STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155344	A. BUILDING 00 B. WING	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00430795, IN00430978 and IN00431405. Complaint IN00430795 - Federal/State deficiencies related to the allegations are cited at F554 and F684. Complaint IN00430978 - Federal/State deficiencies related to the allegations are cited at F684 and F689. Complaint IN00431405 - Federal/State deficiencies related to the allegations are cited at F580, F684, and F689. Survey dates: April 1 and 2, 2024 Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 20 Medicaid: 49 Other: 16 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/9/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terri Phillips	Executive Director	04/19/2024

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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F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had an assessment and Physician's Orders to self-administer their own medications, for 4 of 4 residents reviewed for self-administration of medication. (Residents C, F, G and H) Findings includes 1. During a random observation on 4/1/24 at 1:37 p.m., Resident C was observed in bed and awake. The resident was confused and not oriented to time and place. At that time, there was a tube of Bacitracin ointment on the dresser and 1 over the counter bottle of Genteal tears eye solution. The bottle of eye drops was located on a high top dresser and completely out of reach for the resident. During a random observation, on 4/2/24 at 8:25 a.m., the resident was observed in bed. At that time, the bottle of eye drops was still located on the high top dresser and out of reach for the resident. The record for Resident C was reviewed on 4/1/24 at 3:20 p.m. Diagnoses included, but were not limited to, contusion right lower leg and foot, osteoarthritis, dry eye syndrome, high blood pressure, difficulty walking, and muscle weakness. Physician's Orders, dated 3/28/24, indicated Bacitracin Zinc External Ointment, apply to toes topically one time a day and leave open to air until	F 0554	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 Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City 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. F554 Residents Self Administer Medications-clinically appropriate What corrective actions will be accomplished for those residents found to be affected by this deficient practice: 1. Resident C: The Bacitracin ointment and eye drops were removed from her bedside table and her dresser. Both items were placed in the appropriate cart per	04/30/2024

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	healed. Physician's Orders, dated 8/20/23, indicated Refresh Tears 0.5%, instill 1 drop in both eyes three times a day for dry eyes. The patient may self-administer. There was no documentation of a self-administration of medication assessment or an order for the Bacitracin ointment to be left at the bedside. During an interview, on 4/2/24 at 11:30 a.m., the Director of Nursing (DON) indicated the resident's son could have brought in the bottle of eye drops and given them to her, however, the Bacitracin ointment should not have been left at the bedside. 2. During a random observation, on 4/1/24 at 1:00 p.m., Resident F was observed sitting on the side of the bed. At that time, the Physical Therapist (PT) was in the room preparing to change the bandages on the left foot. There were 2 medication cups observed on the resident's over bed table with the resident's name written on them. One of the medication cups contained 1 white unidentified pill. During an interview at that time, the resident indicated it was a Melatonin tablet that he had requested last evening, but never took it. The record for Resident F was reviewed on 4/2/24 at 9:25 a.m. The resident was admitted on 3/6/24 from the hospital. Diagnoses included, but were not limited to, osteomyelitis left ankle and foot, abscess to the left foot, type 2 diabetes, open wound to the left foot, high blood pressure, and peripheral vascular disease.		medication administration policy. No negative outcomes were noted. 2. Resident F: Evening shift nurse from 3-31-24 was educated on 4-4-24 regarding not leaving medications at the bedside. Medication that was left at the bedside was disposed of per policy. No negative outcomes were noted. 3. Resident G: Self administration of medication assessment was completed. Resident now has an order to self-administer eye drops and may leave them at the bedside. No negative outcomes were noted. She has received training and a lock box to store medication. 4. Resident H: Day shift nurse from 4-1-24 was educated on 4-15-24 regarding not leaving medications at the bedside. No negative outcomes were 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. The DON completed a full house audit on 4-3-24 and one additional resident was identified that was self-administering medications without an assessment. Self-administration assessment was completed and the order to keep at bedside was updated. What measures and what systemic changes will be made to	

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	The Admission Minimum Data Set (MDS) assessment, dated 3/8/24, indicated the resident was cognitively intact for daily decision making. The resident was admitted with a diabetic foot ulcer. Physician's Orders, dated 3/12/24, indicated Melatonin 5 milligrams (mg), give 1 tablet by mouth as needed for insomnia. There was no documentation of a self-administration of medication assessment or a Physician's Order to self-administer his own medications. During an interview, on 4/2/24 at 11:30 a.m., the Director of Nursing indicated she was aware of the medication cups with the resident's name on them and the pill that was left inside of one of them. She had them on her desk in her office. The resident had no order to self-administer his own medications or an assessment to do so. 3. During a random observation, on 4/1/24 at 9:50 a.m., Resident G was observed in her bed reading a book. At that time, there was a bottle of eye drops placed inside a medication cup on the over bed table. The resident indicated she administered the eye drops to herself every evening, that way she knew she got them. The record for Resident G was reviewed on 4/2/24 at 11:14 a.m. Diagnoses included, but were not limited to, high blood pressure and type 2 diabetes. Physician's Orders, dated 1/25/23, indicated Latanoprost Ophthalmic Solution 0.005%, instill 1		ensure the practice does not recur 1. All licensed nursing staff received education by the DON on 4-4-24 regarding the right to self-administer medications when clinically appropriate along with the need for the completion of a self-administration assessment and an appropriate order. 2. New licensed nursing staff will receive this education prior to working. How will the corrective action be monitored to ensure the deficient practice will not recur: 1. The DON and/or designee will audit all intake assessments for all residents to verify a self-administration assessment has been completed and those that can self-administer, have the opportunity to self-administer their medications, 3x weekly x 2months, then 2x weekly x 2 months, then weekly x 2months. 2. The results of these reviews will be discussed monthly at the QAPI meeting for a total of 3 months and then quarterly thereafter. Frequency and duration of the reviews will be increased as needed. Compliance date: 4.30.24 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	

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	drop in both eyes at bedtime for ocular hypertension. There was no Physician's Order for the resident to self-administer the eye drops. There was no self-administration of medication assessment to self-administer the eye drops. During an interview, on 4/1/24 at 1:25 p.m., the Director of Nursing indicated there was no order for the resident to administer the eye drops or a self-administration of medication assessment completed. 4. During a random observation, on 4/1/24 at 9:59 a.m., Resident H was seated in a wheelchair with an over bed table. There was a medication cup on that table with 3 white pills on a napkin. During an interview with the resident at that time, she indicated she was taking her water pills. The record for Resident H was reviewed on 4/2/24 at 10:16 a.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, edema, chronic obstructive pulmonary disease. The Care Plan, dated 3/6/24, indicated, the resident had a Physician's Order for self-administration of the following medications: Vicks VapoRub, Saline Nasal Spray, Sore throat spray, Ludens throat drops, and an inhaler. There was no Physician's Order for the resident to self-administer her daily medications. There was no self-administration of medication assessment to self-administer her daily medications. During an interview, on 4/2/24 at 1:15 p.m., the Director of Nursing indicated the resident had no			

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	Physician's Order to self-administer her daily medications and no assessment completed. The current 8/29/24 "Self-Administration of Medication" policy, provided by the Infection Preventionist on 4/2/24 at 12:54 p.m., indicated the team in consultation with the Physician for the resident will conduct an assessment of the resident's cognitive, physical, and visual ability to carry out this responsibility. The interdisciplinary assessment will be completed in the electronic medication record. This citation relates to Complaint IN00430795. 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in			

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	§483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's Physician was notified in a timely manner of increased pain and leg swelling, for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: The closed record for Resident D was reviewed on 4/1/24 at 1:04 p.m. Diagnoses included, but were not limited to, history of falling, metabolic	F 0580	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 Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such	04/30/2024

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	encephalopathy (an infection that causes brain damage), and osteomyelitis (bone infection). The Significant Change Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident was cognitively impaired for daily decision making and dependent on staff for bed mobility and transfers. An Event Note, dated 3/14/24 at 3:00 p.m., indicated the CNA asked LPN 1 to look at the resident's right leg. The resident's leg was assessed and their left leg was observed to be pressing against the right leg. An indentation from the left leg was visible on the right leg. The right leg had bruising and a "stage one" area to the right leg. The Nurse Practitioner (NP), Director of Nursing (DON), and the resident's spouse were notified. The NP assessed the resident and ordered a pillow to be placed between the resident's legs at bedtime. A Nurses' Note, dated 3/14/24 at 9:04 p.m., indicated the resident had received two Tylenol 325 milligram (mg) tablets for pain. An entry at 10:14 p.m., indicated the NP was notified the resident appeared to be in pain throughout the day but would not complain. A Nurses' Note, dated 3/15/24 at 9:31 a.m., indicated the resident was receiving 650 mg Tylenol twice a day (BID) for complaints of leg pain, continued as ordered. A Skilled Note, dated 3/15/24 at 11:03 a.m., indicated routine Tylenol continued for complaints of leg pain. A Nurses' Note, dated 3/15/24 at 1:45 p.m., indicated an x-ray of the left hip and knee was		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. F580 Notification of Changes What corrective actions will be accomplished for those residents found to be affected by this deficient practice: 1. Resident D no longer resides at the facility. 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. The DON completed a full house audit on 4-4-24 and no additional residents were identified that the MD had failed to be notified of a change. What measures and what systemic changes will be made to ensure the practice does not recur 1. All licensed nursing staff were educated by the DON on 4-4-24 regarding timely notification to MD of any significant changes. 2. New licensed nursing staff will receive this education prior to working. How will the corrective action be	

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	ordered related to pain and deformity. At 6:20 p.m., the NP was notified of the x-ray results and orders were received to send the resident to the emergency room. The resident was diagnosed with a left femoral shaft fracture and bilateral tibia/fibula fractures with diffuse osteoporosis. A facility investigation was initiated. A statement obtained from LPN 1 on 3/15/24 indicated a CNA asked the LPN to look at the resident's right leg. The resident's leg was assessed and the left leg was observed to be pressing against the right leg. An indentation from the left leg was visible on the right leg. The right leg was bruised with a nonblanchable red spot. The NP assessed the resident and ordered a pillow to be placed between the resident's legs at bedtime. Around 9:20 p.m., she began to complete sacral wound care. As the LPN and CNA were turning the resident in bed, the resident was to be groaning more as if in pain. The resident denied pain. The LPN asked the CNA if she thought the resident appeared to be in more pain than usual, and the CNA replied she wasn't sure. The LPN noticed the left leg looked "deformed" but with no bruising or swelling. On 3/15/24 at about 7:00 a.m., the same CNA told LPN 1 the resident did seem to be in more pain, although the resident denied being in pain. The LPN reached to touch the resident's left leg to see if it hurt. The resident slapped the LPN's hand away and admitted that the left leg did hurt. The NP was notified. During an interview, on 4/2/24 at 11:50 a.m., LPN 1 indicated when she was completing wound care for Resident D, the resident seemed to be in more pain than usual, even though the resident denied the pain. LPN 1 indicated she couldn't call the NP		monitored to ensure the deficient practice will not recur: 1. The DON and/or designee will review 24/72 hour report to verify that MD/NP notification occurred as required for changes 3x weekly x 2months, then 2x weekly x 2 months, then weekly x 2month. 2. The results of these reviews will be discussed monthly at the QAPI meeting for a total of 3 months and then quarterly thereafter. Frequency and duration of the reviews will be increased as needed. Compliance date: 4.30.24 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction	

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	because it was too late, there were signs posted at the nurses' stations that her hours were until 9:00 p.m., and even though the resident seemed to be in pain, she voiced she wasn't, that's why she didn't call. The NP had assessed the resident earlier in the day. She also indicated the resident's left leg looked different during wound care, but she wasn't sure if that was the norm or not due to having contractures. LPN 1 indicated the next morning, the resident's left leg definitely looked different and wouldn't let her touch it, the resident kept "shooing" her hand away. It was then that she notified the NP again, and the resident was seen and orders were received. During an interview, on 4/2/24 at 1:20 p.m., the Director of Nursing indicated the Physician should have been contacted after the resident seemed to be experiencing pain, and after the leg swelling was noted. Even if the NP did not want to be contacted after 9:00 p.m., the Physician should have been contacted. The DON indicated staff could call her any time for guidance. This citation relates to Complaint IN00431405. 3.1-5(a)(2)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident was sent to the hospital in a timely manner, related to complaints of increased pain and leg swelling, for 1 of 3 residents reviewed for accidents. The facility also failed to ensure treatments were completed for diabetic ulcers and an assessment was completed for new non-pressure wounds to the toes, for 3 of 3 residents reviewed for skin conditions non-pressure related. (Residents D, B, C, and F) Findings include: 1. The closed record for Resident D was reviewed on 4/1/24 at 1:04 p.m. Diagnoses included, but were not limited to, history of falling, metabolic encephalopathy (an infection that causes brain damage), and osteomyelitis (bone infection). The Significant Change Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident was cognitively impaired for daily decision making and dependent on staff for bed mobility and transfers. A Care Plan, dated 1/23/24, indicated the resident required ADL (activities of daily living) assistance and therapy services to maintain or attain their highest level of function. Interventions included, but were not limited to, extensive assist of 2 to complete transfers. A Physician's Order, dated 2/19/24, indicated the resident was to receive Acetaminophen (Tylenol) 325 milligrams (mg), 2 tablets every 4 hours as needed (PRN) for pain or fever. Nurses' Notes, dated 3/14/24 at 2:30 p.m., indicated the resident was medicated with two	F 0684	his plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City 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. F684 Quality of Care What corrective actions will be accomplished for those residents found to be affected by this deficient practice: 1. Resident D is no longer at this facility 2. Resident B is no longer at this facility 3. Resident C had a wound assessment completed on 4-4-24 by the wound nurse. No negative outcome was noted 4. Resident F was assessed by the wound care nurse on 4-3-24 and the treatment was completed. No negative outcome was noted	04/30/2024

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LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Tylenol 325 mg tablets for complaints of right leg pain. An Event Note, dated 3/14/24 at 3:00 p.m., indicated the CNA asked LPN 1 to look at the resident's right leg. The resident's leg was assessed and the left leg was observed to be pressing against the right leg. An indentation from the left leg was visible on the right leg. The right leg had bruising and a "stage one" area to the right leg. The Nurse Practitioner (NP), Director of Nursing (DON), and the resident's spouse were notified. The NP assessed the resident and ordered a pillow to be placed between the resident's legs at bedtime. The resident was helped out of bed. The resident was complaining of pain and given as needed (PRN) Tylenol. A Nurses' Note, dated 3/14/24 at 9:04 p.m., indicated the resident had received two Tylenol 325 mg tablets for pain. An entry at 10:14 p.m., indicated the NP was notified that the resident appeared to be in pain throughout the day, but would not complain. A Physician's Order, dated 3/14/24, indicated the resident was to receive Tylenol 325 mg, 2 tablets twice a day for pain starting 3/15/24. A Nurses' Note, dated 3/15/24 at 9:31 a.m., indicated the resident was receiving 650 mg Tylenol twice a day (BID) for complaints of leg pain, continued as ordered. A Skilled Note, dated 3/15/24 at 11:03 a.m., indicated routine Tylenol continued for complaints of leg pain. A Nurses' Note, dated 3/15/24 at 1:45 p.m.,		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. The DON completed a full house audit on 4-5-24 on all residents with bruising and pain to verify that an x- ray or other appropriate interventions were ordered. No additional residents were identified requiring additional interventions. 2. The wound nurse completed a full house audit on those residents that had treatments on 4-5-24. No additional missing treatments were identified. 3. On 4-5-24 the wound nurse completed a full house audit to verify that wound assessments were completed on all residents with wounds and open areas. No additional concerns were found. What measures and what systemic changes will be made to ensure the practice does not recur 1. All licensed nursing staff received education by the DON on 4-4-24 regarding obtaining orders for any additional interventions for residents with bruising and/or pain, treatments completed per MD orders, wound assessments completed on all residents with wounds and open areas. 2. New licensed nursing staff will receive this education prior to working. How will the corrective action be	

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	indicated an x-ray of the left hip and knee was ordered, related to pain and deformity. At 6:20 p.m., the NP was notified of the x-ray results and orders were received to send the resident to the emergency room. At 6:32 p.m., transport was dispatched to the facility. The resident was admitted to the hospital with a left femoral shaft fracture and bilateral tibia/fibula fractures with diffuse osteoporosis. A facility investigation was initiated. A statement obtained from LPN 1 on 3/15/24 indicated a CNA asked the LPN to look at the resident's right leg. The resident's leg was assessed and the left leg was observed to be pressing against the right leg. An indentation from the left leg was visible on the right leg. The right leg was bruised with a nonblanchable red spot. The NP assessed the resident and ordered a pillow to be placed between the resident's legs at bedtime. Around 9:20 p.m., the LPN began to complete sacral wound care. As the LPN and CNA were turning the resident in bed, the resident was to be groaning more as if in pain, although the resident denied pain. The LPN asked the CNA if she thought the resident appeared to be in more pain than usual and the CNA replied she wasn't sure. The LPN noticed the left leg looked "deformed", but had no bruising or swelling. On 3/15/24 at about 7:00 a.m., the same CNA told LPN 1 the resident did seem to be in more pain. The resident denied being in pain. The LPN reached to touch the resident's left leg to see if it hurt. The resident slapped the LPN's hand away and admitted that the left leg did hurt. The NP was notified. During an interview, on 4/2/24 at 11:50 a.m., LPN 1 indicated when she was completing wound care for Resident D, the resident seemed to be in more		monitored to ensure the deficient practice will not recur: 1. The DON or designee will audit all residents receiving treatments and wound care for assessments and treatments as ordered, 5 residents 3x weekly x 2months, then 2x weekly x 2 months, then weekly x 2 months. 2. The results of these reviews will be discussed monthly at the QAPI meeting for a total of 3 months and then quarterly thereafter. Frequency and duration of the reviews will be increased as needed. Compliance date: 4.30.24 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	

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	pain than usual, even though the resident denied the pain. LPN 1 indicated she couldn't call the NP because it was too late, there were signs posted at the nurses' stations that her hours were until 9:00 p.m. and even though the resident seemed to be in pain, they voiced they weren't, that's why she didn't call. The NP had assessed the resident earlier in the day. She also indicated the resident's left leg looked different during wound care, but she wasn't sure if that was the norm or not due to having contractures. LPN 1 indicated the next morning, the resident's left leg definitely looked different and the resident wouldn't let her touch it, the resident kept "shooing" her hand away. It was then that she notified the NP again, and the resident was seen and orders were received. During an interview, on 4/2/24 at 1:20 p.m., the Director of Nursing (DON) indicated x-rays should have been ordered when the bruising and pain were noted on 3/14/24 or the resident should have been sent out for evaluation. The DON indicated staff could call her any time for guidance. 2. The closed record for Resident B was reviewed on 4/1/24 at 11:32 a.m. The resident was admitted on 1/5/24 from the hospital, and expired in the facility on 3/13/24. Diagnoses included, but were not limited to, stroke, sepsis, absence of the left foot, chronic kidney disease, end stage renal disease, type 2 diabetes, atrial fibrillation, adult failure thrive, dependence on renal dialysis, high blood pressure, and severe peripheral vascular disease. The Admission Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was cognitively intact for daily decision making and needed substantial to maximal assist with rolling to the left and right. The resident was			

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	admitted with diabetic ulcers. The Care Plan, revised on 3/14/24, indicated the resident had diabetic ulcers to the right inner ankle, left foot, right 4th toe, right great toe, right second toe, right lateral foot, and right heel. A Nursing Admission Assessment, dated 1/5/24, indicated the resident was admitted with necrotic areas to both feet and right heel, an open wound with necrotic tissue to the right inside of the right foot, and an open wound to the left outer foot. The Wound Observation Tool, dated 1/10/24, indicated the following wounds and measurements: a. right heel: 100% black necrotic tissue with no drainage, measured 6 centimeter (cm) by 3.8 cm. b. right lateral foot: 100% black necrotic tissue with no drainage, measured 6 cm by 2.9 cm. c. right great toe: 100% black necrotic tissue with no drainage, measured 1.8 cm by 1.5 cm. d. right 4th toe: 100% black necrotic tissue with no drainage, measured 1.5 cm by 1.5 cm e. left foot (stump): granulation tissue with small amount of drainage, measured 4.8 cm by 3.4 cm by 0.3 cm (depth) f. right inner ankle: 100% black necrotic tissue with no drainage, measured 2.5 cm by 2 cm The Wound Observation Tool, dated 2/28/24, indicated the following wounds and measurements: a. right heel: 100% black necrotic tissue with no drainage, measured 7.5 centimeter (cm) by 6 cm. b. right lateral foot: 100% black necrotic tissue with no drainage, measured 3.2 cm by 3 cm. c. right great toe: 100% black necrotic tissue with no drainage, measured 1.5 cm by 2.5 cm. d. right 4th toe: 100% black necrotic tissue with no			

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	drainage, measured 1.5 cm by 1.5 cm Physician's Orders, dated 1/5/24, indicated to cleanse the left outer foot with normal saline, apply a non-adherent gauze, and wrap with kerlix, every Tuesday, Thursday and Saturday. Physician's Orders, dated 1/10/24, indicated to cleanse the wounds to the right heel, right lateral foot, right great toe and 4th toe with normal saline, apply Iodosorb External Gel 0.9%, and cover with a non-adherent gauze and wrap with kerlix, every Tuesday, Thursday and Saturday. The Treatment Administration Record (TAR), dated 1/2024, indicated the Iodosorb treatment to the right foot wounds was coded with a "10" (other see nurses notes) on 1/11 and a "7" (hold see progress notes) on 1/18/24. The left outer foot bandage change was not signed out as being completed and was coded with a "10" on 1/11/24 and a "7" on 1/18/24. Nurses' Notes, dated 1/11/24 at 2:45 p.m., indicated "...Bandages not changed today per wound care nurse, [name] LPN. Bandages changed and treatment done yesterday. Bandages are clean and dry Schedule will resume on Saturday. Pt. [patient] aware." Nurses' Notes, dated 1/18/24 at 1:53 p.m., indicated wound treatments were not completed due to the resident being at the foot doctor. Physician's Orders, dated 2/1/24, indicated to cleanse the right heel, right great toe, right lateral foot and right ankle with normal saline, apply a foam dressing, and wrap with kerlix, every Monday, Wednesday, and Saturday for black areas. Cleanse the left outer foot with normal			

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	saline, apply Iodosorb to the wound, cover with a dry dressing, and wrap with kerlix, every other day. The 2/2024 TAR, indicated a "7" was documented on 2/12/24 and the treatments were not signed out as being completed, for both the right foot and left outer foot. Nurses' Notes, dated 2/12/24 at 1:55 p.m., indicated the wound treatments were not completed as ordered due to the treatments being done the previous shift. There was no documentation on the TAR or in Nurses' Notes to indicate the treatment to the resident's wounds had been completed on the previous shift. During an interview, on 4/2/24 at 11:30 a.m., the Wound Nurse indicated the resident's wound treatments should have been completed as ordered by the doctor. 3. During a random observation, on 4/1/24 at 1:37 p.m., Resident C was observed in bed and awake. The resident's feet were observed in bilateral heel boots, and the top of her toes on both feet were noted with dried blood and open areas. The record for Resident C was reviewed on 4/1/24 at 3:20 p.m. Diagnoses included, but were not limited to, contusion right lower leg and foot, osteoarthritis, dry eye syndrome, high blood pressure, difficulty walking, and muscle weakness. The resident was admitted to the hospital on 3/18/24 after a fall, and returned back to the facility on 3/21/24.			

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Physician's Orders, dated 3/21/24 and discontinued on 3/28/24, indicated Bacitracin Ointment, apply to the toes topically, one time after cleansing with normal saline, and cover with a Band-Aid.

Physician's Orders, dated 3/28/24, indicated Bacitracin Zinc External Ointment, apply to the toes topically, one time a day, and leave open to air until healed.

The Nurse Admission Assessment, dated 3/21/24, indicated the resident was readmitted with "lost toe nails on both feet" and there was a treatment in place.

There was no wound assessment of the resident's toes and open areas.

During an interview, on 4/2/24 at 1:15 p.m., the Director of Nursing indicated there was no assessment of the resident's feet and her missing toe nails.

4. During a random observation, on 4/1/24 at 1:00 p.m., Resident F was observed sitting on the side of the bed. At that time, the Physical Therapist (PT) was in the room preparing to change the bandages on the left foot. The resident's left heel was observed with a large amount of yellow slough (dead tissue, usually cream or yellow in color) and a moderate amount of black necrotic tissue. There was also another black and hard necrotic area on the left foot between the second and third toes. After cleansing the wound, the PT squeezed a dime size amount of Santyl (debriding agent) ointment onto a dry gauze sponge. She picked up the gauze sponge and spread the Santyl

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	ointment onto the wound, and left the sponge in place. She then put a dry foam bandage over the top of the gauze sponge and wrapped the foot with a kerlix bandage. During an interview at that time, the PT indicated they were only doing a treatment to the left heel. On 4/2/24 at 8:22 a.m., the resident was observed sitting up in bed with the left foot in a heel boot and a red non-skid sock over the tip of his foot. The resident was asked to remove the red sock so the bandage could be viewed. After the sock was removed, there was no bandage observed covering the black necrotic area between the second and third toe. The resident indicated no staff had completed a treatment to the toe the previous day. The record for Resident F was reviewed on 4/2/24 at 9:25 a.m. The resident was admitted on 3/6/24 from the hospital. Diagnoses included, but were not limited to, osteomyelitis left ankle and foot, abscess to the left foot, type 2 diabetes, open wound to the left foot, high blood pressure, and peripheral vascular disease. The Admission Minimum Data Set (MDS) assessment, dated 3/8/24, indicated the resident was cognitively intact for daily decision making. The resident was admitted with a diabetic foot ulcer. Physician's Orders, dated 3/29/24, indicated to cleanse the left second toe with wound wash, apply Santyl, cover with gauze, and wrap in kerlix, every evening shift. Physician's Orders, dated 4/1/24, indicated PT wound care to the left heel 5 times a week for 30			

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	days. Cleanse the area with wound cleanser, and perform sharp, selective debridement using forceps, scissors, or scalpel. The PT may perform CPI (Close Pulse Irrigation) as needed to remove nonviable, necrotic tissue to the wound bed. Apply Santyl and cover with a foam dressing. The Wound Observation Tool, dated 3/27/24, indicated the following measurements: a. left toe, unchanged, 100% black necrotic and measured 1 centimeter (cm) by 0.8 cm. b. left heel, unchanged 25% black necrotic and 75% slough, measured 6 cm by 6 cm. During an interview, on 4/2/24 at 11:30 a.m., the Director of Nursing indicated treatments were to be done as ordered by the Physician. The current 3/31/23 "Skin Integrity and Pressure Ulcer/Injury Prevention and Management" policy, provided by the Infection Preventionist on 4/2/24 at 12:34 p.m., indicated a skin assessment/inspection occurred on admission/readmission. Skin observations also occurred throughout points of care provided by CNAs. Any changes or open areas were to be reported to the nurse, as well as if topical bandages were identified as soiled, saturated, or dislodged. The nurse would complete further inspection/assessment and provide treatment if needed. This citation relates to Complaints IN00430795, IN00430978, and IN00431405. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided in the shower for a resident who was leaning in their shower chair, for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: The closed record for Resident D was reviewed on 4/1/24 at 1:04 p.m. Diagnoses included, but were not limited to, history of falling, metabolic encephalopathy (an infection that causes brain damage), and osteomyelitis (bone infection). The Significant Change Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident was cognitively impaired for daily decision making and dependent on staff for bed mobility and transfers. A Care Plan, dated 1/23/24, indicated the resident required ADL (activities of daily living) assistance and therapy services to maintain or attain their highest level of function. Interventions included, but were not limited to, extensive assist of 2 to complete transfers. Nurses' Notes, dated 2/11/24 at 10:05 p.m., indicated the CNA notified the writer the resident was on the floor in the shower room. The resident was assessed and a bump was noted on the left	F 0689	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 Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City 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. F689 free from accidents hazards What corrective actions will be accomplished for those residents found to be affected by this deficient practice: 1. Resident D is no longer at this facility How other residents having the	04/30/2024

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	side of their forehead. The resident was a three person assist back into the wheelchair. The resident was transferred back to bed with a two person assist. Neurological checks were performed and the resident was later transported to the hospital for evaluation. The facility fall investigation, dated 2/11/24, indicated the resident was being assisted in the shower room and they were leaning in the shower chair. The CNA attempted to reposition them and they fell forward hitting their face. The resident was noted to have a bump on the left side of the forehead. . A statement obtained from the CNA, on 2/11/24, indicated the incident took place on 2/11/24 at 5:00 p.m. The CNA indicated when she was in the shower room with the resident, they kept leaning over in the shower chair. The CNA tried readjusting the resident a few times, but they kept leaning, and then they leaned again and the chair tipped over, and the resident fell on their face. During an interview, on 4/2/24 at 1:20 p.m., the Director of Nursing (DON) indicated the CNA who had the resident in the shower room should have pulled the emergency call light and waited for more assistance. The DON indicated the resident did not normally lean in the shower chair when being bathed. This citation relates to Complaints IN00430978 and IN00431405. 3.1-45(a)(2)		potential to be affected by the same deficient practice will be identified and what corrective action will be taken 1. The DON completed a full house audit on all residents that used shower chairs to verify that there were no safety concerns with their positioning on 4-9-24. No additional residents were identified requiring additional interventions. What measures and what systemic changes will be made to ensure the practice does not recur 1. All licensed nursing staff received education by the DON on 4-4-24 on positioning/safety concerns when showering residents and utilizing the call light system for assistance if needed. 2. New licensed nursing staff will receive this education prior to working. How will the corrective action be monitored to ensure the deficient practice will not recur: 1. The DON/designee will audit 5 residents 3X weekly utilizing shower chairs when showering for positioning/safety through direct observation x3 months and then 5 residents weekly x3 months. 2. The results of these reviews will be discussed monthly at the QAPI meeting for a total of 3 months and then quarterly thereafter. Frequency and duration of the reviews will be increased as needed. Compliance date: 4.30.24	

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			The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	