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	07/03/2023

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: June 26, 27, 28, 29, 30, and July 3, 2023. Facility number: 011039 Provider number: 155675 AIM number: 200299100 Census Bed Type: SNF: 7 SNF/NF: 48 Residential: 13 Total: 68 Census Payor Type: Medicare: 6 Medicaid: 41 Other: 8 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 11, 2023.	F 0000	Please find attached our POC for Survey dates June 26- July 3. We would like to request a desk review. Please feel free to contact me with any questions regarding this POC. Thank you in advance for your consideration. Holly Witkemper, HFA Morning Breeze 812.662.7778	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Witkemper	HFA	07/19/2023

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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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the residents' physician for medications not administered for 2 of 15 residents reviewed for notification of change. (Residents 23 and 32) Findings include: 1. The clinical record for Resident 23 was reviewed on 06/28/23 at 9:29 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/05/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, anemia, hypertension, and diabetes. An open-ended physician's order, with a start date of 04/27/23, indicated the resident was to receive Humalog (an insulin medication) 20 units in the morning. The May and June EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had not received the medication on the following dates: - 05/05/23, due to the resident eating less than 50% of meal, - 05/06/23, due to the resident eating less than 50% of meal, - 05/07/23, due to out of range vital, - 05/12/23, due to out of range vital, - 05/15/23, due to the resident eating less than 50% of meal, - 05/17/23, due to out of range vital, - 05/18/23, refused,	F 0580	**F 580- Notify of change** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents audited to ensure notification of change occurred. MD notification for medication not administered for resident 32 and 23 completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice, but no other residents were affected by this alleged deficiency after review. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were educated on notifying MD when medications not administered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and A Performance Improvement Tool	07/19/2023

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	- 05/19/23, refused, - 05/21/23, due to out of range vital, - 05/22/23, due to out of range vital, - 05/28/23, unknown, - 06/02/23, due to the resident eating less than 50% of meal, - 06/12/23, due to no insulin required, - 06/15/23, due to out or range vital, - 06/16/23, due to out of range vital, and - 06/22/23, due to no insulin required. An open-ended physician order, with a start date of 04/27/23, indicated the resident was to receive Humalog 10 units in the afternoon. The May and June EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had not received the medication on the following dates: - 05/04/23, due to resident not eating well, - 05/05/23, due to out of range vital, - 05/08/23, due to out of range vital, - 05/09/23, due to low blood sugar of 83, - 05/11/23, due to the resident had a poor appetite, - 05/14/23, due to the resident refused, - 05/21/23, due to the resident was out of the facility, - 05/29/23, due to the resident refused - 06/01/23, due to the resident refused, - 06/06/23, due to resident refused meal, - 06/12/23, due to no insulin required, - 06/15/23, due to out of range vital, - 06/16/23, due to out of range vital, and - 06/22/23, due to no insulin required. The clinical record lacked documentation that the physician had been notified of the Humalog not being administered.		has been developed that will monitor compliance MD notification of medications not administered. DON/Designee will complete PI tool daily (Mon- Fri) for one month, then weekly for one month, then monthly for four months, with results being presented at the QAPI committee meeting and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits. By what date the systemic changes for each deficiency will be completed. Alleged compliance date 7/19/23	

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During an interview on 06/29/23 at 9:54 A.M., LPN (Licensed Practical Nurse) 3 indicated if a resident had hold parameters (instructions for not administering a medication), then the nurse could hold a medication. If the medication did not have hold parameters, they could hold a medication as a nursing precaution, but the physician would have to be notified the medication was held and staff would have to document in a progress note that the physician was notified.

2. The clinical record for Resident 32 was reviewed on 06/27/23 at 2:33 P.M. A Quarterly MDS assessment, dated 04/09/23, indicated the resident was moderate cognitively impaired. The diagnoses included, but were not limited to, dementia, cancer, hypertension, diabetes, anxiety, and depression.

An open-ended physician's order, with a start of 12/15/22, indicated the resident was to receive Lantus (an insulin medication) 72 units at bedtime (7:00 P.M.).

The June 2023 EMAR/ETAR indicated the resident had not received the Lantus on the following dates:

- 06/01/23, due to blood sugar of 107,
- 06/07/23, due to blood sugar of 178,
- 06/08/23, due to blood sugar of 219,
- 06/12/23, due to blood sugar of 115,
- 06/15/23, due to blood sugar of 182,
- 06/17/23, due to unknown,
- 06/21/23, due to blood sugar of 167,
- 06/22/23, due to blood sugar of 170, and
- 06/25/23, due to no insulin required.

The clinical record lacked documentation the

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	physician had been notified of the resident's Lantus not being administered. During an interview on 06/29/23 at 10:10 A.M., a facility Nurse Practitioner indicated once a resident received Lantus it should last about 12 hours. A resident's Lantus shouldn't be held since it was a long-acting insulin. If the staff were holding the resident's Lantus, then the physician should have been notified. During an interview on 06/29/23 at 10:16 A.M., the DON (Director of Nursing) indicated if a resident's Lantus didn't have hold parameters the medications should not have been held. If it was held due to nursing judgement the physician should be notified and staff should document the notification in the clinical record. The current, undated, facility policy titled, "Change in a Resident's Condition or Status" was provided by the DON on 06/30/23 at 2:03 P.M. The policy indicated, "...The nurse will notify the resident's attending physician or physician on call when there has been a(an):...need to alter the resident's medical treatment...The nurse will record in the resident;s medical record information relative to changes in the resident;s medical/mental condition or status..." 3.1-5(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure the resident's wound treatments were administered appropriately and accurately assess for 1 of 2 residents reviewed for pressure ulcers. (Resident 6) Findings include: During an interview on 06/28/23 at 10:46 A.M., the FWN (Facility Wound Nurse) indicated Resident 6 had a wound on her right heel and a wound on her coccyx. The heel wound was identified in March. The coccyx wound was identified more recently. The resident was receiving hospice services, so she worked with hospice to manage and treat the resident's wounds. There was a lack of communication related to documentation between the facility and hospice regarding the resident's wounds. Resident 6's wounds were observed with the FWN on 06/29/23 at 9:35 A.M. The FWN removed the resident's sock on her right foot. An undated dressing was observed on the resident's heel. The skin around the wound was dry and flaky. The wound measured 4 cm (centimeters) x 4 cm. The wound was reddish purple, with a quarter sized area in the center that was blackish purple in color. The skin appeared to be hard. There was no	F 0686	**F686- Treatment/ Services** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #6 wound was reassessed and notes with measurements have been documented. Wound dressing dated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice, but no other residents were affected by the alleged deficiency. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place All nurses were provided education	07/19/2023

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	drainage or odor. The FWN indicated the dressing was last changed by a hospice nurse. The FWN administered the treatment to the heel and then prepared to treat the wound on the resident's coccyx. The resident rolled over and the FWN adjusted the resident's clothing to expose the wound. The dressing on the resident's coccyx was undated as well. There was reddish brown drainage visible through the transparent portion of the dressing. The coccyx wound measured 4.3 cm x 4.8 cm, with a depth of 0.4 cm. The wound bed was dark red in color. There was no odor or signs of infection. The FWN indicated the wound was a Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer) pressure ulcer and the dressing was changed daily and as needed. Both dressings should have been dated and initialed. The resident's clinical record was reviewed on 06/28/23 at 2:22 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/28/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, cancer, hypertension, renal disease, non-Alzheimer's dementia, and malnutrition. The resident was on hospice. The resident was at risk for pressure ulcers but had no pressure injuries at the time of the assessment. The FWN provided the resident's wound assessments on 06/28/23 at 11:15 A.M. The documentation included "Skin Observation Tool" assessments from the resident's EHR (Electronic Health Record), the FWN's handwritten notes, and a document from the hospice provider that listed measurements of the resident's wounds. The documentation included, but were not limited to, the following:		on wound treatment and proper documentation and wound treatment dating. Assessments will be completed weekly and PRN. The information will be entered into the residents clinical records upon completion of the assessment. All treatments will be administered per MD orders. All residents wound documentation will be monitored weekly for 26 weeks by the DON or designee to ensure weekly wound assessments are completed, wound dressings dated and proper documentation was entered. Any missing assessments and documentation will be completed immediately and education to include progressing discipline will be completed. Results of the audit will be presented as a QAPI meeting and if 90% or greater compliance obtained, the committee will make a decision on continuing or discontinuing the audit. Alleged compliance date 7/19/2023	

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	- A "Skin Observation Tool", dated 05/23/23, indicated sites observed as the right heel and coccyx. "No new areas noted" was documented in the notes section of the assessment. - A "Skin Observation Tool", dated 05/30/23, indicated sites observed as the right heel and coccyx. There was no further documentation on the assessment. - A handwritten note, dated 05/31/23, that listed the resident's name and a measurement of the wound on the resident's right heel. The wound measured 1.1 cm x 1.1 cm. - A Skin/Wound Progress Note, dated 06/01/2023, indicated the resident had a new area on their coccyx that measured 3 cm x 3 cm x 0.1 cm. A necrotic area was observed. A new MD order was obtained to cleanse the wound and apply Santyl (an ointment that removes dead skin from wounds). - A "Skin Observation Tool", dated 06/07/23, indicated sites observed as the right heel and coccyx. There was no further documentation on the assessment. - A handwritten note, dated 06/09/23, that listed the resident's name and indicated the wound on the right heel measured 1.0 cm x 1.2 cm. The wound on the coccyx measured 5.4 cm x 6.5 cm x 2.6 cm. During an interview on 06/30/23 at 11:44 A.M., the FWN indicated she would normally document wound measurements, the wound bed description, a description of the skin around a wound, signs of infection, and any drainage from the wound as part of the weekly wound assessment in the			

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	resident's EHR. The current wound documentation lacked information about the wounds. She thought the coccyx wound would have been classified as an Unstageable (obscured full-thickness skin and tissue loss, full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough [moist dead tissue] or eschar [dry dead tissue]) wound when it was discovered. She would think it should have been discovered before it was unstageable. During an interview on 07/03/23 at 9:47 A.M., the resident's family member indicated she talked to the facility about dating the dressings on the resident's wounds because there was no date on the dressings when she was in the facility yesterday visiting with the resident. If the dressings weren't dated, staff wouldn't know when the dressings were last changed and if they still needed to be changed. The current facility policy, titled "Skin and Wound Care Management Program", with an effective date of 04/12/23, was provided by the DON (Director of Nursing) on 06/30/23 at 2:35 P.M. The policy indicated, "...the facility provides care and services consistent with professional standards of practice...weekly wound rounds are completed for residents with wounds. Rounds include wound assessment and measurements of wounds documented...as appropriate..." The current facility policy, titled "Dressings, Dry/Clean", with a revised date of September 2013, was provided by the DON on 07/03/23 at 9:21 A.M. The policy indicated, "...label tape or dressing with date, time and initials...the following information should be recorded in the resident's			

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	medical record...or designated wound form...wound appearance, including wound bed, edges, presence of drainage...type of dressing used, and wound care given...all assessment data...wound bed color, size, drainage, etc..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to follow a physician's order related to fluid restriction for 1 of 1 resident reviewed for dialysis. (Resident 43) Findings include: During an observation on 06/30/23 at 10:25 A.M., Resident 43 was out of her room. A large plastic cup was sitting on the overbed table and was full of clear fluid. The cup was undated. During an observation on 06/30/23 at 1:23 P.M., Resident 43 was sitting in her recliner holding a glass of clear liquids and taking drinks. There was a large plastic cup full of clear liquids, that was undated on the overbed table. The clinical record for the resident was reviewed on 06/28/23 at 1:31 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/23/23, indicated the resident was cognitively intact. The	F 0698	F698 Dialysis (fluid restriction) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 43's water pitcher was removed and other residents with fluid restrictions audited for need to remove pitcher with no concerns noted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; One additional resident had the potential to be affected. No concerns identified. What measures will be put into place and what systemic changes	07/19/2023

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

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	diagnoses included, but were not limited to, anemia, hypertension, renal insufficiency, diabetes, anxiety, and dependence on renal dialysis. The resident received dialysis while a resident at the facility. An open-ended physician's order, dated 06/15/23, indicated the resident was on a fluid restriction of 1200 ml (milliliters) per day, 240 ml per meal and 160 ml per shift for medication pass. The June 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked a documented amount of fluids in ml during each shift. The June records for "Amount Eaten and Fluids" consumed during meals lacked documentation of fluid intakes on the following dates and meal times: - 06/21/23 at breakfast or lunch, - 06/22/23 at breakfast or dinner, - 06/23/23 at breakfast and dinner, - 06/24/23 at dinner, - 06/25/23 at dinner, and - 06/29/23 at dinner. During an interview on 06/29/23 at 9:50 A.M., LPN (Licensed Practical Nurse) 3 indicated the resident was alert and oriented and went to dialysis three time a week. The resident would consume breakfast before she left for dialysis and would then eat lunch when she returned. She was able to take snacks with her. During an interview on 06/30/23 at 10:15 A.M., LPN 4 indicated if a resident was on a fluid restriction, she would check the order to see how		will be made to ensure that the deficient practice does not recur; All staff educated on fluid restriction policy. Education provided to our current orders for restrictions. Education included to not place water pitcher in rooms of residents with restrictions. A Performance Improvement Tool has been developed that will monitor compliance with water restrictions. DON/Designee will complete PI tool daily (Mon- Fri) for one month, then weekly for one month, then monthly for four months, with results being presented at the QAPI committee meeting and if 90% or greater compliance is obtained, the committee will make a decision on continuing or discontinuing the audits. By what date the systemic changes for each deficiency will be completed. Alleged compliance date 7/19/2023	

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	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	much they could consume in a day. She would continue to check the resident throughout the day to see if they had consumed extra fluids. The total amount of fluids consumed throughout the day would be documented in the EMAR. During an interview on 06/30/23 at 1:24 P.M., CNA (Certified Nurse Aide) 5 indicated to determine if a resident was on a fluid restriction, she would be informed during report at the beginning of her shift or look on the resident's profile. She was aware the resident was on a fluid restriction. The kitchen would bring out the fluids on the meal tray and the nurse would give fluids with medication pass. She wouldn't pass ice water to the resident. If the resident refused to abide by the fluid restriction and wanted more to drink, she would alert the nurse. The current facility policy titled, "Encouraging and Restricting Fluids" with a revised date of October 2021, was provided by the DON (Director of Nursing) on 06/30/23 at 2:03 P.M. The policy indicated, "...The purpose is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids...Record fluid intake...Documentation...The amount (in mLs) of fluids consumed by the resident during the shift...If the resident refused the treatment, the reason(s) why and the intervention taken..." 3.1-37(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.	R 0000	Please find attached our POC for Survey dates June 26- July 3. We would like to request a desk	

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	Survey dates: June 26, 27, 28, 29, 30 and July 03, 2023. Facility number: 011039 Residential Census: 13 Morning Breeze Retirement Community And Healthcare was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.		review. Please feel free to contact me with any questions regarding this POC. Thank you in advance for your consideration. Holly Witkemper, HFA Morning Breeze 812.662.7778	