CENTERS FO	R MEDICARE & MED	ICAID SERVICES				ON	IB NO. 0938-039	
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMP	LETED	
		155344	B. W	ING		04/02/2024		
				CERTE	A DODEGO OUTV CT ATE JID COD			
NAME OF	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP COD			
	DE OENTED OF	MOULO AND OUT!			HIGHWAY 20 EAST			
LIFE CA	RE CENTER OF I	WICHIGAN CITY		MICHIC	GAN CITY, IN 46360			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE	COMPLETION	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00								
		the Investigation of Complaints	F 00	000				
	IN00430795, IN0	00430978 and IN00431405.						
	_	30795 - Federal/State deficiencies						
		gations are cited at F554 and						
	F684.							
	G 1 ' DIOO	120070 F 1 1/G . 1 6						
	_	30978 - Federal/State deficiencies						
	related to the allegations are cited at F684 and							
	F689.							
	Complaint INIO04	31405 - Federal/State deficiencies						
	_	gations are cited at F580, F684,						
	and F689.	gations are ched at 1300, 1004,						
	and 100).							
	Survey dates: Ap	oril 1 and 2, 2024						
	Facility number:							
	Provider number:							
	AIM number: 10	00287700						
	Census Bed Type							
	SNF/NF: 85	···						
	Total: 85							
	10.0.1. 03							
	Census Payor Ty	ne:						
	Medicare: 20	r - ·						
	Medicaid: 49							
	Other: 16							
	Total: 85							
		es reflect State Findings cited in						
	accordance with	410 IAC 16.2-3.1.						
	Quality review co	ompleted on 4/9/24.						

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

Terri Phillips Executive Director 04/19/2024

Any defiency statement 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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	COMPLETED	
		155344	B. WI	NG		04/02/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	<u>t</u>		802 US	HIGHWAY 20 EAST			
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0554	483.10(c)(7)							
SS=E		nin Meds-Clinically Approp						
Bldg. 00	- , , , ,	right to self-administer						
		interdisciplinary team, as						
		1(b)(2)(ii), has determined						
		s clinically appropriate.	F 0.	4			0.4/2.0/2.02.4	
		on, record review, and	F 05	554	This plan of correction is prepa	ared	04/30/2024	
	· ·	ty failed to ensure residents			and executed because the			
		and Physician's Orders to			provisions of state and federal			
		r own medications, for 4 of 4			require it and not because Life			
		for self-administration of			Care Center of Michigan City			
	medication. (Reside	ents C, F, G and H)			agrees with the allegations and citations listed. Life Care Cent			
	Findings includes				Michigan City maintains that the			
	C				alleged deficiencies do not			
	1. During a random	observation on 4/1/24 at 1:37			jeopardize the health and safe	ty of		
	p.m., Resident C wa	as observed in bed and awake.			the residents nor is it of such			
	The resident was co	onfused and not oriented to			character to limit our capabilitie	es		
	time and place. At	that time, there was a tube of			to render adequate care. Pleas	se		
	Bacitracin ointment	on the dresser and 1 over the			accept this plan of correction a	as		
	counter bottle of Ge	enteal tears eye solution. The			our credible allegation of			
	bottle of eye drops v	was located on a high top			compliance that the alleged			
	dresser and complet	tely out of reach for the			deficiencies have or will be co	rrect		
	resident.				by the date indicated to remain	n in		
					compliance with state and fede	eral		
	During a random ob	oservation, on 4/2/24 at 8:25			regulations, the facility has tak	en		
	a.m., the resident wa	as observed in bed. At that			or will take the actions set fortl	n in		
	time, the bottle of e	ye drops was still located on			this plan of correction. We			
	the high top dresser	and out of reach for the			respectfully request a desk rev	/iew.		
	resident.				F554 Residents Self Administe	er		
					Medications-clinically appropri	ate		
		dent C was reviewed on 4/1/24			What corrective actions will be	:		
		ses included, but were not			accomplished for those reside	nts		
		n right lower leg and foot,			found to be affected by this			
		ye syndrome, high blood			deficient practice:			
	pressure, difficulty	walking, and muscle weakness.			1. Resident C: The Bacitracin			
					ointment and eye drops were			
		dated 3/28/24, indicated			removed from her bedside tab			
		ernal Ointment, apply to toes			and her dresser. Both items w	ere		
	topically one time a	day and leave open to air until			placed in the appropriate cart	per		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	ING		04/02/	/2024
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			HIGHWAY 20 EAST		
LIFF CAF	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360		
	Г						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	healed.				medication administration pol	-	
	DI COL	1 . 10/20/22 : 1: 1			No negative outcomes were r		
		, dated 8/20/23, indicated			2. Resident F: Evening shift n		
		6, instill 1 drop in both eyes			from 3-31-24 was educated o	n	
	three times a day for dry eyes. The patient may self-administer.				4-4-24 regarding not leaving		
					medications at the bedside.		
	Th				Medication that was left at the)	
	There was no docu				bedside was disposed of per		
		of medication assessment or			policy. No negative outcomes	i	
	the bedside.	citracin ointment to be left at			were noted.	-4: - ·-	
	the bedside.				3. Resident G: Self administra		
	D	4/2/24 -4 11.20 41-			of medication assessment wa		
	_	w, on 4/2/24 at 11:30 a.m., the			completed. Resident now has		
		g (DON) indicated the resident's			order to self-administer eye d	rops	
		ught in the bottle of eye drops			and may leave them at the		
		her, however, the Bacitracin of have been left at the bedside.			bedside. No negative outcom		
	ointment should no	of have been left at the bedside.			were noted. She has received		
					training and a lock box to stor	е	
	2 Duning a non-dam	n observation, on 4/1/24 at 1:00			medication.		
	_	as observed sitting on the side			4. Resident H: Day shift nurse from 4-1-24 was educated on		
	1 ~	time, the Physical Therapist					
		om preparing to change the			4-15-24 regarding not leaving medications at the bedside. N		
	1 ' '	ft foot. There were 2					
		oserved on the resident's over			negative outcomes were note How other residents having the		
		resident's name written on			potential to be affected by the		
		nedication cups contained 1			same deficient practice will be		
	white unidentified				identified and what corrective		
	c amaciniilea	r			action will be taken		
	During an interview	w at that time, the resident			1. The DON completed a full		
	_	Melatonin tablet that he had			house audit on 4-3-24 and on	e	
		ing, but never took it.			additional resident was identif		
		5,			that was self-administering		
	The record for Res	ident F was reviewed on 4/2/24			medications without an		
		sident was admitted on 3/6/24			assessment. Self-administrati	on	
		Diagnoses included, but were			assessment was completed a		
		omyelitis left ankle and foot,			the order to keep at bedside v		
		foot, type 2 diabetes, open			updated.		
	wound to the left foot, high blood pressure, and				What measures and what		
	peripheral vascular	-			systemic changes will be mad	le to	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155344	B. W	/ING		04/02/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST		
LIEE CAE	DE CENTED OF MI	CHICAN CITY					
LIFE CAR	RE CENTER OF MI	CHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ensure the practice does not r	ecur	
	The Admission Mir	nimum Data Set (MDS)			All licensed nursing staff		
	assessment, dated 3	/8/24, indicated the resident			received education by the DO	N on	
	was cognitively into	act for daily decision making.			4-4-24 regarding the right to		
	The resident was ac	lmitted with a diabetic foot			self-administer medications wl	hen	
	ulcer.				clinically appropriate along wit	h	
					the need for the completion of	а	
	Physician's Orders,	dated 3/12/24, indicated			self-administration assessmer	nt	
	Melatonin 5 milligr	rams (mg), give 1 tablet by			and an appropriate order.		
	mouth as needed fo	r insomnia.			2. New licensed nursing staff v	will	
					receive this education prior to		
	There was no docur	mentation of a			working.		
	self-administration	of medication assessment or a			How will the corrective action	be	
	Physician's Order to	self-administer his own			monitored to ensure the defici-	ent	
	medications.				practice will not recur:		
					1. The DON and/or designee v	will	
	During an interview	y, on 4/2/24 at 11:30 a.m., the			audit all intake assessments for	or	
	Director of Nursing	indicated she was aware of			all residents to verify a		
	the medication cups	s with the resident's name on			self-administration assessmer	nt	
	them and the pill th	at was left inside of one of			has been completed and those	e	
	them. She had them	on her desk in her office. The			that can self-administer, have	the	
	resident had no orde	er to self-administer his own			opportunity to self-administer	their	
	medications or an a	ssessment to do so.			medications, 3x weekly x		
					2months, then 2x weekly x 2		
					months, then weekly x 2month	ıs.	
	_	observation, on 4/1/24 at 9:50			2. The results of these reviews		
	a.m., Resident G wa	as observed in her bed reading			be discussed monthly at the C	(API	
	a book. At that time	e, there was a bottle of eye			meeting for a total of 3 months	3	
		a medication cup on the over			and then quarterly thereafter.		
	bed table. The resid	lent indicated she administered			Frequency and duration of the	:	
	the eye drops to her	rself every evening, that way			reviews will be increased as		
	she knew she got th	iem.			needed.		
					Compliance date: 4.30.24		
		dent G was reviewed on 4/2/24			The Administrator at Life Care		
	at 11:14 a.m. Diagnoses included, but were not				Center of Michigan City is		
	_	od pressure and type 2			responsible in ensuring		
	diabetes.				compliance in this Plan of		
					Correction.		
	-	dated 1/25/23, indicated					
	Latanoprost Ophtha	almic Solution 0.005%, instill 1					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155344	B. W	ING		04/02	/2024
NAME OF I	PROVIDER OR SUPPLIEI		-		ADDRESS, CITY, STATE, ZIP COD	-	
					HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF M	ICHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	hypertension.	t bedtime for ocular					
	hyperension.						
	There was no Phys	ician's Order for the resident to					
	self-administer the	eye drops. There was no					
		of medication assessment to					
	self-administer the	eye drops.					
	During an interview	v, on 4/1/24 at 1:25 p.m., the					
	_	g indicated there was no order					
	_	administer the eye drops or a					
		of medication assessment					
	completed.	of incurent assessment					
	4.5.	1 4 4 4 1 24 4 0 50					
	_	n observation, on 4/1/24 at 9:59					
	· ·	as seated in a wheelchair with					
		There was a medication cup on hite pills on a napkin. During an					
		resident at that time, she					
		aking her water pills.					
	maleated sile was a	uking ner water pins.					
		ident H was reviewed on 4/2/24					
	_	noses included, but were not					
		sease, high blood pressure,					
	edema, chronic obs	structive pulmonary disease.					
	The Care Plan data	ed 3/6/24, indicated, the					
	resident had a Phys						
		of the following medications:					
		aline Nasal Spray, Sore throat					
	_	at drops, and an inhaler.					
		ician's Order for the resident to					
		daily medications. There was					
		ion of medication assessment					
	to self-administer h	ner daily medications.					
	During an interview	w, on 4/2/24 at 1:15 p.m., the					
		g indicated the resident had no					

PRINTED: 05/01/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					O	MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		 UILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/02/2024		
	PROVIDER OR SUPPLIEI		802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST SAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
IAG	Physician's Order to medications and no The current 8/29/24 Medication" policy Preventionist on 4/2	o self-administer her daily assessment completed. 4 "Self-Administration of t, provided by the Infection 2/24 at 12:54 p.m., indicated the n with the Physician for the	TAG			BATE
	resident will condu resident's cognitive carry out this respo	ct an assessment of the physical, and visual ability to insibility. The interdisciplinary completed in the electronic				
		s to Complaint IN00430795.				
F 0580 SS=D Bldg. 00	§483.10(g)(14) No (i) A facility must is resident; consult to physician; and no her authority, the when there is- (A) An accident in results in injury ar requiring physicia (B) A significant of physical, mental, (that is, a deterior psychosocial state conditions or clinic (C) A need to alte (that is, a need to form of treatment consequences, or of treatment); or	s (Injury/Decline/Room, etc.) otification of Changes. immediately inform the with the resident's tify, consistent with his or resident representative(s) avolving the resident which and has the potential for an intervention; shange in the resident's or psychosocial status ration in health, mental, or us in either life-threatening cal complications); or treatment significantly discontinue an existing				

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resident from the facility as specified in

Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG <u>00</u>	COMPLETED	
		155344	B. WING		04/02/2024	
	PROVIDER OR SUPPLIER		802	EET ADDRESS, CITY, STATE, ZIP COD 2 US HIGHWAY 20 EAST CHIGAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC		DATE	
	(g)(14)(i) of this see ensure that all per in §483.15(c)(2) is upon request to the (iii) The facility muresident and the reany, when there is (A) A change in reassignment as specific (B) A change in reassignment as specific (B) A change in reassignment as specific (C)(10) (iv) The facility mure update the address phone number of representative(s). §483.10(g)(15) Admission to a confacility that is a condefined in §483.5) admission agreement configuration, incluted that comprise the and must specify room changes before under §483.15(c)(Based on record reason that the comprise the analytic facility that it is a configuration, included that comprise the analytic facility that it is a configuration, included that comprise the analytic facility that it is a configuration, included that comprise the analytic facility that it is a configuration, included that comprise the analytic facility that it is a configuration, included that comprise the analytic facility for the configuration of th	ast also promptly notify the esident representative, if som or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. Ist record and periodically as (mailing and email) and the resident Imposite distinct part. A mposite distinct part (as must disclose in its nent its physical uding the various locations composite distinct part, the policies that apply to tween its different locations 9). In the policies that apply to the entity of	F 0580	This plan of correction is preand executed because the provisions of state and feder require it and not because L Care Center of Michigan Citagrees with the allegations a citations listed. Life Care Ce Michigan City maintains that alleged deficiencies do not jeopardize the health and sattle provided to the control of th	ral law ife y and nter of the	
	_	Diagnoses included, but were rv of falling, metabolic		jeopardize the health and sa	· •	

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Event ID:

M7YS11 Facility ID: 000236 If continuation sheet Page 7 of 23

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	ING		04/02	/2024
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			HIGHWAY 20 EAST		
	RE CENTER OF MI	ICHIGAN CITY					
LIFE CAP	L CENTER OF MI	IOTHGAN OTT		MICHIC	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	encephalopathy (an infection that causes brain				character to limit our capabiliti		
	damage), and osteomyelitis (bone infection).				to render adequate care. Plea		
					accept this plan of correction a	as	
	The Significant Change Minimum Data Set (MDS)				our credible allegation of		
	assessment, dated 2/22/24, indicated the resident				compliance that the alleged		
	was cognitively impaired for daily decision making		1		deficiencies have or will be co		
	_	taff for bed mobility and			by the date indicated to remain		
	transfers.				compliance with state and fed		
					regulations, the facility has tak		
		ed 3/14/24 at 3:00 p.m.,			or will take the actions set fort	h in	
		asked LPN 1 to look at the			this plan of correction. We		
		The resident's leg was	1		respectfully request a desk rev	view.	
		eft leg was observed to be			F580 Notification of Changes		
	1	e right leg. An indentation			What corrective actions will be		
	_	as visible on the right leg. The			accomplished for those reside	nts	
		ng and a "stage one" area to			found to be affected by this		
		Nurse Practitioner (NP),			deficient practice:		
		g (DON), and the resident's	1		Resident D no longer resident	es at	
	_	d. The NP assessed the			the facility.		
		d a pillow to be placed			How other residents having th		
	between the residen	nt's legs at bedtime.			potential to be affected by the		
	4.37	12/14/24 + 0.04	1		same deficient practice will be	!	
		ted 3/14/24 at 9:04 p.m.,			identified and what corrective		
		ent had received two Tylenol			action will be taken		
) tablets for pain. An entry at			1. The DON completed a full		
	_	ed the NP was notified the	1		house audit on 4-4-24 and no	ere i	
		o be in pain throughout the			additional residents were iden	titied	
	day but would not o	compiain.			that the MD had failed to be		
	A Niveage! NI-4- 1	to d 2/15/24 at 0.21	1		notified of a change.		
		ted 3/15/24 at 9:31 a.m.,			What measures and what	o to	
		ent was receiving 650 mg			systemic changes will be mad		
	Tylenol twice a day (BID) for complaints of leg				ensure the practice does not r		
	pain, continued as ordered.				1. All licensed nursing staff we		
	A Skilled Note dated 3/15/24 at 11:02 a m				educated by the DON on 4-4-2		
	A Skilled Note, dated 3/15/24 at 11:03 a.m.,				regarding timely notification to	טואו	
	indicated routine Tylenol continued for complaints of leg pain.				of any significant changes.	a dill	
	complaints of leg pa	aiii.			2. New licensed nursing staff v	WIII	
	A Numaci Nata 1-4	tod 2/15/24 at 1:45			receive this education prior to		
		ted 3/15/24 at 1:45 p.m.,			working.	ho	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155344	B. W	ING		04/02/	2024
				OTD DEET	ADDRESS CITY STATE ZIR COP		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
		CLUCAN CITY			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	ordered related to p	ain and deformity. At 6:20			monitored to ensure the defici-	ent	
	p.m., the NP was no	otified of the x-ray results and			practice will not recur:		
	1 ~	d to send the resident to the			1. The DON and/or designee v	will	
	emergency room.				review 24/72 hour report to ve		
					that MD/NP notification occurr	-	
	The resident was di	agnosed with a left femoral			as required for changes 3x we		
		ilateral tibia/fibula fractures			x 2months, then 2x weekly x 2	-	
	with diffuse osteopo				months, then weekly x 2month		
					2. The results of these reviews		
	A facility investigat	tion was initiated. A statement			be discussed monthly at the C		
		1 on 3/15/24 indicated a CNA			meeting for a total of 3 months		
		ook at the resident's right leg.			and then quarterly thereafter.		
		vas assessed and the left leg			Frequency and duration of the		
	_	pressing against the right leg.			reviews will be increased as		
		n the left leg was visible on the			needed.		
		leg was bruised with a			Compliance date: 4.30.24		
		spot. The NP assessed the			The Administrator at Life Care		
		d a pillow to be placed			Center of Michigan City is		
		it's legs at bedtime. Around			responsible in ensuring		
		n to complete sacral wound			compliance in this Plan of		
		nd CNA were turning the			Correction		
		resident was to be groaning			Correction		
		The resident denied pain. The					
	_	A if she thought the resident					
		ore pain than usual, and the					
		asn't sure. The LPN noticed the					
		ormed" but with no bruising or					
		44 at about 7:00 a.m., the same					
		e resident did seem to be in					
		the resident denied being in					
		hed to touch the resident's left					
	1 ~	The resident slapped the LPN's					
	_	nitted that the left leg did hurt.					
	The NP was notified	C					
	THE INT WAS HOUTHE	u.					
	During an interview, on 4/2/24 at 11:50 a.m., LPN 1						
	_ ~	was completing wound care					
		resident seemed to be in more					
	· · · · · · · · · · · · · · · · · · ·	en though the resident denied					
	_	icated she couldn't call the NP					
	i me pam. Len i mu	icaica she couldn't call the INF	1		I		

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Event ID:

M7YS11 Facility ID: 000236

If continuation sheet Page 9 of 23

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING B. WING	00	COM	E SURVEY PLETED 12/2024	
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP C S HIGHWAY 20 EAST GAN CITY, IN 46360	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		(X5) COMPLETION DATE
F 0684 SS=E	the nurses' stations to p.m., and even though in pain, she voiced so didn't call. The NP earlier in the day. SI left leg looked differs he wasn't sure if the having contractures, morning, the resider different and would kept "shooing" her have seen and orders were buring an interview Director of Nursing should have been conseemed to be experificated after should have been constaff could call her as	ate, there were signs posted at that her hours were until 9:00 gh the resident seemed to be she wasn't, that's why she had assessed the resident me also indicated the resident's rent during wound care, but at was the norm or not due to LPN 1 indicated the next at the leg definitely looked in't let her touch it, the resident mand away. It was then that again, and the resident was e received. To on 4/2/24 at 1:20 p.m., the indicated the Physician ontacted after the resident encing pain, and after the leg Even if the NP did not want to 9:00 p.m., the Physician ontacted. The DON indicated any time for guidance. To Complaint IN00431405.				
SS=E Bldg. 00	§ 483.25 Quality of Quality of care is a applies to all treatr facility residents. E comprehensive as facility must ensure treatment and care professional stand	a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive in accordance with ards of practice, the erson-centered care plan,				

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		155344	B. W	ING		04/02	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	ICHIGAN CITY			SAN CITY, IN 46360		
	Г		1		, · · · · · · · · · · · · · · · · · · ·		OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		on, record review, and	F 06	TAG	his plan of correction is prepar	rod	DATE 04/20/2024
		ity failed to ensure a resident	F 00	084	and executed because the	eu	04/30/2024
	i i	•			provisions of state and federal	Llow	
	was sent to the hospital in a timely manner, related to complaints of increased pain and leg swelling,				require it and not because Life		
	for 1 of 3 residents reviewed for accidents. The				Care Center of Michigan City	7	
		to ensure treatments were			agrees with the allegations an	d	
	· ·	etic ulcers and an assessment			citations listed. Life Care Cent		
	1 -	new non-pressure wounds to			Michigan City maintains that the		
	_	residents reviewed for skin			alleged deficiencies do not		
		ssure related. (Residents D, B,			jeopardize the health and safe	ety of	
	C, and F)	, , , ,			the residents nor is it of such	,	
					character to limit our capabiliti	es	
	Findings include:				to render adequate care. Plea		
	_				accept this plan of correction a		
	The closed recor	rd for Resident D was reviewed			our credible allegation of		
	on 4/1/24 at 1:04 p.	.m. Diagnoses included, but			compliance that the alleged		
	were not limited to,	, history of falling, metabolic			deficiencies have or will be co	rrect	
	encephalopathy (an	infection that causes brain			by the date indicated to remain	n in	
	damage), and osteo	omyelitis (bone infection).			compliance with state and fed	eral	
					regulations, the facility has tak	en	
	_	ange Minimum Data Set (MDS)			or will take the actions set fort	h in	
		2/22/24, indicated the resident			this plan of correction. We		
		paired for daily decision making			respectfully request a desk rev	view.	
	_	taff for bed mobility and			F684 Quality of Care		
	transfers.				What corrective actions will be		
		4/00/04 1 1 1 1 1 1			accomplished for those reside	nts	
		1/23/24, indicated the resident			found to be affected by this		
		vities of daily living) assistance			deficient practice:		
	1	es to maintain or attain their			Resident D is no longer at t	his	
	_	ection. Interventions included,			facility	L:-	
		d to, extensive assist of 2 to			2. Resident B is no longer at the	nis	
	complete transfers.				facility		
	A Dhygiciania O. 1-	r dated 2/10/24 indicated the			3. Resident C had a wound	24	
	A Physician's Order, dated 2/19/24, indicated the				assessment completed on 4-4		
	resident was to receive Acetaminophen (Tylenol)				by the wound nurse. No negat outcome was noted	iiv e	
	325 milligrams (mg), 2 tablets every 4 hours as needed (PRN) for pain or fever.				4. Resident F was assessed b	w	
	inceded (1 Kiv) for p	oani oi ievei.			the wound care nurse on 4-3-2	-	
	Nurses' Notes date	d 3/14/24 at 2:30 p.m.,			and the treatment was comple		
		ent was medicated with two			No pegative outcome was not		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		155344	B. W	ING		04/02/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
1155 045	DE OENTED OF M	OLUGANI OLTV			HIGHWAY 20 EAST		
LIFE CAR	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Tylenol 325 mg tab	lets for complaints of right leg			How other residents having th	е	
	pain.				potential to be affected by the		
					same deficient practice will be	:	
	An Event Note, date	ed 3/14/24 at 3:00 p.m.,			identified and what corrective		
	indicated the CNA	asked LPN 1 to look at the			action will be taken		
	resident's right leg.	The resident's leg was			1. The DON completed a full		
	assessed and the lef	t leg was observed to be			house audit on 4-5-24 on all		
	pressing against the	right leg. An indentation			residents with bruising and pa	in to	
	from the left leg wa	s visible on the right leg. The			verify that an x- ray or other		
	right leg had bruisir	ng and a "stage one" area to			appropriate interventions were	•	
	the right leg. The N	Jurse Practitioner (NP),			ordered. No additional resider	nts	
	Director of Nursing	(DON), and the resident's			were identified requiring additi	onal	
	spouse were notifie	d. The NP assessed the			interventions.		
	resident and ordered	d a pillow to be placed			2. The wound nurse complete	d a	
	between the residen	t's legs at bedtime. The			full house audit on those resid	ents	
	resident was helped	out of bed. The resident was			that had treatments on 4-5-24	. No	
	complaining of pair	and given as needed (PRN)			additional missing treatments		
	Tylenol.				were identified.		
					3. On 4-5-24 the wound nurse	:	
	A Nurses' Note, dat	ed 3/14/24 at 9:04 p.m.,			completed a full house audit to)	
	indicated the reside	nt had received two Tylenol			verify that wound assessment	S	
		pain. An entry at 10:14 p.m.,			were completed on all residen	ts	
		as notified that the resident			with wounds and open areas.	No	
		in throughout the day, but			additional concerns were foun	d.	
	would not complain	ı.			What measures and what		
					systemic changes will be mad		
		r, dated 3/14/24, indicated the			ensure the practice does not r	ecur	
		ive Tylenol 325 mg, 2 tablets			All licensed nursing staff		
	twice a day for pain	starting 3/15/24.			received education by the DO		
					4-4-24 regarding obtaining ord		
		ed 3/15/24 at 9:31 a.m.,			for any additional interventions		
		nt was receiving 650 mg			residents with bruising and/or		
		(BID) for complaints of leg			pain, treatments completed pe		
	pain, continued as o	ordered.			MD orders, wound assessmer		
					completed on all residents wit	h	
	A Skilled Note, dated 3/15/24 at 11:03 a.m.,				wounds and open areas.		
	indicated routine Tylenol continued for		New licensed nursing staff will				
	complaints of leg pain.		receive this education prior to				
					working.		
	A Nurses' Note, dat	ed 3/15/24 at 1:45 p.m.,			How will the corrective action	be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF P	PROVIDER OR SUPPLIER	. {		ADDRESS, CITY, STATE, ZIP COD	-
	RE CENTER OF MI			S HIGHWAY 20 EAST IGAN CITY, IN 46360	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		of the left hip and knee was		monitored to ensure the defic	cient
		pain and deformity. At 6:20		practice will not recur:	
	*	otified of the x-ray results and		1. The DON or designee will	
		d to send the resident to the		all residents receiving treatm	l l
		at 6:32 p.m., transport was		and wound care for assessm	
	dispatched to the fa	ciity.		and treatments as ordered, 5	
	The resident was	lmitted to the hospital with a		residents 3x weekly x 2month	
		acture and bilateral tibia/fibula		then 2x weekly x 2 months, to	ien
	fractures with diffus			weekly x 2 months. 2. The results of these review	ve will
	naciules with dillu	se osteoporosis.		be discussed monthly at the	
	A facility investigat	tion was initiated. A statement		meeting for a total of 3 month	
		1 on 3/15/24 indicated a CNA		and then quarterly thereafter	
		ook at the resident's right leg.		Frequency and duration of th	l l
		vas assessed and the left leg		reviews will be increased as	
		pressing against the right leg.		needed.	
		n the left leg was visible on the		Compliance date: 4.30.24	
		leg was bruised with a		The Administrator at Life Car	e e
		spot. The NP assessed the		Center of Michigan City is	
		d a pillow to be placed		responsible in ensuring	
		it's legs at bedtime. Around		compliance in this Plan of	
		began to complete sacral		Correction.	
		LPN and CNA were turning			
		the resident was to be			
	· ·	in pain, although the resident			
		PN asked the CNA if she			
	-	t appeared to be in more pain			
	than usual and the C	CNA replied she wasn't sure.			
		ne left leg looked "deformed",			
	but had no bruising	or swelling. On 3/15/24 at			
	about 7:00 a.m., the	e same CNA told LPN 1 the			
	resident did seem to	be in more pain. The resident			
	denied being in pair	n. The LPN reached to touch			
		g to see if it hurt. The resident			
	slapped the LPN's h	nand away and admitted that			
	the left leg did hurt.	. The NP was notified.			
	During an interview	v, on 4/2/24 at 11:50 a.m., LPN 1			
		was completing wound care			
		resident seemed to be in more			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2024	
	ROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST SAN CITY, IN 46360	
LIFE CAP	RE CENTER OF IVII	CHIGAN CITY	MICHIC	SAN CITT, IN 40300	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	en though the resident denied			
	-	licated she couldn't call the NP			
		ate, there were signs posted at			
		that her hours were until 9:00			
	-	gh the resident seemed to be in			
		ey weren't, that's why she			
		had assessed the resident			
	-	he also indicated the resident's			
		erent during wound care, but			
		at was the norm or not due to			
	_	LPN 1 indicated the next			
	•	nt's left leg definitely looked			
		sident wouldn't let her touch it,			
	_	hooing" her hand away. It was ed the NP again, and the			
		nd orders were received.			
	resident was seen a	ild orders were received.			
	During an interview	v, on 4/2/24 at 1:20 p.m., the			
	_	g (DON) indicated x-rays should			
	_	when the bruising and pain			
		/24 or the resident should have			
		raluation. The DON indicated			
		any time for guidance.			
		d for Resident B was reviewed			
		a.m. The resident was admitted			
		hospital, and expired in the			
	facility on 3/13/24.				
	_	, but were not limited to,			
		nce of the left foot, chronic			
	•	stage renal disease, type 2			
	· ·	llation, adult failure thrive,			
	_	ıl dialysis, high blood			
	pressure, and severe	e peripheral vascular disease.			
	The Admission Mir	nimum Data Set (MDS)			
		/10/24, indicated the resident			
		act for daily decision making			
		tial to maximal assist with			
		nd right. The resident was			
1	<u>-</u>	-	1	1	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 04/02/2024				
		155344	B. W	ING		04/02/2024	
NAME OF I	DROLUDED OD GUDDU IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF			802 US	HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	admitted with diabe	etic ulcers.					
	The Care Plan, revi	sed on 3/14/24, indicated the					
		c ulcers to the right inner					
		nt 4th toe, right great toe, right					
	_	teral foot, and right heel.					
	_						
	_	on Assessment, dated 1/5/24,					
		nt was admitted with necrotic					
		nd right heel, an open wound					
		to the right inside of the right					
	foot, and an open w	yound to the left outer foot.					
	The Wound Observ	ration Tool, dated 1/10/24,					
	indicated the follow						
	measurements:	and we are and					
		black necrotic tissue with no					
	_	6 centimeter (cm) by 3.8 cm.					
	_	100% black necrotic tissue					
	_	neasured 6 cm by 2.9 cm.					
	_	00% black necrotic tissue with					
		red 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, n	neasured 2.5 cm by 2 cm					
	The Wound Observ	ration Tool, dated 2/28/24,					
	indicated the follow						
	measurements:						
		black necrotic tissue with no					
		7.5 centimeter (cm) by 6 cm.					
	_	100% black necrotic tissue					
	_	neasured 3.2 cm by 3 cm.					
	_	00% black necrotic tissue with					
		red 1.5 cm by 2.5 cm.					
	_	% black necrotic tissue with no					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155344	B. W	ING		04/02/	2024
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	drainage, measured	1.3 cm by 1.3 cm					
	Physician's Orders,	dated 1/5/24, indicated to					
	1 -	er foot with normal saline,					
	apply a non-adherer	nt gauze, and wrap with kerlix,					
	every Tuesday, Thu	ırsday and Saturday.					
	Dhygigian's Onder-	dated 1/10/24, indicated to					
		to the right heel, right lateral					
		and 4th toe with normal saline,					
		ernal Gel 0.9%, and cover with					
		ze and wrap with kerlix, every					
	Tuesday, Thursday	-					
		ninistration Record (TAR),					
		ated the Iodosorb treatment to					
	_	ds was coded with a "10"					
	1	otes) on 1/11 and a "7" (hold					
		on 1/18/24. The left outer foot					
		s not signed out as being coded with a "10" on 1/11/24					
	and a "7" on 1/18/2						
	and a 7 on 1/16/2	т.					
	Nurses' Notes, dated	d 1/11/24 at 2:45 p.m.,					
	indicated "Bandag	ges not changed today per					
	_	name] LPN. Bandages					
	_	ent done yesterday. Bandages					
	I	chedule will resume on					
	Saturday. Pt. [patier	nt] aware."					
	Nurses' Notes, date	d 1/18/24 at 1:53 p.m.,					
		eatments were not completed					
		being at the foot doctor.					
		_					
		dated 2/1/24, indicated to					
	_	el, right great toe, right lateral					
	_	with normal saline, apply a					
	_	wrap with kerlix, every					
	· ·	y, and Saturday for black					
	areas. Cleanse the le	eft outer foot with normal					

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Event ID:

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PRINTED: 05/01/2024 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 04/02	LETED
	PROVIDER OR SUPPLIE		802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	IICHIGAN CITY	MICHIG	GAN CITY, IN 46360		_
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
		sorb to the wound, cover with a wrap with kerlix, every other				
	on 2/12/24 and the	indicated a "7" was documented treatments were not signed out d, for both the right foot and left				
	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.					
	Nurses' Notes to in	nmentation on the TAR or in adicate the treatment to the had been completed on the				
	Wound Nurse indi	w, on 4/2/24 at 11:30 a.m., the cated the resident's wound have been completed as tor.				
	p.m., Resident C w The resident's feet boots, and the top	m observation, on 4/1/24 at 1:37 was observed in bed and awake. were observed in bilateral heel of her toes on both feet were lood and open areas.				
	at 3:20 p.m. Diagn limited to, contusion osteoarthritis, dry	oident C was reviewed on 4/1/24 coses included, but were not on right lower leg and foot, eye syndrome, high blood walking, and muscle weakness.				
	The resident was a	dmitted to the hospital on				

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on 3/21/24.

3/18/24 after a fall, and returned back to the facility

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155344	B. WING		04/02	/2024	
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
		ICLUCAN CITY			HIGHWAY 20 EAST		
LIFE CAR	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	Physician's Orders,	dated 2/21/24 and					
	-	28/24, indicated Bacitracin					
		the toes topically, one time					
		normal saline, and cover with					
	a Band-Aid.	inormal same, and cover with					
	a Bana i na.						
	Physician's Orders,	dated 3/28/24, indicated					
	-	ternal Ointment, apply to the					
	toes topically, one t	time a day, and leave open to					
	air until healed.						
	The Nurse Admissi	on Assessment, dated 3/21/24,					
		nt was readmitted with "lost					
	toe nails on both fe	et" and there was a treatment					
	in place.						
	There was no woun	nd assessment of the resident's					
	toes and open areas						
	During an interview	v, on 4/2/24 at 1:15 p.m., the					
	-	g indicated there was no					
		esident's feet and her missing					
	toe nails.						
	4. During a random	observation, on 4/1/24 at 1:00					
	~	as observed sitting on the side					
	of the bed. At that t	ime, the Physical Therapist					
	(PT) was in the roo	m preparing to change the					
	bandages on the lef	t foot. The resident's left heel					
	was observed with	a large amount of yellow					
		, usually cream or yellow in					
	· · ·	ate amount of black necrotic					
		lso another black and hard					
		e left foot between the second					
		r cleansing the wound, the PT					
	-	ze amount of Santyl (debriding					
		to a dry gauze sponge. She					
	bicked up the gauze	e sponge and spread the Santyl	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/02 /	ETED	
	PROVIDER OR SUPPLIER			802 US	DDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST AN CITY, IN 46360		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	ointment onto the v place. She then put	vound, and left the sponge in a dry foam bandage over the onge and wrapped the foot ge.		TAG	DEFICIENCE		DATE
	_	w at that time, the PT indicated ag a treatment to the left heel.					
	sitting up in bed wi and a red non-skid. The resident was as the bandage could be removed, there was covering the black second and third to	.m., the resident was observed the the left foot in a heel boot sock over the tip of his foot. It is divided to remove the red sock so be viewed. After the sock was no bandage observed necrotic area between the earth resident indicated no la a treatment to the toe the					
	at 9:25 a.m. The res from the hospital. I not limited to, oster abscess to the left f	dent F was reviewed on 4/2/24 sident was admitted on 3/6/24 Diagnoses included, but were omyelitis left ankle and foot, oot, type 2 diabetes, open oot, high blood pressure, and disease.					
	assessment, dated 3 was cognitively into	nimum Data Set (MDS) /8/24, indicated the resident act for daily decision making. Imitted with a diabetic foot					
	cleanse the left seco	dated 3/29/24, indicated to ond toe with wound wash, with gauze, and wrap in kerlix,					
	1 -	dated 4/1/24, indicated PT eft heel 5 times a week for 30					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		l í	JILDING	NSTRUCTION 00	(X3) DATE COMPL 04/02 /	ETED	
	ROVIDER OR SUPPLIER			802 US	DDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST AN CITY, IN 46360		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	days. Cleanse the apperform sharp, selectorceps, scissors, or CPI (Close Pulse Ir nonviable, necrotic Apply Santyl and control of the Wound Observindicated the follow at left toe, unchanged measured 1 centimes be left heel, unchanged and interview Director of Nursing be done as ordered. The current 3/31/23 Ulcer/Injury Prever provided by the Infact 12:34 p.m., indicate assessment/inspectical admission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmission/readmiss	ged, 100% black necrotic and eter (cm) by 0.8 cm. ged 25% black necrotic and red 6 cm by 6 cm. y, on 4/2/24 at 11:30 a.m., the gindicated treatments were to by the Physician. S "Skin Integrity and Pressure ation and Management" policy, ection Preventionist on 4/2/24 ated a skin on occurred on sion. Skin observations also at points of care provided by s or open areas were to be e, as well as if topical atified as soiled, saturated, or see would complete further ent and provide treatment if		TAG			DATE
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervis	ion/Devices					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155344 B. WING 04/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §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. F 0689 Based on record review and interview, the facility This plan of correction is prepared 04/30/2024 failed to ensure adequate supervision was and executed because the provided in the shower for a resident who was provisions of state and federal law leaning in their shower chair, for 1 of 3 residents require it and not because Life reviewed for accidents. (Resident D) Care Center of Michigan City agrees with the allegations and Finding includes: citations listed. Life Care Center of Michigan City maintains that the The closed record for Resident D was reviewed on alleged deficiencies do not 4/1/24 at 1:04 p.m. Diagnoses included, but were jeopardize the health and safety of not limited to, history of falling, metabolic the residents nor is it of such encephalopathy (an infection that causes brain character to limit our capabilities damage), and osteomyelitis (bone infection). to render adequate care. Please accept this plan of correction as The Significant Change Minimum Data Set (MDS) our credible allegation of assessment, dated 2/22/24, indicated the resident compliance that the alleged was cognitively impaired for daily decision making deficiencies have or will be correct and dependent on staff for bed mobility and by the date indicated to remain in transfers. compliance with state and federal regulations, the facility has taken A Care Plan, dated 1/23/24, indicated the resident or will take the actions set forth in required ADL (activities of daily living) assistance this plan of correction. We and therapy services to maintain or attain their respectfully request a desk review. highest level of function. Interventions included, F689 free from accidents hazards but were not limited to, extensive assist of 2 to What corrective actions will be complete transfers. accomplished for those residents found to be affected by this Nurses' Notes, dated 2/11/24 at 10:05 p.m., deficient practice: indicated the CNA notified the writer the resident 1. Resident D is no longer at this was on the floor in the shower room. The resident facility

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was assessed and a bump was noted on the left

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How other residents having the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155344	B. W	ING		04/02/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
1.155.041	DE OENTED OF M	OLUGAN CITY			HIGHWAY 20 EAST		
LIFE CAR	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	side of their forehea	ad. The resident was a three			potential to be affected by the		
	person assist back in	nto the wheelchair. The			same deficient practice will be		
	resident was transfe	erred back to bed with a two			identified and what corrective		
		ological checks were			action will be taken		
	1 ~	resident was later transported			1. The DON completed a full		
	to the hospital for e				house audit on all residents th	at	
					used shower chairs to verify the		
	The facility fall inv	estigation, dated 2/11/24,			there were no safety concerns		
	1	nt was being assisted in the			with their positioning on 4-9-24		
		ney were leaning in the shower			additional residents were iden		
		tempted to reposition them and			requiring additional intervention		
		tting their face. The resident			What measures and what	113.	
		bump on the left side of the			systemic changes will be mad	o to	
	forehead.	bump on the left side of the					
	Toreneau.				ensure the practice does not r	ecui	
	A statement obtains	ed from the CNA, on 2/11/24,			1. All licensed nursing staff	Nan	
		nt took place on 2/11/24 at 5:00			received education by the DO	IN OH	
		icated when she was in the			4-4-24 on positioning/safety		
	1 ~	he resident, they kept leaning			concerns when showering	li au la 4	
		chair. The CNA tried			residents and utilizing the call	_	
					system for assistance if neede		
		dent a few times, but they kept			2. New licensed nursing staff v	WIII	
		ey leaned again and the chair			receive this education prior to		
	upped over, and the	resident fell on their face.			working.		
	D	4/2/24 + 1 20 + 1			How will the corrective action		
	1	y, on 4/2/24 at 1:20 p.m., the			monitored to ensure the defici	ent	
	_	(DON) indicated the CNA			practice will not recur:		
		nt in the shower room should			1. The DON/designee will aud	it 5	
		ergency call light and waited			residents 3X weekly utilizing	_	
		. The DON indicated the			shower chairs when showering	_	
		mally lean in the shower chair			positioning/safety through dire		
	when being bathed.				observation x3 months and the	en 5	
					residents weekly x3 months.		
		to Complaints IN00430978			2. The results of these reviews		
	and IN00431405.				be discussed monthly at the C		
					meeting for a total of 3 months	3	
	3.1-45(a)(2)				and then quarterly thereafter.		
					Frequency and duration of the	:	
					reviews will be increased as		
					needed.		
					Compliance date: 4.30.24		

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

PRINTED: 05/01/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/02/2024		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY			8	802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST BAN CITY, IN 46360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
					The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.			

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