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	11/23/2021

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

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00365300 and IN00367235. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00365300 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00367235 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Survey dates: November 22 and 23, 2021. Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 26 Medicaid: 42 Other: 13 Total: 81 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/24/21.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of decisions, or of any violation of regulation. The facility respectfully requests a desk review in lieu of a traditional revisit.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff using inappropriate eyewear during resident care, incorrect isolation signage on resident rooms, and staff unaware of residents' isolation status. (Rooms 307 and 410), as well as failing to screen all staff prior to working for 1 of 3 staff reviewed for COVID-19 screening. (Employee 3) The facility also failed to store residents' personal care items properly, left	F 0880	1. No residents in the entire building had negative outcomes from the alleged deficient practices. All residents are monitored daily for signs and symptoms of infection. The DON and IP audited all staff during the survey and in-serviced them to wear full face shields when within 6 feet of any resident or providing care. The ED sent a message to all staff on 11/22/21	12/15/2021

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	an overflowing waste basket and stored a commode basket on a bathroom floor in three randomly observed rooms during initial tour. (Rooms 303, 309 and 408) Findings include: 1. The following observations were made during the initial tour of the facility on 11/22/21: a. On 11/22/21 at 8:37 a.m., Maintenance employee 1 was observed in the 100 unit hallway where residents were present. He was wearing a facemask and regular glasses. He indicated he was not aware he had to wear a face shield or full eye protection. b. On 11/22/21 at 8:45 a.m., RN 1 was observed walking out of a resident's room. The nurse had on an N95 mask and her regular glasses. The nurse indicated she and a CNA were working on the unit. She was unaware how many residents were on TBP because today was her first day back from being off for 7 weeks. She looked at the rooms and said 2 of the rooms she had were on transmission based precautions (TBP). The nurse indicated she thought her glasses were all the eye protection she needed. Her goggles she was given to wear over her glasses were in her car. c. On 11/22/21 at 8:55 a.m., the Director of Nursing (DON) was observed coming out of a resident's room and proceeded to push a medication cart down the hall. She was wearing trauma glasses that were not completely making a form fitting seal around the eyes. There was gaps on the tops and the sides of the glasses. She indicated she thought the glasses were appropriate. She would go around and make sure all staff was wearing either face shields or form fitting goggles.		instructing them to wear full face shields when within 6 feet of any resident or proving care. Maintenance employee #1, RN #1, DON, PTA were educated by the IP on 11/22/21 for the need to wear well-fitting eye protection when within 6 feet of a resident. All staff will be retrained on wearing appropriate face protection on 12/15/21 by the IP. The incorrect signage on rooms 307 and 410 were taken down the day of the survey on 11/22/21 by the ED. DON audited all charts on 11/23/21 to verify which residents were on contact precautions and TBP. There were no additional precautions that were need for any residents in the building. The IP audited all rooms for people on precautions on 11/23/21 to verify that the appropriate isolation bins were present. On 11/22/2021 the ED in-serviced all housekeeping staff on location of contact isolation or TBP signage and procedure to follow. The IP was in-serviced by the DON on proper signage for residents and the need to take down signs when a resident is no longer in facility. All staff will be trained on all signage used in the facility for precautions residents may have on 12/15/21 by the IP. The DON audited the sign in sheet on 11/23/21 to verify that all staff had signed in. Three additional staff were fgound that failed to sign	

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	d. On 11/22/21 at 9:00 a.m., Physical Therapy Assistant (PTA) 1 was observed in the therapy room with a couple residents. She had on a pair of trauma glasses over regular glasses. There were gaps all around the glasses. They were not form fitting around the eyes for droplet precautions. The PTA indicated she didn't think the trauma glasses were adding any more protection than her regular glasses did. The Indiana Department of Health document, "COVID-19 Infection Control Guidance in Long-term Care Facilities", indicated "...Continue universal source controls with well-fitting face mask use by all HCP (medical grade) and visitors (cloth is acceptable) and eye protection for HCP when delivering care within 6 feet of the resident...." Interview with Administrator on 11/22/21 at 8:50 a.m., indicated RN 1 should have on eye protection over her glasses. 2. During the initial tour of the facility, on 11/22/21 at 8:37 a.m., contact isolation signs were observed on rooms 307 and 410. There were no isolation bins outside or inside the door of either room. On 11/22/21 at 9:54 a.m., Housekeeper 1 was observed in room 307. He was wearing a faceshield and mask, he had no gloves or gown on. When he exited the room, he indicated he was not aware the resident was on isolation, and had not noticed the contact isolation sign. Interview with the Infection Prevention (IP) nurse, on 11/22/21 at 9:05 a.m., indicated the resident in room 307 was new and she didn't know why they		in. On 11/23 employee #3 and the three additional staff were educated by the DON on the proper screening procedure when entering the building. On 11/23/21 the ED sent a message to all staff informing them on the need to screen prior to starting their shift or entering the building. All staff will be trained by DON or designee on the procedure for staff screening when entering the building on 12/15/21 On 11/22/21 the DON audited all rooms to verify that no additional commode splash guards were sitting on the floor or any unused commodes were against the wall. The DON removed the commode splash guard that was on the floor and the commode against the wall on 11/22/21. The DON in-serviced the staff that left the commode bucket on the floor and the commode against the wall on 11/22/22. The DON will in-service all therapy staff on placement of new adaptive equipment and removing any old/unused equipment on 12/15/21. The DON will in-service all staff on infection control practices relating to leaving items on the floor or against the wall on 12/15/21. On 11/23/21 the IP audited all rooms to verify that there were no personal items sitting on the floor. No additional concerns were found. On 11/22/21 the DON removed the bottle of shampoo, 3	

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	were on contact isolation. She indicated there should be an isolation bin outside the rooms for personal protective equipment (PPE). She did not know why the resident in room 410 was on isolation. Interview with CNA 1 at the same time, indicated she did not know why the residents in room 307 and 410 were on contact isolation. Interview with Administrator, on 11/22/21 at 10:11 a.m., she indicated the signs should not have been there, the residents were not on isolation. They should have been removed when previous resident's vacated the rooms. 3. The employee COVID-19 screening records were reviewed for the week of 11/14-11/20/21. Employee 3 had been screened on 11/18/21. There were no additional screenings for the week. Interview with the DON on 11/23/21 at 9:50 a.m., indicated the employee had also worked on 11/16 and 11/19 that week, but there was no evidence he had been screened on those days. The policy, "Coronavirus (COVID-19)", updated 11/15/21, was provided by the DON. The policy indicated, "...Associates (HCP/Staff) will be actively screened at the beginning of their work day and each shift in accordance with current guidance...." 4. The following observations were made during the initial tour of the facility on 11/22/21: a. At 8:45 a.m., in Room 408, there was a bedside commode bucket sitting on the bathroom floor and the bedside commode was against a wall in the resident's room. Two residents resided in that		bottles of personal care items, a basket, and briefs from the bathroom floor of room 303. On 11/22/21 the maintenance director placed a storage bin in resident's bathroom for her to keep her personal items in. On 12/6/21 the IDT is meeting to address choice issues with resident in 303 and preference of where she stores personal items. The IP will in-service all staff on 12/15/21 on storage of personal items. On 11/22/21 the ED audited all rooms in the building to ensure that no additional bags of overflowing trash were left on the floor. No additional concerns were found. On 11/22/21 the housekeeping supervisor removed the bags of trash from room 309. All staff was in-serviced by the IP on proper disposal of trash on 11/23/21. The IP will in-service all staff on proper disposal of trash on 12/15/21. 2. All residents in the building have the potential to be affected by the alleged deficient practice. All residents are monitored daily for signs and symptoms of infection. 3. To ensure future compliance all staff will be trained upon hire on the appropriate use of face shields by IP or designee. Staff will be expected to follow PPE policy. Each supervisor will monitor 100% of their staff each week for proper	

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	room. b. At 8:49 a.m. in Room 303, there was a bottle of shampoo and 3 other bottles of personal care items, a basket with person care items, and a bag of disposable briefs sitting directly on the bathroom floor under the sink. One resident resided in that room. c. At 9:00 a.m., in Room 309, the garbage in the bathroom was overflowing onto the floor, and included a used disposable brief. Two residents resided in that room. Observations of the rooms and interview with the DON on 11/22/21 at 10:32, indicated the bedside commode in room 408 should not be in there as it did not belong to either resident, it should have been in the dirty utility room for cleaning. The items on the bathroom floor in room 303 should not be stored on the floor. The overflowing garbage should not be there as housekeeping had recently been on that hall. This Federal tag relates to Complaints IN00365300 and IN00367235. 3.1-18(a)		face shield usage and report results to the monthly QUAPI meeting. Revisions or adjustments to the plan will be developed based on results/outcomes. All concerns identified/reported will continue to be addressed with nursing management per facility guidelines and regulatory guidelines. The IP or designee will audit all new admission charts to verify what, if any signage is needed on their room. The IP or designee will audit rooms upon discharge to verify that signs are removed after discharge. The IP or designee will audit rooms upon admission to verify that appropriate signage is in place and will audit any new conditions that warrant an isolation sign. The IP will add storage bins and supplies outside of each required room if required. All results will be reported to the monthly QUAPI meeting. Revisions or adjustments to the plan will be developed based on results/outcomes. All concerns identified/reported will continue to be addressed with nursing management per facility guidelines and regulatory guidelines. All supervisors or designees will audit the sign in sheets on random days 5x weekly x 3months, then 2x/week x2 months and then weekly x1 month to verify that all their staff on duty have signed in	

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			and filled out the form appropriately. All results will be reported to the monthly QUAPI meeting. Revisions or adjustments to the plan will be developed based on results/outcomes. All concerns identified/reported will continue to be addressed with nursing management per facility guidelines and regulatory guidelines. The housekeeping supervisor or designee will round at least 10 rooms 5x weekly x 3months, then 2x/week x2 months and then weekly x1 month to verify that no personal items or commode splash guards are on floor or against the walls and that no overflowing trash is in the resident's bathrooms or rooms. All results will be reported to the monthly QUAPI meeting. Revisions or adjustments to the plan will be developed based on results/outcomes. All concerns identified/reported will continue to be addressed with nursing management per facility guidelines and regulatory guidelines.	