PRINTED: 07/03/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/14/2024		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360				
	T			I	7/5		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0000	REGUENTURY G				5.112		
Bldg. 00	This visit was for a Licensure Survey.	Recertification and State	F 0000				
	Survey dates: June	10, 11, 12, 13, and 14, 2024.					
	Facility number: 00 Provider number: 1 AIM number: 1002	55344					
	Census Bed Type: SNF/NF: 86 Total: 86						
	Census Payor Type Medicare: 14 Medicaid: 58 Other: 14 Total: 86	:					
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review con	npleted on 6/18/24.					
F 0640 SS=A Bldg. 00	requirement- §483.20(f)(1) Enc after a facility con assessment, a fac	itting Resident ated data processing oding data. Within 7 days upletes a resident's cility must encode the ion for each resident in the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(i) Admission assessment. (ii) Annual assessment updates.

> 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PIOW11 Facility ID: 000236 If continuation sheet Page 1 of 17

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	ING		06/14/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	ICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	(iii) Significant change in status						
	assessments.						
	(iv) Quarterly review assessments.						
	, ,	ms upon a resident's					
		discharge, and death.					
		face-sheet) information, if					
	there is no admiss	sion assessment.					
	8493 20/f\/2\ Tra-	esmitting data Within 7					
	_ ,,,,	nsmitting data. Within 7 y completes a resident's					
	-	cility must be capable of					
	transmitting to the CMS System information for each resident contained in the MDS in a						
		ms to standard record					
		dictionaries, and that					
	•	zed edits defined by CMS					
	and the State.	<b>, _</b>					
	§483.20(f)(3) Trar	nsmittal requirements.					
	Within 14 days af	ter a facility completes a					
	resident's assessi	ment, a facility must					
	electronically tran	smit encoded, accurate,					
	and complete MD	S data to the CMS System,					
	including the follo	wing:					
	(i)Admission asse						
	(ii) Annual assess						
	(iii) Significant cha	ange in status assessment.					
	, , -	rrection of prior full					
	assessment.						
	, , =	rection of prior quarterly					
	assessment.						
	(vi) Quarterly revi						
	, ,	ems upon a resident's					
	-	discharge, and death.					
	` '	(face-sheet) information, for					
		sion of MDS data on					
		s not have an admission					
	assessment.						
	§483.20(f)(4) Data	a format. The facility must					

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Event ID:

PIOW11 Facility ID: 000236

If continuation sheet Page 2 of 17

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155344	B. W	ING _		06/14	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			S HIGHWAY 20 EAST		
LIFF CA	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360		
	TE GENTER OF IN			WIIOTH	7		1
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	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 app						
		view and interview, the facility	F 0	640	This plan of correction is prepared		07/12/2024
		Minimum Data Set (MDS)			and executed because the		
		equired time frame for 1 of 20			provisions of state and federa		
	MDS assessments i	reviewed. (Resident 71)			require it and not because Life	9	
	F. 1				Care Center of Michigan City		
	Finding includes:				agrees with the allegations an		
	TI D 11 (A	T I MDC . I'			citations listed. Life Care Cent		
	The Resident Assessment Task MDS tracking data indicated Resident 71's last MDS assessment				Michigan City maintains that the	ne	
					alleged deficiencies do not	<b>.</b>	
	was over 120 days	oid.			jeopardize the health and safe	ety of	
	Dagand marriagy famil	Dogidant 71 was samulated on			the residents nor is it of such		
		Resident 71 was completed on			character to limit our capabiliti		
		n. The resident was discharged ng facility on 1/3/24 and never			to render adequate care. Plea		
	returned to the facili	-			accept this plan of correction	as	
	returned to the raci	nty.			our credible allegation of		
	The Admission MI	OS assessment, dated 1/3/24,			compliance that the alleged deficiencies have or will be co	rroot	
		nent completed for the			by the date indicated to remai		
	resident.	nent completed for the			compliance with state and fed		
	resident.				regulations, the facility has take		
	During an interview	w on 6/14/24 at 10:27 a.m., MDS			or will take the actions set fort		
	_	cated there should have been a			this plan of correction. We	!!!	
		ansmitted when the resident			respectfully request a desk re	view	
	_	ursing facility and there was			F 640- Encoding/Transmitting	VICVV.	
	not one completed.				Resident Assessments		
	l sampatou.				What Corrective Action will be	<b>!</b>	
					accomplished for those reside		
					found to have been affected b		
					deficient practice:	, <u>-</u>	
					Resident 71 had no negative	'e	
					outcomes. The resident involv		
					had discharge MDS complete		
					and submitted.		
					How other residents having th	е	
					potential to be affected by the		
					same deficient practice will be		

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

PRINTED: 07/03/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155344	A. BUILDING B. WING	00	COMPLETED 06/14/2024
	ROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD BHIGHWAY 20 EAST BAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				identified and what corrective action will be taken:  1. MDS will complete an in ho audit on residents that dischar in last 60 days to ensure discharge assessment was completed and submitted. Any issues identified will be correct by day of compliance.  What measures and what systemic changes will be madensure that the deficient practidoesn't recur:  1. CRS will educate MDS on transmission of discharge assessments by date of compliance.  How the corrective action will monitored to ensure the deficipractice will not recur, i.e., who quality assurance program will put in place:  1. DON/designee will audit and residents discharged from facito ensure transmission of discharge assessment x 6 months. Audits will be present to QAPI x 6 months and QAPI determine the need for further audits.  2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter. Frequenciand duration of reviews will be increased as needed.  Compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and compliance date: 7/12/24. The Administrator at Life Care Ceriples and complex a	ged  / ted  e to ice  be ent at I be  y llity  ed will  s will  or a  y  e

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Event ID:

PIOW11 Facility ID: 000236

If continuation sheet

Page 4 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155344	B. W	NG		06/14	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			S HIGHWAY 20 EAST		
LIFF CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN 46360		
Lii L 0/1		011107111		Wilonic	1		1
(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	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					of Michigan City is responsible		
					ensuring compliance in this Pl	an	
					of Correction.		
F 0685	492 25(2)(4)(2)						
SS=D	483.25(a)(1)(2)	a to Maintain Haaring/Vision					
Bldg. 00	§483.25(a) Vision	s to Maintain Hearing/Vision					
Diag. 00	- ' '	sidents receive proper					
		sistive devices to maintain					
		abilities, the facility must,					
	if necessary, assis	•					
	ii ricocooary, assic	of the resident-					
	8483 25(a)(1) In n	naking appointments, and					
	3403.23(a)(1) III making appointments, and						
	\$483.25(a)(2) By	arranging for transportation					
		fice of a practitioner					
		treatment of vision or					
	1	nt or the office of a					
		ializing in the provision of					
	vision or hearing a	-					
	Based on observation	on, record review, and	F 0	585	his plan of correction is prepar	red	07/12/2024
	interview, the facili	ty failed to ensure a resident			and executed because the		
	received the assistiv	ve devices needed to maintain			provisions of state and federal	law	
		earing aids not administered to			require it and not because of L	₋ife	
		physician's order for 1 of 2			Care Center of Michigan City		
	residents reviewed	for vision/hearing. (Resident 4)			agrees with the allegations an	d	
					citations listed. Life Care Cent		
	Finding includes:				Michigan City maintains that the	ne	
					alleged deficiencies do not		
		3 a.m., Resident 4 was observed			jeopardize the health and safe	ty of	
		area with other residents. The			the residents nor is it of such		
		g "huh" when other people			character to limit our capabiliti		
		esident did not have hearing			to render adequate care. Plea		
	aids observed to eit	her ear.			accept this plan of correction a	as	
	0 (/11/24 / 2.00	D 11 44 122 1			our credible allegation of		
		p.m., Resident 4 was sitting in a			compliance that alleged		
		om. The resident indicated he			deficiencies have or will be		
could not hear the questions being asked. The					corrected by the date indicated		
		re hearing aids observed to			remain in compliance with state		
	either ear and was t	maware where his hearing aids			and federal regulations, the fa	cility	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11 Facility ID: 000236

If continuation sheet Page 5 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	ING		06/14/	2024
		<u> </u>	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF F	PROVIDER OR SUPPLIEF	₹			HIGHWAY 20 EAST		
	RE CENTER OF MI	ICHIGAN CITY					
LIFE CAN	TE CENTER OF MI	CHIGAN CHT		MICHIC	GAN 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were.				has taken or will take the action	ons	
					set forth in this plan of correct	ion.	
	Record review for Resident 4 was completed on				We respectfully request a des	k	
	6/11/24 at 3:11 p.m. Diagnoses included, but were				review.		
	not limited to coronary artery disease, heart				F685-Treatment/Devices to		
	failure, and hyperte	ension.			Maintain Hearing/Vision		
					What Corrective Action will be		
		imum Data Set (MDS)			accomplished for those reside	ents	
		3/26/24, indicated the resident			found to be affected by this		
		paired. The resident had			deficient practice:		
		nd used a hearing aid. The			1. Resident 4 had no negative	<b>!</b>	
		partial moderate assistance for			outcomes related to alleged		
	dressing the upper	body.			deficient practice. New hearing	-	
					devices obtained and delivere	d to	
		9/19/23, indicated the resident			resident.		
	_	assistance from staff to			How other residents having th		
		(assistance of daily living)			potential to be affected by the		
		ty, transfers, and limited			same deficient practice will be	<b>!</b>	
		s. An intervention, dated			identified and what corrective		
		or his hearing aids to be put in			action will be taken:		
		ning and taken out at night			Complete audit of all reside	nts	
	time.				with an assistive device		
					completed.		
		4/2/24, indicated the resident			2. Education to nursing staff o	n	
		on problem related to hearing			assistive devices regarding		
		nt had hearing aids which he			ensuring compliance with		
		nd misplaced them under the			administration of hearing devi	ce	
	bed, under dressers				per physician order to be		
		ded to assist with hearing aids			completed by date of complian	nce.	
		nove hearing aids and place in			What measures and what		
		l, and search the resident's			systemic changes will be mad		
	room if the resident, staff, or visitors report the				ensure that the deficient pract	ice	
	hearing aids are mis	ssing.			does not recur:		
	TI I 2024 P1				1. Education to be provided to	all	
		sician's Order Summary			staff related to ensuring		
	indicated the follow	_			compliance with administration		
	_	e morning and out at night			hearing device per physician of	order	
		hen put in and removal at	1		to be completed by date of		
	bedtime.				compliance.		
			1		How the corrective action will	be	

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MICHIGAN CITY  X4 ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 supposed to put them in and take them out every  STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360  ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPERTIES CROSS-REFERENCED TO THE APPROPRIATE DOMPLETON DATE  ID PROVIDERS HAN OF CORRECTION (X5)  COMPLETION  PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPERTIES CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE  TAG  MICHIGAN CITY, IN 46360  (X5)  PREFIX PROVIDERS HAN OF CORRECTION (X5)  PREFIX PROVIDERS HAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE  PROVIDERS HAN OF CORRECTION (X5)  PREFIX PROVIDERS HAN OF CORRECT	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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SUZ US HIGHWAY 20 EAST   MICHIGAN CITY   SUMMARY STATEMENT OF DEFICIENCIE   EACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   PROVIDERS PLAN OF CORRECTION   (EACH CORRICTIVE ACTION SHOULD BE   COMPLETION DATE   COMPLETION DATE      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   SUB HIGHWAY 20 EAST MICHIGAN CITY, IN 46360      SUMMARY STATEMENT OF CORRECTION (IXS) COMPLETION DATE   IDDEFICIENCY   TAG PROVIDERS PLAN OF CORRECTION (IXS) (COMPLETION DEFICIENCY   DATE   COMPLETION DATE      DREFIX (EACH DEFICIENCY   TAG STOR   COMPLETION DATE   TAG   PREFIX TAG PROVIDERS PLAN OF CORRECTION (IXS) (COMPLETION DATE   COMPLETION DATE   COMPLETION DATE     DEFICIENCY   TAG STOR   COMPLETION DATE   COMPLETION DATE   COMPLETION DATE   COMPLETION DATE     DATE   TAG   PROVIDERS PLAN OF CORRECTION (IXS) (COMPLETION DATE   COMPLETION DATE   COMPLETIO			155344	B. W	ING		06/14/	/2024
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resident would take them out himself sometimes, set them down and lose them. The staff were facility Quality Assurance Committee meeting monthly for a		believed the resident's hearing aids were lost and					s will	
set them down and lose them. The staff were Committee meeting monthly for a						-		
						-		
supposed to put them in and take them out every total of 3 months and then						Committee meeting monthly for	or a	
						total of 3 months and then		
day and put them in the medication cart. She was quarterly thereafter. Frequency						quarterly thereafter. Frequenc	у	
unaware if that was supposed to be documented and duration of reviews will be			supposed to be documented			and duration of reviews will be	<b>!</b>	
anywhere. increased as needed.		anywhere.				increased as needed.		
Compliance date: 7/12/24 The						Compliance date: 7/12/24 The	<b>!</b>	
During an interview on 6/11/24 at 3::25 p.m., the  Administrator at Life Care Centers		_	-					
Director of Nursing (DON) indicated she was not of Michigan City is responsible in		_				of Michigan City is responsible	e in	
sure why the hearing aid order did not populate ensuring compliance in this Plan		-					an	
for the nursing staff to document the resident's of Correction.						of Correction.		
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		aids once because h	e had lost them. The staff					
were supposed to be making sure they had								
documented when they are put in and then taken		documented when t	hey are put in and then taken					
out, and that they are placed into the medication								
cart after they are removed.		cart after they are re	emoved.					
3.1-39(a)		3.1-39(a)						
F 0692 483,25(g)(1)-(3)	E 0602	402 25(~\/4\ /2\						
			n Status Maintanana					
		_						
	ыug. 00	,						
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11 Facility ID: 000236

If continuation sheet Page 7 of 17

STATEMEN	NT OF DEFICIENCIES	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155344	B. W	ING		06/14/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	₹			HIGHWAY 20 EAST			
LIFE CA	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360			
	THE GENTLE OF THE			WHOTHE				
(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		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	gastrostomy and percutaneous endoscopic							
	1	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							
		lyte balance, unless the						
	_	condition demonstrates						
	that this is not pos							
	preferences indica							
	'	,						
	§483.25(g)(2) Is o	offered sufficient fluid intake						
	to maintain prope	r hydration and health;						
	§483.25(g)(3) Is o	ffered a therapeutic diet						
		utritional problem and the						
		ler orders a therapeutic diet.						
		view and interview, the facility	F 00	592	This plan of correction is prepare	ared	07/12/2024	
		d consumption logs were			and executed because the			
	_	ents with a history of weight			provisions of state and federal			
		ents reviewed for nutrition.			require it and not because of L	_ite		
	(Residents 59, 14, a	and 42)			Care Center of Michigan City			
	Findings include:				agrees with the allegations an			
	rmanigs include:				citations listed. Life Care Cent			
	1 Record review for	or Resident 59 was completed			Michigan City maintains that the	IC		
		p.m. Diagnoses included, but			alleged deficiencies do not jeopardize the health and safe	aty of		
		, hypertension, dementia, and			the residents nor is it of such	iy Oi		
	failure to thrive.	, napertension, dementia, and			character to limit our capabiliti	es		
					to render adequate care. Plea			
	The Quarterly Mini	imum Data Set (MDS)			accept this plan of correction a			
		5/13/24, indicated the resident			our credible allegation of			
		paired. The resident required a			compliance that alleged			
		l assistance with eating.			deficiencies have or will be			
		-			corrected by the date indicated	d to		
	A Care Plan, dated	1/11/24, indicated the resident			remain in compliance with stat			
	had unplanned/une	xpected weight loss related to			and federal regulations, the fa			
	poor food intake. In	nterventions included to alert			has taken or will take the actic	-		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11 Facility ID: 000236

If continuation sheet Page 8 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155344	B. WING		06/14/2024
NAME OF T	DOMDED OF GUIDN IS	D	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEI	К	802 US	S HIGHWAY 20 EAST	
LIFE CAF	RE CENTER OF M	ICHIGAN CITY	MICHIO	GAN CITY, IN 46360	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		consumption was poor for		set forth in this plan of correct	
	more than 48 hours	s and to record food intake at		We respectfully request a des	k
	each meal.			review.	
				F692-Nutrition/Hydration State	ıs
	_	ed 109 pounds on 11/30/23. A		Maintenance	
		6/7/24 indicated the resident		What Corrective Action will be	
		s, which was a 11.01 %		accomplished for those reside	ents
	(percent) weight lo	SS.		found to be affected by this	
				deficient practice:	
		nsumption Logs were		1. Residents 59, 14, and 42 h	
		percentage of meals eaten. The		had no negative outcomes rel	ated
	I -	documentation for the		to alleged deficient practice.	
	following meals:			How other residents having th	e
		5/24, 5/22/24, 5/25/24, 5/26/24,		potential to be affected by the	
	5/29/24, 6/1/24, 6/3	3/24, 6/9/24, 6/10/24, and 6/12/24.		same deficient practice will be	
		, 5/22/24, 6/10/24, and 6/12/24.		identified and what corrective	
	- Dinner on 5/16/24	4, 6/9/24, 6/10/24, and 6/11/24.		action will be taken:	
				Complete audit of all reside	
	_	w on 6/13/24 at 1:20 p.m., the		with a documented weight los	
	1	g (DON) indicated the CNAs		completed. Meal consumption	1
	_	ocument meal consumption		audited to verify accurate	
		the computer under the Task		percentage documented.	
	section for Meal Co	-		2. Education to nursing staff of	n
		2:15 p.m., Resident 14 was		appropriate documentation	
	1	nch. Resident 14 received a		regarding documentation of	
		er lunch. Resident 14		consumption to be completed	by
		5% of her shake and ate about		date of compliance.	
	50% of the food on	her plate.		Weight report to be reviewed	ed on
				a weekly basis to ensure all	
		rd was reviewed on 6/13/24 at		residents with a documented	
		ses included, but were not		weight loss are being audited	for
	_	ophageal reflux disease		accurate documentation of	
		s, constipation, and type 2		consumption.	
	diabetic mellitus w	ith diabetic neuropathy.		What measures and what	
				systemic changes will be mad	
		S assessment, dated 3/12/24,		ensure that the deficient pract	ice
	indicated the reside	ent was cognitively impaired.		does not recur:	
				Weight report to be ran wee	
	A Care Plan, dated	5/14/24, indicated to record		to determine residents that ha	ve a

Resident 14's food intake at each meal.

documented weight loss.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLE	ΓED
		155344	B. W	ING		06/14/2	024
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
1.155.041		IOLUGANI OLTV			HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	ICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(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 APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
					2. Consumption report will be		
	Weight Assessment	ts indicated the resident			audited to ensure accurate		
	1	ls on 1/12/24 and 162 pounds			documentation of consumption	n for	
		as an 8.47% weight loss.			all residents with a documente		
	on 0, ,, 2 i, windi w	us un orr, , o weight less.			weight loss.		
	The meal consumpt	tion logs indicated the			3. Education provided to all st	aff	
	following:	tion logo maleated the			related to appropriate		
	~	eal was not documented			documentation of consumption	n to	
	5/18/24 - no meals				be completed by date of	11 10	
		and lunch meals were not			compliance.		
	documented	and functi means were not			How the corrective action will	ho	
		and dinner were not					
	documented	and diffier were not			monitored to ensure the defici		
		eal were not documented			practice will not recure, i.e. wh		
					quality assurance program wil	i be	
		and lunch meals were not			put in place:	1:1	
	documented	11 1 41 41			1. The DON/designee will aud		
		nd lunch were not documented			weight report weekly to determ	nine	
	6/7/24 - no meals w				residents with a documented		
		nd lunch were not documented			weight loss x 6 months.		
	6/10/24 - no meals	were documented			2. The DON/Designee will aud		
	D	6/12/24 + 2.25 + 4			consumption report to ensure		
	_	v on 6/13/24 at 2:35 p.m., the			proper documentation of meal	l	
		of Nursing (ADON) indicated			intakes 5 times a week for 4	,	
		on logs should have been			weeks, then 4 times a week x		
		esident. 3. The record for			weeks, then 3 times a week x		
		viewed on 6/10/24 at 12:19 p.m.			weeks, then 2 times a week x		
	_	uded, but were not limited to,			weeks, then weekly x 4 weeks		
		bnormal heart rhythm),			3. The results of these reviews	s WIII	
	_	on, muscle weakness, adult			be discussed at the monthly		
	failure to thrive, and	xiety, and left shoulder fracture.			facility Quality Assurance		
	TEL C: : C	MDG			Committee meeting monthly for	or a	
	_	ange MDS assessment, dated			total of 3 months and then		
	· ·	he resident was severely			quarterly thereafter. Frequence	•	
		decision making. The resident			and duration of reviews will be	•	
	_	of the upper and lower			increased as needed.	1	
		d a wheelchair. Eating and oral			Compliance date: 7/12/24 The		
		pervision or touching			Administrator at Life Care Cer		
		oody dressing, toileting and			of Michigan City is responsible		
	bathing required de	pendent assistance.			ensuring compliance in this Pl	lan	
					of Correctio		

PRINTED: 07/03/2024

CENTERS FO		OMB NO. 0938-039					
	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 06/14/2024	
	PROVIDER OR SUPPLIEI		802 US	ADDRESS, CITY, STATE, ZIP COI S HIGHWAY 20 EAST GAN CITY, IN 46360	)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	A Care Plan, dated had unplanned/uner poor intake. Interver intake for each measupplements were inthan 48 hours.  The resident weight weight obtained on weighed 87 pounds loss in 3 months.  The meal consumpt following:  The breakfast measure 5/21,5/22, 5/25, 5/26/12/24.  The lunch meal read of 1/24.  The dinner meal weight of 1/24.	4/12/24, indicated the resident expected weight loss related to entions were to record food al, and alert the dietician when not being consumed for more ed 106 pounds on 2/27/24. A 5/24/24 indicated the resident which was a 28.57% weight etion intake logs indicated the earl was not documented on 5/15, 26, 5/30, 6/1, 6/8, 6/10, 6/11, and not documented on 5/22, 5/25, was not documented on 5/18, 6/9, and 6/10/24.  In one of 13/24 at 1:20 p.m., the CNAs were expected to esumption percentage eaten in the Task section for Meal colicy titled, "Nutritional					
	6/14/24 at 3:03 p.m	y the Director of Nursing on  ., indicated "the facility will tional intake on each individual					
	3.1-46(a)(1)						
F 0695	483.25(i)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Suctioning

Respiratory/Tracheostomy Care and

§ 483.25(i) Respiratory care, including

SS=D

Bldg. 00

Event ID:

PIOW11

Facility ID: 000236

If continuation sheet

Page 11 of 17

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 06/14/2024 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 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 F 0695 Th plan of correction is prepared 07/12/2024 interview, the facility failed to ensure oxygen was and executed because the at the correct flow rate for 2 of 3 residents provisions of state and federal law reviewed for oxygen use. (Residents 42 and 48) require it and not because Life Care Center of Michigan City Findings include: agrees with the allegations and citations listed. Life Care Center of 1. On 6/10/24 at 11:25 a.m., Resident 42 was Michigan City maintains that the observed lying in bed wearing oxygen via nasal alleged deficiencies do not cannula. The oxygen flow rate was set under 2 jeopardize the health and safety of liters. the residents nor is it of such character to limit our capabilities On 6/10/24 at 12:04 p.m., the resident's oxygen was to render adequate care. Please in place and the flow rate was set under 2 liters. accept this plan of correction as our credible allegation of On 6/11/24 at 11:59 a.m., the resident was compliance that the alleged observed lying in bed and oxygen was in place via deficiencies have or will be correct nasal cannula. The flow rate was set just under 2 by the date indicated to remain in liters. compliance with state and federal regulations, the facility has taken On 6/11/24 at 3:36 p.m., the resident was observed or will take the actions set forth in asleep in bed. Oxygen was in place and the flow this plan of correction. We rate was set below 2 liters. respectfully request a desk review. F 695- Respiratory/Tracheostomy The record for Resident 42 was reviewed on Care and Suctioning 6/10/24 at 12:19 p.m. The diagnoses included, but What Corrective Action will be were not limited to, atrial fibrillation (abnormal accomplished for those residents heart rhythm), dementia, depression, muscle found to have been affected by this weakness, adult failure to thrive, anxiety, and left deficient practice: shoulder fracture. 1. Residents 42 and 48 had no negative outcomes. O2 sats were

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11

Facility ID: 000236

If continuation sheet

Page 12 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	ING		06/14/	2024
		1	1	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			HIGHWAY 20 EAST		
LIEE CAI	DE CENTED OF MI	ICHICAN CITY					
LIFE CAI	RE CENTER OF MI	ICHIGAN CITT		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	The Significant Change Minimum Data Set (MDS)				taken with no issues noted an	d	
	Assessment, dated 5/29/24, indicated the resident				O2 liter flows adjusted to orde	red	
	was severely impaired for daily decision making.				liter flow immediately.		
		impairment of the upper and			How other residents having th	е	
		nd used a wheelchair. Eating			potential to be affected by the		
		quired supervision or touching			same deficient practice will be	!	
		oody dressing, toileting and			identified and what corrective		
	bathing required de	ependent assistance.			action will be taken:		
					An Audit was completed on		
		4/25/24, indicated the resident			residents in house with curren		
		erapy. Interventions were to			orders to assure orders accura		
		settings per physician orders			and clinical team observed lite		
	and administer med	lications as ordered.			flow being administered per or	rder.	
					No other issues have been		
		, dated 4/25/24, indicated to			identified. Audit completed by		
		via nasal cannula continuously			nursing management by date	of	
	at 2 liters/minute fo	or hypoxia.			compliance.		
					What measures and what		
		dication Administration Record			systemic changes will be mad		
	, ,	xygen was signed out as being			ensure that the deficient pract	ice	
	_	ery shift on the following			doesn't recur:		
	dates: 6/10/24 and	6/11/24.			1. Don and/or designee to		
					complete education to license		
	_	v on 6/12/24 at 11:34 a.m., the			nursing staff and certified aide		
		g (DON) indicated she would			observe liter flow on residents		
		's oxygen flow rate. No			using 02 and assure liter flow		
	additional informat	ion was provided.			accurate per order. This will be		
	2.0. (/10/24 : 2 :	10 D 11 440			completed by date of compliar		
		18 a.m., Resident 48 was			How the corrective action will		
	_	her wheelchair watching her			monitored to ensure the defici		
	-	t wore oxygen via nasal			practice will not recur, i.e., who		
		w rate was set at 3.5 liters. The			quality assurance program wil	ı pe	
		d an oxygen sticker label that			put in place:	النم	
	was marked 2 liters	o III Icu.			1. Don/Nursing management		
	On 6/10/24 at 11:54	5 a m the resident was			observe 5 residents daily Mon	-	
		5 a.m., the resident was			through Friday x 8 weeks, the		
	_	bed, her nasal cannula was in en flow rate was set at 2.5 liters.			residents daily Monday throug		
	place and the oxyge	on now rate was set at 2.3 fiters.			Friday x 8 weeks, then 2 resid		
	On C/11/24 + 11 59	0 41			daily Monday through Friday x	ďδ	
	On 0/11/24 at 11:58	8 a.m., the resident's oxygen was			weeks to assure compliance.		

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  06/14/2024			
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 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  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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Audits will be presented to QA 6 months and then QAPI will determine the need for further audits. Any noted issues will be addressed immediately. 2. The results of these review be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter. Frequency	API x  r  pe s will  or a		
	daily decision mak impairment on one extremity. The resi wheelchair.  A Care Plan, dated received oxygen the administer oxygen and to administer oxygen administer oxygen administer oxygen.	ing. The resident had an eside of her upper and lower dent used oxygen and a 6/11/24, indicated the resident herapy. Interventions were to settings per physician orders medications as ordered.  The resident had an esident had an esident herapy. Interventions were to settings per physician orders medications as ordered.  The resident had an esident had a es		increased as needed. Compliance date: 7/12/24. The Administrator at Life Care Cell of Michigan City is responsible ensuring compliance in this Period of Correction.	e nter e in		
F 9999	The June 2024 MA out as being given following dates: 6/ During an interview DON indicated she	AR indicated oxygen was signed at 2 liters every shift on the					
Bldg. 00							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11 Facility ID: 000236

If continuation sheet Page 14 of 17

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155344	B. WING			06/14/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					S HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY					GAN CITY, IN 46360		
					T	<u> </u>	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY 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		EG	TAG		DATE	
	410 IAC 16.2-3.1-14 Personnel		F 99	999	This plan of correction is prepared to the correction of the correction is prepared to the correction of the correction is prepared to the correction of the	ared 07/12/2024	
	(t) A physical examination shall be required for				and executed because the	U.S.	
				provisions of state and			
	each employee of a facility within one (1) month prior to employment The facility must assure				require it and not because Life	,	
		The facility shall maintain a		Care Center of Michigan (		4	
		· ·		agrees with the allegat			
	health record of each employee that includes:			citations listed. Life Care			
	(A) a report of the preemployment physical examination; and			Michigan City maintains the alleged deficiencies do not			
	· ·	nnlovment-related health			jeopardize the health and safe	ety of	
	(B) reports of all employment-related health examinations.				the residents nor is it of such	., :	
					character to limit our capabiliti	es	
	This rule is not met as evidenced by:				to render adequate care. Plea		
		,			accept this plan of correction a		
	Based on record rev	view and interview, the facility		our credible allegation of			
		h employee had a complete		compliance that the alleged			
		on completed by a licensed		deficiencies have or will be correct			
	Physician or Nurse Practitioner (NP) within one		by the date indicated to remain in			n in	
	month prior to employment for 5 of 10 employees			compliance with state and federal			
	reviewed. (Housekeeping 1, Housekeeping 2, RN			regulations, the facility has taken			
	1, Dietary Aide 1 and CNA 2)			or will take the actions set forth in			
					this plan of correction. We		
	Findings include:				respectfully request a desk rev	view.	
	Review of the employee files was completed on				- F 9999 Personnel		
6/13/24 at 9:45 a.m. The "physical exam" forms			What Corrective Action will be				
	were completed for the following employees upon			accomplished for those			
	hire. The forms included only documentation of			residents found to have been			
	the employees' vital signs, signed as completed			affected by this deficient			
	by an LPN. The forms lacked any documentation			practice:			
	to indicate any other examination besides vitals			1 Zero residents were		ere	
	signs had been completed on the employees by a			affected or had negative outcomes		omes	
	licensed physician or NP.			due to staff lacking a physical			
					examination		
	1. Housekeeping 1 was hired on 2/27/24.				How other residents having	having the	
<ul><li>2. Housekeeping 2 was hired on 3/25/24.</li><li>3. RN 1 was hired on 3/13/24.</li></ul>				potential to be affected by the same deficient practice will be			
				identified and what correctiv	re		
				action will be taken:			
				1 Zero residents w	ere		

07/03/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155344 B. WING 06/14/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 4. Dietary Aide 1 was hired on 8/30/23. affected or had negative outcomes due to staff lacking a physical 5. CNA 2 was hired on 4/25/24. examination. Housekeeper 1 and 2, dietary aide 1, RN 1, CNA 2 will During an interview on 6/13/24 at 1:50 p.m., the all have a physical exam Human Resources Director indicated they were completed by a NP or MD by unaware the forms they had for each employee 7/12/24 were not complete physical examinations. What measures and what systemic changes will be made 3.1-14(t)to ensure that the deficient practice doesn't recur: 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. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PIOW11

Facility ID: 000236

If continuation sheet

Compliance date: 7/12/24. The Administrator at Life Care Center of Michigan City is responsible in

Page 16 of 17

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

PRINTED: 07/03/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00  B. WING			X3) DATE SURVEY COMPLETED 06/14/2024	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ensuring compliance in this Pla of Correction.	an	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PIOW11 Facility ID: 000236 If continuation sheet Page 17 of 17