STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155343	A. BUILDING 00 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF LAGRANGE	0770 NORTH 075 EAST LAGRANGE, IN 46761

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00404252. Complaint IN00404252 - Federal/state deficiencies related to the allegations are cited at F725. Survey date: March 30, 2023 Facility number: 000235 Provider number: 155343 AIM number: 100267740 Census Bed Type: SNF/NF: 44 Total: 44 Census Payor Type: Medicare: 1 Medicaid: 34 Other: 9 Total: 44 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 3, 2023	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of LaGrange agrees with the allegations and citations listed. Life Care Center of LaGrange maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Ready	RVP/HFA	05/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to maintain adequate staffing levels to implement fall prevention interventions and meet personal needs for 2 of 6 residents reviewed (Resident R and Resident V). Findings include: An anonymous complaint to the Indiana Department of Health, indicated there was a concern regarding not enough staff available to care for residents, especially on weekends. 1. On 3/30/23 at 10:17 A.M., Resident R was observed lying in a low bed, snoring loudly. A family member, who was sitting in the room, indicated the resident had just returned from the hospital the day before following a fall and fractured hip. The resident had several falls recently with the last one occurring on 3/26/23	F 0725	F 725- Sufficient Nursing Staff What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Audit has been completed to ensure all fall interventions that are care planned are in 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 will be completed by activities and SSD and/or for current residents to update their personal preferences. If unable to	04/30/2023

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	which resulted in the fracture and need for surgery. The family member indicated they believed the resident wouldn't have fallen so often had there been adequate staffing to monitor her. On 3/30/23 at 3:10 P.M., Staff 3 was interviewed. They indicated on Sunday, 3/26/23, Resident R had been restless all day long. She wandered up and down the hallways in her wheelchair and when she stopped, would get up from the chair and attempt to walk. Staff tried to keep her at the nurses station for closer monitoring but were unable to provide 1:1 supervision. On 3/26/23 at 3:00 p.m., A visitor reported they heard a fall. Resident R was found on the floor in the hallway by the nurses station. 2. On 3/30/23 at 11:00 A.M., Resident V, identified as interviewable by the facility, indicated they were not assisted to bed at their preferred time late in the evening after their last medication was given. The resident indicated they hadn't known why the staff couldn't do it consistently and believed staffing was the reason. On 3/30/23 at 10:14 A.M. and 4:04 P.M., the Director of Nursing was interviewed. She indicated she tried to schedule 2 nurses for the 6 a.m. to 6 p.m. shift and 2 nurses from 6 p.m. to 6 a.m. but wasn't able to always have a nurse. She indicated at times, there would be only 1 nurse scheduled with a QMA (Qualified Medication Aide) to cover a 12 hour shift. There were to be 4 CNA's (Certified Nurse Aide) scheduled for the day shift (6 a.m. to 2 p.m.); 4 CNA's for evening shift (2 p.m. to 10 p.m.); and 2 CNA's for night shift (10 p.m. to 6 a.m.). She indicated weekends were very difficult to staff, especially since the facility no longer used agency staff. She indicated currently, of the 44 residents in the facility, 17		make POA and/or family will be contacted to give information by date of compliance. Resident preferences will be updated and put on care plans and by date of compliance. 2. Fall interventions will be monitored during IDT meetings to ensure What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. SSD and Activities will be educated by ED and/or designee on updating preferences at least quarterly with care plans and prn as indicated. SSD and activities will be responsible for updating care plan and with changes. Education will be completed by date of 2. Fall incidents to be discussed during clinical meeting and prn as indicated. 3. Scheduler and nurse admin will be educated by ED/ and/or Designee related to facility staffing model and recruitment process to meet facility needs. Staffing to be discussed 5 times a week in meeting to ensure adequate PPD. The facility will continue to actively recruit nursing staff. Education will be completed by of compliance.	

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	residents required assistance of 2 staff members for completing activities of daily living. On 3/30/23 at 12:30 P.M., the Interim Administrator provided a copy of the Facility Assessment (used to determine what resources, including nursing staff, are necessary to care for residents), dated 10/21/22. The facility's calculated per patient day (PPD-hours worked by nursing staff in a 24 hour day divided by number of residents) staffing for nurses was to be 1.08. For CNA's the PPD was to be 2.25 based on care needs of residents who were independent, needed assistance from 1 or 2, or were totally dependent on staff. Residents requiring assistance from 2 staff members were assessed at 7. However, the CNA's were currently providing care for 17 residents who required assistance of 2 staff for ADL's. Review of average daily census, licensed nurse, and CNA time cards, in March 2023, indicated the following days PPD's were not met according to the facility assessment: -3/4/23: CNA PPD = 1.77 -3/5/23: CNA PPD = 1.95 -3/11/23: Nurse PPD = .56 and CNA PPD = 2.19 -3/12/23: Nurse PPD = .56 and CNA PPD = 1.63 -3/18/23: Nurse PPD = .84 and CNA PPD = 1.63 -3/19/23: CNA PPD = 1.5 -3/25/23: Nurse PPD = .53 and CNA PPD = 2.25 -3/26/23: Nurse PPD = .55 and CNA PPD = 2.0 This Federal tag relates to Complaint IN00404252. 3.1-17(b)		4. The facility assessment will be reviewed and updated as indicated. 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 and/or will audits on resident preferences for 5 charts weekly x , then 3 charts weekly x 8 weeks, then 2 charts weekly x 8 weeks. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 2. DON and/or Designee will review incident reports 5 times weekly to ensure fall interventions in place and effective x 6 months. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 3. ED, DON, Scheduler, and/or Designee will review direct care staffing schedules for the upcoming weekend every Thursday to ensure facility staffing model is appropriate x 6 months. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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			4. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 4/30/23. The Administrator at Life Care Center of LaGrange is responsible ensuring compliance this Plan of Correction.¿¿	