STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155343	A. BUILDING 00 B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF LAGRANGE	0770 NORTH 075 EAST LAGRANGE, IN 46761

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00452893 and IN00453955. Complaint IN00452893 - No deficiencies related to the allegations are cited. Complaint IN00453955 - No deficiencies related to the allegations are cited. Survey dates: March 5, 6, 7, 10, and 11, 2025 Facility number: 000235 Provider number: 155343 AIM number:100267740 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 30 Other:18 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 13, 2025	F 0000	=”” b=””>=”” b=””> **b=””>=”” b=””>=”” b=””>** b=””>=”” b=””> =”” b=””>=”” b=””>=”” b=””>=”” b=””>=”” b=””> This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center LaGrange agrees with the allegations and citations listed. Life Care Center of LaGrange maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record	F 0677	**What corrective action will be accomplished for residents**	04/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Grostefon	Executive Director	03/27/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	review, the facility failed to ensure a resident received oral hygiene for 1 of 5 residents reviewed (Resident 10). Findings include: On 3/5/25 at 10:30 AM, Resident 10 was observed from the hallway lying in bed. Resident 10 was lying on their right side facing the open door. Resident 10's mouth was open with their tongue protruding. Resident 10's record was reviewed on 3/7/25 at 9:08 AM. Diagnoses included cerebral palsy, curvature of the spine and curvature of the neck. Resident 10's Quarterly Minimum Data Set (MDS) dated 2/5/25,Brief Interview for Mental Status (BIMS) assessment indicated Resident 10's cognition was severely impaired. The MDS indicated Resident 10 was entirely dependent on the staff for all aspects of care. Resident 10's Care Plan, dated 12/14/23, indicated the resident was totally dependent on staff for oral care. On 3/6/25 at 10:04 AM, Resident 10 was observed lying in bed. The resident's mouth was open, their tongue was protruded. On 3/7/25 at 1:33 PM. Resident 10 was observed lying in bed. The resident's mouth was open, their tongue was protruded. The resident's lips were dry with white caking. Resident 10's tongue was protruding and covered with a dry, white colored coating. In an interview, on 3/7/25 at 1:51 PM, Registered Nurse (RN) 25 indicated Resident 10's lips and		**found to have been affected by this deficient practice?** Oral care was immediately provided to the resident. Oral cavity checked and no noted concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. An audit will be completed to ensure no other resident having the same need is affected by the deficient practice. Any issues identified will be corrected immediately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Oral Care assignment sheets will be created for residents that could have the potential to be affected. Nursing staff will ensure that daily Oral Care is provided so the deficient practice does not recur. Nursing staff will be educated on Life Care Centers policy and procedures on Oral Care and its importance. No licensed nursing staff or CNA's will work past the date of compliance without this education being completed. **How the corrective action will**	

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	tongue were extremely dry. RN 25 indicated Resident 10 should receive oral care every 2 hours. A current facility policy, titled" Oral Care" provided by the Administrator on 3/11/25 at 9:30 AM, indicated dependent residents should be provided with oral care every 2 to 4 hours. 3.1-38(a)(3)		**be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The IDT/Clinical team will review Oral Care assignment sheets during clinical meetings 5 days a week. Nurse managers will round/audit Oral Care with nursing staff 5 days a week. A QAPI has been put in place that will be reviewed and monitored monthly with the QAPI committee for 6 months or until the QAPI committee deems compliant. This will ensure the deficient practice does not recur. **Compliance date by: April 5, 2025**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview and record review, the facility failed to ensure maintenance of a tube feeding for 1 of 1 resident reviewed (Resident 10). Findings include: On 3/5/25 at 10:30 AM, Resident 10 was observed lying in bed. A tube feeding pump was observed in Resident 10's room. Resident 10's record was reviewed on 3/7/25 at 9:08 AM. Diagnoses included cerebral palsy,	F 0693	**What corrective action will be accomplished for residents found to have been affected by this deficient practice?** The tubing was changed immediately by the nurse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. An audit will be completed on	04/05/2025

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	curvature of the spine and curvature of the neck. Resident 10's Quarterly Minimum Data Set (MDS), dated 2/5/25, indicated Resident 10's Brief Interview for Mental Status (BIMS) assessment indicated the resident was severely impaired. The MDS indicated Resident 10 was entirely dependent on the staff for all aspects of care. Resident 10's Care Plan, dated 1/3/24, indicated the resident required tube feeding and was to have nothing by mouth. On 3/7/25 at 1:33 PM, Resident 10 was observed lying in bed. Resident 10's tube feeding pump was running. The tube feeding formula container was dated 3/5/25 at 9:00 PM. The tube feeding water container was dated 3/5/25 at 9:00 PM. In an interview, on 3/7/25 at 1:51 PM, Registered Nurse (RN) 25 indicated Resident 10's tube feeding bags were dated 3/5/25 at 9:00 PM. RN 25 indicated tube feeding supplies were supposed to be changed daily and labeled with the date and time. A current facility policy, titled "Enteral Nutrition Therapy," dated 9/20/24, provided by the Administrator on 3/10/25 at 9:00 AM, indicated the tube feeding sets should be replaced every 24 hours. 3.1-44(a)(1) 3.1-44(a)(2)		current residents to ensure the deficient practice does not recur. Any issues identified will be corrected immediately. **What measures and what systemic changes will be made to ensure that the deficient practice does not recur?** A task will be placed in the electronic charting system to ensure that each nurse has completed the task with the proper date and time of when feeding supplies have been administered. Nurses will be educated on Life Care Centers policy and procedure on Enteral Nutrition Therapy. No licensed nurse will work past date of compliance without this education being completed. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., What quality assurance program will be put into place?** The IDT/Clinical team will monitor all residents with Enteral Nutrition on appropriate charting 5 days a week. Nurse managers will audit during rounds to ensure nurses have the appropriate date and time on feeding supplies. A QAPI has been put in place that will be reviewed and monitored monthly with the QAPI committee, and this will be monitored for 6 months or until the QAPI committee deems compliance. This will ensure the deficient practice does not recur.	

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			Compliance date by: April 5, 2025	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on interview and record review, the facility failed to ensure freedom from unnecessary medications for 1 of 3 residents reviewed (Resident 17). Findings include: Resident 17's record was reviewed on 3/7/25 at 10:16 AM. Diagnoses included diabetes, chronic kidney disease, Parkinson's and coronary artery disease. Resident 17's Quarterly Minimum Data Set, (MDS) dated 12/19/24, indicated the resident's Brief Interview for Mental Status (BIMS) was 14 (no cognitive loss). The MDS indicated Resident 17 required an indwelling urinary drainage catheter. A physician order, dated 6/12/24, indicated resident 17 was to be administered an antibiotic injection every day for 3 days for a UTI. A progress note, dated 6/20/24 at 11:36, indicated Resident 17 had completed antibiotics for an unknown infection. The note indicated a medication error had been made by the prescriber. The note indicated the resident did not have a urinalysis to support the diagnosis of a urinary tract infection (UTI).	F 0757	**What corrective action will be accomplished for residents found to have been affected by this deficient practice?** Resident with no noted harm. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. An audit will be completed on all residents who are currently receiving an antibiotic to ensure Life Care Centers policy and procedures are followed. Any issues identified will be corrected immediately. **What measures and what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and IP will be notified of the potential of a new antibiotic prior to administering to ensure that Life Care Centers policy and procedure is being followed. The provider and	04/05/2025

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	Resident 17's Medication Administration Record, (MAR) dated June 2024, indicated the resident had been administered an antibiotic injection for UTI on 6/11/24, 6/12/24 and 6/13/24. In an interview, on 3/11/25 at 9:20 AM, the Administrator indicated they had not been aware of Resident 17 receiving an antibiotic without infection. A current facility policy, titled "Medication Related Errors," dated 5/1/10, provided by the Administrator on 3/11/25 at 9:45 AM, indicated in the event of a medication prescribing error, the facility staff should follow incident policy, associated forms and performance improvement processes. 3.1-48(a)(1)-(6)		nurses will be educated on the policy and procedure in the event of a Medication Related Error as well as the incident policy, associated forms and the performance improvement process. No provider(s) or licensed nurse will work past the date of compliance without this education being completed. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., What quality assurance program will be put into place?** The IDT/Clinical team will review 5 days a week all newly prescribed antibiotics to ensure that Life Care Centers policy and procedures are followed. A QAPI has been put in place that will be reviewed and monitored monthly by the QAPI committee, and this will be monitored for 6 months or until the QAPI committee deems compliant. This will ensure the deficient practice does not recur. **Compliance date by: April 5, 2025**	
F 9999 Bldg. 00	Based on interview and record review the facility failed to ensure employees received 6 hours of	F 9999	**What corrective action will be accomplished for residents**	04/05/2025

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	dementia training upon new hire for 2 of 5 employees reviewed (CNA 3, QMA 2), ensure employees received a 2 step Tuberculosis skin test and specific orientation for 5 of 5 employees reviewed (QMA 2, Cook 6, CNA 3, CNA 4, RN 5). Findings include: 1. A file folder for Certified Nurse Aide (CNA) 3 was provided by the Administrator on 3/7/24 at 9 AM. The file did not include any dementia training for CNA 3. A file folder for Qualified Medication Aide (QMA) 2 was provided by the Administrator on 3/7/24 at 9 AM. The file did not include any dementia training for QMA 2. During an interview, on 3/7/25 at 11:45 AM, the Accounting Clerk indicated employees received 6 hours of dementia training within 6 months of hire. The Accounting Clerk indicated neither CNA 3 nor QMA 2 received the required 6 hours dementia training within 6 months of hire. A policy, last reviewed 9/22/2023, titled "Dementia Required Education," was provided by the Administrator on 3/7/25 at 12:40 PM. The policy indicated employees should have a minimum of 6 hours of dementia-specific training within 6 months of initial employment. 2. A file folder for Registered Nurse (RN) 5 was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The file included an "Individual TB risk assessment and screening tool for non-residents" and a 1 step tuberculosis (TB) skin test for RN 5. The file did not include a 2nd step TB skin test or proof of a previous TB skin test.		**found to have been affected by this deficient practice?** Staff identified during the survey process will complete 6 hours of Dementia Training to ensure the facility is compliant per Life Care Centers policy and procedures and will not work past the date of compliance without this education being completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. Upon date of hire each new employee will be assigned and complete 6 hours of Dementia Training per Life Care Centers policy and procedure. **What measures and what systemic changes will be made to ensure that the deficient practice does not recur?** An audit log will be completed weekly by the Staff Development Coordinator and HR on all new hires to ensure the deficient practice does not recur. The audit will ensure completion of each new hires Dementia Training to meet Life Care Centers policy and procedure. **How the corrective action will be monitored to ensure the**	

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	A file folder for CNA 4 was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The file included an "Individual TB risk assessment and screening tool for non-residents" and a 1 step TB skin test for CNA 4. The file did not include a 2nd step TB skin test or proof of a previous skin TB test. A file folder for CNA 3 was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The file included an "Individual TB risk assessment and screening tool for non-residents" and a 1 step TB skin test for CNA 3. The file did not include a 2nd step TB skin test or proof of a previous TB skin test. A file folder for Cook 6 was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The file included an "Individual TB risk assessment and screening tool for non-residents" and a 1 step TB skin test for Cook 6. The file did not include a 2nd step TB skin test or proof of a previous skin TB skin test. A file folder for QMA 2 was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The file included an "Individual TB risk assessment and screening tool for non-residents" and a 1 step TB skin test for QMA 2. The file did not include a 2nd step TB skin test or proof of a previous TB skin test. During an interview, on 3/7/25 at 11:45 AM, the Accounting Clerk, indicated an "individual TB risk assessment and screening tool for non-residents," was completed by employees prior to employment. The Accounting Clerk indicated a 2 step TB skin test was also performed upon hire. The Accounting Clerk also indicated QMA 2, Cook 6, CNA 3, CNA 4, and RN 5 did not complete		**deficient practice will not recur i.e., What quality assurance program will be put into place?** The audit log will be used to ensure each new employee has completed the required Dementia Training by HR and Staff Development Coordinator. The log will have date of hire, date of any/all Dementia Training along with the required completion date and total hours completed. The findings will be brought to the IDT meeting weekly to ensure all new employees have their required Dementia training. A QAPI has been put in place that will be reviewed and monitored monthly with the QAPI committee, and this will be monitored for 6 months or until the QAPI committee deems compliant. This will ensure the deficient practice does not recur. **Compliance date by: April 5, 2025** **What corrective action will be accomplished for residents found to have been affected by this deficient practice?** All employee found not to have a 2nd step TB test during the annual survey process will be provided a 1st TB test. HR and Nursing personnel education will be provided along with hiring managers. **How other residents having the potential to be affected by the**	

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	the 2 step TB skin test upon employment nor was prior TB skin test results provided to the facility. A policy, last revised 1/21/2015, titled "Tuberculosis - Testing and Screening," was provided by the Administrator on 3/7/25 at 12:40 PM. The policy indicated all employees are screened for tuberculosis at the time of hire with the Lippincott 2 step skin testing. The policy indicated the new employees were given a 2-step procedure skin test using the Mantoux TST skin test. 3. A file folder for QMA 2, Cook 6, CNA 3, CNA 4 and RN 5, was provided by the Accounting Clerk on 3/7/24 at 11:45 AM. The files did not include specific job orientation documentation. During an interview, on 3/7/25 at 11:45 AM, the Accounting Clerk indicated after completion of general orientation, employees received a specific orientation on the floor. The specific orientation was completed with a designated employee for multiple shifts to ensure the new employee was aware of specific job duties/training. The Accounting Clerk indicated she had no documentation for QMA 2, Cook 6, CNA 3, CNA 4 or RN 5's specific on the job orientation/training. A specific job orientation policy was not provided by the facility at the time of exit. 3.1-14(t)(1)(u)		**same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. HR will initiate the 1st TB with nursing personnel on all new employees. A Life Care Centers form specifically for TB testing will be utilized to complete with each step. A copy will be given to the IP once the first step is given and the IP will monitor 1st and 2nd step testing along with HR to ensure compliance. **What measures and what systemic changes will be made to ensure that the deficient practice does not recur?** HR and the IP will track all 1st and 2nd step TB testing for employees by utilizing a log to ensure all new hires have received all steps of the TB process so the deficient practice does not recur. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., What quality assurance program will be put into place?** HR and the IP will bring the TB log to the IDT meeting for review 5 days a week to ensure the deficient practice does not recur. A QAPI has been put in place that will be reviewed and monitored monthly with the QAPI committee and this will be monitored for 6 months or until the QAPI committee deems it is compliant.	

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			This will ensure the deficient practice does not recur **Compliance date by: April 5, 2025** **What corrective action will be accomplished for residents found to have been affected by this deficient practice?** All employees found not to have a Job Specific Orientation checklist have been provided with one. Each manager will be educated in using the form and will review with their employees their specific job functions to ensure they have a clear understanding of their role and knowledge. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All new employee files will have a Job Specific checklist in their file. Each new employee will receive a Job Specific Orientation checklist after their general orientation and will be used for their specific job training. **What measures and what systemic changes will be made to ensure that the deficient practice does not recur?** Each new employee will receive a Job Specific checklist for job specific training. The hiring manager will ensure that after Job Specific orientation is completed the form is initialed and signed by the	

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			employee and manager. HR will track the progress of the Job Specific training by utilizing a log. Once completed it will be placed in the employee file and logged as completed by HR. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., What quality assurance program will be put into place?** HR will provide the new employee with a job specific checklist and track the progress with the hiring manager by utilizing a log. Once job specific training is completed and signed off on the manager will provide the job specific checklist to HR. HR will log the form as completed and place it in the employee file. HR will bring the tracking log to the IDT meeting weekly for review. A QAPI has been put in place that will be reviewed and monitored monthly with the QAPI committee, and this will be monitored for 6 months or until the QAPI committee deems compliant. This will ensure the deficient practice does not recur. **Compliance date by: April 5, 2025**	