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	01/29/2024

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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. This visit included the Investigation of Complaint IN00426969. Complaint: IN00426969 - No deficiencies related to the allegations are cited. Survey dates: January 22, 23, 24, 25, 26 & 29, 2024 Facility number: 000169 Provider number: 155269 AIM number: 100267100 Census Bed Type: SNF: 9 NF: 57 SNF/NF: 24 Total: 90 Census Payor Type: Medicare: 9 Medicaid: 57 Other: 24 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/1/24.	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 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
McKenzie Hojara	Executive Director	02/09/2024

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(iii) Be culturally-competent and trauma-informed. Based on record review, observation, and interview, the facility failed to ensure a person-centered care plan was developed for 1 of 26 residents whose care plans were reviewed. (Resident 12) Finding includes: A record review was completed on 1/25/2024 at 1:14 P.M. Resident 12's diagnoses included, but were not limited to: acute and chronic respiratory failure with hypoxia, Atrial Fibrillation, Congestive Heart Failure, and chronic Pleural Effusion (build up of fluid between lungs and chest). A Physicians' Order, dated 1/15/2024, indicated Resident 12 had a PleurX Drain (an indwelling suction tube used to remove excess fluid or air) to drain fluid and record output every day. A hospital Discharge Note, dated 12/12/2023, indicated the resident still required a PleurX catheter for daily drainage upon admission to the facility for chronic right pleural effusion. Resident 12's current care plans lacked a specific care plan for the use and care the PleurX drain, including potential respiratory complications and interventions. A Care Plan, dated 12/20/2023, indicated the resident was at risk for fluid imbalance due to acute kidney failure, DM II (Diabetes Mellitus), obstructive and reflux uropathy, chronic combined systolic and Congestive Heart Failure, chronic kidney disease, moderate protein calorie malnutrition, weakness, PleurX drain. Interventions included, but were not limited to:	F 0656	It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan developed. The care plans for resident 12 have been reviewed and updated to include a care plan for PluerX Drain care. All residents have the potential to be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans related to PlureX Drains has been completed and updated appropriately. Comprehensive Care Plans will be reviewed to ensure care plans are resident centered. Comprehensive Care Plans will be established for all residents upon Admissions and quarterly thereafter or when changes occur. All staff in-servicing will be conducted by the ED/designee on or before 2/20/24 and will review the facility policy related to Comprehensive Care Plans. This will ensure that all residents are provided with comprehensive care plans are resident centered. IDT will review care plans during morning meeting to ensure care plans are resident centered and address PluerX Drains if indicated. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).	02/20/2024

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	Administer medications as ordered, resident will be free from signs and symptoms of fluid volume deficit, and document and notify Medical Doctor of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decrease blood pressure, weak or rapid pulse, change in mental status, decreased urine output, abnormal labs, and poor skin turgor. During an interview, on 1/26/2024 at 11:28 A.M., the MDS (Minimum Data Set assessment) Nurse indicated normally, a resident would have had a care plan in place for care of a chest tube. She indicated there was acknowledgement of the PleurX tube only on his 12/20/2023 fluid imbalance care plan. When asked if Resident 22 should have had a care plan in place specific to care for PleurX, she indicated she would have to investigate further. A policy was provided on 1/26/2024 at 12:15 P.M. as current by the Director of Nursing, titled, "IDT Comprehensive Care Plan Policy", and dated 1/2010, with a revision date of 8/2023. The policy indicated " ...The care plan must include measurable goals and resident specific interventions based on the resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial well-being ...." 3.1-35(a)		The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” 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.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			

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	Based on interview, observation, and record review, the facility failed to ensure residents received showers or complete bed baths as scheduled for 2 of 4 residents reviewed for Activities of Daily Living. (Residents 12 and 22) Findings include: 1. During an interview, on 1/22/2024 at 1:37 P.M., Resident 12 indicated he had received only one shower since admitting to the facility on 12/12/2023. An Admission MDS (Minimum Data Set) Assessment, dated 12/19/2023, indicated the resident was dependent on staff for bathing and showering needs. A Significant Change MDS, dated 1/2/2024, indicated it was very important to choose between tub bath, shower or bed baths. A review of the facility January 2024 shower binder, on 1/25/2024 at 3:00 P.M., indicated Resident 12 had the following shower sheets documented in the binder: 1/5/24 - shower 1/7/24 - shower 1/8/24 - complete bed bath 1/19/24 - shower During an interview, on 1/25/2024 at 3:54 P.M., Unit Manager 11 indicated the resident should have had more documented showers or baths located in the binder for the month of January 2024. 2. During an interview, on 1/22/2024 at 2:41 P.M.,	F 0677	It is the practice of this facility to ensure residents receive showers or complete bed baths as scheduled. Residents 12 and 22 have been provided with a shower or complete bed bath as scheduled per resident preference. All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and frequency will be completed on or before 2/20/24. The DNS/designee will ensure Shower schedules are maintained per resident preference. The DNS/Designee will review Shower Sheets with resident preferences daily to ensure showers are provided per resident preference. Furthermore, all staff will be educated on or before 2/20/24 on completing showers or bed baths per schedule. 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.	02/20/2024

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	Resident 22 indicated he was not getting his showers like he should have been. A record review was completed on 1/25/2024 at 3:00 P.M. An Admission MDS (Minimum Data Set) Assessment, dated 9/22/2023, indicated it was very important for resident to choose between tub bath, shower, complete bed bath or partial bed baths. A Quarterly MDS, dated 12/11/2023, indicated Resident 22 required maximum assist for bathing. The January 2024 binder containing bathing sheets, contained only 3 sheets, dated 1/10/2024, 1/19/2024, & 1/24/2024, which were all marked as showers. During an interview, on 1/25/2024 at 3:54 P.M., Unit Manager 11 indicated all shower and or complete bed bath documentation was completed by the staff and kept in the shower sheet binder. Sheets were to be filled out when a resident refused or requested a different day for their shower. Staff tried to accommodate requests to bathe on a different day. Unit Manager 11 indicated that she tried to ask residents if they got their shower or baths, if not documented. She indicated Resident 22 should have had more than 3 documented showers or complete bed baths, and residents should receive at least 2 showers or complete bed baths per week. A policy was requested on 1/26/2024 at 12:15 P.M., but none was provided. 3.1-38(a)(2)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure Oxygen usage signage was posted outside resident rooms and failed to ensure residents had current Physician Orders for the use of oxygen for 2 of 3 residents reviewed for respiratory care. (Residents 12 and 136) Findings include: 1. During an observation, on 1/23/2024 at 2:38 P.M., Resident 12 was observed receiving oxygen. There was no oxygen signage posted in or outside of room. During an observation, on 1/24/2024 at 9:30 A.M., Resident 12 was observed receiving oxygen. There was no oxygen signage posted in or outside of room. During an observation, on 1/25/2024 at 9:13 A.M., Resident 12 was observed receiving oxygen. There was no oxygen signage posted in or outside of room. During an interview, on 1/25/2024 at 9:55 A.M., LPN 3 and LPN 12 both indicated there should	F 0695	It is the practice of this facility to ensure Oxygen usage signage is posted outside resident rooms and residents have Physician Orders for use of oxygen. Proper 02 signage was placed on the door for resident 12 . Resident 136 has a physician order for oxygen and signage has been placed on the door. All residents utilizing oxygen have the potential to be affected by this finding. The DNS/designee will complete an audit of all residents receiving oxygen to ensure Physicians Orders are present and proper 02 signage is in place on or before 2/20/24. The DNS/designee will in-service nurses on proper 02 signage and Physicians Orders for 02 on or before 2/20/24. The DNS/designee will ensure proper 02 signage is present and Physician Orders for oxygen usage are maintained. Ongoing compliance with this corrective action will be monitored	02/20/2024

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	have been oxygen signage posted outside of Resident 12's door indicating oxygen use. During an observation, on 1/26/2024 at 2:35 P.M., Resident 12 was observed receiving oxygen. There was no oxygen signage posted in or outside of room. A record review was completed on 1/25/2024 at 1:14 P.M. Resident 12's diagnoses included but were not limited to: acute and chronic respiratory failure with hypoxia, Atrial Fibrillation, Congestive Heart Failure, A Physician's Order, dated 12/12/2023, indicated oxygen at 4 Liters per nasal cannula. 2. During an interview, on 1/22/2024 at 2:13 P.M., Resident 136 was observed to be using oxygen (O2). The resident indicated staff had not changed the O2 cannula. During an observation, on 1/23/2024 at 11:38 A.M., there was no O2 signage regarding the use of O2 on the resident's door or surrounding area. A record review was completed on 1/24/2024 at 2:28 P.M. A Discharge Summary, dated 1/5/2024, indicated continue to wean O2 as tolerated. The record lacked a current Physician's Order for the use of the O2. During an interview, on 1/25/2024 at 10:46 A.M., LPN 5 indicated normally they did not have an O2 sign posted. During an interview, on 1/25/2024 at 10:52 A.M., LPN 5 indicated there should be an O2 sign on the door.		through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Oxygen Therapy” 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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	During an interview, on 1/25/2024 at 11:32 A.M., RN 9 indicated there should have been an active Physician's Order for the O2. On 1/26/2024 at 11:56 A.M., the Director of Nursing provided the policy titled," Oxygen Therapy and Devices", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...1). No Smoking signs need to be affixed to the FRONT and BACK of doors (OSHA regulations). Initiation of Oxygen. 1). Verify physician order... 8) Place O2 signs...." 3.1-47(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to date multi-dose medication containers when opened, for 2 of 3 medication carts observed. (100 hall & 600 hall) Findings include: 1. During an observation of a 100 hall medication cart with LPN 6, on 1/24/2024 at 9:58 A.M., the following multi-dose medication containers lacked a date that indicated when it was opened: 1 bottle of atropine eye drops, and 1 bottle of Mylanta. 2. During an observation of a 600 hall medication cart with LPN 5, on 1/24/2024 at 10:17 A.M., the following multi-dose medication containers lacked a date that indicated when it was opened: 3 bottles of polyethylene glycol, 1 bottle of simethicone, 1 bottle of icosapent ethyl, and 1 bottle of potassium. A policy, titled, "Storage and Expiration Dating of Medications, Biologicals," and dated 7/21/2022, was provided by the Director of Nursing on 1/26/2024 at 9:15 A.M. as current. The policy indicated, " ...Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened ...." 3.1-25(j)	F 0761	It is the practice of this facility to date multi-dose medication containers when opened. Multi-dose medication containers on 100 hall and 600 hall were properly dated upon opening. All residents have the potential to be affected by this finding. The DNS/designee will complete an inspection on or before 2/20/24 of all medication rooms, medication room refrigerators, medication carts and treatment carts to ensure that all multi-dose medication containers have a proper date when opened. In addition, the DNS/designee will be responsible for a facility wide weekly medication cart/room inspection. This will ensure that all multi-dose medication containers are properly dated upon opening per facility policy and procedure. The DNS/designee will in-service nurses on Medication Storage on or before 2/20/24. The in-service will be conducted by the DNS/designee and will review the facility policy related to Storage and Expiration dates of medications and biologicals. Nursing staff will be re-educated on proper dating of multi-dose medication containers when opened. DNS/designee will inspect the medication storage	02/20/2024

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			areas to ensure multi-dose medications containers have the proper date when opened. 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 “Medication Storage” 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.	
F 0880 SS=D 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 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			

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	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 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			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 and interview, the facility staff failed to perform proper hand hygiene when preparing medications for administration to residents, for 2 random infection control observations during medication administration. Findings include: 1. During an observation of medication pass, on 1/23/2024 at 11:41 A.M., LPN 3 approached the medication cart and failed to perform hand hygiene before setting up medications for a resident. Alcohol based hand rub (ABHR) was available on the medication cart. During an interview on 1/23/2024 at 11:42 A.M., LPN 3 indicated she should have used the ABHR to clean her hands before setting up medications. 2. During an observation of medication pass, on 1/24/2024 at 8:45 A.M., LPN 4 made notes and documented medication for one resident, and failed to perform hand hygiene before setting up medications for another resident. ABHR was available on the medication cart. During an interview on 1/24/2024 at 8:47 A.M., LPN 4 indicated she should have washed her	F 0880	It is the practice of this facility to perform proper hand hygiene when preparing medications for administration to residents. LPN 3 and LPN 4 have been educated by DNS/designee on or before 2/20/24 regarding proper hand hygiene during medication administration. All residents have the potential to be affected by this finding. The DNS/designee will complete hand hygiene observation tool daily for licensed nursing staff for 1 week to ensure hand hygiene is being performed prior to preparing medications for administration to residents. The DNS/designee will in-service nurses on hand hygiene on or before 2/20/24. The in-service will be conducted by the DNS/designee and will review the facility policy related to performing hand hygiene when preparing medications for administration to residents. Furthermore, all staff will be educated utilizing hand	02/20/2024

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	01/29/2024

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	hands before preparing medications for the next resident. On 1/26/2024 at 9:15 A.M., the DON (Director of Nursing) indicated there is not a policy for when to use hand hygiene during medication preparation or administration. 3.1-18(b)		hygiene skills validation to ensure proper competency regarding hand hygiene. DNS/designee will conduct rounds each shift to observe proper hand hygiene during medication administration. 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 “Hand Hygiene Observation Tool” 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.	