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	01/28/2025

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 a Recertification and State Licensure Survey. Survey dates: January 21, 22, 23, 24, 27 and 28, 2025. Facility number: 000169 Provider number: 155269 AIM number: 100267100 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 9 Medicaid: 58 Other: 21 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality Review completed on 2/5/2025	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 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living (ADLs) for a dependent resident timely related to nail care and shaving for 1 of 3 reviewed for ADLs. (Resident 35) Finding includes:	F 0677	It is the practice of this facility to ensure Activities of Daily Living (ADLs) for dependent residents are performed timely related to nail care and shaving. Shaving and nail care was provided for resident 35. All dependent residents have the potential to be impacted by this	02/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
McKenzie Hojara	Executive Director	02/14/2025

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	During an observation and interview, on 1/23/2025 at 10:21 A.M., Resident 35 had a full beard and his nails were jagged with a brown substance under them. Resident 35 indicated he received bed baths twice a week and did not have any problems with them but preferred to have assistance with shaving and nail care. Resident 35 indicated staff had only offered to assist him with shaving once or twice a month. During an observation and interview on 1/24/2025 at 9:11 A.M., Resident 35 had a full beard and jagged nails with a brown substance under them. He indicated that no one had offered to assist him with shaving or nail care. During an observation and interview on 1/27/2025 at 9:27 A.M., Resident 35 indicated the night shift CNA had shaved him and he was happy that his goatee and mustache were now trimmed. He indicated he preferred to have the whiskers on the sides of his face, cheek and neck area shaved at least weekly. Resident 35 indicated he had not refused any offered shaving assistance. He indicated he used to shave every day at home and preferred to be shaved at least weekly. He indicated if he had access to fingernail clippers, he would attempt to trim his own nails, but no one had offered him fingernail clippers when he received his bed baths. During an observation and interview on 1/28/2025 at 9:36 A.M., Resident 35 had facial hair growth on his cheek, sides of his face and his neck but he indicated he did not need shaved yet. He indicated he would like to be shaved weekly. His fingernails remained jagged with a brown substance under them and he indicated no one had offered nail care but if they gave him clippers, he would have tried to trim his own nails.		deficient practice. An audit of nail care and shaving for dependent residents will be completed by 2/24/25 to ensure timely care is provided. The DNS/designee will ensure dependent residents receive nail care and shaving by rounding each day. Furthermore, all staff will be educated on or before 2/24/25 on providing timely nail care and shaving for dependent residents. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” daily for 7 days, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. 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.	

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	A record review was completed on 1/24/2025 at 10:01 A.M. Diagnoses included, but were not limited to: hypertension heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, peripheral vascular disease, type 2 diabetes mellitus and right above the knee amputation. A Quarterly Minimum Data Set (MDS) assessment dated 11/12/2024, indicated Resident 35's cognition was intact and he required substantial/maximal assistance with personal hygiene and was dependent on staff assistance with bathing. A current Care Plan, initiated on 8/8/2017, indicated the resident required assistance/monitoring for activities of daily living for A.M. and P.M. care. During an interview on 1/28/2025 at 9:49 A.M., CNA 2 indicated when she provided A.M. care, she completed peri-care, toileted the resident, combed their hair, brushed their teeth and shaved them, if needed. When she provided a complete bed bath, she washed their hair with a shampoo cap, washed their body, applied lotion, shaved the resident, if they needed to be shaved and dressed the resident. She indicated there were no residents on the hall that refused care except for the two female residents who were combative with care. CNA 2 indicated she had not noticed that Resident 35's nails were jagged and not clean when she had provided A.M. care for the resident earlier in the morning. During an interview on 1/28/2025 at 10:18 A.M., CNA 3 indicated when he provided A.M. care, he changed the resident's brief and performed			

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	peri-care, brushed their teeth, and offered to shave them. When he provided a complete bed bath, he washed their hair with a shampoo cap, cleaned their body, dried their body and dressed them, then brushed teeth, nail care and shaved them. He indicated Resident 35 had not refused care. On 1/28/2025 at 11:33 A.M., Regional Nurse indicated the facility did not have a policy for nail care or shaving; but they followed the regulations related to resident rights. 3.1-38(3)(D)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to follow the plan of care for a resident who required two staff present for care for 1 of 3 residents reviewed for care plans. (Resident 34) Finding includes: During an observation on 1/27/2025 at 9:27 A.M., CNA 8 exited Resident 35's room by herself. During an interview on 1/27/2025 at 9:29 A.M., Resident 35 indicated the CNA that had just left the room had helped him with toileting. He indicated he usually only had one caregiver in the room providing assistance because that was usually all they had working on the floor. He indicated it was rare that two staff members assisted him with care in his room, but occasionally two staff providing transfer assistance with the mechanical lift.	F 0684	It is the practice of this facility to ensure the plan of care for residents who require two staff present for care is followed. Resident 35 plan of care reviewed with IDT and MD and discontinued care in pairs. All residents who require two staff present have the potential to be impacted by this deficient practice. An audit of residents who require two staff present to be completed by 2/24/25 to ensure an up-to-date care plan and resident profile is present. The DNS/designee will ensure residents will receive care in pairs by rounding each shift to ensure care in pair is provided. The DNS/Designee will review residents who require two staff present to ensure care is being	02/24/2025

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	During an observation on 1/28/2025 at 9:13 A.M., CNA 2 answered Resident 35's call light and asked the resident what he needed. The resident informed the CNA that he needed to use the urinal and CNA 2 proceeded into the resident's room and closed the room door. A record review was completed on 1/24/2025 at 10:01 A.M. Diagnoses included, but were not limited to: hypertension heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, peripheral vascular disease, type 2 diabetes mellitus and right above the knee amputation. A Quarterly Minimum Data Set (MDS) assessment dated 11/12/2024, indicated Resident 35's cognition was intact and he required substantial/maximal assistance with personal hygiene and was dependent on staff assistance with bathing. A current Care Plan initiated on 8/7/2017, indicated Resident 35 needed staff assistance with activities of daily living. Interventions included, but were not limited to: care in pairs, which was typed in capital letters. A current behavior Care Plan initiated on 12/28/2020, indicated Resident 35 made false allegations and negative statements regarding staff members at time. The interventions, included but were not limited to: Care in pairs. A current Resident Profile, dated 7/9/2021, indicated "care in pairs" was typed in capital letters. During an interview on 1/28/2025 at 9:49 A.M., CNA 2 indicated that there were no residents in		followed per the plan of care. Furthermore, all staff will be educated on or before 2/24/25 on ensuring residents who require two staff present receive care in pairs per their resident plan of care. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Quality of Care” daily for 7 days, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. 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.	

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	the hall that required care to be provided in pairs. During an interview on 1/28/2025 at 10:18 A.M., CNA 3 indicated that there were no residents in the hall that required care to be provided in pairs. On 1/28/2025 at 11:58 A.M., the DON indicated the facility did not have a policy regarding following the plan of care. 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to infection control measures were followed during medication administration observation for 1 of 8 residents observed receiving medications (Resident 17) and a linen cart was covered for 1 of 5 halls. (Hall 500) Findings include: 1. During an observation of a medication pass for Resident 17 on 1/24/2025 at 10:22 A.M., QMA 7 dropped a calcium tablet onto the medication cart. She picked up the tablet with her bare hand and placed it into a medication cup with Resident 17's other medications. During an interview with QMA 7 during the medication pass, she indicated she should not have administered the medications to the resident and should have destroyed all of the resident's medications once she had put the calcium table into the medication cup with the other medications. During an interview on 1/24/2025 at 10:26 A.M., QMA 17 indicated she was unsure of the facility policy for destruction of contaminated	F 0880	It is the practice of this facility to maintain infection control measures during medication administration and on linen carts. Medication for resident 17 was properly destroyed. 500 hall linen cart was covered and bleach wipes removed. All residents have the potential to be affected by this finding. The DNS/designee will complete medication administration observations for 1 week to ensure all licensed nursing staff maintain infection control practices during medication administration to residents. Linen cart audit to be completed before 2/24/25 to ensure all linen carts maintain infection control practices including being covered and bleach wipes not present. The DNS/designee will in-service all staff on infection control practices for medication	02/24/2025

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	medications. During an interview with the Assistant Director of Nursing, who was present at the time, she indicated she was also not sure of the policy. 2. During an observation on 1/24/2025 at 2:54 P.M., the linen cart in the 500 hall's cover was on top of the cart exposing the clean linens and an opened container of micro kill bleach wipes with a wipe hanging out of the top. During an interview on 1/24/2025 at 2:55 P.M. with CNAs 4 and 5, they indicated the linen should have been covered. CNA 4 indicated the container of bleach wipes should not have been left open. She then proceeded to pull the exposed wipe out of the top of the container, but then stuffed it back into the container, under the lid and closed the lid. On 1/27/2025 at 11:37 A.M., the Regional Nurse provided a policy titled, "Laundry/Linen," revised 12/2021, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. Resident care areas: clean linen a. Clean linen must be protected from soiling or contamination. i. Carts/racks must be covered including transportation of clean and soiled linen..... " On 1/24/2025 at 10:54 A.M. a current policy titled, "General Dose Preparation and Medication Administration,"dated 11/15/2024, was provided by the Director of Nursing. The policy indicated, "...Facility staff should avoid touching the medication with bare hands when opening a bottle or unit dose package...." and "...If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy...." 3.1-18		administration and linen carts by 2/24/25. Furthermore, all licensed nursing staff will be observed on medication administration practices to ensure infection control measures are maintained. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Infection Control” daily for 7 days, weekly for 4 weeks, monthly for 6 months, and quarterly thereafter for at least 2 quarters. 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.	

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