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	06/14/2024

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 a Recertification and State Licensure Survey. Survey dates: June 10, 11, 12, 13, and 14, 2024. Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 14 Medicaid: 58 Other: 14 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/18/24.	F 0000		
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terri Phillips	Executive Director	07/02/2024

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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	(iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must			

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	transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to transmit a Minimum Data Set (MDS) assessment in the required time frame for 1 of 20 MDS assessments reviewed. (Resident 71) Finding includes: The Resident Assessment Task MDS tracking data indicated Resident 71's last MDS assessment was over 120 days old. Record review for Resident 71 was completed on 6/14/24 at 9:59 a.m. The resident was discharged to a different nursing facility on 1/3/24 and never returned to the facility. The Admission MDS assessment, dated 1/3/24, was the last assessment completed for the resident. During an interview on 6/14/24 at 10:27 a.m., MDS Coordinator 1 indicated there should have been a Discharge MDS transmitted when the resident went to the other nursing facility and there was not one completed.	F 0640	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. F 640- Encoding/Transmitting Resident Assessments What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident 71 had no negative outcomes. The resident involved had discharge MDS completed and submitted. How other residents having the potential to be affected by the same deficient practice will be	07/12/2024

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			identified and what corrective action will be taken: 1. MDS will complete an in house audit on residents that discharged in last 60 days to ensure discharge assessment was completed and submitted. Any issues identified will be corrected by day of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. CRS will educate MDS on transmission of discharge assessments by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/designee will audit any residents discharged from facility to ensure transmission of discharge assessment x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 7/12/24. The Administrator at Life Care Center	

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			of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and interview, the facility failed to ensure a resident received the assistive devices needed to maintain hearing related to hearing aids not administered to a resident as per the physician's order for 1 of 2 residents reviewed for vision/hearing. (Resident 4) Finding includes: On 6/11/24 at 11:48 a.m., Resident 4 was observed sitting in the dining area with other residents. The resident kept saying "huh" when other people were talking. The resident did not have hearing aids observed to either ear. On 6/11/24 at 3:08 p.m., Resident 4 was sitting in a wheelchair in his room. The resident indicated he could not hear the questions being asked. The resident did not have hearing aids observed to either ear and was unaware where his hearing aids	F 0685	his plan of correction is prepared and executed because the provisions of state and federal law require it and not because of 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 alleged deficiencies have or will be corrected by the date indicated to remain in compliance with state and federal regulations, the facility	07/12/2024

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	were. Record review for Resident 4 was completed on 6/11/24 at 3:11 p.m. Diagnoses included, but were not limited to coronary artery disease, heart failure, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 3/26/24, indicated the resident was cognitively impaired. The resident had difficulty hearing and used a hearing aid. The resident required a partial moderate assistance for dressing the upper body. A Care Plan, dated 9/19/23, indicated the resident required extensive assistance from staff to complete his ADL (assistance of daily living) tasks of bed mobility, transfers, and limited assistance for meals. An intervention, dated 1/25/24, included for his hearing aids to be put in his ears in the morning and taken out at night time. A Care Plan, dated 4/2/24, indicated the resident had a communication problem related to hearing deficit. The resident had hearing aids which he removed at times and misplaced them under the bed, under dressers, and his covers. Interventions included to assist with hearing aids (left and right), remove hearing aids and place in container as needed, and search the resident's room if the resident, staff, or visitors report the hearing aids are missing. The June 2024 Physician's Order Summary indicated the following order: - Hearing aids in the morning and out at night time. Document when put in and removal at bedtime.		has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. F685-Treatment/Devices to Maintain Hearing/Vision What Corrective Action will be accomplished for those residents found to be affected by this deficient practice: 1. Resident 4 had no negative outcomes related to alleged deficient practice. New hearing devices obtained and delivered to resident. 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. Complete audit of all residents with an assistive device completed. 2. Education to nursing staff on assistive devices regarding ensuring compliance with administration of hearing device per physician order to be completed by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice does not recur: 1. Education to be provided to all staff related to ensuring compliance with administration of hearing device per physician order to be completed by date of compliance. How the corrective action will be	

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	The June 2024 Medication Administration Record and Treatment Administration Record did not have any documentation related to the hearing aid order. During an interview on 6/11/24 at 3:09 p.m., CNA 1 indicated she was unaware if the resident wore hearing aids. During and interview on 6/11/24 at 3:16 p.m., LPN 1 looked into her medication cart and could not find the resident's hearing aids. She indicated she believed the resident's hearing aids were lost and she would go to his room and look for them. The resident would take them out himself sometimes, set them down and lose them. The staff were supposed to put them in and take them out every day and put them in the medication cart. She was unaware if that was supposed to be documented anywhere. During an interview on 6/11/24 at 3::25 p.m., the Director of Nursing (DON) indicated she was not sure why the hearing aid order did not populate for the nursing staff to document the resident's hearing aids were put in and taken out each day. The facility had replaced the resident's hearing aids once because he had lost them. The staff were supposed to be making sure they had documented when they are put in and then taken out, and that they are placed into the medication cart after they are removed. 3.1-39(a)		monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put in place: 1. The DON/Designee will complete observations to ensure assistive device present on resident per order 5 times a week for 4 weeks, then 4 times a week x 4 weeks, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 7/12/24 The Administrator at Life Care Centers of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 3 of 5 residents reviewed for nutrition. (Residents 59, 14, and 42) Findings include: 1. Record review for Resident 59 was completed on 6/12/24 at 3:11 p.m. Diagnoses included, but were not limited to, hypertension, dementia, and failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance with eating. A Care Plan, dated 1/11/24, indicated the resident had unplanned/unexpected weight loss related to poor food intake. Interventions included to alert	F 0692	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because of 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 alleged deficiencies have or will be corrected by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions	07/12/2024

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	the dietician when consumption was poor for more than 48 hours and to record food intake at each meal. The resident weighed 109 pounds on 11/30/23. A weight obtained on 6/7/24 indicated the resident weighed 97 pounds, which was a 11.01 % (percent) weight loss. The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - Breakfast on 5/16/24, 5/22/24, 5/25/24, 5/26/24, 5/29/24, 6/1/24, 6/3/24, 6/9/24, 6/10/24, and 6/12/24. - Lunch on 5/18/24, 5/22/24, 6/10/24, and 6/12/24. - Dinner on 5/16/24, 6/9/24, 6/10/24, and 6/11/24. During an interview on 6/13/24 at 1:20 p.m., the Director of Nursing (DON) indicated the CNAs were expected to document meal consumption percentage eaten in the computer under the Task section for Meal Consumption. 2. On 6/13/24 at 12:15 p.m., Resident 14 was observed eating lunch. Resident 14 received a house shake with her lunch. Resident 14 consumed about 75% of her shake and ate about 50% of the food on her plate. The resident's record was reviewed on 6/13/24 at 11:26 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux disease without esophagitis, constipation, and type 2 diabetic mellitus with diabetic neuropathy. The Quarterly MDS assessment, dated 3/12/24, indicated the resident was cognitively impaired. A Care Plan, dated 5/14/24, indicated to record Resident 14's food intake at each meal.		set forth in this plan of correction. We respectfully request a desk review. F692-Nutrition/Hydration Status Maintenance What Corrective Action will be accomplished for those residents found to be affected by this deficient practice: 1. Residents 59, 14, and 42 have had no negative outcomes related to alleged deficient practice. 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. Complete audit of all residents with a documented weight loss completed. Meal consumption audited to verify accurate percentage documented. 2. Education to nursing staff on appropriate documentation regarding documentation of consumption to be completed by date of compliance. 3. Weight report to be reviewed on a weekly basis to ensure all residents with a documented weight loss are being audited for accurate documentation of consumption. What measures and what systemic changes will be made to ensure that the deficient practice does not recur: 1. Weight report to be ran weekly to determine residents that have a documented weight loss.	

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	Weight Assessments indicated the resident weighed 177 pounds on 1/12/24 and 162 pounds on 6/7/24, which was an 8.47% weight loss. The meal consumption logs indicated the following: 5/17/24 - dinner meal was not documented 5/18/24 - no meals were documented 5/19/24 - breakfast and lunch meals were not documented 5/20/24 - breakfast and dinner were not documented 5/27/24 - dinner meal were not documented 5/31/24 - breakfast and lunch meals were not documented 6/6/24 - breakfast and lunch were not documented 6/7/24 - no meals were documented 6/8/24 - breakfast and lunch were not documented 6/10/24 - no meals were documented During an interview on 6/13/24 at 2:35 p.m., the Assistant Director of Nursing (ADON) indicated the food consumption logs should have been completed for the resident. 3. The record for Resident 42 was reviewed on 6/10/24 at 12:19 p.m. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), dementia, depression, muscle weakness, adult failure to thrive, anxiety, and left shoulder fracture. The Significant Change MDS assessment, dated 5/29/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating and oral hygiene required supervision or touching assistance. Lower body dressing, toileting and bathing required dependent assistance.		2. Consumption report will be audited to ensure accurate documentation of consumption for all residents with a documented weight loss. 3. Education provided to all staff related to appropriate documentation of consumption to be completed by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put in place: 1. The DON/designee will audit weight report weekly to determine residents with a documented weight loss x 6 months. 2. The DON/Designee will audit consumption report to ensure proper documentation of meal intakes 5 times a week for 4 weeks, then 4 times a week x 4 weeks, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks. 3. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 7/12/24 The Administrator at Life Care Centers of Michigan City is responsible in ensuring compliance in this Plan of Correctio	

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	A Care Plan, dated 4/12/24, indicated the resident had unplanned/unexpected weight loss related to poor intake. Interventions were to record food intake for each meal, and alert the dietician when supplements were not being consumed for more than 48 hours. The resident weighed 106 pounds on 2/27/24. A weight obtained on 5/24/24 indicated the resident weighed 87 pounds, which was a 28.57% weight loss in 3 months. The meal consumption intake logs indicated the following: - The breakfast meal was not documented on 5/15, 5/21,5/22, 5/25, 5/26, 5/30, 6/1, 6/8, 6/10, 6/11, and 6/12/24. - The lunch meal not documented on 5/22, 5/25, and 6/1/24. - The dinner meal was not documented on 5/18, 5/19, 6/3,6/4, 6/5, 6/9, and 6/10/24. During an interview on 6/13/24 at 1:20 p.m., the DON indicated the CNAs were expected to document meal consumption percentage eaten in the computer under the Task section for Meal Consumption. A current facility policy titled, " Nutritional Intake", provided by the Director of Nursing on 6/14/24 at 3:03 p.m., indicated "the facility will document the nutritional intake on each individual resident". 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 2 of 3 residents reviewed for oxygen use. (Residents 42 and 48) Findings include: 1. On 6/10/24 at 11:25 a.m., Resident 42 was observed lying in bed wearing oxygen via nasal cannula. The oxygen flow rate was set under 2 liters. On 6/10/24 at 12:04 p.m., the resident's oxygen was in place and the flow rate was set under 2 liters. On 6/11/24 at 11:59 a.m., the resident was observed lying in bed and oxygen was in place via nasal cannula. The flow rate was set just under 2 liters. On 6/11/24 at 3:36 p.m., the resident was observed asleep in bed. Oxygen was in place and the flow rate was set below 2 liters. The record for Resident 42 was reviewed on 6/10/24 at 12:19 p.m. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), dementia, depression, muscle weakness, adult failure to thrive, anxiety, and left shoulder fracture.	F 0695	Th 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. F 695- Respiratory/Tracheostomy Care and Suctioning What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Residents 42 and 48 had no negative outcomes. O2 sats were	07/12/2024

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	155344	A. BUILDING 00 B. WING	06/14/2024

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	The Significant Change Minimum Data Set (MDS) Assessment, dated 5/29/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating and oral hygiene required supervision or touching assistance. Lower body dressing, toileting and bathing required dependent assistance. A Care Plan, dated 4/25/24, indicated the resident received oxygen therapy. Interventions were to administer oxygen settings per physician orders and administer medications as ordered. A Physician's order, dated 4/25/24, indicated to administer oxygen via nasal cannula continuously at 2 liters/minute for hypoxia. The June 2024 Medication Administration Record (MAR) indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 6/10/24 and 6/11/24. During an interview on 6/12/24 at 11:34 a.m., the Director of Nursing (DON) indicated she would correct the resident's oxygen flow rate. No additional information was provided. 2. On 6/10/24 at 9:18 a.m., Resident 48 was observed sitting in her wheelchair watching her phone. The resident wore oxygen via nasal cannula and the flow rate was set at 3.5 liters. The oxygen canister had an oxygen sticker label that was marked 2 liters in red. On 6/10/24 at 11:55 a.m., the resident was observed asleep in bed, her nasal cannula was in place and the oxygen flow rate was set at 2.5 liters. On 6/11/24 at 11:58 a.m., the resident's oxygen was		taken with no issues noted and O2 liter flows adjusted to ordered liter flow immediately. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. An Audit was completed on residents in house with current 02 orders to assure orders accurate and clinical team observed liter flow being administered per order. No other issues have been identified. Audit completed by nursing management by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Don and/or designee to complete education to licensed nursing staff and certified aides to observe liter flow on residents using 02 and assure liter flow is accurate per order. This will be completed by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Don/Nursing management will observe 5 residents daily Monday through Friday x 8 weeks, then 3 residents daily Monday through Friday x 8 weeks, then 2 residents daily Monday through Friday x 8 weeks to assure compliance.	

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	in place via nasal cannula and the flow rate was set at 2.5 liters. The record for Resident 48 was reviewed on 6/11/24 at 3:19 p.m. The diagnoses included, but were not limited to, hemiplegia, heart failure, stroke, diabetes, hypertension (high blood pressure), and chronic obstructive pulmonary disease. The Quarterly MDS Assessment, dated 6/6/24, indicated the resident was cognitively intact for daily decision making. The resident had an impairment on one side of her upper and lower extremity. The resident used oxygen and a wheelchair. A Care Plan, dated 6/11/24, indicated the resident received oxygen therapy. Interventions were to administer oxygen settings per physician orders and to administer medications as ordered. A Physician's order, dated 6/3/24, indicated to administer oxygen via nasal cannula continuously at 2 liters/minute for shortness of breath. The June 2024 MAR indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 6/10/24 and 6/11/24. During an interview on 6/12/24 at 11:34 a.m., the DON indicated she would correct the resident's oxygen flow rate. No additional information was provided. 3.1-47(a)(6)		Audits will be presented to QAPI x 6 months and then QAPI will determine the need for further audits. Any noted issues will be addressed immediately. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 7/12/24. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 9999 Bldg. 00				

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	410 IAC 16.2-3.1-14 Personnel (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment ... The facility must assure the following: ... (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee had a complete physical examination completed by a licensed Physician or Nurse Practitioner (NP) within one month prior to employment for 5 of 10 employees reviewed. (Housekeeping 1, Housekeeping 2, RN 1, Dietary Aide 1 and CNA 2) Findings include: Review of the employee files was completed on 6/13/24 at 9:45 a.m. The "physical exam" forms were completed for the following employees upon hire. The forms included only documentation of the employees' vital signs, signed as completed by an LPN. The forms lacked any documentation to indicate any other examination besides vitals signs had been completed on the employees by a licensed physician or NP. 1. Housekeeping 1 was hired on 2/27/24. 2. Housekeeping 2 was hired on 3/25/24. 3. RN 1 was hired on 3/13/24.	F 9999	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. **F 9999 Personnel** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Zero residents were affected or had negative outcomes due to staff lacking a physical examination.. ***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 Zero residents were	07/12/2024

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	4. Dietary Aide 1 was hired on 8/30/23. 5. CNA 2 was hired on 4/25/24. During an interview on 6/13/24 at 1:50 p.m., the Human Resources Director indicated they were unaware the forms they had for each employee were not complete physical examinations. 3.1-14(t)		affected or had negative outcomes due to staff lacking a physical examination. Housekeeper 1 and 2, dietary aide 1, RN 1, CNA 2 will all have a physical exam completed by a NP or MD by 7/12/24 ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 HR director or ED will complete a new hire checklist that includes a physical completed by a NP or MD. For all new hires. 7/12/24 ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1 ED/designee will sign off on all new hires personnel file that includes a physical completed by NP or MD and review new hire checklist on all new hires for 3 months to assure compliance, then will complete random spot checks monthly for 3 months. 2 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 7/12/24. The Administrator at Life Care Center of Michigan City is responsible in	

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			ensuring compliance in this Plan of Correction.	