at 2:49 P.M. The policy indicated, "...All services provided to the		DON/Designee will review discharge notes in Interdisciplinary team meeting to ensure discharge notes are recorded on PI tool daily for one month, then weekly for one month then monthly for four months will complete PI tool with results being forwarded to QAPI committee for any further recommendations and/or resolution. Monitoring will be stopped at 6 months if threshold is 100% compliance. If 100% compliance is not achieved QAPI will initiate further monitoring criteria. Compliance Date September 1, 2022	

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	resident, progress toward the care plan goal, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care..." 3.1-50(a)(1) 3.1-50(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure survey. Survey dates: August 8, 9, 10, 11, and 12, 2022 Facility number: 011039 Residential Census: 12 Morning Breeze was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on August 19, 2022.	R 0000	Please find our POC and audit tools with education materials and employee education list check off. We would like to request a desk review. If there are additional documents I can submit for you please let me know. Thank you, Holly Witkemper	