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	07/08/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00356092, IN00356725, and IN00356837. Complaint IN00356092 - Substantiated. Federal/State deficiencies related to the allegations are cited at F659. Complaint IN00356725 - Unsubstantiated due to lack of evidence. Complaint IN00356837 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558. Survey dates: July 6, 7 and 8, 2021 Facility number: 000169 Provider number: 155269 AIM number: 100267100 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 8 Medicaid: 61 Other: 16 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on July 12, 2021.	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 0558 SS=D	483.10(e)(3) Reasonable Accommodations			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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Bldg. 00	Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to provide sufficient physical space to allow for resident independence with in room activities for 1 of 1 residents reviewed for accommodation of needs (Resident E). Findings include: 7/6/21 at 12:50 P.M., Resident E's records were reviewed. Diagnoses included, but were not limited to, morbid obesity and chronic wound to the left leg. A Social Services Progress note, dated 6/9/21 at 2:56 p.m., indicated attempts had been made to meet with the resident to complete a quarterly assessment however, the resident did not wish to participate. The note indicated the resident had no issues with short or long term memory. A Care Plan, reviewed/revised on 5/19/21, indicated the resident needed assistance with his activities of daily living due to weakness, morbid obesity, chronic lymphedema, and difficulty in walking (Resident is non-ambulatory). Interventions included, but were not limited to, encourage resident to do as much for self as possible and praise efforts at self care; set up hygiene/grooming equipment in easy reach. On 7/6/21 at 9:45 A.M., Resident E's room was observed with the door open. The resident was	F 0558	**F558 – Reasonable Accommodations Needs/Preferences** It is the practice of this facility to provide sufficient physical space to allow for resident independence with in room activities. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E – room was reorganized per resident preference and made to accommodate resident independence. **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 this finding. All resident rooms have been reviewed to ensure that sufficient physical space is provided to allow for resident independence. **What measures will be put into place or what systemic**	07/23/2021

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	not present. A bariatric bed was against the window side of the room with approximately a foot and a half space between the bed and wall. At the bottom of the bed, was a dresser and night stand that had several items piled up on top of them. An extra wide and very large wheelchair (w/c) sat in the middle of the room which took up a lot of space. A second bed was made up and positioned long ways against the wall with the foot of the bed adjacent to the head of Resident E's bed. The space between the end of the bed and dresser was not large enough for a w/c to fit through and open the drawers. On 7/7/21 at 11:15 A.M., Resident E, identified as being interviewable by the facility, was interviewed in his room. He shared that he had recently been relocated from his room next door to his current room. His old room had been a private one which he could easily navigate with his large wheelchair and bed. He indicated he had not wanted to move rooms. The resident demonstrated how his w/c could not fit between the end of the bed and his dresser which made it impossible for him to independently get things from the dresser. He indicated he was unable to reach the air conditioner unit which was positioned on the wall below the window and was accessed by going between his bed and the dresser. He had bottles of soda and other boxes of items next to the side of his bed between the bed and wall which he could not get to himself and would have to "bother" staff to come and give him a soda when he wanted one. He was unable to have his bedside stand next to the bed due to the other bed in the room being adjacent to his. Resident E indicated he'd had a roommate until just recently who had been moved due to splashing water on him and having arguments but that the resident's stuff was still in the closet.		**changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 7/23/2021. This in-service will be conducted by the Executive Director and will include review of the facility policy related to Accommodation of Needs. ED/designee will round daily to ensure all residents are provided sufficient physical space in rooms to allow independence. **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 Executive Director/designee will be responsible for completing the QAPI Audit tools labeled "Reasonable Accommodation of Needs" 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: 7/23/2021** Compliance Date = 7/23/2021	

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	When he had the roommate, staff had asked him if there was another way to rearrange the room for him but he indicated there was no space to rearrange; there had been 2 of them in the room with large w/c's and there simply was no room to move. He wanted to be independent and not have to call staff to get items for him in his room that he should be able to reach himself. He indicated the staff wanted him to do things for himself but was unable to when he couldn't reach his things. He was supposed to elevate his left leg, per the wound clinic, due to a wound and extremely edematous left foot but indicated he couldn't because he hadn't enough room. He indicated while there was no roommate currently, he would be getting one so didn't want to temporarily move his things around only to have them moved again when a roommate moved in. Progress notes indicated the following: -6/11/21 at 2:10 p.m., the Social Services Director spoke with the resident about moving rooms on Monday and that he would have a roommate. The resident became verbally aggressive and was very upset about changing rooms. He was assured that he would have enough room for his belongings and that he would be able to move around. Resident E later apologized for the way he had acted and indicated he would move rooms on Monday. -6/14/21 at 3:21 p.m., the resident was moved to a different room and was not real happy with it. -6/16/21 at 9:33 a.m., social services indicated the resident was adjusting to his new room and roommate and had indicated it's been an			

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	adjustment because there wasn't much room. The resident's feelings were validated and it was explained to him that if there was a way to move the room around so he was more comfortable, staff would assist with this. -6/24/21 at 4:37 p.m., social services was notified that Resident E's roommate had splashed water on the resident out of anger and had removed himself from the room. On 7/7/21 at 3:05 P.M., the Social Services Director was interviewed. During the interview, she indicated she had been aware that Resident E had been unhappy about moving and that he hadn't enough room to move about his room freely. This Federal tag relates to IN00356837. 3.1-3(v)(1)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders for 1 of 3 residents reviewed for physician orders (Resident H). Findings include: On 7/7/21 at 10:07 A.M., Resident H's record was reviewed. Diagnoses included, but were not limited to, hyponatremia (low blood sodium) and	F 0659	**F659 – Qualified Persons** It is the practice of this facility to follow physician orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident H – not available for	07/23/2021

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	gastrostomy with enteral feedings (feeding tube). The resident was prescribed a full liquid diet and was offered an additional 240 ml's (milliliters) of fluids every shift. A quarterly MDS (Minimum Data Set) assessment, dated 6/21/21, indicated the resident had a BIMS (Brief Interview Mental Status) score of 14-no cognitive impairment. A Nurse note, dated 6/18/21 at 4:50 p.m., indicated the resident had returned from a doctor's appointment with critical lab results-his blood sodium level was 124 (normal-135-145 milliequivalents per liter). New orders were to start sodium chloride (salt) tablets and fluid restriction of 1200 ml's in 24 hours for one week and then repeat lab work. A Physician order, dated 6/18/21 at unknown time, was for 1. Fluid restriction of 1200 ml in 24 hours and 2. Discontinue offering additional 240 ml's fluids every shift. A Medication Administration Record (MAR) for June 2021, indicated the resident was to have his fluids restricted to 1200 cc's in 24 hours- 4 times per day. The MAR indicated, by nurse initials, that the resident's fluids had been restricted however, there were no amounts listed as to how much fluid the resident was given 4 times per day. A Treatment Administration Record (TAR) for June 2021, indicated the order to offer additional 240 ml's of fluids every shift had not been discontinued on 6/18/21 and the resident received these additional fluids from 6/18 through 6/24/21.		review **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 this finding. All residents prescribed an altered fluid consistency and/or fluid restriction have been reviewed by the IDT team to ensure that physician orders are correct and being followed. **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 7/23/2021. This in-service will be conducted by the Director of Nursing and will include review of the facility policy related to Altered Fluid Consistency and Physician Orders. The Director of Nursing or Designee will review MAR/TAR for residents receiving altered fluid consistency and/or fluid restriction diets to ensure physician's orders are followed. **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	

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	A hospital progress note, dated 6/25/21, indicated the resident had been hospitalized for a scheduled procedure but prior to the procedure, lab work was completed and indicated the resident was still hyponatremic. His blood sodium level was 122 milliequivalents per liter. The nursing home had been advised to restrict Resident H's water intake. The resident and his family member, who had been present at the hospital, indicated the resident had been drinking a lot of water and the nursing home had not restricted his intake. On 7/7/21 at 11:27 P.M., LPN 3 (Licensed Practical Nurse) was interviewed. During the interview, LPN 3 indicated if a resident were on a fluid restriction, the amount of fluid to be given each shift would be listed on the MAR or TAR. On 7/7/21 at 2:49 P.M., CNA 5 (Certified Nurse Assistant) was interviewed. CNA 5 indicated they had provided care to Resident H prior to his hospital visit. They indicated not being aware that the resident had been on a fluid restriction and that the resident normally drank a lot of water each day. On 7/8/21 at 9:54 A.M., the Certified Dietary Manager was interviewed. During the interview, she indicated that she would be notified of a fluid restriction via their electronic medical records or during the managers daily meeting. When notified, she would provide nursing staff with a breakdown of how the fluids would be distributed to the resident over a 24 hour period. She indicated Resident H did not routinely receive a full liquid diet tray from the kitchen, per his request, therefore she had not been involved in how his fluid restriction had been managed.		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 "Altered Fluid Consistency" weekly x4 weeks then monthly times 6 months. If 100% compliance is not received an action plan will be completed. 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: 7/23/2021** Compliance Date = 7/23/2021	

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	On 7/7/21 at 12:29 P.M., the Administrator provided a current copy of the facility policy titled "Fluid Restriction" which stated the following: "Residents with a physician's order for a fluid restriction will be followed by the facility and divided between Dietary and Nursing Services. PROCEDURE: 1. The Dietary Services Manager/Dietary Clinician will meet with any resident on a fluid restriction to determine how total fluids will be divided throughout the day...." This Federal tag relates to Complaint IN00356092. 3.1-35(g)(2)			