DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNING POINTE OF FRANKLIN	75 S MILFORD DR FRANKLIN, IN 46131

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00425523. Complaint IN0000425523 - No deficiencies related to the allegations are cited. Survey dates: January 11 and 12, 2024 Facility number: 002858 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 16, 2024.	R 0000	Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement by the provider of the truth of statement of deficiency. The Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Glidden	Executive Director	01/29/2024

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

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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 5 of 12 calendar months for 2023. Finding includes: On 1/11/24 at 1:15 p.m., the Administrator provided documentation of fire drills conducted for the past year; January 2023 through December 2023. A review of the records indicated the following months lacked documentation that fire drills were conducted: - March 2023 - June 2023 - October 2023 - November 2023 - December 2023 During an interview on 1/11/24 at 1:15 p.m., the Administrator indicated that fire drills were to be conducted monthly and that the documentation for some months were missing. During an interview on 1/12/24 at 10:55 a.m., the Administrator indicated that no additional fire drill documentation for the missing months had been located. On 1/12/24 at 11:00 a.m., the Administrator provided a copy of the Fire Safety Policy/Procedure, with a revision date of 3/17/15,	R 0092	**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** On 1/16/2024, the new Maintenance Director was train by the Facilities Service Director on State regulations and company policy for Fire Drills. Training documentation will be kept in the employee's file. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Staff on each shift will participate in the Fire Drills, this will be documented on the monthly fire drill form. All new hires will be trained on Fire Drills upon hire in orientation. **What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** The Executive Director or designated staff will audit the fire drill book monthly for 6 months	01/31/2024

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	and indicated it was the current policy in use by the facility. A review of the document indicated, "One fire drill per month shall be conducted ..."		**How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:** We will review fire drill in monthly QA meeting to ensure compliance.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.			

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	Based on interview and record review, the facility failed to ensure an Alzheimer's/Dementia Special Care Unit disclosure was submitted for 1 of 1 special care units. Findings include: On 1/11/24 at 9:15 a.m., the Administrator indicated the facility had a locked dementia care unit. The Administrator indicated she was unsure if the facility had submitted an Alzheimer's/Dementia Special Care Unit disclosure form. The Administrator indicated she had only been employed at the facility for a few months and would have to look for the disclosure form. On 1/11/24 at 11:33 a.m., the Administrator provided a copy of the facilities Residency and Services Agreement, dated 6/2/23 and indicated it was the current agreement being used by the facility. The agreement indicated " ...I ...C. Alzheimer's Care. In addition to completion of the Medical Evaluation and the Service Assessment described above, in order to receive Alzheimer's care, the Resident must be diagnosed by his or her physician with Alzheimer's disease, dementia or some other form of memory impairment and the Resident's physician must authorize that the Resident receives this special care. The resident will reside in an area of the Community that has been specially designed for such care and the doors to this area are locked twenty-four (24) hours a day with magnetic locks ..." During an interview on 1/12/24 at 8:33 a.m., the Administrator indicated the Alzheimer's/Dementia Special Care Unit disclosure was due to be submitted in December 2023. The facility failed to	R 0095	**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** The ED has added the submission of the Disclosure Form to the calendar to ensure that it will be submitted in a timely manner each year. ED will educate the Business Office Director on how to report the Disclosure Form and due date. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** No residents were found to be affected by this practice. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The Executive Director and Business Office Director will set reminders on a calendar to ensure that it is submitted in a timely manner. **How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:** The Executive Director and Business Office Director will set	01/31/2024

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	submit the discloser. During an interview on 1/12/24 at 10:00 a.m., the Administrator indicated the facility policy for the disclosure was not available.		reminders on a calendar to ensure that it is submitted in a timely manner. Will review annually at each Novembers QA meeting.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials for 1 of 2 observations. (Housekeeping Storage Closet) Findings include: On 1/11/24 from 9:08 a.m., the Housekeeping Storage Closet, located on the 100 hall, was observed. The door had a key pad for entry, but when the door was pulled the door opened. Inside the closet, the hazardous materials included	R 0148	**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** The coded lock has been changed out and the door now shuts and locks **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	01/31/2024

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	but were not limited to: - 1 full gallon of Dawn Heavy Duty Degreaser, 128 ounce Magnum Blue Concentrate Multi-Purpose Commercial Cleaner and Degrease, with a label indicating: Keep out of reach. - 1 Full plastic bottle of 2.5 gallon Oasis 146 multi-Quart Sanitizer, with a label indicating: Keep out of reach. - 3 full bottles of 32 ounce Eco-shine Water-based stainless steel polish, with a label indicating: Keep out of reach. - 5 full plastic 1 gallon bottles of Grease Express fast foam degreaser, with a label indicating: Keep out of reach. - Each plastic bottle in the House Keeping storage had the pre-printed manufacturer's warning; "Keep out of Reach." No staff were visible in the supply room or in the immediate area. At 9:10 a.m., Housekeeper 2 was observed to enter and exit the Housekeeping Storage Closet, the door did close but did not lock. During an interview on 1/11/24 at 9:15 a.m., Housekeeper 2 indicated that the door did not lock, it did have a keypad but did not lock and had not been locking since she began employment in October, she also indicated that the broken lock had been reported to the Director of Nursing and Executive Director. On 1/12/24 at 8:40 a.m., the Director of Nursing provided a list of self-mobile cognitively impaired residents residing in the facility. A review of the document indicated there were 10 of 38 residents		All residents were found to have the potential to be affected by this practice. The coded lock was changed out and the door now shuts and locks. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The housekeeper and all staff with access to closet has been in-serviced to report any issues with the lock to the new maintenance director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Maintenance Director and/or Executive Director will be responsible for monitoring the housekeeping door 5 days per week for 1 month, 3 times a week for two months, then 1 day weekly for 3 months.	

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	residing in the facility who were self-mobile and cognitively impaired. On 1/12/24 at 8:40 a.m., the Director of Nursing provided a policy titled Dietary Program Policies and Procedures, Policy 303- Non-Food-Storage dated 7/1/13, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...2. Chemical and toxic products must be stored in a separate closet, closed cabinet or outside of the kitchen area." The policy lacked documentation indicating chemicals and toxic products are to be in a secured area.			
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items.			
	Based on observation, interview, and record review, the facility failed to ensure the dumpster container's lid and sliding side door were kept closed when not in use and failed to ensure the ground surrounding the dumpster area was free of debris for 2 of 2 observations. Findings include: 1. During the initial facility tour with the Cook 3 on 1/11/24 from 9:45 a.m. to 9:50 a.m., the dumpster area was observed. The dumpster area was located to the right of the facility's front door. The dumpster had two separate top lids and two sliding side panel doors. The dumpster container was approximately 1/2 full	R 0155	**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** The facility will ensure that it has an effective garbage and waste disposal program. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No residents were found to be affected by this practice. **What measures will be put in place or what systemic**	01/31/2024

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	of filled trash bags. The lid and sliding side panel door, on the right side of the dumpster, were observed to not be closed. The lid was bent in half and resting inside the dumpster container with trash bags leaning near and on top of the lid. The area surrounding the dumpster had multiple eating utensils, paper, cups, plastic materials and other debris observed on the ground. During an interview at that time, Cook 3 indicated the dumpster lid had been broken for "awhile." The dumpster container was to be kept closed when not in use and the area was to be kept free of rubbish. No staff were visible in the area at that time. 2. A follow up tour of the dumpster area with the Administrator on 1/11/24 from 12:50 p.m. to 12:55 p.m., was conducted. The dumpster container was approximately 1/2 full of filled trash bags. The top lid, on the right side of the dumpster, was observed to not be closed. The lid was bent in half and resting inside the dumpster container with trash bags leaning near and on top of the lid. The area surrounding the dumpster had multiple eating utensils, paper, cups, plastic materials and other debris observed on the ground. During an interview at that time, the Administrator indicated she was unaware of the broken dumpster lid. The area was to be kept free of rubbish and the dumpster container was to be kept closed when not in use. No staff were visible in the area at that time. On 1/12/24 at 8:40 a.m., the Administrator provided copy of the Dietary Program Policies and Procedures - Disposal of Garbage Rubbish policy,		**changes the facility will make to ensure that the deficient practice does not recur.** We have replaced the old dumpster with a new dumpster on 1/19/2024 and the debris has been cleaned up. All staff were re-educated on the requirements to close the door promptly after each use. And the new maintenance director was trained on maintaining a clean area by the Facilities Maintenance Director **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Food Service Director and/or Executive Director will be responsible for monitoring the dumpster area 5 days per week, 3 times a day for two months, then 4 days per week, 2 times a day for two months, then 3 days a week, 1 time a day for two months. The Executive Director (ED) and/or Food Service Director (FSD) will monitor for compliance. Any deficiencies discovered will be discussed at daily morning meetings, with instructions to inform all staff promptly of the non-compliance. All new associates will be educated upon hire in the requirements of proper garbage disposal.	

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	dated 7/1/13, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...outside dumpsters provided by garbage pickup services will be kept closed and the surrounding are will be free of litter..." On 1/12/24 at 4:00 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			
	Based on observation, interview, and record review, the facility failed to ensure food items were stored in a sanitary manner for 1 of 2 kitchen observations. Food did not have a tightly fitted covering, foods were unlabeled, and products were not discarded after their "use-by date". Findings include: During the initial facility kitchen tour with Cook 3, on 1/11/24 from 9:30 a.m. to 9:40 a.m., the following was observed: - The reach in refrigerator unit, located near the food preparation table, was observed. Inside the refrigerator unit 5 prepared salad plates, 1 fruit	R 0273	**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** All kitchen staff have been in-serviced on how to properly store and label food in a sanitary manner, as well as to discard food that is past it's use by date. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents were found to be	01/31/2024

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	plate, and multiple plates of desserts were observed. The food plates had a loosely fitted covering over the items and they lacked a label to indicate when they were placed into the refrigerator. - The refrigerator unit, located near the steam table, was observed. Inside the refrigerator unit were 2 one-gallon jugs of Country Fresh 2% milk. The milk jugs were ½ full of milk. The manufacturer's pre-printed "use by date - 1/10/24" was observed near the top of the milk jugs. During an interview at that time, Cook 3 indicated she was unsure when the food plates were prepared or placed into the refrigerator unit. The plates should have had a tightly fitted cover with a date for when the items were placed into the refrigerator. The outdated milk jugs should have been discarded as they were beyond "the use by date." On 1/12/24 at 8:40 a.m., the Administrator provided a copy of the Dietary Program - Storage of Food in Refrigeration policy, dated 7/1/13, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...food being returned to storage after cooking or preparation must be covered ...all containers must be labeled...date food item was placed in storage..." On 1/12/24 at 3:30 p.m., a review of the retail Food Establishment Sanitation Requirements Title 10 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready to eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on		potentially affected by this practice. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Education of staff on how to properly store food and label them correctly. Ensure they are cleaning out any outdated food daily. All new staff will be educated during their training. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Food Service Director and/or Executive Director will be responsible for monitoring the food storage for proper covering and labeling and the expiration dates 5 days per week, for two months, then 3 days per week, for two months, then 1 day a week, for two months.	

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	the premises...discarded..."			