| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155352 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/30/2024 | |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| | PROVIDER OR SUPPLIEI | ł | 2600 M | ADDRESS, CITY, STATE, ZIP COD IOREHOUSE AVE IRT, IN 46517 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| F 0000 | REGUENTORT | CESC IDENTIFIED IN ORMATION | 1710 | | DATE |
| Bldg. 00 | Licensure Survey. Survey dates: Aug Facility number: 0 Provider number: 1002 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type Medicaid: 32 Other: 19 Total: 51 These deficiencies accordance with 41 | 155352 289830 :: reflect State Findings cited in | F 0000 | The facility requests that this pof correction be considered its credible allegation of complian Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions sof forth in the statement of deficiencies. The plan of correctists prepared and/or executed subsective because it is required by the provisions of federal and states. We respectfully request a destreview for compliance instead post visit review on or before 9/22/24. Elkhart Meadows requests additional evidentiary informations and the considered to delete or red in scope F 812, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information at therefore misrepresents the cannot service administered by provider to its residents. | ince. of of ot ment the et ection olely e law. k of a |
| F 0636 SS=D Bldg. 00 | 483.20(b)(1)(2)(i) Comprehensive A | (iii) Assessments & Timing | | provider to its residents. | |
| | failed to complete a | view and interview, the facility an Annual Minimun Data Set for 1 of 15 residents who were tt 107) | F 0636 | F 636 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient | |

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 10WY11 Facility ID: 000243 If continuation sheet Page 1 of 12

10/23/2024 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/30/2024 155352 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2600 MOREHOUSE AVE **ELKHART MEADOWS** ELKHART, IN 46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Finding includes: practice; MCSS completed section C of the A record review was completed on 8/28/2024 at annual Minimum data set 9:52 A.M. for Resident 107. Diagnoses included assessment for resident 107. All but were not limited to: vascular dementia and annual minimum data set obsessive compulsive disorder. assessments will be completed in its entirety within the specified An Annual (MDS) assessment, dated 6/4/2024, time frame. indicated Section C was not completed. How other residents having the potential to be affected by the

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)

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

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

| STREET ADDRESS, CITY, STATE, ZIP COD 2800 MOREHOUSE AVE ELKHART, IN 46617 | | | ILDING | onstruction 00 | (X3) DATE : COMPL 08/30/ | ETED | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------|
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFY INFORMATION REGULATORY OR LARGEST TO BE APPROPRIATE CREATION IN THE APPROPRIATE CARCETORY OR INFORMATION REGULATORY OR LSC IDENTIFY IN THE APPROPRIATE OR CARCETORY OR INTO INTO INTO INTO INTO INTO INTO INTO | | | | | 2600 M | OREHOUSE AVE | | |
| F 0638 SS=D Bldg. 00 F 0638 SS=D 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, F 0638 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, F 0638 F 0638 | PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| 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. 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; | F 0638 SS=D | 483.20(c) Qrtly Assessment Based on record rev failed to complete a (MDS) assessment f (Resident 25) Finding includes: A record review for 8/28/2024 at 2:06 P were not limited to: anxiety disorder, de An Admission MDS on 3/19/2024. Resid documentation to in assessment was com | at Least Every 3 Months iew and interview, the facility Quarterly Minimum Data Set for 1 of 15 residents reviewed. Resident 25 was completed on M. Her diagnoses included, but major depressive disorder, lete comma and dementia. S assessment was completed lent 25's record lacked the dicate a Quarterly MDS | F 06 | 538 | recur, i.e., what quality assurance program will be printo place; and by what date the systemic changes for each deficiency will be completed; MCSS will complete section C 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, at action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 9/22 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 All quarterly MDS assessment will be completed in its entiret 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 will be identified and what corrective. | ch; of se, nne nd s/24 | 09/22/2024 |

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10WY11 Facility ID: 000243

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PRINTED: 10/23/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | r í | | ONSTRUCTION | (X3) DATE SURVEY | | |
|------------------------------------------------------|----------------------|--------------------------------|------|-------------|---------------------------------------------------------------------------------------|--------------------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPLETED | |
| | | 155352 | B. W | B. WING | | 08/30/2024 | |
| NAME OF P | PROVIDER OR SUPPLIER | . | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | T MEADOWS | | | | OREHOUSE AVE | | |
| | I MEVDOM9 | | | LLNHA | RT, IN 46517 | r | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE | N |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | + | TAG | All residents that are assesse | Ditte | |
| | During an interview | v on 8/29/2024 at 10:45 A.M., | | | a quarterly MDS assessment | | |
| | _ | for indicated the resident had | | | the potential to be affected by | | |
| | not had an MDS ass | sessment completed since | | | deficient practice. MDSC has | | |
| | 3/19/2024 and shou | lld have had a quarterly MDS | | | been educated on ensuring th | at all | |
| | I | /2024. She indicated the | | | quarterly MDS assessments a | | |
| | 1 | e a policy on completing MDS | | | completed in its entirety within | the | |
| | assessments but fol | | | | specified time frame. | | |
| | | nent (RAI) as a guide to | | | What measures will be put in | ito | |
| | completing MDS as | ssessments. | | | place and what systemic changes will be made to | | |
| | 3.1-31 (d)(3) | | | | ensure that the deficient | | |
| | | | | | practice does not recur; | | |
| | | | | | MDSC educated on RAI proce | ess | |
| | | | | | and on ensuring that all quarte | erly | |
| | | | | | MDS assessments are comple | eted | |
| | | | | | in its entirety within the specifi | ed | |
| | | | | | time frame. IDT will review | | |
| | | | | | quarterly assessments to ensi | ıre | |
| | | | | | the assessment is completed | | |
| | | | | | timely | | |
| | | | | | How the corrective action(s) | | |
| | | | | | will be monitored to ensure t | | |
| | | | | | deficient practice will not | | |
| | | | | | recur, i.e., what quality | | |
| | | | | | assurance program will be p | ut | |
| | | | | | into place; and by what date | | |
| | | | | | the systemic changes for ea | | |
| | | | | | deficiency will be completed MDSC will complete the RAI | , | |
| | | | | | Process QAPI tool weekly for | 4 | |
| | | | | | weeks, monthly for 6 months. | | |
| | | | | | threshold of 90% is not met, a | | |
| | | | | | action plan will be developed. | | |
| | | | | | Findings will be submitted to t | ne | |
| | | | | | QAPI Committee for review ar | nd | |
| | | | | | follow up. | | |
| | | | | | Deficiencies corrected by 9/22 | 124 | |

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Event ID:

10WY11 Facility ID: 000243

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| f ´ | | l í | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------|----------------|---------------------------------------------------------------------|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING 00 | | | COMPLETED | |
| 155352 | | B. WING 08/30/2024 | | | | | | |
| | PROVIDER OR SUPPLIER | | <u> </u> | 2600 M | ADDRESS, CITY, STATE, ZIP COD | • | | |
| ELKHAR | T MEADOWS | | | ELKHA | ART, IN 46517 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE (| COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| F 0759 SS=D Bldg. 00 | | n Error Rts 5 Prent or More | F 0' | 759 | F-759 | | 09/22/2024 | |
| | | ty failed to ensure it was free of | 1 0 | 139 | What corrective action(s) wi | | 0912212024 | |
| | | rate of greater than 5 percent | | | be accomplished for those | " | | |
| | | (Resident 2 & 49) observed | | | residents found to have bee | n | | |
| | during medication p | | | | affected by the deficient | •• | | |
| | | ved with 2 medication errors, | | | practice; | | | |
| | | ation error rate of 8 percent. | | | Resident 2 is receiving insulir | n per | | |
| | _ | | | | protocol. Resident 49 is recei | - | | |
| | Findings include: | | | | meds per MD order. | | | |
| | | | | | All nurses educated on prope | r | | |
| | 1. During an observation of insulin administration | | | | insulin administration. All nurs | ses | | |
| | | 8/27/2024 at 4:27 P.M., LPN 2 | | | and QMA's educated on follo | wing | | |
| | 1 ~ | wing steps: First, she attached | | | physician medication orders. | | | |
| | | sulin pen and set the dose | | | How other residents having | the | | |
| | | Next, she entered Resident 49's | | | potential to be affected by the | | | |
| | | his arm with an alcohol pad, | | | same deficient practice will | be | | |
| | | e medication into the | | | identified and what corrective | /e | | |
| | | mmediately removed the | | | action(s) will be taken; | | | |
| | needle/pen from the | e resident's arm. | | | All residents that receive insu | | | |
| | | | | | or medication have the poten | tial to | | |
| | | s completed on 8/27/2024 at | | | be affected by the deficient | | | |
| | | ent 49. Diagnoses included, | | | practice. All nurses educated | | | |
| | | l to: type 2 diabetic mellitus | | | proper insulin administration. | | | |
| | with diabetic chroni | ic kidney disease. | | | nurses and QMA's educated | | | |
| | A Dhysioianla Onda | datad 9/14/2024 indicated | | | following physician medicatio | n | | |
| A Physician's Order, dated 8/14/2024, indicated | | | | | orders. | | | |
| | Resident 49 was to receive Humalog Junior KwikPen U-100, administer 10 units subcutaneous three times a day. | | | | What measures will be put | _ | | |
| | | | | | into place and what systemi changes will be made to | | | |
| | | | | | ensure that the deficient | | | |
| | During the interview | w on 8/27/2024 at 4:31 P.M., | | | practice does not recur; | | | |
| | _ | e thought she had primed the | | | All nurses educated on prope | r | | |
| | | needle should have remained | | | insulin administration. All nurs | | | |
| | | n 3-5 seconds after the | | | and QMA's educated on follow | | | |
| | | ninistered with the insulin pen | | | physician medication orders. | 9 | | |
| | | mount pon | | | IP/Designee will complete a | | | |
| | During an interview | on 8/28/2024 at 11:30 A.M., | | | medication administration skil | ls I | | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|---------------------------------------------------------------------------------------------|----------------------------------|--------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------|-----------|------------------|--|
| AND PLAN | AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. B | UILDING | 00 | COMPLETED | | |
| | | 155352 | B. WING 08/30/2024 | | | | 2024 | |
| | | | | CTREET | ADDRESS CITY STATE ZID COD | | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| FLICHAR | T ME A DOMA | | | | OREHOUSE AVE | | | |
| ELKHAR | T MEADOWS | | | ELKHA | RT, IN 46517 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | DROVIDED'S DI AN OF CODDECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | \\\L | DATE | |
| | the Director of Nur | sing (DON) indicated the | | | validation with each QMA, LP | N & | | |
| | insulin pen should | have been primed, with 2 units | | | RN. Any concerns will be | | | |
| | _ | he needle should have been | | | addressed immediately. | | | |
| | left in the arm for 5 | -10 seconds after the | | | · | | | |
| | medication was adr | ninistered. | | | | | | |
| | | | | | How the corrective action(s |) | | |
| | During an interview | v on 8/29/2024 at 9:48 A.M., the | | | will be monitored to ensure | | | |
| | 1 | icated that when the insulin | | | deficient practice will not | | | |
| | _ | d and the needle was not left | | | recur, i.e., what quality | | | |
| | | onds after the medication was | | | assurance program will be p | ut I | | |
| | | the correct dose would not | | | into place; and by what date | | | |
| | have been given. | | | | the systemic changes for ea | | | |
| | | | | | deficiency will be completed | | | |
| | 2. During an observation of a medication pass on 8/29/2024 at 7:48 A.M., QMA 4 administered | | | | IP/Designee will complete the | | | |
| | | | | | Medication error QAPI tool we | | | |
| | | 1 3350 powder to Resident 2. | | | for 4 weeks, monthly for 6 mo | - | | |
| | | o place the powdered | | | If threshold of 90% is not met, | | | |
| | | mall plastic cup containing | | | action plan will be developed. | | | |
| | | ances of water and mixed the | | | Findings will be submitted to t | he | | |
| | | ter together before handing the | | | QAPI Committee for review a | | | |
| | | Resident 2 consumed the | | | follow up. | | | |
| | liquid. | | | | Deficiencies corrected by 9/22 | 2/24 | | |
| | | | | | , | | | |
| | A record review wa | as completed on 8/29/2024 at | | | | | | |
| | | dent 2. Diagnoses included, | | | | | | |
| | · · | d to: constipation, unspecified. | | | | | | |
| | | - • | | | | | | |
| | A Physician's Orde | r, dated 4/28/2022, indicated | | | | | | |
| | | receive polyethylene glycol | | | | | | |
| | | rams with 8 ounces of water. | | | | | | |
| | | | | | | | | |
| | A Care Plan, dated | 5/2/2022, indicated Resident 2 | | | | | | |
| | was at risk for cons | tipation due to decreased | | | | | | |
| | | tervention to administer | | | | | | |
| | medication as order | | | | | | | |
| | | | | | | | | |
| | During an interview | v on 8/29/2024 at 9:04 A.M., | | | | | | |
| | | the order indicated to give the | | | | | | |
| | 1 | l powder with 8 ounces of | | | | | | |
| | | ne cup over and it was stamped | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155352 | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/30/2024 | | | |
|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS | | 2600 N | ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE ART, IN 46517 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | tom. She did not think they | TAG | DEFICIENCY | DATE |
| | | 245 A.M., the DON indicated the e a policy on following | | | |
| | skills competency to Administration", da competency was the facility. The skills competency cap and cover. 10. units. 11. Push the cap and cover. 10. units. (A small druff insulin does not a insulin dosage to be Push injection botto completely to give to while keeping insulin to ensure all insulin | atted, "Insulin Pen ted 6/2018, and indicated the e one currently used by the competency indicated "9. outer pen needle protective Prime the pen by dialing 2 end of the pen to push out the op of insulin should be visible. administered to resident. 17. om down to end of pen insulin. 18. Wait 5-10 seconds in pen and pen needle in place, is given. 19. Pull the insulin from the injection site" | | | |
| F 0812 SS=F Bldg. 00 | 483.60(i)(1)(2) Food Procurement, Store Based on observation failed to maintain of preparation and store | e/Prepare/Serve-Sanitary ons and interviews the facility lean and sanitary food rage areas, which had the 1 of 51 residents whose food e kitchen. | F 0812 | Elkhart Meadows is requesting a paper review. Elkhart Meadows requests additional evidentiary information be considered to delete or recommendations. | tion luce |
| | area with the Maint | on of the dining room kitchen enance Supervisor on a.M, the microwave had food | | in scope F 812, from the 2567 The current statement of deficiencies on the 2567 omits significant facility information a therefore misrepresents the ca and services administered by | s and are |

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/30/2024 155352 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2600 MOREHOUSE AVE **ELKHART MEADOWS** ELKHART, IN 46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE spilled on the turn table, and the door. The provider to its residents. reach-in refrigerator and freezer contained F 812 Federal Regulations: undated food and liquids which belonged to staff members. In addition, there was a yellow liquid Rev. 211; Issued: 02-03-23; spilled in the bottom of the freezer. Effective: 10-21-22: Implementation: 10-24-22) During an interview on 8/30/2024 at 10:00 A.M., §483.60(i) Food safety the Maintenance Supervisor indicated requirements. housekeeping staff were responsible for cleaning The facility must the dining room microwave and refrigerator. He §483.60(i)(1) - Procure food from indicated staff should not have kept food in the sources approved or dining room refrigerator or freezer. considered satisfactory by federal, state or local On 8/30/2024 at 11:00 A.M., the Executive Director authorities. (ED) provided a current policy, dated 7/15/2024, (i) This may include food items titled, "Cleaning Microwave Oven." The policy obtained directly from local indicated, " ...1. Remove glass tray, if applicable, producers, subject from inside the oven, wash, rinse, sanitize and to applicable State and local allow to air dry. 2. Remove any food particles laws or regulations. from interior of oven with a clean, wet cloth. 3. (ii) This provision does not Wipe the interior of the oven with hot soapy prohibit or prevent facilities water" from using produce grown in facility gardens, On 8/30/2024 at 11:00 A.M., the Executive Director subject to compliance with (ED) provided a current policy, dated 7/15/2024, applicable safe growing titled, "Cleaning Refrigerators." The policy and food-handling practices. indicated, "...1. Remove all food from reach-in (iii) This provision does not refrigerator. Store food in another refrigerator or preclude residents from cooler until refrigerator is cleaned. 2. Remove consuming foods not shelves, drawers and other removable parts. Clean procured by the facility. and sanitize. 3. Wash walls and base with warm §483.60(i)(2) - Store, prepare, detergent water. 4. Rinse and sanitize. Allow to air distribute and serve food in dry" accordance with professional standards for food 3.1-21(i)(3)service safety. Scope and Severity Grid

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Event ID:

10WY11

Facility ID: 000243

Scope is isolated when one or a very limited number of residents are affected and/or

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| | OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/30/2024 |
|--------------------------|-------------------------------|-------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| | ROVIDER OR SUPPLIEF | ₹ | 2600 N | ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE ART, IN 46517 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | one or a very limited number of staff are involved, and/or t situation has occurred only occasionally or in a very limited number of locations. | the |
| | | | | 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 | fr r |
| | | | | effect of the deficient practic 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 | he |
| | | | | systemic failure that affected has the potential to affect a large portion or all of the facility's residents. Widesprescope refers to the entire facility population, not a sub of residents or one unit of a facility. In addition, widesprescope may be identified if a systemic failure in the facility (e.g., failure to maintain food | ead set ead y |
| | | | | at safe temperatures) would likely to affect a large number of residents and is, therefore pervasive in the facility. | er |

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| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/30/2024 |
|--------------------------|------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| | ROVIDER OR SUPPLIE | R | 2600 N | ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE NRT, IN 46517 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | Deficient Practice Statement Based on observations and interviews the facility failed to maintain clean and sanitary fo preparation and storage areas which had the potential to affe 51 of 51 residents whose food prepared by the kitchen. Evidence to Refute the Findi 1 The microwave and refrigerator mentioned in the 2 are located in the facility dining room, not in the kitchen. Attachment 1 2 The microwave has not been operable for several mor Attachment 2 3 The refrigerator in the di room is not used by the kitche staff or by the residents. Food residents is stored in the refrigerator in supply room. Attachment 3 4 At the time of the survey there was no resident food in a 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 food is kept in a different refrigerator and an alternate | ct was ng: 2567 g nths. ning n for |

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/30/2024 |
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| | ROVIDER OR SUPPLIEI T MEADOWS | R | 2600 M | ADDRESS, CITY, STATE, ZIP COD IOREHOUSE AVE .RT, IN 46517 | |
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| | | | | microwave is used for residents. This deficiency do not have the potential to affer 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 reduce 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 Microw and refrigerator/freezer immediately cleaned and sani and undated food and liquids immediately removed. How other residents having 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 icrowave and refrigerator/fredaily. What measures will be put into place and what systemic changes will be made to ensure that the deficient | ct cs. cs. d l n ave tized were the ne ce ce ce com neezer |

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ЛLDING | 00 | COMPL | ETED |
| | | 155352 | B. WI | ING | | 08/30/ | 2024 |
| | PROVIDER OR SUPPLIER | 1 | | 2600 M | ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE RT, IN 46517 | • | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | practice does not recur; Housekeeping department educated on completing the cleaning of the main dining roo microwave and refrigerator/fre daily. ED/designee will check cleanliness of the refrigerator freezer daily located in the din room. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; and by what date the systemic changes for eact deficiency will be completed Housekeeping supervisor/des will complete the Cleaning of refrigerator/freezer and microv in the Main dining room QAPI weekly for 4 weeks, monthly for months. If threshold of 90% is met, an action plan will be developed. Findings will be submitted to the QAPI Commi for review and follow up. Deficiencies corrected by 9/22 | eezer the and ing the ut ch ; ignee wave tool or 6 not | |

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