STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhart Meadows	2600 Morehouse Ave Elkhart, IN 46517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on record review and interview, the facility failed to complete an Annual Minimun Data Set (MDS) assessment for 1 of 15 residents who were reviewed. (Resident 107) Finding includes: A record review was completed on 8/28/2024 at 9:52 A.M. for Resident 107. Diagnoses included but were not limited to: vascular dementia and obsessive compulsive disorder. An Annual (MDS) assessment, dated 6/4/2024, indicated Section C was not completed. 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 [DATE]. 3.1-31 (c)(12)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 48145 Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment for 1 of 15 residents reviewed. (Resident 25) 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, anxiety disorder, delete comma and dementia. 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. During an interview on 8/29/2024 at 10:45 A.M., the MDS Coordinator indicated the resident had not had an MDS assessment completed since 3/19/2024 and should have had a quarterly MDS assessment by 6/19/2024. She indicated the facility did not have a policy on completing MDS assessments but followed the Resident Assessment Instrument (RAI) as a guide to completing MDS assessments. 3.1-31 (d)(3)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 9 residents (Resident 2 & 49) observed during medication pass. There were 25 opportunities observed with 2 medication errors, resulting in a medication error rate of 8 percent. Findings include: 1. During an observation of insulin administration for Resident 49, on 8/27/2024 at 4:27 P.M., LPN 2 performed the following steps: First, she attached the needle to the insulin pen and set the dose meter to 10 units. Next, she entered Resident 49's room and cleansed his arm with an alcohol pad, Last she injected the medication into the resident's arm and immediately removed the needle/pen from the resident's arm. A record review was completed on 8/27/2024 at 4:40 P.M. for Resident 49. Diagnoses included, but were not limited to: type 2 diabetic mellitus with diabetic chronic kidney disease. A Physician's Order, dated 8/14/2024, indicated Resident 49 was to receive Humalog [NAME] KwikPen U-100, administer 10 units subcutaneous three times a day. During the interview on 8/27/2024 at 4:31 P.M., LPN 2 indicated she thought she had primed the insulin pen and the needle should have remained in the resident's arm 3-5 seconds after the medication was administered with the insulin pen During an interview on 8/28/2024 at 11:30 A.M., the Director of Nursing (DON) indicated the insulin pen should have been primed, with 2 units add of insulin and the needle should have been left in the arm for 5-10 seconds after the medication was administered. During an interview on 8/29/2024 at 9:48 A.M., the Regional Nurse indicated that when the insulin pen was not primed and the needle was not left in the arm 5-10 seconds after the medication was administered, then the correct dose would not have been given. 2. During an observation of a medication pass on 8/29/2024 at 7:48 A.M., QMA 4 administered polyethylene glycol 3350 powder to Resident 2. She was observed to place the powdered medication into a small plastic cup containing approximately 4 ounces of water and mixed the medication and water together before handing the cup to Resident 2. Resident 2 consumed the liquid. A record review was completed on 8/29/2024 at 9:20 A.M., for Resident 2. Diagnoses included, but were not limited to: constipation, unspecified. A Physician's Order, dated 4/28/2022, indicated the resident was to receive polyethylene glycol 3350 powder, 17 grams with 8 ounces of water. A Care Plan, dated 5/2/2022, indicated Resident 2 was at risk for constipation due to decreased mobility with an intervention to administer medication as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/2024 at 9:04 A.M., QMA 4 confirmed the order indicated to give the polyethylene glycol powder with 8 ounces of water She turned the cup over and it was stamped 5 ounces on the bottom. She did not think they had 8- ounce cups. On 8/29/2024 at 11:45 A.M., the DON indicated the facility did not have a policy on following physician orders. On 8/28/2024 at 12:00 P.M., the DON provided a skills competency titled, Insulin Pen Administration, dated 6/2018, and indicated the competency was the one currently used by the facility. The skills competency indicated .9. pull off and remove outer pen needle protective cap and cover. 10. Prime the pen by dialing 2 units. 11. Push the end of the pen to push out the 2 units. (A small drop of insulin should be visible. If insulin does not appear, repeat). 12. Dial desired insulin dosage to be administered to resident. 17. Push injection bottom down to end of pen completely to give insulin. 18. Wait 5-10 seconds while keeping insulin pen and pen needle in place, to ensure all insulin is given. 19. Pull the insulin pen and needle out from the injection site . 3.1-48(c)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47419 Based on observations and interviews the facility failed to maintain clean and sanitary food preparation and storage areas, which had the potential to affect 51 of 51 residents whose food was prepared by the kitchen. Finding includes: During an observation of the dining room kitchen area with the Maintenance Supervisor on 8/30/2024 at 9:52 A.M, the microwave had food spilled on the turn table, and the door. The reach-in refrigerator and freezer contained undated food and liquids which belonged to staff members. In addition, there was a yellow liquid spilled in the bottom of the freezer. During an interview on 8/30/2024 at 10:00 A.M., the Maintenance Supervisor indicated housekeeping staff were responsible for cleaning the dining room microwave and refrigerator. He indicated staff should not have kept food in the dining room refrigerator or freezer. On 8/30/2024 at 11:00 A.M., the Executive Director (ED) provided a current policy, dated 7/15/2024, titled, Cleaning Microwave Oven. The policy indicated, .1. Remove glass tray, if applicable, from inside the oven, wash, rinse, sanitize and allow to air dry. 2. Remove any food particles from interior of oven with a clean, wet cloth. 3. Wipe the interior of the oven with hot soapy water On 8/30/2024 at 11:00 A.M., the Executive Director (ED) provided a current policy, dated 7/15/2024, titled, Cleaning Refrigerators. The policy indicated, .1. Remove all food from reach-in refrigerator. Store food in another refrigerator or cooler until refrigerator is cleaned. 2. Remove shelves, drawers and other removable parts. Clean and sanitize. 3. Wash walls and base with warm detergent water. 4. Rinse and sanitize. Allow to air dry 3.1-21(i)(3)