

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN 46360
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00195228 and IN00195407.</p> <p>Complaint IN00195228- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00195407- Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey date: March 17, 2016.</p> <p>Facility number: 000236 Provider number: 155344 AIM number: 100287700</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 33 Medicaid: 39 Other: 7 Total: 79</p> <p>Sample: 6</p> <p>This deficiency reflects State findings</p>	F 0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and it also not to not to be construed as of an admission of interest against the facility, the Administrator or any employee or agents, or any other individuals who draft or may be discussed in the Plan of Correction. In addition preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirement under State and federal law that mandates submission of the Plan of Correction a condition to participate in the Title 18 and Title 19 programs. The submission of this plan of correction within this timeframe should in no way be of non-compliance or admission by the facility. This provider is respectfully requesting paper</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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F 0323 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 32883 on 3/18/16.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to staff transferring a resident without foot wear in place for 1 of 3 residents reviewed for accidents in a sample of 6. (Resident #G)</p> <p>Finding includes:</p> <p>On 3/17/16 at 5:15 a.m., Resident #G was observed asleep in bed. The bed was in the low position. A floor mat was in place.</p> <p>On 3/17/16 at 7:15 a.m., CNA #1 was observed pushing the resident in her wheelchair into the bathroom in her room. The resident did not have any socks, slippers, or footwear on. A small</p>	F 0323	<p>compliance. If accepted, all documentation is attached. Should you need additional information, provider will fax or mail a hard copy.</p> <p>F323 Supervision 1) Resident #G has been discharged from facility. The resident had a history of falls prior to her admission. The resident did not have any falls during this or any other staff assisted transfers. 2) Other residents, who have the potential to be affected by the same practice, who require 1 or 2 person assists and/or transfers were identified through a house audit conducted on 3/15/16 by the DON. Non skid footwear was added as an intervention on their care plans. All nursing staff were re-educated on 3/17/ 2016 and again on 3/21/2016 on resident safety during transfers. C.n.a #1 was re-educated on resident safety and on using proper footwear during transfers by the Staff Development Coordinator on 3/21/16. 3) All nursing staff have been educated on proper</p>	04/08/2016

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	<p>white towel was on the floor in front of the commode. The CNA assisted the resident to a standing position on the white towel. CNA #1 then assisted to the resident onto the commode.</p> <p>The record was Resident #G was reviewed on 3/17/16 at 6:00 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, muscle weakness, anemia, heart failure, and a history of falling.</p> <p>Review of the 3/7/16 Minimum Data Set (MDS) admission assessment indicated the resident required limited assistance of one staff member for transfers. The assessment indicated the resident had one fall since her admission to the facility.</p> <p>The 2/29/16 admission Fall Risk Evaluation indicated the resident's score was (14). A score of 10 or higher indicated the resident was at high risk for falls.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 3/9/16 indicated the resident had an Alteration in Mobility and Safety due to history of poor safety awareness, poor cognition, and weakness. Care Plan interventions included, but were not limited to, floor mat in place, concave</p>		<p>transfers. Nursing staff will complete a return demonstration of a proper transfer with the Therapy department and or Nursing Administration by April 1st, 2016. An audit of random observations of 20% of resident's proper transfers will be conducted weekly by the DON/designee including all shifts for the next six months. 4) Audits results and system components will be reviewed by the Performance Review Committee with subsequent plans of correction developed and implemented as deemed necessary for 6 months until 100% compliance is reached. 5) Date certain is April 8th 2016.</p>	

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	<p>mattress, and non skid socks to be in place.</p> <p>The 3/17/16 Care Directive sheet for Resident #G was reviewed. The Care Directive indicated the resident required assistance of one staff member for transfers. The Care Directive indicated the resident was to wear non-skid socks.</p> <p>The 3/2016 Nursing Progress Notes were reviewed. An entry written on 3/2/16 at 9:00 a.m. indicated at 1:15 a.m., the CNA heard someone knocking on the wall and entered the room. The resident was laying on the floor in the bathroom. No visible injuries were noted. The fall was unwitnessed. The resident was in her bare feet and did not use her call light to ask for assistance.</p> <p>A late entry for 3/9/16 indicated staff entered the resident's room at 6:00 a.m. and noted the resident laying on her back on the floor next to her bed. No visible injuries were noted. No socks or shoes were on her feet. The fall was not witnessed.</p> <p>A late entry for 3/10/16 indicated staff entered the resident's room at 5:15 a.m. and noted the resident was in a sitting position on the floor next to her bed. No visible injuries were noted. The</p>			

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	<p>resident's feet were bare.</p> <p>When interviewed on 3/17/16 at 12:55 p.m., the Director of Nursing indicated the resident should not have been transferred from the wheelchair to the commode in her bare feet.</p> <p>This Federal tag relates to Complaint IN00195407.</p> <p>3.1-45(a)(2)</p>			