

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155352	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2014
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NAME OF PROVIDER OR SUPPLIER  ELKHART REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00143947.</p> <p>Complaint #IN00143947 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: March 4, 5, 6, 7, 10, &amp; 11, 2014</p> <p>Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830</p> <p>Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Sharon Ewing, RN Shelly Miller-Vice, RN (3/4 and 3/11, 2014) Pam Williams, RN (3/11, 2014)</p> <p>Census Bed Type: SNF/NF: 49 Total: 49</p> <p>Census Payor Type: Medicare: 4 Medicaid: 39 Other: 6 Total: 49</p>	F000000	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F000160 SS=B	<p>Complaint Sample:</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality Review completed on March 17, 2014, by Brenda Meredith, R.N.</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on interview and record review, the facility failed to return funds within 30 days of death on 2 of 3 residents sampled. (Resident #15 and Resident #72)</p> <p>Finding includes:</p> <p>On 3-10-2014 at 11:43 A.M., a record review for Resident #15 indicated that Resident #15 expired on 11-1-2013. Resident funds for Resident #15 were returned on 12-12-2013.</p>	F000160	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F 160 483.10(c)(6) Conveyance of personal funds upon death. The facility will make every effort upon the death of a resident with a personal fund	04/10/2014			

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	<p>On 3-10-2014 at 11:43 A.M., a record review for Resident #72 indicated that Resident #72 expired on 10-26-2013. Resident funds for Resident #72 were returned on 12-12-2013.</p> <p>On 3-10-2014 at 1:18 P.M., an interview with the BOM (Business Office Manager) indicated that "...it (return of the money) just didn't get done in the 30 days...."</p> <p>On 3-10-2014 at 1:30 P.M., a review of the "Resident Trust Policy Manua,l" received from the BOM on 3-10-2014 at 1:18 P.M., indicated "...The resident trust savings account must be closed when a resident leaves the center or expires....This must be done within 30 days of the discharge date...."</p> <p>3.1-6(h)</p>		<p>deposited with the facility to return funds within 30 days of death with a final accounting of those funds attached. Business office manager was re-educated on conveyance of personal property funds upon death. The facility will develop and utilized a form outlining the steps in closing a resident fund account after a resident's death. This form will be initiated upon death of a resident with a personal fund account. The Business office Manager then has 30 days in which to close the personal fund account. The form will be reviewed by the Administrator on day 30. Monthly QPI meetings will review all resident death with personal funds. Any negative findings will be immediately addressed by the facility Administrator or designee. All residents have the potential to be effected by this deficient practice. Completion date April 10, 2014.</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	This plan of correction constitutes	04/10/2014			

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	<p>review, the facility failed to ensure an unusual occurrence was reported to the appropriate state agency for 1 of 1 unusual occurrence reviewed. (Resident # 12)</p> <p>Finding includes:</p> <p>On 3/5/14 at 1:40 P.M., an interview with Resident # 63. He indicated he was eating his dinner about a week ago when a woman came in to the dining room and removed a resident (Resident #12) who wanted to finish her meal. Resident #63 indicated "... All I know is that the resident (Resident #12) wanted to finish her meal before she took a bath. A woman came and said 'you are going now' and took her out of the dining room [main dining room] I think she was one of the administrators here..." Resident # 63 indicated he did not report the incident to the facility.</p> <p>On 3/5/14 between 2:15 P.M. and 2:45 P.M., the Director of Nurses (DON) was notified of the allegation of abuse Resident #63 indicated while being interviewed. The Director of Nurses indicated that she was aware of the incident Resident #63 had reported. She further indicated that on that day, 2/27/14,</p>		<p>this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction.</p> <p>F-225 483.13(c)(1)(ii)-(iii), (c)(2)-4 Investigate/report allegations/Individuals.</p> <p>The facility had developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>All residents have the potential to be affected by this deficient practice. Residents residing in facility will have their allegations investigated and reported to ISDH, Ombudsman, Adult protective services, and possibly Elkhart Police.</p> <p>All facility staff has been re-educated on the Abuse policy and types of abuse by the facility Staff development coordinator or designee. Each employee will continue to review the facility Abuse policy and procedure at the time of their New Employee orientation and at least annually thereafter. Each employee will receive a sticker listing the types Of Abuse to be worn on the back of their name badge for quick reference as a required part of</p>				

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	<p>Resident #12 had been incontinent and an odor was present in the main dining room. They (facility staff) had received multiple complaints from resident's regarding the odor. The Director of Nurses indicated she asked Resident #12 if she could take her out of the dining room to clean her up but Resident #12 refused. Resident #12 then asked her tablemate Resident #63 if she had an odor to which Resident #63 replied, " No." Director of Nurses then notified the Administrator of the incident.</p> <p>On 3/5/14 at 3:00 P.M., an interview with Administrator indicated the incident occurred on 2/27/14. The Director of Nurses had notified me of the complaints the residents had made regarding the odor in the dining room. I tried to get the resident (Resident #12) to go be "freshened" ( periwash and brief change) but she wanted to stay and eat her meal. I told her she had to go be freshened and then she could return because there were multiple complaints regarding an odor and it was upsetting the other residents. I took the resident out of the dining room and to her room where she was cared for by a CNA (Certified Nursing Assistant). The next</p>		<p>their uniform. Administrator and/or designee will continue to follow up on all allegation of abuse immediately. An accident and incident form will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All accident /incident forms are reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. All concern forms will continue to be reviewed daily. All findings will be reviewed at monthly QPI meeting. Any identified non-compliance will be addressed through one to one re-education up to and including termination. The facility Abuse Policy and procedure and types of abuse will be reviewed at the monthly all staff meetings for a period on 90 days and quarterly thereafter by the staff development coordinator or designee. The facility Administrator/DON or designee will monitor for compliance as part of their daily facility rounding activities. Any staff found in violation will be required to immediately acquire a sticker for the facility DON/designee. All re-education results will be reviewed at the facility monthly QPI meetings for the next three months and quarterly thereafter. Any negative findings will be immediately addressed by the facility administrator.</p>		

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	<p>morning I was notified that Resident #12 had called the police alleging she had been abused. An officer with the local Police Department came to the facility and concluded that Resident #12 had not been abused. I did not report it to the Indiana State Department of Health because the police were called but at that point we (facility) had not been notified of an allegation of abuse. We did initiate a soft file ( an timeline of the incident with witness statements and notifications) on the incident.</p> <p>On 3/5/14 at 3:30 P.M., a review of the current procedure, provided by the Administrator, with a revised date of April 2013 and titled, " Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" was conducted. The procedure indicated "... Reporting 2. Report the incident immediately to the Administrator and DON/Designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies. a. "</p>				

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F000226 SS=D	<p>Immediately" means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...."</p> <p>On 3/11/14 at 3:33 P.M., an interview with Administrator indicated that there was "No Excuse " for her not reporting the unusual occurrence of alleged abuse.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policy and procedure by not ensuring an unusual occurrence was reported to the appropriate state agency for 1 of 1 unusual occurrence reviewed. (Resident # 12)</p>	F000226	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection	04/10/2014	

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	<p>Finding includes:</p> <p>On 3/5/14 at 1:40 P.M., an interview with Resident # 63. He indicated he was eating his dinner about a week ago when a woman came in to the dining room and removed a resident (Resident #12) who wanted to finish her meal. Resident #63 indicated "... All I know is that the resident (Resident #12) wanted to finish her meal before she took a bath. A woman came and said 'you are going now' and took her out of the dining room [main dining room] I think she was one of the administrators here..." Resident # 63 indicated he did not report the incident to the facility.</p> <p>On 3/5/14 between 2:15 P.M. and 2:45 P.M., the Director of Nurses (DON) was notified of the allegation of abuse Resident #63 indicated while being interviewed. The Director of Nurses indicated that she was aware of the incident Resident #63 had reported. She further indicated that on that day, 2/27/14, Resident #12 had been incontinent and an odor was present in the main dining room. They (facility staff) had received multiple complaints from resident's regarding the odor. The</p>		<p>report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-226 483.13 (3) Development /implement abuse /neglect policies. The facility had developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. All residents have the potential to be affected by this deficient practice. Residents residing in facility will have their allegations investigated and reported to ISDH, Ombudsman, Adult protective services, and possibly Elkhart Police. All facility staff has been re-educated on the Abuse policy and types of abuse by the facility Staff development coordinator or designee. Each employee will continue to review the facility Abuse policy and procedure at the time of their New Employee orientation and at least annually thereafter. Each employee will receive a sticker listing the types Of Abuse to be worn on the back of their name badge for quick reference as a required part of their uniform. All accident /incident forms are reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. All concern forms will continue to be reviewed daily. The facility Abuse Policy and procedure and types of abuse will be reviewed at the monthly all staff meetings for</p>				

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	<p>that Resident #12 had not been abused. I did not report it to the Indiana State Department of Health because the police were called but at that point we (facility) had not been notified of an allegation of abuse. We did initiate a soft file (an timeline of the incident with witness statements and notifications) on the incident.</p> <p>On 3/5/14 at 3:30 P.M., a review of the current procedure, provided by the Administrator, with a revised date of April 2013 and titled, " Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" was conducted. The procedure indicated "... Reporting 2. Report the incident immediately to the Administrator and DON/Designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies. a. " Immediately" means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...."</p>						

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F000241 SS=D	<p>On 3/11/14 at 3:33 P.M., an interview with Administrator indicated that there was "No Excuse " for her not reporting the unusual occurrence of alleged abuse.</p> <p>3.1-28(c)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to</p>	F000241	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies	04/10/2014			

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	<p>promote dignity for 1 of 1 residents with a urinary catheter bag. (Resident #10)</p> <p>Finding includes:</p> <p>On 3-5-2014 at 10:15 A.M., an interview with DON (Director of Nursing) indicated Resident #10 had a suprapubic catheter (an incision through the umbilicus into the bladder that allows urine to flow out through tubing into a bag).</p> <p>On 3-5-2014 at 10:45 A.M., a record review of Discharge Summary from local acute care facility, dated 10-23-2013, for Resident #10, indicated diagnoses were, but not limited to, "...suprapubic catheter, Alzheimer disease, Parkinson disease, Leukopenia...."</p> <p>On 3-6-2014 at 8:53 A.M., an interview with spouse of Resident #10 indicated "...his urine bag is covered when they get him up to his wheelchair...." Spouse of Resident #10 pointed to a black bag (dignity bag) attached to the under side of the residents wheelchair. Spouse of Resident #10 indicated "...they don't cover it when he is in bed or in his recliner...I wish they would...." Spouse of Resident #10 pointed to</p>		<p>cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-241 483.15(a) Dignity and respect of individuality. The facility will listen treat all resident with dignity and respect. The facility did not provide Resident # 10 with a dignity bag for a supra pubic catheter bag. All nursing staff will be re-educated on the usage of dignity bags in the facility and facility policy for urine collection bags. Resident # 10 care plans were reviewed and updated as needed to reflect current status. All resident with urine collection bags could be affected. The use of the dignity bag will be added to the Treatment administration Record. Nursing will document use of dignity bag with all residents with a urine collection bag. The DON/designee will audit this daily for 30 days then three times a week for 30 days and then once a week for 30 days and then monthly thereafter. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly thereafter. Any negative findings will be immediately addressed by facility administrator or designee.</p>				

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	<p>the catheter bag hanging under the residents recliner with yellow fluid observed in bag.</p> <p>On 3-7-2014 at 8:50 A.M., an observation, from the hallway, indicated the resident was in his room, in his recliner, in a reclined position, with the urinary catheter bag hanging under the recliner. A yellow fluid was observed in the bag.</p> <p>On 3-10-2014 at 3:15 P.M., an interview with DON indicated "...urinary catheter bags should be kept covered in a dignity bag...."</p> <p>On 3-10-2014 at 3:15 P.M., a review of manual titled Basic Patient and Resident Care, Unit 3, Chapter 21, Figure 21-11, received from the DON on 3-7-2014 at 11 A.M., indicated placing the catheter bag inside a dignity bag. Interview with the DON at that time indicated "...this is what we use for training of our nurses and CNAs [Certified Nursing Assistants]...."</p> <p>3.1-3(t)</p>		Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.		

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F000256 SS=D	<p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS</p> <p>The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide adequate lighting in 2 shared bathrooms. This deficiency had the potential to affect 3 residents. (Resident #48, #36, #29)</p> <p>Findings include:</p> <p>On 3-5-14 at 10:35 A.M., the bathroom shared by Resident's #36 and #29 was observed to have dim lighting. Interview with Resident #29 indicated it had been that way for a while, "...I think a light is burned out...."</p> <p>On 3-6-14 at 9:30 A.M., the bathroom used by Resident #48 was observed to have dim lighting. Interview with Resident #48 at this time indicated "...yeah...it's kinda dark in there...."</p> <p>On 3-11-14 from 10:40 A.M. to 12:00 P.M., an environmental tour was conducted of the facility with the Maintenance Supervisor, the Housekeeping Supervisor, and the Administrator, during which the following was observed:</p>	F000256	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F256 483.15(h)(5) adequate and comfortable lighting levels. Based on observation and interview, the facility failed to provide adequate lighting in 2 shared bathrooms. The deficiency had the potential to affect 3 residents. Bathroom # 6 and 17 light bulbs were changed out from 13 watt to 23 watt for resident usage. All facility staff re-educated on how to correctly fill out a maintenance form. Maintenance will audit 20 rooms weekly for dim or burned out bulbs. Housekeeping staff will monitor and report lights issues daily for each room. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly thereafter. Any negative findings will be immediately addressed by facility administrator, or designee.</p>	04/10/2014			

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	<p>At 10:45 A.M., the bathroom shared by Resident's #36 and #29 was observed to have dim lighting. One light bulb in the over sink light was observed to be burned out. Interview with the Maintenance Supervisor at this time indicated it was dim, "...I periodically check the bathroom lights to see if they need to be changed...." but hadn't gotten to this one.</p> <p>At 11:16 A.M., the bathroom used by Resident #48 was observed to have dim lighting. Interview with the Administrator at this time indicated it appeared the opaque light cover "...seems to be covering up too much of the light...." making it appear dim.</p> <p>3.1-19(dd)</p>		Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.		

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy for catheter maintenance for 1 of 1 residents with a urinary catheter bag. (Resident #10)</p> <p>Findings include:</p> <p>On 3-5-2014 at 10:15 A.M., an interview with DON (Director of Nursing) indicted Resident #10 had a suprapubic catheter (an incision through the umbilicus into the bladder that allows urine to flow out through tubing into a bag).</p> <p>On 3-5-2014 at 10:45 A.M., a record review of Discharge Summary from a local acute care facility, dated 10-23-2013, for Resident #10, indicated diagnoses were, but not limited to, "...suprapubic catheter,</p>	F000315	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-315 483.25(d) No catheter, prevent UTI, restore bladder. The facility did not follow their policy for catheter management for 1 of 1 resident. Resident #10 urine collection bag was changed by licensed nurses and certified nursing assistants. The facility policy along with DON/clinical educator state that licensed nurses are the personnel trained to change urine collection bags per facility policy. All nursing staff will be re-educated on the facility policy on changing urine collection bags Resident #</p>	04/10/2014	

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	<p>Alzheimer disease, Parkinson disease, Leukopenia...."</p> <p>On 3-10-2014 at 2 P.M., an observation of Resident #10 in his room, in his recliner, indicated the absence of a Foley urine collection bag.</p> <p>On 3-10-2014 at 2:05 P.M., an interview with DON, in Resident #10's room, indicated Resident #10 "...has his leg bag on at this time...." Observation of leg bag on side of right leg indicated the leg bag had yellow liquid in the bag.</p> <p>On 3-10-2014 at 3:31 P.M., an interview with Clinical Educator (RN #9) indicated "...nurses place the leg bag on in the morning for dignity issues and replace the Foley bag at night because it holds more...the nurses and CNA's [Certified Nursing Assistants] are told in orientation that the practice here is to have only the nurses change out the bags...."</p> <p>On 3-10-2014 at 3:37 P.M., an interview with DON indicated "...nurses are the only ones who should be changing the Foley to the leg bag and back...."</p> <p>On 3-11-2014 at 7:40 A.M., an</p>		<p>10 care plans were reviewed and updated as needed to reflect current status. All resident with urine collection bags could be affected. The changing of the urine collection bags will be added to the Treatment administration Record. Nursing will document changing the urine collection bag with all residents with a urine collection bag. The DON/designee will audit this daily for 30 days, then three times a week for 30 days, and once a week for 30 days and then monthly. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly thereafter. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p>				

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	<p>observation of Resident #10, in the assisted dining room, indicated a leg bag for urine collection from suprapubic catheter was in place on right leg.</p> <p>On 3-11-2014 at 7:45 A.M., an interview with Employee #2 RN (Registered Nurse) caring for Resident #10 indicated "...he [Resident #10] has a leg bag on right now...nurses switch out the Foley bag for the leg bag sometimes but sometimes the CNA's take the initiative and change it out...."</p> <p>On 3-11-2014 at 7:51 A.M., an interview with Employee #1, the CNA caring for resident #10, indicated "...I put his leg bag on, I usually do it [change the Foley bag to the leg bag] when I get him up...."</p> <p>On 3-11-2014 at 9:28 A.M., a review of the CNA assignment sheet, dated 3-7-2014, received on 3-11-2014 at 9:28 A.M. from the DON, indicated Resident #10 "...Suprapubic cath [catheter], drain straight down leg bag, nurse to switch bags...."</p> <p>3.1-41(a)(1)</p>			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation and interview, the facility failed to store only oxygen and oxygen supplies in the oxygen storage room. This affected 1 of 1 oxygen storage room.</p> <p>Finding includes:</p> <p>On 3-11-14 from 10:40 A.M. to 12:00 P.M., an environmental tour was conducted of the facility with the Maintenance Supervisor, the Housekeeping Supervisor, the Director of Nursing (DON), and the Administrator, during which the following was observed:</p> <p>At 11:30 A.M., the oxygen storage room was observed with a tube feeding pump on an IV pole in the back left corner of the room, a black wheelchair pad on the shelving unit to the left the door, and a "Heeleze"</p>	F000328	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-328 483.25(k) Treatment/care for special needs. The facility must ensure the resident receive proper treatment and care for the following services Respiratory care. The facility failed to store only oxygen and oxygen supplies in the oxygen storage room. This affected 1 of 1 oxygen storage areas. Nursing staff will be re-educated on policy for oxygen room storage. Each shift the designated nurse will evaluate the Oxygen room for items not oxygen in nature and supervise</p>	04/10/2014	

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F000371 SS=F	<p>foam pad used for supporting residents feet while in bed.</p> <p>During an interview at this time, the DON indicated "...those should not be in here...those aren't usually kept in here..." An interview with the Administrator at this time indicated this room was to be used for oxygen storage only.</p> <p>3.1-47(a)(6)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to clean and maintain 2 of 2 ice machines in the building. (Kitchen and Main Dining Room Ice Machines) This had the potential to effect all residents using ice.</p> <p>Finding includes:</p> <p>On 3-4-14 at 2:00 P.M., the ice machine in the kitchen was</p>	F000371	<p>the removal of items. DON/designee will complete audit for Oxygen room three times a week for 30 days, then twice a week for 30 days and then monthly. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p> <p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-371 483.35(i) Food procure, store/prepare/serve-Sanitary</p>	04/10/2014	

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	<p>observed with cloudy water standing under the machine and a foul smell coming from that area. Interview with the CDM (Certified Dietary Manager) at this time indicated the machine is not used on a regular basis, it does not drain properly, and there is frequently a foul odor coming from it.</p> <p>On 3-10-14 at 11:45 A.M., the ice machine in the kitchen was observed with the CDM to have cloudy water standing under the machine and a foul smell coming from that area.</p> <p>On 3-11-14 from 10:40 A.M. to 12:00 P.M., an environmental tour was conducted of the facility with the Maintenance Supervisor, the Housekeeping Supervisor, the Director of Nursing, and the Administrator, during which the following was observed:</p> <p>At 11:20 A.M., the ice machine in the Main Dining Room was observed with a white film on the front panel of the machine under the dispenser. Interview with the Housekeeping Supervisor at this time indicated her staff cleans the outside of the machine on a regular basis, usually "...after every meal...."</p>		<p>The facility must store prepare and distribute and serve food under sanitary conditions. Facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities. Potential to impact all resident in facility regarding ice machine conditions. The ice machine in the kitchen was removed from service. The remaining ice machine in the main dining room will be cleaned per policy. Dietary and housekeeping staff will be re-educated on cleaning of ice machine. Audit will be completed by dietary services and housekeeping services. Housekeeping services will clean outside of machine at least daily and evaluate after each meal the need to clean outside of machine. Dietary services will check inside of ice machine daily to ensure ice making capacity is sanitary. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and quarterly thereafter. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p>				

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	<p>At 12:00 P.M., observation of the ice machine in the Kitchen with the CDM, the Administrator, and the Maintenance Supervisor indicated a foul smell coming from the area. Interview with the Maintenance Supervisor at this time indicated "...yeah...that does smell...."</p> <p>On 3-11-14 at 4:25 P.M., review of the Ice Machine policy, last updated on January 2007, received from the DON, indicated "...the ice machine will be cleaned once per month or more often as needed...3. Wash interior and exterior thoroughly using a clean cloth soaked in warm detergent solution...."</p> <p>3.1-21(h)(i)(2)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>1. Based on observation, interview and record review, the facility failed</p>	F000441	This plan of correction constitutes this facilities written allegation of	04/10/2014	

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	<p>to ensure blood glucometer machines used for checking a residents blood sugar were cleaned appropriately between uses. This deficiency had the potential to affect 2 of 14 residents who receive blood sugar checks. (Resident #5 and Resident #38)</p> <p>2. Based on observation, interview and record review, the facility failed to maintain proper infection control for 1 of 1 residents with Foley catheters. (Resident #10)</p> <p>Findings include:</p> <p>1. On 3-11-14 at 7:10 A.M., RN #10 was observed to check Resident #5's blood sugar. After checking the blood sugar, RN #10 returned to her med cart, donned gloves, and proceeded to clean the hand-held glucometer device for 3 minutes with an Alcohol Prep Swab "...saturated with 70% Isopropyl Alcohol...."</p> <p>On 3-11-14 at 7:40 A.M., RN #10 was observed to check Resident #38's blood sugar. After checking the blood sugar, RN #1 returned to her med cart, donned gloves, and proceeded to clean the hand-held glucometer device for 3 minutes with an Alcohol Prep Swab "...saturated</p>		<p>compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-441 483.65 Infection controls prevent spread, linens. The facility must establish and maintain an infection control program designed to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Facility must ensure blood glucometer machines used for checking resident blood sugars are cleaned appropriately between residents. This had the potential to affect 2 of 14 residents who receive blood sugar checks. All licensed nursing staff will be re-educated on proper policy for glucometer reading. DON/designee will audit one nurse five days a week for compliance with policy for 30 days (various shifts, then 1 nurse on various shift 3 times a week for 30 days, then 1 nurse on various shift weekly for 30 days, and then 1 nurse monthly. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and quarterly thereafter. Any negative findings</p>		

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	<p>with 70% Isopropyl Alcohol...." An interview with RN #10 at this time indicated she was cleaning the machine "...with alcohol...the night shift has those special wipes that you have to use gloves with...they clean them good every night...I always use this...."</p> <p>On 3-11-14 at 9:30 A.M., an interview with the DON (Director of Nursing) indicated it is her expectation for staff to "...Use the Super Sani-Cloth disposable wipes...and let it dry for 2 minutes...."</p> <p>On 3-11-14 at 9:50 A.M., an interview with the DON indicated the hand-held glucometers are new to the facility and they have not had time to draft their own policy related to cleaning so for now they use the manufacturer guidelines.</p> <p>On 3-11-14 at 10:00 A.M., a review of the "Cleaning and Disinfecting" manufacturer guidelines received from the DON at 9:30 A.M., indicated "...Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicidal wipe...."</p>		<p>will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees. Facility staff to follow policy when caring for urine collection bags. All nursing staff will be re-educated on the facility policy on changing urine collection bags Resident # 10 care plans were reviewed and updated as needed to reflect current status. All resident with urine collection bags could be affected. The changing and care of the urine collection bags will be added to the Treatment administration Record. Nursing will document changing and care of the urine collection bag with all residents with a urine collection bag. The DON/designee will audit this daily for 30 days, then three times a week for 30 days, then once a week for 30 days and then monthly thereafter. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees</p>		

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	<p>2. On 3-5-2014 at 10:15 A.M., an interview with DON (Director of Nursing) indicated Resident #10 had a suprapubic catheter (an incision through the umbilicus into the bladder that allows urine to flow out through tubing into a bag).</p> <p>On 3-5-2014 at 10:45 A.M., a record review for Resident #10 of Discharge Summary from a local acute care facility, dated 10-23-2013, indicated diagnoses were, but not limited to, "...suprapubic catheter, Alzheimer disease, Parkinson disease, Leukopenia...."</p> <p>On 3-11-2014 at 7:45 A.M., an interview with Employee #2 indicated "...after the Foley bag is changed out for the leg bag, we keep it in the residents bathroom...I didn't change it this morning...." Observation of the Foley bag in a plastic bag in Resident #10's bathroom with Employee #2 indicated the tip of the tubing was not capped and the tip of the tubing was touching the inside of the plastic bag. The plastic bag was tied to a hand rail in the bathroom. Yellow fluid was observed in the bottom of the plastic bag. Employee #2 indicated "...I will just replace the</p>	F000441	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-441 483.65 Infection controls prevent spread, linens. The facility must establish and maintain an infection control program designed to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Facility must ensure blood glucometer machines used for checking resident blood sugars are cleaned appropriately between residents. This had the potential to affect 2 of 14 residents who receive blood sugar checks. All licensed nursing staff will be re-educated on proper policy for glucometer reading. DON/designee will audit one nurse five days a week for compliance with policy for 30 days (various shifts, then 1 nurse on various shift 3 times a week for 30 days, then 1 nurse on various shift weekly for 30 days, and then 1 nurse monthly. All audit results will be reviewed at the facility monthly QPI meetings	04/10/2014			

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	<p>cap...I should probably just replace the whole thing...Do you think it's contaminated...."</p> <p>On 3-11-2014 at 8:30 A.M., a review of manual titled Basic Patient and Resident Care, Unit 3, Chapter 21, received from the DON on 3-7-2014 at 11 A.M., indicated "...If you must disconnect the tubing from the bag, be sure to prevent the end of the tubing from touching anything...because the inside of the catheter and tubing are sterile...."</p> <p>3.1-18(a)</p>		<p>for the next 90 days and quarterly thereafter. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees. Facility staff to follow policy when caring for urine collection bags. All nursing staff will be re-educated on the facility policy on changing urine collection bags Resident # 10 care plans were reviewed and updated as needed to reflect current status. All resident with urine collection bags could be affected. The changing and care of the urine collection bags will be added to the Treatment administration Record. Nursing will document changing and care of the urine collection bag with all residents with a urine collection bag. The DON/designee will audit this daily for 30 days, then three times a week for 30 days, then once a week for 30 days and then monthly thereafter. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees</p>		

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F000465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>1. Based on observation, interview and record review, the facility failed to provide a safe and clean resident environment in regard to resident shower rooms and privacy curtains. This deficiency affected 2 of 2 halls observed (North and South Halls)</p> <p>Finding includes:</p> <p>On 3-11-14 from 10:40 A.M. to 12:00 P.M., an environmental tour was conducted of the facility with the Maintenance Supervisor, the Housekeeping Supervisor, the Director of Nursing, and the Administrator, during which the following was observed:</p> <p>At 10:50 A.M., the shared shower room between Room 6 and Room 8 was observed with a blue air mattress standing up against the door for Room 8. 2 bottles of "Cucumber Melon Shampoo/Body Wash" and 1 bottle of Suave conditioner was observed to be unlabeled as for which resident they belonged to and sitting on a metal grab bar in the shower. Interview</p>	F000465	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Elkhart Rehabilitation Center requests consideration for a desk review of the plan of correction. F-465 483.70(h) Safe/functional/sanitary/comfortable environment. Facility staff will provide a safe and clean resident environment in regard to resident shower rooms and privacy curtains. This has the potential to affect 2 of 2 halls. The findings reflected issues with the north hall only as rooms 6/8 and 10/12 and room 15. In shower room of room 6/8 a blue bed mattress was found. Resident shampoo and conditioner were unmarked in the same shower room. In room 10/12 shower room it was noted 2 bottles of Selenium sulfide lotion and multiple unmarked resident shampoos. One washcloth was noted to have a brown substance on it. Room 15 was found with a dirty privacy curtain. All staff will be re-educated on the Safety</p>	04/10/2014			

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	<p>with the DON (Director of Nursing) at this time indicated the air mattress should not be stored in there and the bottles of shampoo and conditioner "...should be labeled and put away...."</p> <p>At 11:00 A.M., the shared shower room between Room 10 and Room 12 was observed with a resident shower chair and a shower stool being stored. 2 bottles of "Selenium Sulfide Lotion" were observed face down and open on the floor. 1 bottle of "Anti-Dandruff Shampoo", 1 bottle of Suave shampoo, 3 bottles of "Cucumber Melon Shampoo/Body Wash", were observed on the metal grab bar in the shower. 1 washcloth was observed with brown substance on it on the shower stool. 1 small bottle of shave cream and 1 washcloth were observed sitting on top of the sharps container attached to one wall of the shower room. All bottles were unlabeled as for which resident they belonged to. Interview with the Administrator at this time indicated "...this is not how this room should be kept...."</p> <p>At 11:10 A.M. in Room 18, the privacy curtain between Bed A and Bed B was observed with a large dark stain on it. Interview with the</p>		<p>policy, personal items, and cleaning methods. Shower rooms will be audited for cleanliness each shift by licensed nursing staff. DON/designee will spot audit three rooms/shower rooms daily for 30 days, then three rooms/shower rooms three times a week for 30 days, then three rooms/shower rooms audited once a week for 30 days and then monthly. All audit results will be reviewed at the facility monthly QPI meetings for the next 90 days and then quarterly thereafter. Any negative findings will be immediately addressed by facility administrator, or designee. Resident residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees.</p>				

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	<p>Housekeeping Supervisor at this time indicated "...that should have been taken down...the curtains are supposed to be cleaned with every 'deep clean' of the room...once a month...but spot checked in between and cleaned if dirty...."</p> <p>On 3-11-14 at 4:25 P.M., review of the "Safety Rules and Regulations" policy, last updated January 2011, and received at this time from the DON, indicated "...Environmental:...pick up paper and other items noted on the floor...."</p> <p>Review of the "Personal Items - Care Of" policy, last updated April 2013, received from the DON, indicated "...1. Attempt to identify each personally owned item by placing the resident's name on the item...3. Store personal hygiene items utilizing infection prevention practice...."</p> <p>Review of the "Cleaning Methods (Housekeeping)" policy, last updated July 2012, received from the DON, indicated "...8. Change and clean curtains on a routine schedule and when visibly soiled...."</p> <p>3.1-19(f)</p>						

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