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	06/07/2023

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 Complaint IN00408833. This visit was also in conjunction with Investigation of Complaint IN00409388. Complaint IN00408833 - No deficiencies related to the allegations are cited. Survey dates: June 1, 2, 5, 6, and 7, 2023. Facility number: 000235 Provider number: 155343 AIM number: 100267740 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 2 Medicaid: 31 Other: 12 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 13, 2023	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of 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 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would			

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

Kim Stanley | Interim Executive Director | 06/26/2023

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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	endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure wheelchair mobility was provided for 1 of 4 residents reviewed (Resident 3). Findings include: During an interview on 6/1/23 at 10:16 AM, Resident 3 indicated she stays in her bed most times because she has difficulty mobilizing her wheelchair. She indicated staff had not assisted her with her wheelchair concerns. During an observation on 6/2/23 at 11:43 AM Resident 3 was lying in bed. During an observation on 6/2/23 at 2:40 PM Resident 3 was lying in bed. During an observation and interview on 6/6/23 11:47 AM Resident 3 was lying in bed. Licensed Practical Nurse (LPN) 6 indicated Resident 3 was almost always in bed, and she did not know why. Certified Nurse Aide (CNA) 7 indicated Resident 3 only got up for showers and returned to bed. She did not know why Resident 3 did not get up in her wheelchair and move about the facility. LPN 6 and CNA 7 indicated they were assigned to care for Resident 3 on a frequent basis. During an interview on 6/6/23 at 11:53 AM the Minimum Data Set (MDS) Coordinator indicated any care refusals should be documented in the medical record. She also indicated frequent refusal of any specific area of care should be addressed in the care plan.	F 0558	**What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:** 1. Resident # 3 was evaluated by therapy and new wheelchair provided. Resident continues with occupational therapy r/t wheelchair mobility. 2. Care plans and preferences for resident # 3 were reviewed and updated as indicated. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** 1. Therapy to complete screens based on MDS assessment schedule and as needed with change in condition. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** 1. Education provided to all nursing staff regarding ensuring all ADL decline and/or mobility function have appropriate documentation entered into PCC/POC. 2. Education provided to all nursing staff regarding procedure for resident refusal of care. **How the corrective action will be monitored to ensure the**	06/30/2023

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	Resident 3's record was reviewed on 6/5/23 at 2:56 PM. Diagnoses included diabetes mellitus without complications, essential hypertension, and polyneuropathy. A review of Resident 3's current MDS dated 4/27/23 included a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). There was no indication of refusal behavior noted on the MDS. A review of Resident 3's current Care plan titled ADL (activities of daily living) indicated the resident had a problem with self-care deficit, with a goal date of 7/23/23. Interventions included using a high-back wheelchair for mobility and a hoyer lift for transfers. Refusal of care or preference to remain in bed was not addressed on the care plan. A review of progress notes between January 2023 and May 2023 did not indicate the staff had offered to get the resident up nor the resident refused to get up. A current policy titled Activities of Daily Living last reviewed 8/22/22 provided by the Administrator did not address assistance with wheelchair mobility. She indicated there were no other policies pertaining to wheelchair mobility. 3.1-3(v)(1)		**deficient practice will not recur, i.e., what quality assurance program will be put in place:** 1. DON/Designee to review 24/72 hour report 5 times a week to ensure all resident refusal of care and/or ADL declined or change in mobility function are documented referred to therapy as indicated x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 06.30.23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident			

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	choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review the facility failed to ensure resident request for a shower schedule was honored for 1 of 4 residents reviewed. (Resident 24) Findings include: In an interview on 6/1/23 at 10:09 AM, Resident 24 indicated she was waiting to receive a shower. The resident indicated she had to miss an activity at 10:00 AM due to waiting on a shower. The resident indicated numerous requests had been made to receive showers early in the morning prior	F 0561	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 24 immediately received shower. 2. Shower schedules and care plans for resident 24 were reviewed and updated as indicated. ***How other residents having the potential to be affected by the same deficient practice be***	06/30/2023

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	to activities being scheduled. The resident indicated the staff had promised to accommodate the request of 5:00 AM showers but showers continued to be offered during activities. Resident 24's record was reviewed on 6/5/23 at 9:45 AM. Diagnoses included seizure disorder, history of falling, lack of coordination, and muscle weakness. A review of Resident 24's current quarterly Minimum Data Set (MDS) assessment indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). The MDS indicated the resident required moderate staff assistance for bathing. A review of Resident 24's current Care Plan titled Activities of Daily Living (ADLs) indicated the resident was an early riser and preferred early morning showers. A review of Resident 24's quarterly preference questionnaire dated 5/18/23 indicated the resident preferred to wake at 5:00 AM and to receive early morning showers. The resident's shower documentation indicated the resident had received a shower on 5/15/23 at 1:59 PM, on 5/18/23 at 1:59 PM, on 5/22/23 at 11:25 AM A review of Resident 24's Activity Log dated May 2023 indicated the resident had declined an activity scheduled for 5/15/23 at 2:00 PM, on 5/18/23 at 2:00 PM, on 5/22/23 at 11:00 AM. A review of Resident 24's Activity Log dated June 2023 indicated the resident declined an activity scheduled for 6/1/23 at 10:00 AM.		***identified and what corrective action will be taken:*** 1. Audit of resident preference sheets to verify shower schedule in PCC/POC matches preferences to be completed by date of compliance. 2. Update PCC/POC as indicated with shower information. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur*:** 1. Education provided to nursing staff regarding ensuring resident preferences are honored and documentation is completed accurately, to include resident refusal, by CNAs for each shower scheduled/completed and appropriate documentation is entered into PCC. **H*ow the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON and/or designee will complete audit to ensure showers are performed and documented per resident preference and policy 5x/week x 4 weeks, then 2x/week x 4 weeks, then 1x/week x 8 weeks, then monthly for 8 weeks. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once	

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	In an interview on 6/1/23 at 10:09 AM the resident indicated they were upset due having to miss an activity while waiting to have a shower. In an interview on 6/6/23 at 11:55 AM the Administrator indicated they were not aware of Resident 24 missing activities on scheduled shower days. The Administrator voiced understanding Resident 24's Activity Log contradicted the resident's interview and shower documentation. A current policy dated 10/2/22 provided by the Administrator on 6/7/23 at 11:28 AM indicated planned programming of activities would be coordinated with and communicated to all departments. The policy indicated the facility would support residents in their choice of activities. 3.1-3(u) (u)(1) (u)(2)		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 06.30.23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.			

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	§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on record review and interview the facility failed to ensure code status was clearly indicated for 1 of 16 residents reviewed. (Resident 149). Findings include: Resident 149's record was reviewed on 6/1/23 at 3:49 PM. Diagnoses included lumbar vertebra osteomyelitis, infection of lumbar intervertebral disc (pyogenic), repeated falls, metabolic	F 0578	**What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:** 1. Resident # 149: Advanced directives were immediately reviewed and orders/care plan updated to reflect current code status.	06/30/2023

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	encephalopathy, altered mental status, unspecified severe protein-calorie malnutrition, and alcohol abuse. A review of Resident 149's current baseline care plan titled Advanced Directives indicated the resident was a Full Code (all resuscitation procedures including chest compressions, intubation, and defibrillation). A review of a physician order dated 5/22/23 indicated Resident 149 was a Full Code. A review of the Resident 149's current medical record indicated the resident was a Full Code. A form regarding code status was reviewed on 6/1/23 at 4:02 PM. the form included code status had been discussed with facility representative, family and the resident. Everyone was in agreement on the wishes indicated on the form. The form indicated Resident 149 was a Full Code with no intubation. The form was dated 5/22/23 by Resident 149's wife on his behalf. A current Indiana Default Surrogates hierarchy, undated, provided by the Regional Director of Clinical Operation, indicated who can make decisions for incapacitated individuals if there is no legally appointed representative. The hierarchy indicated the resident's spouse was able to sign the form. In an interview on 6/06/23 at 9:47 AM, the Assistant Director of Nursing indicated the code status discussed, signed by Resident 149's wife, the physician orders should be the same and they are not. In an interview on 6/07/23 at 9:48 AM, the		2. No negative outcomes noted. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** 1. Audit to be completed by date of compliance to ensure advanced directives are correctly reflected in PCC. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** 1. Education provided to all nursing staff regarding ensuring advanced directives are correctly reflected in PCC orders by date of compliance. 2. Education provided to all licensed nursing staff regarding procedure for advanced directives. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** 1. DON/Designee to review all new admissions and/or re-admissions to verify accurate code status order in PCC x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once	

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	Administrator indicated the code status discussed, signed by Resident 149's wife, the physician orders should be the same and they are not. A current policy titled "Advance Directives and Advance Care Planning", dated 9/30/22, provided by the Administrator, indicated a health care surrogate is any competent adult who carries out the resident's medical decisions if he/she is not able to give informed consent ...if not named ...order of consideration ...a) resident's spouse. The policy indicated documentation in the MDS should reflect the correct advance directives. No additional policies regarding advance directives were provided by time of the survey exit. 3.1-4(l)(5)		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Date of compliance: 06/30/2023 The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 0637	**F 637 –** Comprehensive Assessment after Significant	06/30/2023

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	Based on interview and record review the facility failed to ensure a comprehensive assessment was completed upon a significant change in condition for 1 of 4 residents reviewed (Resident 28). Findings include: Resident 28's record was reviewed on 6/6/23 at 10:28 AM. Diagnoses included hemiplegia and hemiparesis following cerebral infarction right dominant side, unspecified dementia, and muscle weakness. A review of Resident 28's current quarterly Minimum Data Set (MDS) indicated her BIMS (Basic Interview for Mental Status) score was not obtained due to inability to complete the interview. An MDS dated 11/30/22 indicated Resident 28 required supervision and set-up help only for transfers, toileting, and personal hygiene. The MDS indicated Resident 28 needed supervision and one-person physical assistance with bed mobility. An MDS dated 12/21/22 indicated Resident 28 required extensive assistance and two-person physical assistance with bed mobility, transfers, toileting, and personal hygiene. A document titled Rehabilitation Services Multidisciplinary Screening Tool dated 1/2/23 received from the Administrator on 6/6/23 at 3:34 PM indicated Resident 28 declined in activities of daily living, transfers, and mobility. In an interview on 6/6/23 at 11:57 AM the MDS Coordinator indicated a significant change assessment should be completed when a resident		Change ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 28: MDS assessment was previously updated on 2/21/23 to reflect current status. No negative outcomes noted. ***How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:*** 1. Audit to be completed by date of compliance to ensure all residents with a significant change in condition based on the RAI manual in the last 30 days have the correct assessment completed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur*:** 1. Education provided to MDS coordinator regarding scheduling of significant change assessments per RAI guidelines. **H*ow the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. MDS coordinator/designee will audit all quarterly assessments to ensure a significant change assessment is	

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	has a decline in two or more areas. The MDS Coordinator indicated she was not sure why a significant change assessment was not completed. During an interview on 6/6/23 at 4:15 PM, the Regional Director of Clinical Services indicated there was no specific facility policy for completing a comprehensive assessment upon a significant change in condition. She indicated the facility should follow the RAI guidelines. The Resident Assessment Instrument (RAI) Manual dated 10/1/19 indicated a significant change MDS should be completed when a resident has a major decline in more than one care area. RAI guidelines indicate if a significant change is determined during the process of completing a quarterly assessment, a significant change comprehensive assessment should be performed instead. 3.1-31(d)(1)		not indicated for the next 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 06.30.23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry			

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	out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview and record review, the facility failed to ensure culturally appropriate communication interventions were attempted in a non-English speaking resident in 1 of 2 residents reviewed (Resident 28). FIndings include: During an observation on 6/5/23 at 9:32 AM Resident 28 was observed receiving medication from Registered Nurse (RN) 4. During the interaction, Resident 28's daughter indicated to RN 4, Resident 28 spoke Polish and was unable to speak or understand English.	F 0676	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 28: Care plan updated to reflect language of communication 2. Translation service to be utilized for communication 3. No negative outcomes noted ***How other residents having the potential to be affected by the same deficient practice be identified and what corrective***	06/30/2023

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	155343	A. BUILDING 00 B. WING	06/07/2023

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	During an interview on 6/6/23 at 2:12 PM, Certified Nurse Aide (CNA) 5 indicated Resident 28 only spoke Polish and was not able to understand English. CNA 5 indicated new, or agency staff would normally look at the Kardex to learn the care needs of the residents. CNA 5 reviewed the Kardex screen for Resident 28 and indicated it did not contain any information about Resident 28 speaking Polish. Resident 28's record was reviewed on 6/6/23 at 11:21 AM. Diagnoses included hemiplegia and hemiparesis following cerebral infarction following right dominant side, unspecified dementia, and muscle weakness. A review of Resident 28's current quarterly Minimum Data Set (MDS) indicated her BIMS (Basic Interview for Mental Status) score was not available due to the interview not being completed. The MDS indicated Resident 28 was sometimes able to make herself understood and usually understands others. A review of progress notes dated 12/16/22 at 12:13 AM indicated Resident 28 had fallen and was not able to communicate with the staff due to only speaking Polish. A review of Resident 28's current Care plan titled Communication indicated the resident had a problem communicating, with a goal date of 8/7/23. Interventions included anticipating and meeting needs, observe for effectiveness of communication, and refer to speech therapy for evaluation and treatment as ordered. There were no interventions regarding communication helps addressed in the care plan.		***action will be taken:*** 1. Audit of communication language preference for all current residents to be completed by date of compliance. 2. Update Care Plan in PCC with communication method as indicated. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur*:** 1. Education to be provided to staff regarding ensuring resident communication preferences are honored and translation services utilized as indicated by date of compliance. 2. Education to be provided to MDS coordinator regarding ensuring care plan reflects communication preferences by date of compliance. **H*ow the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON and/or designee will complete audit to ensure all new admissions/re-admissions have communication preferences documented correctly in care plan x 6 months. 2. Management team to complete observations to ensure translation services are utilized for non-English speaking residents x 6 months. 2. The results of these	

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	No care plan pertaining to the use of the Polish language was available for review at the time of exit. No speech therapy notes pertaining to communication in the last 12 months were available for review at the time of exit. No progress notes pertaining to offering an interpreter were available for review at the time of exit. A current policy titled Meaningful Communication with Persons with Limited English Proficiency last reviewed 10/7/22 provided by the Administrator on 6/7/23 at 11:27 AM indicated interpreter services should be offered to the resident or representative. 3.1-38(a)(2)(E)		reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 06.30.23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review the facility failed to ensure interventions were implemented to correct significant weight loss for 2 of 8 residents reviewed. (Resident 41 and Resident 23) Findings include: 1. Resident 23's record was reviewed on 6/1/23 at 2:47 PM. Diagnoses included Alzheimer's disease, dementia without behavior, psychotic, and mood disturbance, psychosis not due to a substance or known physiological condition, generalized anxiety disorder, major depressive disorder, cognitive impairment, lymphedema, diaphragmatic hernia without obstruction or gangrene, chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM) type 2, heart failure, stage 4 chronic kidney disease (severe) and adult body mass index [BMI] 36.0-36.9. Resident 23's current comprehensive Minimum Data Set (MDS) assessment, dated 2/22/23, indicated her Basic Interview for Mental Status (BIMS) score was 99 (unable to complete the interview). The MDS indicated the resident was sometimes understood and she usually understood others. The MDS indicated she received diuretics 7 days a week. The MDS did not indicate the resident was at risk for losing weight. Resident 23's current care plan titled Nutrition indicated the resident had a problem of weight fluctuation related to severe cognitive impairment,	F 0692	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** · Resident 41 o Experienced no negative outcomes o A physical assessment was completed on Resident 41 by licensed nursing staff with no issues identified o MD notified with new order received for weekly weights to be obtained with supplemental documentation linked to the order o Supplement orders update to reflect RD recommendations · Resident 23 o Experienced no negative outcomes o A physical assessment was completed on Resident 23 by licensed nursing staff with no issues identified o MD notified with new order received for weekly weights to be obtained with supplemental documentation linked to the order and supplement TID with documented consumption ***How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:***	06/30/2023

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	heart disease, pain, COPD, DM type 2, and use of high-risk medications with a goal to maintain current weight. Interventions included a mechanically altered diet with no salt packets and thin liquid, to obtain and observe weight as scheduled, and refer to the Registered Dietitian for screen as needed. Physician orders dated 3/5/21 at 6:00 AM indicated Resident 23 received 20 mg of Furosemide (a medication to treat fluid retention and swelling) by mouth once a day related to heart failure. Resident 23's weights indicated a 5.70% (severe) weight loss in 1 month and 10.66% (severe) weight loss in 6 months as follows: Date Weight Calculation* Percentage Loss 5/31/2023 183.5 lbs. 4/10/2023 194.6 lbs. 194.6-183.5/194.6 x100 5.70% 11/7/2022 205.4 lbs. 205.4-183.5/205.4x100 10.66% *(Starting weight minus current weight) / (starting weight) x 100 = % of body weight loss In an interview on 6/7/23 at 10:06 AM, the Administrator indicated Resident 23's nurse should have identified the weight loss, had the resident's weight rechecked, and if the weight loss exceeded 5% in 1 month or 10% in 6 months notified the physician of Resident 23's weight loss. The Administrator indicated the resident's nurse did not recheck the resident's May weight. The Administrator indicated Resident 23's record had shown a greater than 5% weight loss in 1 month and 10% weight loss in 6 months. The Administrator indicated the resident's physician		· Residents experiencing significant weight loss have the potential to be affected · Dietary Director and DON/designee will review 90 days weight history on current residents and ensure that the RD has evaluated and that dietary interventions are in place for residents experiencing significant weight loss by date of compliance · Any issues identified via this audit will be addressed by the RD with MD notification as per facility policy. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** · The weight summary report will be run weekly by DON/designee and used to audit to identify any new residents that trigger for a significant weight loss · Licensed and Certified nursing associates will be provided with education by the DON/designee on obtaining accurate weights and ensuring appropriate nutritional interventions have been implemented. · Nursing Management will educate licensed nursing staff on appropriate implementation of RD recommendations by date of compliance ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance***	

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	should have been notified of Resident 23's weight loss.2) In an interview on 6/1/23 at 10:15 AM, Resident 41 indicated she had not unintentionally lost weight. Resident 41's record was reviewed on 6/5/23 at 10:41 AM. Diagnoses included high blood pressure, heart disease and a pressure wound. Resident 41's current quarterly Minimum Data Set assessment (MDS) indicated the residenet's Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). The MDS indicated the resident had a 5 % weight loss in the last month. Resident 41' s current Care plan titled Alteration in Nutrition indicated the resident had a problem of weight loss with a goal date of 8/23/23. Interventions included assistance with meals as needed, diet supplement as ordered for increased protein to promote wound healing, offer substitutes as needed, and obtain weights as ordered and observe for changes. Resident 41's weight summary indicated the resident weighed 106.4 pounds on 4/19/23. The resident weighed 103.6 pounds on 5/5/23. The resident weighed 97.5 pounds on 5/15/23. There were no reweights available for review. Weekly weights were not documented as completed as recommended by the Registered Dietician on 5/5/23. Resident 41's weight on 6/6/23 was 103.1. Current physician orders dated 4/21/23 indicated Resident 41 was to have Prosource Plus 30 milliliters by mouth once daily for wound healing. Progress notes dated 5/3/23 indicated the Registered Dietician (RD) recommended an increase of protein supplements from once to		***program will be put into place?*** · DON/designee will validate nutritional interventions recommended by the RD within 72 hours. This will be a weekly approach that will be ongoing. Any findings will be addressed. · The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6.30.23 The Executive Director at Life Care Center of Lagrange is responsible in ensuring compliance in the plan of correction.	

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	twice daily and weekly weights until the wound healed. An MAR dated May, 2023 indicated Resident 41's Prosource plus was not increased to twice daily. Progress notes dated 5/17/23 the RD indicated the resident had an 8.7% weight loss in 30 days. The RD recommended an increase of protein supplements from twice to three times daily, fortified pudding twice daily and to continue weekly weights until the wound heals. An MAR dated May, 2023 indicated Resident 41's Prosource plus was not increased to three times daily. Resident 41's current tray card did not include fortified pudding. In an interview on 6/5/23 at 3:28 PM Registered Nurse 3 indicated the nursing staff should have notified the physician of RD recommendations A current policy dated 4/25/23 provided by the Administrator on 6/5/23 at 3:05 PM indicated a nursing staff designee was to ensure the physician, resident and family representative were to be notified of a significant change in weight. 3.1-46			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen tubing was properly stored and labeled when not in use for 1 of 3 resident reviewed for respiratory care. (Resident 8). Findings include: During an observation on 6/1/23 at 10:17 AM, Resident 8 was in her chair sleeping wearing her nasal cannula (NC) oxygen tubing (a lightweight tube split into two prongs on one end and placed in the nostrils used to deliver supplemental oxygen) attached to her oxygen condenser (a medical device that gives you extra oxygen). Her portable oxygen condenser (a lightweight transportable oxygen condenser), not in use at that time, was attached to the back of her wheelchair with NC oxygen tubing attached. The NC oxygen tubing extended from the portable oxygen unit and laid on the floor. The NC oxygen tubing was not in a bag labeled with the resident's name. During an observation on 6/1/23 at 11:40 AM, Resident 8 portable oxygen condenser was attached to the back of her wheelchair with NC oxygen tubing attached. The NC oxygen tubing was not being used and wound around the oxygen tank handle. The NC oxygen tubing was not in a bag labeled with the resident's name. During an observation on 6/2/23 at 1:02 PM, Resident 8's portable oxygen condenser (a lightweight transportable oxygen condenser) was	F 0695	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident 8: Oxygen tubing was replaced and placed in a labeled bag. MD was notified on tubing not being connected to concentrator. O2 sats were taken immediately with no issues noted. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. An Audit to be completed by nursing management on residents in house with current 02 orders to ensure orders for changing/labeling tubing are accurate. Audit to be completed by date of compliance. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. DON and/or designee will educate licensed nursing staff and certified aides to observe oxygen tubing to ensure tubing is correctly labelled and bagged by date of compliance. ***How the corrective action will***	06/30/2023

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	attached to the back of her wheelchair with NC oxygen tubing attached. The NC oxygen tubing was not being used and wound around the oxygen tank handle. The NC oxygen tubing was not in a bag labeled with the resident's name. Resident 8's record was reviewed on 06/02/23 at 1:28 PM. Diagnoses included heart failure, and dyspnea. A review of Resident 8's current quarterly Minimum Data Set (MDS) assessment, dated 4/24/23, indicated her Basic Interview of Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated she wore oxygen after arriving at the facility. A review of Resident 8's current care plan titled "Cardiac" indicated the resident was at risk for altered cardiovascular status related to hypertension and a history of heart failure with a goal to be free from cardiac complications. Interventions included the staff may titrate oxygen from 1-5 liters up or down for comfort or complaints of shortness. A review of physician orders dated 1/12/21 at 9:00 AM indicated Resident 8's oxygen could be titrated between 1-5 liters up or down for comfort or complaints of shortness of breath. In an interview on 6/06/23 at 02:15 PM, the Assistant Director of Nursing (ADON) indicated, per facility policy, the NC oxygen tubing should have been in a bag and labeled with Resident 8's name when not in use. A current policy titled "Oxygen Administration/Safety/Storage/Maintenance," reviewed 10/7/22, provided by the Administrator		***be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. DON/Nursing management will observe 5 residents daily Monday through Friday x 8 weeks, then 3 residents daily Monday through Friday x 8 weeks, then 2 residents daily Monday through Friday x 8 weeks to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/30/23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	

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	indicated respiratory supplies should be stored in a bag labeled with the resident's name when not in use. 3.1-47(a)(4)(5)(6)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility failed to ensure a personalized plan of care was initiated related to post-traumatic stress disorder for 1 of 1 resident reviewed. (Resident 24) Findings include: In an interview on 6/2/23 at 11:42 AM, Resident 24 indicated she suffered from anxiety, panic attacks, and post-traumatic stress disorder. The resident indicated she had problems sleeping and at times was reluctant to voice her needs to the staff due to the fear of being a bother. Resident 24's record was reviewed on 6/5/23 at 9:45 AM. Diagnoses included major depressive disorder, post-traumatic stress disorder (PTSD) and night terrors. A review of Resident 24's current quarterly Minimum Data Set (MDS) assessment indicated their Basic Interview for Mental Status (BIMS)	F 0699	**What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:** 1. Resident # 24: Care Plan updated to reflect post-traumatic stress disorder. 2. No negative outcomes noted. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** 1. Trauma Informed Care assessment audit to be completed by date of compliance on all current residents to ensure a personalized care plan is in place. **What measures and what systemic changes will be made to ensure that the deficient**	06/30/2023

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	score was 14 (cognitively intact). The MDS indicated the resident had sleeping difficulties. A review of Resident 24's current Care Plan titled Behavior indicated the resident had a problem of feeling burdensome to the facility staff with a goal date of 7/7/23. Interventions included administer medications as ordered, verbal assurance, distraction, attempt to determine underlying cause, and positive praise. A review of Resident 24's current Care Plan titled Mood indicated the resident had a problem with depression and night terrors with a goal date of 7/7/23. Interventions included a psychiatric consult, gradual reduction of medications, verbal assurance, positive redirection, and encouragement of expression. A review of Resident 24's Trauma Informed Care (TIC) assessment dated 12/29/20 indicated the resident had personally experienced and witnessed multiple traumatic events. The TIC assessment indicated the resident had frequent, strong physical reactions to unwanted memories of the events. The TIC assessment indicated the resident had strong negative feelings of guilt and self-blame, and frequently had problems falling asleep or staying asleep. In an interview on 6/6/23 at 11:50 AM, the Administrator indicated Resident 24 had been speaking with a counselor related to PTSD. The Administrator indicated the Social Service Director (SSD) was responsible for mental health condition care, but there was currently no SSD for the facility. The Administrator indicated the facility was responsible to identify stressors related to the resident's night terrors and negative self-viewas well as symptoms of PTSD. The		**practice doesn't recur:** 1. Education provided to MDS coordinator regarding ensuring a personalized care plan is in place for all residents that have a history of trauma by date of compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** 1. MDS coordinator/Designee to audit trauma informed care assessment to ensure personalized care plan is in place weekly x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Date of compliance: 06/30/2023 The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	

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	Administrator indicated the facility did not have a policy related to TIC or PTSD care. The American Psychiatric Association (APA, 2022) indicated patients diagnosed with PTSD may experience frequent intrusive thoughts, nightmares, sleep disturbances, and strong feelings of guilt, shame and unworthiness. Reference American Psychiatric Association. (2022). Trauma and Stressor Related disorders. In Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.). https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the environment was maintined in 5 of 5 rooms reviewed. 5 residents resided in the 5 rooms affected (Resident 9, Resident 10, Resident 12, Resident 26 and Resident 38). Findings include: During an observation on 6/1/23 at 9:23 AM all handrails on the 300, 400, and 500 halls were observed to have bare portions missing finish. Carpeted walls on each of these halls had stains in one-to-six-inch strips. Floor carpeting was observed to have round brown, red and yellowish	F 0921	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Room 305: corner of the wall adjacent to the bathroom to be painted, cracked floor tiles to be replaced 2. Room 306: scratch on back of door to be painted, cracked floor tiles to be replaced 3. Room 308: Black marks at the bottom of the bathroom door and closet door to be removed 4. Room 309: Wall to	07/07/2023

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	06/07/2023

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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	stains form quarter to dinner plate sized throughout all halls too many to count. A document titled Resident Room Check dated 5/31/23 received from the Administrator on 6/1/23 at 2:10 PM was reviewed. The document indicated rooms should be checked for wall and trim paint damage and floor tile damage. The document indicated rooms 305, 306, 308, 309 and 310 were checked and marked completed on time by the Maintenance Man on 5/31/23. Room 305 was observed on 6/5/23 at 9:38 AM. A 2-inch section and a 3.5-inch section of chipped paint was observed on the corner of the wall adjacent to the bathroom. Floor tiles in the main walkway of the room contained a large crack across 3.5 tiles. Two residents reside in room 305. In room 306, a 12-inch scratch was observed on the back side of the door. 6 floor tiles had large cracks across the entire length of each tile. No residents resided in room 306. In room 308, 6-inch by 1-inch black marks were observed near the bottom of the inside of the bathroom door. 6-inch by 2-inch black marks were observed near the bottom of the closet door. No residents resided in room 308. In room 309, a 6-foot section of the wall had grey markings, linear in all directions, too many to count. 6 inch by 0.25-inch black marks were present on the bottom door panels. Rust colored discolorations the size of a pencil lead were present, too many to count throughout the molding on the closet doors. A 12-inch by 1-inch area of chipped paint was observed on the back of the entry door. 1 to 2-inch segments of chipped paint, too numerous		be painted, black marks on bottom door panels to be removed, molding on closet doors to be painted, and inside of bathroom door to be painted 5. Room 310: closet doors to be painted 6. The handrails on the 300, 400, and 500 halls to be refinished 7. The flooring in the 300, 400, and 500 halls to be replaced 8. Wall carpeting to be cleaned ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Other residents had the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Environmental rounds have been completed by maintenance department and plan has been put into place to address scratched/marred walls and doors, cracked floor tiles, handrails missing finish, and stained carpeted walls and floor carpeting on or prior to 7/7/23. 2. The Maintenance Director and/or designee will include identified areas in the current preventive maintenance	

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	to count, were observed on the lower third of the inside of the bathroom door. One resident resided in room 309. In room 310, 6-inch linear markings were observed on the bottom of the closet door. Rust colored spots the size of a pencil lead were observed on the closet doors, too numerous to count. In an interview and observation conducted on 6/5/23 at 10:09 AM, the Administrator indicated the observations in rooms 305, 306, 308, 309, and 310 did not meet the facility's environmental standards. In an interview on 6/5/23 at 11:09 AM, the Maintenance Man indicated he was unable to get to everything on the room check list and prioritized the greatest needs. An invoice dated 11/9/22 from Stanley Steemer for carpet cleaning services was received on 6/1/23 at 2:10 PM from the Administrator. No other invoices or carpet cleaning records were available for review at the time of exit. A current policy titled Plant Operations last reviewed 7/28/22 provided by the Administrator on 6/7/23 at 11:30 AM indicated the facility should maintain a safe, clean, and structurally sound environment. A current policy titled Carpet Shampooing last reviewed 7/28/22 provided by Administrator on 6/7/23 at 11:27 indicated all carpeted floors should be cleaned in a manner to ensure that carpets were free of obvious carpet spots and stains. 3.1-19(4)(f)		program and conduct routine resident room rounds according to the facility policy. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Maintenance Director and/or designee to conduct resident room observations 5x weekly for next 6 months to ensure the resident's environment is in good repair from marred/scratched walls, chipped paint, cracked tile, and stained carpeted walls and floor carpeting. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 7.7.23. The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	