

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 02/27/2025
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: February 26 and 27, 2025 Facility number: 012180 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/3/25.	R 0000			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	R 0217	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All self-med residents were audited	03/05/2025	

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appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 2. Resident 5's record was reviewed on 2/27/25 at 8:51 a.m. Diagnoses included, but were not limited to, hypertension and osteoarthritis. The resident was admitted to the facility on	for proper documentation 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Through the audit, we found that there was a glitch in our assessment system (Vitals) that did not carry over the note indicating the resident partially self-administers medication. 3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Vitals corrected the error on their end. 4 How the corrective action(s) will be monitored to ensure the deficient practice	
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	8/29/24. The Psychiatry Services Consult Notes indicated the resident had been seen on 9/3/24, 11/15/24, 12/30/24, and 1/27/25. A Service Plan, dated 12/26/24, lacked any documentation the resident received mental health services. During an interview on 2/27/25 at 10:40 a.m., the DON indicated mental health services were not listed on the service plan, but she would update it. Based on record review and interview, the facility failed to ensure service plans were updated with changes related to mental health services and self-medication administration for 3 of 7 service plans reviewed. (Residents 4, 5, and 3) Findings include: 1. Record review for Resident 4 was completed on 2/26/25 at 3:15 p.m. Diagnoses included, but were not limited to, anxiety, depression, and dementia.		will not recur, i.e., what quality assurance program will be put into place; and DHW will ensure each note is carried over upon new resident assessment and reassessment for current residents 5 By what date will the systemic changes be completed Audits were completed on 02/27/2025 Vitals completed for the affected resident on 03/05/2025 The system will include the note for any new residents moving forward Mental Health Services	
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	A Service Plan, dated 11/8/24 and signed by the resident's Power Of Attorney, indicated the resident was confused. The Service Plan indicated the resident was on Hospice services but did not include any other outside services. A Psychiatry Progress Note, dated 1/27/25, indicated the resident was currently being seen by mental health services. The assessment and plan indicated the resident was stable and to continue the psychotropic medication. The record lacked any documentation the mental health services was listed on Resident 4's service plan. During an interview on 2/27/25 at 10:42 a.m., the Director of Nursing (DON) indicated she was unaware mental health services were supposed to be listed on the resident's service plans. 3. Resident 3's record was reviewed on 2/26/25 at 1:47 p.m. Diagnoses included, but were not limited to, depression and type 2 diabetes mellitus. The current Service Plan, dated 12/2/24, indicated the resident was cognitively intact, had behaviors on 1/7/25 and 1/12/25 which included defecating and urinating in public spaces, and required staff to assist and		1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Obtained list from Eventus for Psych services provided for residents in the community All assessments were updated immediately 2 How will the facility identify other residents potentially affected by the same deficient practice, and what corrective action will be taken? Audited all residents on service and added to assessment 3 What measures will be put into place	
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administrate medications, blood sugar monitoring, and insulin injections. Resident 3 was on the list of residents who currently received psychiatry services that was provided by the Director of Nursing on 2/26/25. The January 2025 Physician's Order Summary did not indicate the resident was receiving mental health services. A Physician's Order, dated 1/30/25, indicated the resident could not self-administer all medications except for Cialis (erectile dysfunction medication) at bedside. The Service Plan did not indicate the resident self-administered any medications or that the resident received psychiatry services. During an interview on 2/27/25 at 10:40 a.m., the DON indicated she did not have Resident 3's psychiatric services listed on the service plan, but he was currently receiving the services. The resident had a Self-administration of Medication Assessment completed, but it was not added to the current service plan. 2. Resident 5's record was reviewed on 2/27/25 at 8:51 a.m. Diagnoses included, but	or what systemic changes the facility will make to ensure that the deficient practice does not recur; Eventus will email DHW monthly ongoing updated list of residents on service 4 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; and DHW will audit assessments at change of condition and re-evaluations DHW will audit any new residents or discharged residents with the list provided by Eventus to ensure they have been documented for services provided. 5	
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were not limited to, hypertension and osteoarthritis. The resident was admitted to the facility on 8/29/24.

The Psychiatry Services Consult Notes indicated the resident had been seen on 9/3/24, 11/15/24, 12/30/24, and 1/27/25.

A Service Plan, dated 12/26/24, lacked any documentation the resident received mental health services.

During an interview on 2/27/25 at 10:40 a.m., the DON indicated mental health services were not listed on the service plan, but she would update it.

Based on record review and interview, the facility failed to ensure service plans were updated with changes related to mental health services and self-medication administration for 3 of 7 service plans reviewed. (Residents 4, 5, and 3)

Findings include:

1. Record review for Resident 4 was completed on 2/26/25 at 3:15 p.m. Diagnoses included, but were not limited to, anxiety, depression, and dementia.

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By
what date the systemic changes will be completed?

Immediate
and ongoing

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resident was on Hospice services but did not include any other outside services.

A Psychiatry Progress Note, dated 1/27/25, indicated the resident was currently being seen by mental health services. The assessment and plan indicated the resident was stable and to continue the psychotropic medication.

The record lacked any documentation the mental health services was listed on Resident 4's service plan.

During an interview on 2/27/25 at 10:42 a.m., the Director of Nursing (DON) indicated she was unaware mental health services were supposed to be listed on the resident's service plans.

3. Resident 3's record was reviewed on 2/26/25 at 1:47 p.m. Diagnoses included, but were not limited to, depression and type 2 diabetes mellitus.

The current Service Plan, dated 12/2/24, indicated the resident was cognitively intact, had behaviors on 1/7/25 and 1/12/25 which included defecating and urinating in public spaces, and required staff to assist and administer medications, blood sugar monitoring, and insulin injections.

Resident 3 was on the list of

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residents who currently received psychiatry services that was provided by the Director of Nursing on 2/26/25.

The January 2025 Physician's Order Summary did not indicate the resident was receiving mental health services.

A Physician's Order, dated 1/30/25, indicated the resident could not self-administer all medications except for Cialis (erectile dysfunction medication) at bedside.

The Service Plan did not indicate the resident self-administered any medications or that the resident received psychiatry services.

During an interview on 2/27/25 at 10:40 a.m., the DON indicated she did not have Resident 3's psychiatric services listed on the service plan, but he was currently receiving the services. The resident had a Self-administration of Medication Assessment completed, but it was not added to the current service plan.

2. Resident 5's record was reviewed on 2/27/25 at 8:51 a.m. Diagnoses included, but were not limited to, hypertension and osteoarthritis. The resident was admitted to the facility on 8/29/24.

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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 ensure food equipment and food storage areas were clean, food was stored properly, the dishwasher was at proper sanitizing temperatures, sanitizer buckets reached appropriate sanitation level, and staff provided sanitary food	R 0273	1. A,B, C Griddle, stove top and wall- buildup of grease and food debris. Ice cream Cooler debris & Dry storage of debris and food under shelving unit 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	03/31/2025

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service related to touching food and non-food items with the same gloved hands for 1 of 1 kitchen observed. This had the potential to affect all 77 residents who received food from the kitchen. (The Main Kitchen)

Findings include:

1. During the Initial Kitchen Tour with the Executive Chef on 2/26/25 at 10:06 a.m., the following was observed:

a. The griddle, stove top, and the wall behind the griddle had a build up of grease and food debris.

b. The base of the ice cream cooler was dirty with food and debris. There was a cup of ice cream uncovered and undated in the cooler.

c. The dry storage room had debris and food spillage under the shelving unit.

d. There were boxes of food stored up to the ceiling in the walk-in freezer.

e. The dishwasher did not reach the proper temperature for a high temperature dishwasher with the wash cycle reaching 140 degrees Fahrenheit and the rinse cycle reaching 150 degrees Fahrenheit.

f. Two separate sanitizer

No
known residents were affected
by deficient practice

2
How
the facility will identify other
residents having the potential to
be affected
by the same deficient practice
and what corrective action will
be taken

No
known residents were affected
by deficient practice

3
What
measures will be put into place
or what systemic changes will
the facility make
to ensure that the deficient
practice does not recur

Executive
immediately cleaned the area

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FORM APPROVED

OMB NO. 0938-0391

buckets that were in use, which contained Quat sanitizer, were tested with QAC strips and reached a sanitizer level of only 100 PPM (parts per million).

At that time, the Executive Chef indicated the areas indicated were in need of cleaning. The dishwasher temperatures had been a problem for about a week and she had called the service company to come repair it. In the meantime, the staff were still using the dishwasher, but just running the cycle twice to get the dishes clean. The sanitizer buckets were in use and should have a concentration of at least 200 PPM for them to correctly sanitize.

2. During a follow-up tour of the kitchen on 2/27/25 at 12:00 p.m., the following was observed:

a. Cook 1 donned gloves. She did not perform hand hygiene before donning the gloves. She picked up a to-go container and set it down. She opened a salad container touching the outside of the bowl and the plastic wrap covering and then took out salad with her gloved hands. She placed the salad in another container. She picked up a different container, picked up the salad with the gloved hands and moved it from one container to the other. She touched the

All
team members will be educated on cleaning schedules

4
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;
and

Executive
Chef or designee will audit weekly to ensure tasks are completed

5
By
what date will the systemic changes be completed?

Completed
immediately and audit ongoing

B&D-Proper
food storage uncovered and undated cup of ice cream/Boxes stacked to high

preparation area in front of the steam table, opened a lid to retrieve a breadstick with the same gloved hands, and placed it on the plate. She then prepared another salad in the same manner with the same gloved hands.

b. Server 1 was observed retrieving clean dishes from the storage rack to be used for lunch service. She was carrying the dishes against her clothing.

At that time, the Executive Chef indicated she would in-service both staff members.

Kitchen Logs were received on 2/27/25 at 2:44 p.m. from the Executive Director. She indicated the facility did not have specific policies regarding the kitchen concerns and they were to make sure the dishwasher and sanitation levels were within the limits set on the logs. The Sanitation Bucket Log indicated the sanitizer level was to be 200 PPM. The High Temperature Dishwasher Log indicated the wash temperature was a minimum of 150 degrees Fahrenheit and the rinse temperature was a minimum of 180 degrees Fahrenheit.

Based on observation, record review, and interview, the facility failed to ensure food equipment and food storage areas were clean, food was stored properly,

1

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

No

known residents were affected by deficient practice

2

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

No

known residents were affected by deficient practice

3

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur

the dishwasher was at proper sanitizing temperatures, sanitizer buckets reached appropriate sanitation level, and staff provided sanitary food service related to touching food and non-food items with the same gloved hands for 1 of 1 kitchen observed. This had the potential to affect all 77 residents who received food from the kitchen. (The Main Kitchen)

Findings include:

1. During the Initial Kitchen Tour with the Executive Chef on 2/26/25 at 10:06 a.m., the following was observed:

a. The griddle, stove top, and the wall behind the griddle had a build up of grease and food debris.

b. The base of the ice cream cooler was dirty with food and debris. There was a cup of ice cream uncovered and undated in the cooler.

c. The dry storage room had debris and food spillage under the shelving unit.

d. There were boxes of food stored up to the ceiling in the walk-in freezer.

e. The dishwasher did not reach the proper temperature for a high temperature dishwasher with the wash cycle reaching

Immediately
tossed cup and audited other food items for proper storage

Immediately
removed items on top shelf of walk in

All
staff will be educated on proper storage and labelling of food items

4
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;
and

The Executive
Chef or Designee will audit weekly to ensure food is stored properly

5
By
what date will the systemic changes be completed?

140 degrees Fahrenheit and the rinse cycle reaching 150 degrees Fahrenheit.

f. Two separate sanitizer buckets that were in use, which contained Quat sanitizer, were tested with QAC strips and reached a sanitizer level of only 100 PPM (parts per million).

At that time, the Execute Chef indicated the areas indicated were in need of cleaning. The dishwasher temperatures had been a problem for about a week and she had called the service company to come repair it. In the meantime, the staff were still using the dishwasher, but just running the cycle twice to get the dishes clean. The sanitizer buckets were in use and should have a concentration of at least 200 PPM for them to correctly sanitize.

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a. Cook 1 donned gloves. She did not perform hand hygiene before donning the gloves. She picked up a to-go container and set it down. She opened a salad container touching the outside of the bowl and the plastic wrap covering and then took out salad with her gloved hands. She placed the salad in another

Staff will be trained by 03/31. Audits will be ongoing

E&F- The dishwasher is not reaching the regulated temperature

1
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

No known residents were affected by deficient practice

2
How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

3
What measures will be put into place

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container. She picked up a different container, picked up the salad with the gloved hands and moved it from one container to the other. She touched the preparation area in front of the steam table, opened a lid to retrieve a breadstick with the same gloved hands, and placed it on the plate. She then prepared another salad in the same manner with the same gloved hands.

b. Server 1 was observed retrieving clean dishes from the storage rack to be used for lunch service. She was carrying the dishes against her clothing.

At that time, the Executive Chef indicated she would in-service both staff members.

Kitchen Logs were received on 2/27/25 at 2:44 p.m. from the Executive Director. She indicated the facility did not have specific policies regarding the kitchen concerns and they were to make sure the dishwasher and sanitation levels were within the limits set on the logs. The Sanitation Bucket Log indicated the sanitizer level was to be 200 PPM. The High Temperature Dishwasher Log indicated the wash temperature was a minimum of 150 degrees Fahrenheit and the rinse temperature was a minimum of 180 degrees Fahrenheit.

or what systemic changes will the facility make to ensure that the deficient practice does not recur

The dish machine service provider was contacted before the state survey. On 03/07/2025, it was temporarily fixed

New part on order and will be installed once received.

All staff will be trained on daily temperature checks

4
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; and

Executive Chef or Designee will audit weekly to ensure food is stored

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properly

5

By

what date the systemic changes
will be completed.

03/31/2025

and ongoing.

2- Improper

hand hygiene, touching food
and improper dish handling

1

What

corrective action(s) will be
accomplished for those
residents found to have
been affected by the deficient
practice

No

known residents were affected
by deficient practice

2

How

the facility will identify other
residents having the potential to
be affected
by the same deficient practice

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and what corrective action will
be taken

No
known residents were affected
by deficient practice

3
What
measures will be put into place
or what systemic changes will
the facility make
to ensure that the deficient
practice does not recur

Educate
on hand washing and using
proper utensils for food handling

Educate
on proper dish handling

4
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;
and

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The
Executive Chef or Designee will
audit each shift weekly during
meal services to
ensure proper hand washing
and food handling

The
Executive Chef or Designee will
audit each shift weekly for
proper dish
handling

5
By
what date the systemic changes
will be completed.

03/31/2025
and going

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	TITLE	(X6) DATE
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