STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 00 B. WING	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 26, 27, 28, 29 and 30, 2024 Facility number: 000243 Provider number: 155352 AIM number: 100289830 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicaid: 32 Other: 19 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 9/9/2024.	F 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before 9/22/24. Elkhart Meadows requests additional evidentiary information be considered to delete or reduce in scope F 812, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing Based on record review and interview, the facility failed to complete an Annual Minimun Data Set (MDS) assessment for 1 of 15 residents who were reviewed. (Resident 107)	F 0636	**F 636** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/22/2024

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

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	Finding includes: A record review was completed on 8/28/2024 at 9:52 A.M. for Resident 107. Diagnoses included but were not limited to: vascular dementia and obsessive compulsive disorder. An Annual (MDS) assessment, dated 6/4/2024, indicated Section C was not completed. During an interview on 8/28/2024 at 10:27 A.M., the Memory Care Support Specialist indicated Section C was not completed on the Annual MDS and should have been. She indicated she usually completed Section C on day 6 or 7 and Resident 107 admitted on 8/25/2020. 3.1-31 (c)(12)		**practice;** MCSS completed section C of the annual Minimum data set assessment for resident 107. All annual minimum data set assessments will be completed in its entirety within the specified time frame. **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 that are assessed for an annual minimum data set have the potential to be affected by the deficient practice. MCSS has been educated on RAI Process and ensuring annual minimum data set is completed in its entirety within the specified time frame. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** When a resident has an annual minimum data set assessment upcoming, MDSC will send out the schedule to the applicable department heads to ensure that all required sections are completed within the specified time frame. MDSC will review the MDS to ensure it is complete within the specified time frame. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed; MCSS will complete section C of MDS QAPI tool to ensure that section C is completed on the annual Minimum data set assessment. QAPI tool will be completed weekly for 4 weeks, and monthly for 6 months If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 9/22/24	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment for 1 of 15 residents reviewed. (Resident 25) Finding includes: A record review for Resident 25 was completed on 8/28/2024 at 2:06 P.M. Her diagnoses included, but were not limited to: major depressive disorder, anxiety disorder, delete comma and dementia. An Admission MDS assessment was completed on 3/19/2024. Resident 25's record lacked the documentation to indicate a Quarterly MDS assessment was completed after 3/19/2024 and before 8/29/2024.	F 0638	**F-638** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MDSC completed the quarterly MDS assessment on resident 25. All quarterly MDS assessments will be completed in its entirety within the specified time frame. **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;**	09/22/2024

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	During an interview on 8/29/2024 at 10:45 A.M., the MDS Coordinator indicated the resident had not had an MDS assessment completed since 3/19/2024 and should have had a quarterly MDS assessment by 6/19/2024. She indicated the facility did not have a policy on completing MDS assessments but followed the Resident Assessment Instrument (RAI) as a guide to completing MDS assessments. 3.1-31 (d)(3)		All residents that are assessed for a quarterly MDS assessment have the potential to be affected by the deficient practice. MDSC has been educated on ensuring that all quarterly MDS assessments are completed in its entirety within the specified time frame. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MDSC educated on RAI process and on ensuring that all quarterly MDS assessments are completed in its entirety within the specified time frame. IDT will review quarterly assessments to ensure the assessment is completed timely **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 by what date the systemic changes for each deficiency will be completed;** MDSC will complete the RAI Process QAPI tool weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 9/22/24	

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 9 residents (Resident 2 & 49) observed during medication pass. There were 25 opportunities observed with 2 medication errors, resulting in a medication error rate of 8 percent. Findings include: 1. During an observation of insulin administration for Resident 49, on 8/27/2024 at 4:27 P.M., LPN 2 performed the following steps: First, she attached the needle to the insulin pen and set the dose meter to 10 units. Next, she entered Resident 49's room and cleansed his arm with an alcohol pad, Last she injected the medication into the resident's arm and immediately removed the needle/pen from the resident's arm. A record review was completed on 8/27/2024 at 4:40 P.M. for Resident 49. Diagnoses included, but were not limited to: type 2 diabetic mellitus with diabetic chronic kidney disease. A Physician's Order, dated 8/14/2024, indicated Resident 49 was to receive Humalog Junior KwikPen U-100, administer 10 units subcutaneous three times a day. During the interview on 8/27/2024 at 4:31 P.M., LPN 2 indicated she thought she had primed the insulin pen and the needle should have remained in the resident's arm 3-5 seconds after the medication was administered with the insulin pen During an interview on 8/28/2024 at 11:30 A.M.,	F 0759	F-759 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 2 is receiving insulin per protocol. Resident 49 is receiving meds per MD order. All nurses educated on proper insulin administration. All nurses and QMA's educated on following physician medication orders. **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 that receive insulin, or medication have the potential to be affected by the deficient practice. All nurses educated on proper insulin administration. All nurses and QMA's educated on following physician medication orders. **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 educated on proper insulin administration. All nurses and QMA's educated on following physician medication orders. IP/Designee will complete a medication administration skills	09/22/2024

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	the Director of Nursing (DON) indicated the insulin pen should have been primed, with 2 units add of insulin and the needle should have been left in the arm for 5-10 seconds after the medication was administered. During an interview on 8/29/2024 at 9:48 A.M., the Regional Nurse indicated that when the insulin pen was not primed and the needle was not left in the arm 5-10 seconds after the medication was administered, then the correct dose would not have been given. 2. During an observation of a medication pass on 8/29/2024 at 7:48 A.M., QMA 4 administered polyethylene glycol 3350 powder to Resident 2. She was observed to place the powdered medication into a small plastic cup containing approximately 4 ounces of water and mixed the medication and water together before handing the cup to Resident 2. Resident 2 consumed the liquid. A record review was completed on 8/29/2024 at 9:20 A.M., for Resident 2. Diagnoses included, but were not limited to: constipation, unspecified. A Physician's Order, dated 4/28/2022, indicated the resident was to receive polyethylene glycol 3350 powder, 17 grams with 8 ounces of water. A Care Plan, dated 5/2/2022, indicated Resident 2 was at risk for constipation due to decreased mobility with an intervention to administer medication as ordered. During an interview on 8/29/2024 at 9:04 A.M., QMA 4 confirmed the order indicated to give the polyethylene glycol powder with 8 ounces of water She turned the cup over and it was stamped		validation with each QMA, LPN & RN. Any concerns will be addressed immediately. **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 by what date the systemic changes for each deficiency will be completed;** IP/Designee will complete the Medication error QAPI tool weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 9/22/24	

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	5 ounces on the bottom. She did not think they had 8- ounce cups. On 8/29/2024 at 11:45 A.M., the DON indicated the facility did not have a policy on following physician orders. On 8/28/2024 at 12:00 P.M., the DON provided a skills competency titled, "Insulin Pen Administration", dated 6/2018, and indicated the competency was the one currently used by the facility. The skills competency indicated " ...9. pull off and remove outer pen needle protective cap and cover. 10. Prime the pen by dialing 2 units. 11. Push the end of the pen to push out the 2 units. (A small drop of insulin should be visible. If insulin does not appear, repeat). 12. Dial desired insulin dosage to be administered to resident. 17. Push injection bottom down to end of pen completely to give insulin. 18. Wait 5-10 seconds while keeping insulin pen and pen needle in place, to ensure all insulin is given. 19. Pull the insulin pen and needle out from the injection site....." 3.1-48(c)(1)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observations and interviews the facility failed to maintain clean and sanitary food preparation and storage areas, which had the potential to affect 51 of 51 residents whose food was prepared by the kitchen. Finding includes: During an observation of the dining room kitchen area with the Maintenance Supervisor on 8/30/2024 at 9:52 A.M, the microwave had food	F 0812	**Elkhart Meadows is requesting a paper review.** Elkhart Meadows requests additional evidentiary information be considered to delete or reduce in scope F 812, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the	09/22/2024

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	spilled on the turn table, and the door. The reach-in refrigerator and freezer contained undated food and liquids which belonged to staff members. In addition, there was a yellow liquid spilled in the bottom of the freezer. During an interview on 8/30/2024 at 10:00 A.M., the Maintenance Supervisor indicated housekeeping staff were responsible for cleaning the dining room microwave and refrigerator. He indicated staff should not have kept food in the dining room refrigerator or freezer. On 8/30/2024 at 11:00 A.M., the Executive Director (ED) provided a current policy, dated 7/15/2024, titled, "Cleaning Microwave Oven." The policy indicated, " ...1. Remove glass tray, if applicable, from inside the oven, wash, rinse, sanitize and allow to air dry. 2. Remove any food particles from interior of oven with a clean, wet cloth. 3. Wipe the interior of the oven with hot soapy water ...." On 8/30/2024 at 11:00 A.M., the Executive Director (ED) provided a current policy, dated 7/15/2024, titled, "Cleaning Refrigerators." The policy indicated, " ...1. Remove all food from reach-in refrigerator. Store food in another refrigerator or cooler until refrigerator is cleaned. 2. Remove shelves, drawers and other removable parts. Clean and sanitize. 3. Wash walls and base with warm detergent water. 4. Rinse and sanitize. Allow to air dry ...." 3.1-21(i)(3)		provider to its residents. **F 812 Federal Regulations:** **Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)** **§483.60(i) Food safety requirements.** **The facility must –** **§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.** **(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.** **(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.** **(iii) This provision does not preclude residents from consuming foods not procured by the facility.** **§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.** **Scope and Severity Grid** **Scope is isolated when one or a very limited number of residents are affected and/or**	

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			one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations. **Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.** **Scope is widespread when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility.**	

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			Deficient Practice Statement Based on observations and interviews the facility failed to maintain clean and sanitary food preparation and storage areas, which had the potential to affect 51 of 51 residents whose food was prepared by the kitchen. **Evidence to Refute the Finding:** 1 The microwave and refrigerator mentioned in the 2567 are located in the facility dining room, not in the kitchen. **Attachment 1** 2 The microwave has not been operable for several months. **Attachment 2** 3 The refrigerator in the dining room is not used by the kitchen staff or by the residents. Food for residents is stored in the refrigerator in supply room. **Attachment 3** 4 At the time of the survey, there was no resident food in the dining room refrigerator. **Attachment 4** **Conclusion: The microwave was inoperable at the time of the survey, and there was no resident food located in the refrigerator. The refrigerator and microwave are not used for resident use. The resident's food is kept in a different refrigerator and an alternate**	

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			microwave is used for residents. This deficiency does not have the potential to affect a large portion of residents because neither appliance is used for resident food/drinks. Based on the definition of widespread scope, this deficiency should be reduced to a D or A level. **F-812** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The main dining room Microwave and refrigerator/freezer immediately cleaned and sanitized and undated food and liquids were immediately removed. **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 that reside in the facility have the potential to be affected by the deficient practice. Housekeeping department educated on completing the cleaning of the main dining room microwave and refrigerator/freezer daily. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	

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			practice does not recur; Housekeeping department educated on completing the cleaning of the main dining room microwave and refrigerator/freezer daily. ED/designee will check the cleanliness of the refrigerator and freezer daily located in the dining room. **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 by what date the systemic changes for each deficiency will be completed;** Housekeeping supervisor/designee will complete the Cleaning of refrigerator/freezer and microwave in the Main dining room QAPI tool weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 9/22/24	