

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
NAME OF PROVIDER OR SUPPLIER ELMS AT MICHIGAN CITY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD, MICHIGAN CITY, , 46360					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: July 27 and 28, 2026 Facility number: 012180 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 7/31/26.	R 0000					
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the	R 0036	R036 – 410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights 1. Corrective action for residents affected: Resident 2's insulin orders were reviewed. The HSD completed an audit of all residents receiving insulin and contacted			08/04/2026	

resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the physician and/or nurse practitioner (NP) were notified of insulin being held for 1 of 1 resident reviewed for insulin. The facility also failed to ensure the physician and/or NP continued to be contacted for treatment orders for 1 of 2 residents reviewed for wound care. (Residents 2 and 6) Findings include: 1. The record for Resident 2 was reviewed on 7/27/26 at 2:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes and history of stroke. A Physician's Order, dated 6/9/26, indicated the resident received Toujeo (a long acting insulin) 18 units daily. There were no orders to hold the insulin based on the resident's blood sugar. The July 2026 Medication Administration Record (MAR) indicated the resident's insulin was held as a nursing measure		the appropriate physicians to obtain blood glucose/insulin hold parameters as indicated. For Resident 6, the facility reviewed the delay in obtaining treatment orders. The HSD spoke with the Nurse Practitioner regarding the communication process. The facility will no longer rely on fax as the primary method for requesting treatment orders or communicating changes in condition requiring provider response. Perfect Serve, the clinical communication platform, will be utilized to communicate with the resident's physician/NP to reduce delays in treatment. 2. Identification of other residents who could be affected: All residents receiving insulin were audited by the HSD to ensure appropriate physician orders and parameters were in place. Residents receiving treatments or experiencing a significant change in condition have the potential to be affected by delayed provider notification. 3. Measures/systemic changes implemented: Licensed nursing staff will be re-educated that the physician/NP must be notified when insulin is held unless specific physician-ordered parameters are already in place.	
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due to his blood sugar being low on 7/1 (blood sugar 65), 7/7 (no blood sugar documented) and 7/25/26 (blood sugar 62).

There was no documentation indicating the physician or NP had been notified about the insulin being held.

During an interview on 7/28/26 at 2:00 p.m., the Director of Nursing indicated she had interviewed the nurse who had held the insulin and she indicated she did not contact the physician or NP.

2. The record for Resident 6 was reviewed on 7/27/26 at 2:20 p.m. Diagnoses included, but were not limited to, high blood pressure, heart disease, diabetes, dementia, and acute kidney failure. The resident was admitted to the facility on 6/25/26 from a long term care facility

Transfer information provided from the long term care facility, dated 6/21/26, indicated the resident was being treated for moisture associated skin damage (MASD) (inflammation, redness, or breakdown of the skin caused by prolonged exposure to bodily fluids or moisture) to her buttocks. The buttocks were stable with blanching redness/rash and was 100% erythema (redness of the skin caused by increased blood

Staff will also be educated on timely provider notification for changes in condition and treatment needs.

All other physicians/NP not using perfect serve will be faxed. License staff will follow up with unresolved faxes every three days until physician/NP office responds.

4. Monitoring:

The HSD/designee will audit provider notifications and insulin holds weekly for 4 weeks, then monthly for 2 months, to verify that appropriate provider notification occurred and necessary orders were obtained. Findings will be reviewed and corrective action taken as needed.

5. Completion Date:

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flow in tiny blood vessels near the surface).

The Nursing Admission Assessment, dated 6/25/26, indicated the resident had reddened areas to the buttocks.

A Physician Fax, dated 6/26/26, indicated the resident's buttocks were very red, an order was needed for A and D ointment with incontinence care, and the resident had a zinc allergy.

A Physician Fax, dated 7/15/26, indicated "Second Attempt. Buttocks very red, need order for A and D ointment with incontinence care."

A Physician's Order, dated 7/16/26 (20 days after the first fax), indicated A and D ointment to buttocks daily for 14 days.

There was no documentation in the nursing progress notes that the physician or NP (Nurse Practitioner) was notified to obtain an order for the redness from 6/27-7/14/26.

During an interview on 7/28/26 at 10:35 a.m., the Director of Nursing (DON) indicated the NP visited the facility on a weekly basis, however, sometimes it may take up to a week for them to respond to a fax requesting medications or treatments for residents.

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R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dirty and greasy food equipment, food not labeled and dated when opened, and lack of dishwasher temperature monitoring for 1 of 1 kitchen. (The Main Kitchen) Findings include: 1. During the Kitchen Sanitation Tour on 7/27/26 at 10:30 a.m. with Cook 1, the following was observed: a. In the walk-in freezer, packages of the following items were open and undated: pork patties, beef patties, green peas, chocolate pie, and a bag of pie crusts. There was a lidded styrofoam container and two large zipper-sealed plastic bags with unidentified contents that were unlabeled and undated. b. In the walk-in refrigerator,	R 0273	R273 – 410 IAC 16.2-5-5.1(f) Food and Nutritional Services 1. Corrective action for the deficient practice: All identified unlabeled, undated, uncovered, or improperly stored food items were immediately reviewed and either properly labeled/dated or discarded as appropriate. Food storage containers were cleaned, and the flour container/lid was corrected or replaced to ensure a tight-fitting lid. The identified kitchen equipment and areas, including the ovens, fryer, soup cauldron, bulk storage containers, ceilings/corners, and dishwashing area, were thoroughly cleaned. The Culinary Director reviewed the High Temperature Dishwasher Log and reinforced the requirement that dishwasher temperatures be checked and documented during each meal period. 2. Identification of others who could be affected: All residents receiving meals prepared in the main kitchen had the potential to be affected. The Culinary Director/designee inspected food storage areas, kitchen equipment, and	08/10/2026
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there were two cakes on a rack that were uncovered and undated. Open containers of cottage cheese and sour cream were also open and undated.

c. In a chest freezer, there were three open and undated large cartons of ice cream. There was a lidded styrofoam container that was unlabeled and undated.

d. In the reach-in refrigerator, there was a bin filled with unlabeled and undated cups of what Cook 1 indicated was salad dressing.

e. On the counter in the back area of the kitchen, there was an unlabeled, undated bin filled with what Cook 1 identified as breadcrumbs.

f. In the back area of the kitchen, there were two large unlabeled, undated bins filled with white powder. The bins were dirty with a orange/brown substance on the top and sides. Chef 1 indicated the bins were filled with flour and sugar. The lid on the flour bin did not close completely.

g. In the cooking area, the following was observed: the ovens were dirty with a film of spillage on the door and along the bottom of the inside of the lower oven. There was a build-up of grease and food

sanitation practices to identify any additional concerns.

3. Measures/systemic changes implemented:

Culinary staff will be re-educated on the facility's food storage, handling, labeling, and dating policy, including proper covering and storage of opened food products.

Culinary staff will also be re-educated on routine cleaning expectations for kitchen equipment and food preparation/storage areas.

Dietary staff will be re-educated that high-temperature dishwasher temperatures must be recorded during each meal period.

4. Monitoring:

The Culinary Director/designee will complete kitchen sanitation and food storage audits 3x times a week for 4 weeks, weekly ongoing, to verify food is properly labeled, dated, covered, and stored and that kitchen equipment and areas are maintained in a clean and sanitary condition.

Dishwasher temperature logs will be reviewed 3x times a week for 4 weeks, then weekly ongoing, to verify temperatures are documented for each required meal period.

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spillage on the top and side of the fryer. There was a soup cauldron with a build-up of food spillage all over the outside. There were cobwebs in the corners of the ceilings in the back of the kitchen and the dishwashing area.

During an interview at that time, Cook 1 indicated the food items should have been dated when opened and the kitchen had not had a deep cleaning lately.

During an interview on 7/28/26 at 11:03 a.m., the Director of Nursing (DON) and the Executive Director (ED) were informed of the findings. No additional information was received.

Any identified concerns will be corrected immediately and staff re-educated as indicated.

5. Completion Date:
08/10/2026

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FORM APPROVED

OMB NO. 0938-0391

A policy, titled "Food Storage, Handling and Labeling", received as current from the Executive Director on 7/28/26 at 11:15 a.m., indicated, " ... All food in the refrigerator walk-in, freezer and storage areas should be properly labeled and include produced-on and use-by dates. All cooked foods, open containers, salads, desserts and fruits are to be securely covered, labeled and dated ... Dry bulk items, such as rice, sugar, and flour are stored directly inside seamless NSF [a container that meets food-safety requirements] containers with tight fitting lids and are clearly labeled"

2. The High Temperature Dishwasher Log for July 2026 had blanks on the following days/shifts: 7/17/26 and 7/21/26 breakfast, 7/18/26, 7/19/26, 7/20/26, and 7/22/26 breakfast and dinner, 7/23/26 lunch and dinner, 7/24/26 lunch, 7/25/26 and 7/26/26 breakfast, lunch, and dinner.

During an interview at that time, Dietary Aide 1 indicated they were supposed to fill out the temperature log three times a day but sometimes they forgot.

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During an interview on 7/28/26 at 11:03 a.m., the DON and ED were informed of the findings. No additional information was received.

A policy, titled "Dish Machine Temperature Log-High Temperature Machine", received as current from the Executive Director on 7/28/26 at 11:15 a.m., indicated, " ... Temperatures must be recorded during each meal period daily".

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE Tiffany Kuzio

TITLE Executive Director

(X6) DATE 08/13/2026