STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155269	A. BUILDING 00 B. WING	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST LAKE NURSING & REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00367787. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00367787- Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: December 3 & 6, 2021 Facility number: 000169 Provider number: 155269 AIM number: 100267100 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 4 Medicaid: 64 Other: 16 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/8/21.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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

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

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a Hoyer lift (an electric/hydraulic assistive device to transfer a resident between a bed and a chair) sling (device the resident was lifted in when using the Hoyer lift) was used properly to prevent a skin injury for 1 of 3 residents reviewed for Hoyer lift sling use. (Resident E) Finding includes: On 12/3/21 at 11:15 A.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: cellulitis, heart failure, peripheral vascular disease, history of an above the right knee amputation, diabetes and chronic kidney disease. The Minimum Data Set (MDS) Significant Change Assessment, dated 10/14/21, indicated the resident had normal cognition, transferred with total dependence of 2 persons, weighed 378 pounds, had no falls, and was occasionally incontinent of bowel and bladder. The assessment indicated the resident had 2 venous/arterial ulcers. A Wound Management form dated, 11/2/21, indicated the resident had an abrasion to his left posterior thigh which measured 8.0 x 4.0 centimeters (cm). The area was pink with no signs of infection. The medical doctor was notified and wound care orders were received and implemented.	F 0689	**F689 – Free of Accidents Hazards/Supervision/Devices** It is the practice of this facility to ensure a Hoyer lift slings are used properly to prevent skin injury. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E – new Hoyer sling to accommodate resident condition was ordered and delivered prior to survey. **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 utilizing a mechanical lift have the potential to be affected by this finding. All residents utilizing mechanical lifts have been reviewed to ensure that each sling used is appropriate for each resident. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 12/26/2021. This in-service	12/26/2021

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	A Physician's Order, dated 11/2/21, indicated to cleanse the abrasion to left thigh with normal saline, pat dry, apply xeroform (petroleum jelly-skin protectant) and cover with an abdominal dressing pad called ABD. A Progress Note, dated 11/2/21, indicated the following: "...Abrasions to left medial and posterior thigh noted...MD [Medical Doctor] notified of noncompliance with current prevention interventions...education provided by nursing to Resident...allowing staff to place a towel between leg and Hoyer sling. Resident also made aware that of non compliance with this may lead to serious adverse effects including loss of limb, falls, further skin break down pain up to death. Resident voiced understanding but stated : "If you guys would do it right that might work." Resident declines to explain statement...." A Progress Note, dated 11/3/21, indicated the following: "...IDT [Interdisciplinary Team] met to review new skin event. PT [patient] noted to have an abrasion to left posterior thigh measuring 8x4 cm. Epithelial tissue present to wound bed et [and] pink in color no s/s [signs or symptoms] of infection noted. Denies pain to the area. No drainage noted during assessment to area. On assessment it was noted that smaller Hoyer sling was used to transferred Resident which may cause friction/shearing of the skin. Nurse immediately found proper fitting Hoyer sling for Resident; However, the resident refused to have staff pad Hoyer sling around inner thigh areas to prevent friction/shearing. Resident has been educated that refusal to allow staff to pad Hoyer sling could cause abrasion to worsen...." The Progress Note indicated the resident refused to lie down, in bed, during the day. The resident wanted up in his wheelchair early and goes down for bed		will be conducted by the Director of Nursing and will include review of residents utilizing mechanical lifts and appropriate fitting of slings. DNS/designee will round daily to ensure all residents utilizing mechanical lifts are utilizing appropriate slings. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/designee will be responsible for completing the QAPI Audit tools labeled “Mechanical Lifts” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 12/26/2021** Compliance Date = 12/26/2021	

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	around 9:00 P.M., per his preference. A care plan, dated 11/3/21, indicated the resident refused to allow staff to place a pad in the Hoyer sling to prevent a wound, skin tear or shearing. The interventions included, but were not limited to: encourage resident to voice choices and educate resident on risks and benefits. An invoice, dated 11/2/21, indicated the facility had ordered an amputee, padded sling. During an interview, on 12/3/21 at 2:17 P.M., Resident E indicated the only new sore he had was from the Hoyer sling. He indicated the one they used on him was causing his amputated stump to fall out and the staff was worried about him falling so they used a smaller sling and it caused a wound on his left thigh. He stated no one realized the sling was damaging his skin until he noticed something was bothering his leg when they used the sling. The smaller sling was working correctly, but during the short time of using the smaller sling, it caused a wound. He indicated the facility purchased a new sling for him and were currently using it. He did not feel the facility neglected him or purposely tried to give him the wound, they were trying to keep him safe until the sling he needed came in. He indicated a towel or some type of padding was to be used, but that didn't occur until he received the wound. During an interview, on 12/6/21 at 1:06 P.M., the MDS Coordinator indicated the care plan was developed due to a nurse's assessment of a discovered abrasion. And her instructions to the resident about the padding and its use until the new pad arrived. She indicated the IDT team had discussed the concern with the orange sling and			

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	decided to use the smaller blue sling and the resident agreed, this sling kept his stump securely in the sling. The resident had never indicated to anyone, the newer sling was causing discomfort, rolling or anything. When he did tell the staff he was feeling something on his thigh, the damage was already done. She indicated numerous times, it was reported, the staff would use a pad to protect the area and resident wouldn't let it stay in place. She indicated the resident is very noncompliant with his diabetic diet, with turning, positioning and treatments. He wanted things done his way, even if it may cause him a problem later. She indicated the Hoyer slings have a tag in them and it says what the sling weight limit was and if for an amputee or not. She indicated the staff were trained by the Hoyer lift company and then during on boarding. Staff had to pass training before using a Hoyer lift. An observation of the slings and tag on the slings, on 12/6/21 at 1:15 P.M., indicated the orange sling used first was for a person up to 600 pounds. The tag indicated it was an amputation sling. The smaller blue sling which caused the skin injury was for a person who weighed up to 600 pounds and did not indicate use for an amputated leg. The current, newly ordered sling, was for up to 600 pounds and was indicated for an amputated leg. On 12/6/21 at 1:36 P.M., the resident's wound was observed with the Wound Nurse and the Unit Manager. The wound was bright red, with slight serous drainage and documented as an abrasion. The abrasion measured 10 x 9 x 0 cm. and had scattered areas of closed areas throughout the abrasion area. The resident indicated the area that was being observed was the area the Hoyer sling had rubbed him. He indicated if staff didn't get			

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	the sling flat, the sling would roll up and he believes that was the cause of the wound. On 12/6/21 at 1:51 P.M., the Director of Nursing (DON) provided a policy titled, "Skin Management Program", dated 7/21 and indicated the policy was the one currently used by the facility. The policy indicated "...POLICY: It is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing...Pressure Injury: is localized damage to skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present at intact skin or an open ulcer and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...." This Federal tag relates to complaint IN00367787. 3.1-45(a)(1)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to implement infection control procedures, including those to properly prevent and/or contain COVID-19, related to staff not wearing appropriate PPE during random observations for infection control. Finding includes: During an observation of the facility and staff conducted on 12/3/21 from 12:50 P.M. to 1:40 P.M., the following was observed: -some of the nursing staff on the 400 and 600 unit were wearing glasses/eyewear which appeared at	F 0880	**F 880** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All employees to be educated on proper infection control practices including but not limited to, proper use of face mask and face shield. All employees to be educated on encouraging and assisting all residents as needed to utilize masks properly.	12/26/2021

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	times not to touch their foreheads. - at 1:02 P.M., the Infection Control Preventionist (ICP) was observed with eyewear that did not touch her forehead and there were gaps at both sides of the eyewear. The ICP indicated the eyewear should touch the forehead and not have any gaps. -at 1:13 P.M., the activity room was observed and all the residents were 6 feet apart from each other and had a face mask on, except Resident K and Resident M who were sitting next to the Activity Director who had a face mask on and but no face shield, as she was reading to the residents. Resident K did not have her face mask covering her nose and there was no attempt made by the Activity Director to assist resident K with the proper face mask placement. -at 1:25 P.M., CNA 4 was observed in Resident N's room providing care (closer than 6 feet of the resident) with a N95 mask donned but no face shield observed on the CNA. -at 1:31 P.M., a man was walking in the hallway near the activity room without a mask. He indicated he was an employee coming on shift. This employee had no mask on. At 1:35 P.M., the same staff (laundry aide 5) was seen in the hallway wearing his mask, which was covering his mouth but not his nose. This observation occurred in front of the Regional Director of Services. On 12/3/21 at 2:55 P.M., the Regional Director of Services provided a current policy titled, "Implementing Prevention Measures for COVID-19", dated 6/2020 and revised, on 9/28/21. The policy indicated "...Policy: Each facility will implement the following measures to assist in preventing the spread of COVID-19...Mask should cover their mouth and nose when in use...HCP [Health Care Provider] must wear face mask		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. The IP nurse will provide education and training to all staff including infection prevention education, in-service materials, post-test, observation, and QA tools. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. The IP nurse will provide education and training to all staff including infection prevention education, in-service materials, observation, and QA tools. The facility LTC Infection Control Self-Assessment will be reviewed with the IP nurse and Medical Director to determine accuracy Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by	

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	(medical) and eye protection, face shield/or goggles that cover top, bottom, sides of eyes with no gaps) as a standard safety measure to protect LTC [Long Term Care] HCP[Health Care Providers...who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status...." 3.1-18(a)		the IP/designee using the Infection Control QAPI observational rounds tool to observe for proper use of face masks and face shields for both employees and residents. The IP nurse will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. Infection Control QAPI tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. The IP/designee will be responsible for the completion of the Infection Control QAPI Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not	

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			achieved, an action plan will be developed to ensure compliance. The facility will review, update and make changes to the DPOC as needed with input and oversight from the Infection Preventionist and Medical Director for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed: 12/26/2021** Completion Date: 12/26/2021	