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	03/28/2024

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

(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: March 24, 25, 26, 27, and 28, 2024 Facility number: 000235 Provider number: 155343 AIM number: 100267740 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 4 Medicaid: 29 Other: 8 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 2, 2024	F 0000	Dear Ms. Buroker, Please accept this Plan of Correction as our credible allegation of Compliance for Survey Event ID Z14Z11. We have been working this Plan and are submitting supporting documentation. Life Care Center of LaGrange is requesting Desk Review. Respectfully, Mark Thompson, HFA Executive Director.	
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Thompson	Administrator	05/02/2024

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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	(B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review the facility failed to ensure nurse staffing hours were posted for 3 of 4 days reviewed. Findings include: On 3/24/24 at 9:35 AM the facility nurse staffing hours were observed posted near the facility entrance. The nurse staffing hours form was a single sheet of paper dated 3/21/24. On 3/24/24 at 11:45 AM the posted facility nurse staffing hours were observed to be dated 3/21/24.	F 0732	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 if of such character to limit our capabilities to render adequate care.	04/28/2024

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	On 3/24/24 at 1:10 PM the posted facility nurse staffing hours were observed to be dated 3/21/24. In an interview on 3/26/24 at 2:20 PM the Director of Nursing (DON) indicated they had been unaware of the nurse staffing hours posted on 3/24/24 was dated 3/21/24. The DON indicated nurse staffing hours should be posted daily. In an interview on 3/28/24 at 10:14 AM the Administrator indicated they were unaware nurse staffing hours had not been posted for 3 days on 3/24/24. The Administrator indicated nurse staffing hours should be posted daily. A current facility policy dated 4/24/19 provided by the Administrator on 3/27/24 at 9:15 AM indicated the facility must post the nurse staffing data every day at the beginning of each shift. No State Rule.		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. **F732 Posting Nurse Staffing Information** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** • The nursing staffing board was immediately updated to reflect the current date, facility census and staffing. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** • All residents who reside in Life Care Center of Lagrange have the potential to be affected. All residents should have the ability to know the current census and nurse staffing on a daily basis.	

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • Staff responsible for updating the nursing staffing board were immediately educated on the process/procedure/importance of accurate completion of nursing staffing board daily in the AM. • All facility management to be educated on how to accurately update the nursing staffing board with census and staffing for the day by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** • DON/designee will audit the nursing staffing board 5 times weekly x 6 months to ensure it is updated with correct date, census and staffing. • 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: 04/28/24. The Administrator at Life Care Center	

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			of Lagrange is responsible in ensuring compliance in this Plan of Correction	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.			

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	§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those			

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	areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality			

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	deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review the facility failed to ensure quality improvement plans were developed for identified recurrent environmental concerns. 41 residents resided in the facility. Findings include: The facility annual survey completed on 6/7/23 identified concern regarding repair and maintenance of facility floors, walls, and handrails. The facility indicated the noncompliance would be corrected by 6/30/23. The repair and maintenance of facility floors, walls, and handrails was also found to be a concern on the annual survey completed 3/28/24. See F921 for additional information about current environmental findings. A QAPI (Quality Assurance Performance Improvement) committee list was provided by the ED on 3/25/24 at 12:39 PM. The member list included the Executive Director, Director of Nursing Services, Assistant Director of Nursing/Infection Preventionist, Rehab Director, Social Services, Business Office Manager, Admissions/Marketing, Dietary Manager, Activity Director, Medical Records, Maintenance Director, and Compliance Coordinator. In an interview on 3/28/24 at 10:25 AM, the Executive Director (ED) indicated segments of care including clinical services, dietary, maintenance, housekeeping and administration	F 0867	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 867**- QAPI/QAA Improvement Activities ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 No residents were directly affected by the cited deficient practice.	04/28/2024

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	were reviewed in each monthly QAPI meeting. He indicated the meeting reviewed topics identified by staff observations discussed in daily morning meetings, resident and family reports of concerns, survey results, electronic medical record software generated reports and corporate quality measure reports. The environment was an ongoing topic in QAPI meetings. He indicated there was not a current performance improvement plan pertaining to the environment in place. A current policy dated 2024 provided by the ED on 3/25/24 at 12:39 PM indicated Maintenance should provide comprehensive building safety and repairs to ensure all aspects of safety and well-being for each resident, visitor, and associates. The policy indicated the QAPI committee was ultimately responsible for assuring compliance with federal and state regulations. 3.1-52		***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 All residents have the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 The QAPI Team completed a Self –Assessment and modified the QAPI Calendar. 2 On April 12, 2024 the facility conducted its monthly QAPI meeting with the Medical Director. On this date the Executive Director educated QAPI Team that QAPI meetings must be conducted on a monthly basis and the medical director must participate at least on a quarterly basis. 3 A Performance Improvement Plan has been developed based on the current findings described in F 921 Tag. 4 An Audit tool has been developed for F 921 that will be reviewed by QAPI monthly until resolved. ***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 Results of the identified	

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			monitoring activity under the tag F 921 will be reported by the Maintenance Technician to the monthly QAPI meeting for any further recommendations or root analysis. The Maintenance Man will be responsible for any follow –up on any recommendation from the committee and additional tasks as indicated. Regional Vice President will review each months QAPI meeting minutes for the next 6 months and specific audits related to the identified tag shall be a part of the review until it has been resolved. 2 Monthly for 6 months, the Facility Executive Director shall send an email to Regional Vice President of Operations to ensure compliance that QAPI has successfully been conducted. The RVP of Operations shall on a monthly basis for 6 months review the QAPI minutes to ensure compliance. If the QAPI meeting is not conducted timely, the Executive Director shall receive additional education and the issue reported to the facility QAPI committee. Compliance date: 4.28.24 The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure a sanitary environment free of hazards on 4 of 4 halls where residents resided or received services. Findings include: During an observation on 3/24/24 at 10:15 AM. handrails on the 200, 300, 400, and 500 halls were observed to have bare portions missing finish. Baseboards were missing throughout the 100, 200, 300, 400, and 500 halls. Drywall on portions of the walls on each hall below the handrails had grey linear marks scattered throughout in too many locations to count. The bottom of the drywall had chipped, jagged edges observed on all halls. In an observation and interview on 3/27/24 at 9:45 AM the Maintenance Director indicated repairs had been delayed due to problems with the company contracted to install flooring throughout the building. A raised buckle in the vinyl plank flooring was observed on the 100 hall near the door to the maintenance office. The Maintenance Director indicated the flooring installers did not install the flooring correctly resulting in the raised area in the floor. He indicated he had contacted the flooring company requesting repair of this area and others throughout the building. He indicated he was not aware of any current plans for contractors to fix the flooring problems. He indicated the lower portions of the walls were to be painted, then baseboards applied, and handrails refinished after the flooring was laid. He indicated the flooring was completed about three months ago.	F 0921	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 921-** Safe/Functional/Sanitary/Comfortable Environment ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 The handrails on the 200, 300, 400, and 500 halls to be refinished 2 The baseboards in the 300, 400, and 500 halls to be	04/28/2024

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	During an observation and interview on 3/27/24 at 10:35 AM, a buckle in the flooring was observed in front of the door to room 507. Buckled areas were also identified outside rooms 210, 308, 310, 311, 312, 314, 401, and 410. Qualified Medicine Aide (QMA) 2 indicated he noticed raised areas in the flooring throughout the halls and the flooring had not been installed properly. During an interview on 3/27/24 at 10:58 AM, the Executive Director (ED) indicated he began work for the facility in December 2023 and the flooring was complete at that time. He indicated he was not aware of any plans for repairs of the floor. He indicated the painting was in progress and he had not been aware of handrail concerns. A current policy titled Plant Operations last reviewed 7/12/23 provided by the ED on 3/27/24 at 11:12 AM indicated the facility should maintain a safe, clean, and structurally sound environment. 3.1-19(4)(f)		replaced 3 Drywall on portions of the wall below the handrails have been painted. 4 The chipped, jagged edges at the bottom of drywall will be covered by the new baseboard. 5 Vinyl plank flooring on the 200. 300. 400, and 500 halls to be inspected and any areas addressed. ***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 Other residents had the potential to be affected by this deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 QAPI Team has developed a Performance Improvement Plan that focuses on the current findings. 2 The Maintenance Director and/or designee will also include identified areas in the current preventive maintenance program and conduct routine facility/resident room rounds according to the facility policy. 3 Executive Director and Maintenance Director will oversee the Vendors hired to repair walls, handrails and base board. ***How the corrective action will be monitored to ensure the***	

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			deficient practice will not recur, i.e., what quality assurance program will be put in place: 1 Maintenance Director and/or designee to conduct facility/resident room observations 3x weekly for next 6 months to ensure the resident's environment is in good repair from handrails missing finish, missing baseboards, marks on drywall, and any areas of vinyl flooring that is raised/buckled. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then 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: 4.28.24 The Administrator at Life Care Center of LaGrange is responsible in ensuring compliance in this Plan of Correction.	