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	05/20/2022

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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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00376209 and IN00378510. Complaint IN00376209 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00378510 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 16, 17, 18, 19, and 20, 2022. Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 24 Medicaid: 41 Other: 9 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/24/22.	F 0000	Please reference the enclosed 2567 as Plan of Correction for the May 20, 2022 annual survey with two complaints. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth facts alleged or agreement by the provider of the truth facts alleged or conclusions set forth in the statement of deficiencies. The POC is executed solely because it is required by provisions of the Federal and State Law. The facility appreciates the time and dedication of the survey team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the people in our community.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

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

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 8) Finding Includes: On 5/16/22 at 11:44 a.m., a bottle of saline nasal spray solution, a bottle of sore throat spray, and an albuterol inhaler was observed on the bedside stand in Resident 8's room. On 5/17/22 at 3:10 p.m., the bottle of saline nasal spray, a bottle of sore throat spray, and an albuterol inhaler remained on the bedside stand. The record for Resident 8 was reviewed on 5/16/22 at 2:00 p.m. Diagnoses included, but were not limited to, high blood pressure, chronic obstructive pulmonary disease (COPD), and respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/1/22, indicated the resident was cognitively intact. A Physician's Order, dated 8/31/21 at 3:30 p.m., indicated albuterol sulfate aerosol solution 1 puff inhale orally every four hours as needed. The resident did not have a Care Plan for self-administering medications, nor did she have a self-administration of medication assessment completed. The May 2022 Physician's Order Summary	F 0554	DON completed a house audit on residents to ensure no further medications were at residents' bedside without orders on 5-18-22. No other residents were identified. Zero residents were found to have had a negative outcome related to the alleged deficient practice. Resident 8 was assessed by 500 hall nurse on 5-18-22 and was found able to self-administer medications. An order was obtained and her care plan was updated to reflect the ability to self-administer medications. No further issues were identified. Zero residents were found to have a negative outcome related to the alleged deficient practice. The 500 hall nurse obtained an order for resident 8 on 5/17/22 for saline nose spray and sore throat spray. The SDC in serviced all nursing staff on 5-24-22 regarding self-administration of medication policies and procedures relating to medications at bedside. To ensure future compliance all nursing staff will be trained at least annually on self-administration of medication and orders for all medications administered. The DON or designee will audit medication orders and self-administration of medications 5x weekly for two months, 3x a week for 2 months, then weekly	06/05/2022

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	(POS) indicated the resident did not have an order for the saline nasal spray and sore throat spray. Interview with LPN 1 on 5/17/22 at 3:20 p.m., indicated he was not aware of the resident keeping saline nasal spray or sore throat spray at her bedside stand. Interview with the Director of Nursing on 5/17/22 at 3:23 p.m., indicated the resident should have orders and a self-administration assessment completed for the saline nasal spray solution and sore throat spray. 3.1-11(a)		for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and miss opportunities	
F 0568 SS=A Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on record review and interview, the facility failed to ensure quarterly statements were sent to the resident's responsible party for 1 of 1 residents reviewed for personal funds. (Resident 7) Finding includes:	F 0568	On 6/2/22 The personal funds manager did a full house audit to verify that the resident's responsible party received a quarterly statement. Additional residents were found. Zero residents were harmed from the	06/02/2022

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	During an interview on 5/17/22 at 11:12 a.m., Resident 7's daughter-in-law, who was the resident's Power of Attorney (POA), indicated she had not received any quarterly statements since he had been there. The resident was no longer alert and oriented. The personal funds account for the resident was reviewed on 5/20/22 at 10:35 a.m. with the Business Office Manager. The resident had a regular funds account as well as a Miller Trust account. There was no evidence a quarterly statement had been sent to the resident's POA for at least 2 years. Interview with the Business Office Manager at that time, indicated she had been providing the resident a copy of the quarterly statement, however, she was unaware the resident was no longer cognitively intact. 3.1-6(g)		alleged deficient practice. On 6/1/22 the ED inserviced the funds manager on quarterly statements. On 6/2/22 the personal funds manager mailed a copy of resident #7 personal funds account and the other identified residents.The personal funds manager will audit resident responsible party status monthly for the next six months to verify that responsible parties are identified and mailed quarterly statements of resident funds Audits will be reviewed by the QUAPI committee to identify trends and miss opportunities.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail care and bathing for 3 of 3 residents reviewed for ADL's. (Residents D, B and E)	F 0677	DON completed a house audit on all residents to observe fingernails and trim if needed on 5-18-22 and 5-19-22. No other residents were identified that required nails to be trimmed. Zero residents were	06/05/2022

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	Findings include: 1. On 5/17/22 at 3:00 p.m., CNA 3 was asked to remove the bed linens from Resident B so his right arm could be observed. At that time, the residents's right hand was in the shape of a fist and his fingernails were long. The resident's left hand was observed with long and dirty nails. On 5/18/22 10:35 a.m., CNA 1 was observed performing nail care for the resident. The resident's right and left hand nails were long. The left hand nails were dirty as well. She used a wet wash cloth to clean under his left hand nails, in which dark colored debris was removed. She used another wash cloth to clean his right hand. The wash cloth was brown discolored after cleaning the inside of his hand. Interview with CNA 1 at that time, indicated the resident's fingernails were long and in need of trimming. Nail care was to be done as needed. The record for Resident B was reviewed on 05/17/22 at 1:46 p.m. Diagnoses included but were not limited to, stroke, right side hemiplegia, major depressive disorder, paranoid schizophrenia, dysphagia following a stroke, dementia without behaviors, high blood pressure, psychosis, and mental disorders. The Significant Change Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately cognitively impaired, and had no impairment to the upper or lower extremities. The Care Plan, updated on 5/17/22, indicated the resident needed ADL assistance.		found to have had a negative outcome related to the alleged deficient practice. Resident B's nails were trimmed by the CNA on 5/18/22. The SDC in serviced all CNA staff on nail care on 5-24-22. DON completed a house audit on shower logs on 5-23-22. Additional shower logs were identified and that refusals were not documented. Zero residents were found to have had a negative outcome related to the alleged deficient practice. Care plans were updated to reflect refusals. Resident E agreeded to a shopwer on 6/19/22. All CNA staff were in serviced on shower logs and appropriate documentation by the SDC on 5-24-22. To ensure future compliance all CNA staff will be trained at least annually on ADL/nail care and shower log documentation. The DON or designee will audit nail care and shower documentation on 50% of residents weekly for two months, 2X monthly for 2 months, monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities	

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Interview with the Director of Nursing on 5/18/22 at 11:30 a.m., indicated the resident's fingernails were to be cleaned and trimmed as needed.

2. The closed record for Resident B was reviewed on 5/18/22 at 9:18 a.m. The resident was admitted on 1/11/22, discharged to the hospital on 2/24/22, readmitted on 3/1/22, and then discharged again to the hospital on 3/17/22, after which he did not return.

Diagnoses included but were not limited to, kidney disease, open wounds to the right and left hands, end stage renal disease, high blood pressure, type 2 diabetes, congestive heart failure, depression, anemia, and atrial fibrillation.

A Significant Change Minimum Data Set (MDS) assessment, dated 3/8/22, indicated the resident was cognitively intact and was totally dependent on staff for bathing.

A Care Plan, revised on 3/4/22, indicated the resident needed ADL assistance. The approaches were to provide showers on Sunday evenings.

Shower sheets indicated the resident was bathed on 1/29, 2/9, and 3/4/22.

Computer documentation for ADL's indicated the resident was bathed on 1/26, 2/9, and 3/4/22.

There was no Care Plan indicating the resident refused showers or documentation in Nursing Notes the resident refused showers.

Interview with the Director of Nursing on 5/19/22 at 11:30 a.m., indicated the resident

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	would not always let staff give him a shower, however, there was no Care Plan or documentation in progress notes of any refusals.3. The record for Resident E was reviewed on 5/17/22 at 11:48 a.m. Diagnoses included, but were not limited to, non-Alzheimer's dementia, high blood pressure, depression, and chronic lung disease. A Quarterly Minimum Data Set (MDS) assessment, dated 3/22/22, indicated the resident was severely cognitively impaired. Resident E required extensive assistance with one person physical assist for bed mobility, transfers, and toilet use and required a one person physical assist with physical help in part of the bathing activities. A Care Plan, initiated on 3/8/21, indicated the resident had a self-care performance deficit with interventions including, but not limited to, the resident preferred to have showers on Wednesday and Saturday during the day. Shower logs for the months of April and May 2022 indicated the resident did not receive a shower on 4/9/22, 4/13/22, 4/16/22, 4/20/22, 4/23/22, 4/30/22, 5/4/22, 5/11/22, and 5/14/22. Interview with the Director of Nursing (DON) on 5/19/22 at 11:16 a.m., indicated the resident was sent to the hospital on 4/10/22 and since then, he had been feeling down and would often refuse showers. The DON indicated the record lacked any documentation of refusals. This Federal tag relates to Complaint IN00376209. 3.1-38(a)(3)(E)			

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	3.1-38(a)(2)(A)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to assess and monitor residents after a change in condition for 1 of 1 residents reviewed for death and 1 of 1 residents reviewed for edema. The facility also failed to ensure preventive measures were in place to prevent skin tears for 1 of 1 residents reviewed for skin conditions (non-pressure related). (Residents 74, 277, and 18) Findings include: 1. The closed record for Resident 74 was reviewed on 5/19/22 at 9:57 a.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertensive heart disease, cardiomegaly, and history of COVID-19. The Admission Minimum Data Set (MDS) assessment, dated 1/26/22, indicated the resident was cognitively intact and needed extensive assistance with bed mobility and transfers. On 2/21/22, the resident was sent to the emergency room for chest pain and difficulty	F 0684	ADON completed a house audit on all residents that have had a change of condition in the last 30 days to verify that a follow up assessment has been completed. No other residents were identified that lacked a follow up assessment. Zero residents were found to have had a negative outcome related to the alleged deficient practice. Resident 74 is no longer in the facility. All nursing staff were in serviced by the SDC on completing a follow up assessment when a change of condition occurs on 5-24-22. ADON completed a full house audit on 5-20-22 to verify preventive measures were in place as ordered by the physician. No additional issues were found. Zero residents were found to have a negative outcome related to the alleged deficient practice. On 5-19-22 the ADON re- applied the padding to resident	06/05/2022

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	breathing. She returned to the facility on 2/25/22. Nurses' Notes, dated 2/26/22 at 3:45 p.m., indicated the resident had oxygen in use at 5 liters and no acute distress was noted. Nurses' Notes, dated 2/26/22 at 6:00 p.m., indicated the resident's respirations were rapid and even, oxygen was in use and her oxygen saturation level was 78%. Her pulse was 110 and she had no complaints regarding any respiratory distress. She responded to questions appropriately and when asked if she wanted to go to the hospital she said she was okay. The next entry at 10:28 p.m., indicated no rise and fall of the chest was noted and vital signs were absent. The resident's Physician and family were notified. Interview with the Director of Nursing on 5/19/22 at 2:20 p.m., indicated a follow up assessment should have been completed prior to 4 1/2 hours after the documented change in condition. 2. On 5/16/22 at 2:45 p.m., Resident 277 was observed in her wheelchair in her room. She had a gauze dressing to her left lower leg and no padding was noted on her wheelchair leg. On 5/17/22 at 1:52 p.m. and 3:04 p.m., no padding was observed to the resident's wheelchair leg. On 5/18/22 at 11:34 a.m., the resident was observed in her room in her wheelchair. There was no padding to the resident's wheelchair leg.		277 wheelchair leg. SDC in serviced all nursing staff on applying safety devices as ordered on 5-24-22. ADON completed a whole house audit on 5-20-22 to verify all edema is documented and addressed. No additional concerns were identified. Zero residents were found to have a negative outcome related to the alleged deficient practice. The SDC in serviced all nursing staff on documentation that included edema on 5-24-22. The ADON assessed resident 18 edema and documented it on 5-19-22. Resident 18 care plan was updated on 5-19-22 by the MDS coordinator. To ensure future compliance all nursing staff will be trained at least annually on change on condition, assessments, and safety devices. The DON or designee will audit follow up assessments on residents that have an acute change of condition, safety devices and any acute edema on residents three times weekly for two months, then twice weekly for 2 months, then weekly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	

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	The record for Resident 277 was reviewed on 5/17/22 at 2:25 p.m. Diagnoses included, but were not limited to, surgical aftercare following surgery of the digestive system, chronic obstructive pulmonary disease, and emphysema. The resident was admitted to the facility on 5/9/22. The Admission Minimum Data Set (MDS) assessment, dated 5/16/22 was in progress. The resident required extensive assistance with bed mobility and transfers. An Event Note, dated 5/11/22 at 11:41 a.m., indicated the resident was being transferred from the bed to her wheelchair. An open area to the left lateral leg was noted, 5 centimeters (cm) x 2 cm triangle shape. The area was cleansed and a dry dressing was applied. A Physician's Order, dated 5/12/22, indicated the resident's left lateral leg was to be cleansed daily with wound wash, a mediplex dressing was to be applied, the area was to be covered with an abd pad and wrapped with kerlix daily. Special instructions on the May 2022 Physician's Order Summary (POS), indicated the left lower post of the resident's wheelchair was to be padded. The Care Plan, dated 5/12/22, indicated the resident had a break in skin integrity related to a wound to the left lateral leg. Interventions included, but were not limited to, treatment as ordered and weekly skin checks. Interview with the Assistant Director of Nursing on 5/19/22 at 12:15 p.m., indicated she had padded the wheelchair leg herself at the time of			

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	the occurrence. She also indicated the padding must have been removed when the wheelchair was cleaned and not reapplied. 3. During an interview with Resident 18 on 5/16/22 at 2:31 p.m., he indicated his right hand had been swollen for a long time. His right hand and fingers were swollen compared to the left hand. The resident also had a atrial/venous fistula (used for dialysis) in his upper right arm. The record for Resident 18 was reviewed on 5/17/22 at 3:15 p.m. Diagnoses included, but were not limited to, heart disease, end stage renal disease, atrial fibrillation, high blood pressure, heart failure, anemia, right and left leg below the knee amputation, type 1 diabetes, and osteoarthritis. The Significant Change Minimum Data Set (MDS) assessment, dated 3/12/22, indicated the resident was cognitively intact and received Insulin for the last 6 days. There was no Care Plan for edema. There was no documentation in Nursing Notes from 5/1-5/17/22 regarding any swelling of the right hand or fingers. Interview with the Director of Nursing (DON) on 5/19/22 at 1:15 p.m., indicated she was unaware of any swelling to the right hand. Interview with the Assistant Director of Nursing (ADON) on 5/19/22 at 1:25 p.m., indicated she just had the NP (Nurse Practitioner) assess his hand and fingers and the resident indicated it was nothing new and it has always been swollen. The NP asked the resident if he had any pain to the hand and the resident stated he did not. The			

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	ADON indicated there was no documentation in the clinical record regarding the swelling to the right hand. Interview with the DON at 1:30 p.m., indicated there should have been some type of assessment or documentation regarding the swelling of the right hand. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to a hand splint not in place for 1 of 2 residents reviewed for range of motion. (Resident D)	F 0688	DON completed a house audit on all residents that had splint orders for limited range of motion on 5-19-22. No other residents were identified that splints were not in place. Zero residents were found	06/05/2022

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	155344	A. BUILDING 00 B. WING	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

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	Finding includes: On 5/17/22 at 10:45 a.m. and 3:00 p.m., Resident D was observed in bed. At those times, his right hand was in the shape of a fist and there was no hand splint noted. On 5/18/22 at 10:03 a.m., the resident was receiving a.m. care by staff. His right hand was in the shape of a fist and there was no hand splint noted. On 5/18/22 at 1:30 p.m., the resident was observed in bed. At that time, his right hand was in the shape of a fist and there was no hand splint noted. On 5/19/22 at 8:40 a.m., and 10:38 a.m., the resident was observed in bed. At those times, his right hand was in the shape of a fist and there was no hand splint noted. The record for Resident D was reviewed on 5/17/22 at 1:46 p.m. Diagnoses included but were not limited to, stroke, right side hemiplegia, major depressive disorder, paranoid schizophrenia, dysphagia following a stroke, dementia without behaviors, high blood pressure, psychosis, and mental disorders. The Significant Change Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately cognitively impaired, and had no impairment to the upper or lower extremities. The Care Plan, updated on 5/17/22, indicated the resident needed ADL assistance and therapy services. The Nursing approaches were to provide adaptive/safety equipment and educate on		to have had a negative outcome related to the alleged deficient practice. On 5-18-22 the DON obtained an order for the splint to be donned during the day to assist with ROM to his right hand. The SDC in serviced all nursing staff on donning splints as ordered to those residents that have an identified range of motion issue. To ensure future compliance staff will be trained at least annually in splint donning for limited range of motion. The DON or designee will audit all orders for residents that have limited range of motion weekly for two months, 2X monthly for 2 months, monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	

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	use. Resting hand splint when out of bed. Physician's Orders, dated 9/18/20 and on the current 5/2022 Order Summary, indicated resting hand splint to right hand/wrist when out of bed. May remove for care. Interview with the Director of Nursing on 5/19/22 at 11:30 a.m., indicated the resident may get out of bed once or twice a week, but had not been up lately. The hand splint was to be applied when out of bed, however, the order needed to be changed if the resident was no longer getting up every day. 3.1-42(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen was being administered as ordered for 1 of 1 residents reviewed for oxygen. (Resident 277) Finding includes: On 5/16/22 at 2:45 p.m., Resident 277 was in her room seated in her wheelchair. The resident had oxygen by the way of a nasal cannula in use. The	F 0695	DON completed a house audit on 5-19-22 of all residents that have oxygen to verify the correct physician order is place. No other residents were identified that lacked clarification or accurate physician order for oxygen. Zero residents were found to have had a negative outcome related to the alleged deficient practice. The	06/05/2022

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	oxygen concentrator was set at 2 liters. On 5/17/22 at 9:30 a.m., the resident's oxygen was in use. At 10:30 a.m., the resident's oxygen was switched to a portable tank for therapy. At 1:52 p.m. and 3:04 p.m., the resident was in bed sleeping with the oxygen in use. On 5/18/22 at 11:34 a.m. and 1:45 p.m., the resident's oxygen was in use and the oxygen concentrator was set at 2 liters. The record for Resident 277 was reviewed on 5/17/22 at 2:25 p.m. Diagnoses included, but were not limited to, surgical aftercare following surgery of the digestive system, chronic obstructive pulmonary disease, and emphysema. The resident was admitted to the facility on 5/9/22. The Admission Minimum Data Set (MDS) assessment, dated 5/16/22, was in progress. A Physician's Order, dated 5/13/22, indicated the resident was to have oxygen at 2 liters per minute per nasal cannula as needed (prn). The resident's oxygen saturation level was to be checked every shift and staff could titrate to keep above 90% The May 2022 Medication Administration Record (MAR), indicated the prn oxygen had not been signed out as being used 5/13 thru 5/19/22. Interview with the Director of Nursing on 5/19/22 at 2:20 p.m., indicated a clarification order would be obtained. An updated Physician's Order, dated 5/19/22, indicated the resident was to receive oxygen 2 liters per nasal cannula each shift.		DON obtained an updated oxygen order for resident 277 on 5-19-22. The SDC in serviced nursing staff regarding oxygen orders and clarification of orders when appropriate. The DON or designee will audit oxygen orders for accuracy and clarify residents' appropriate oxygen orders are needed weekly for two months, 2X monthly for 2 months, then monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	

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	3.1-47(a)(6)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services 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 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, record review, and interview, the facility failed to ensure a CNA did	F 0726	DON did an observation of all CNA staff on all three shifts on	06/05/2022

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	not provide care outside of the scope of practice related to placing tube feedings on hold and turning on tube feeding pumps for 1 of 1 residents reviewed for tube feeding. (Resident B) Finding includes: On 5/18/22 at 10:03 a.m., CNA 1 and CNA 2 were observed providing a.m. care for Resident B. The resident was connected to a tube feeding pump, however, the pump indicated the enteral feeding was on hold. At 10:15 a.m., the tube feeding pump started to beep. CNA 2 pushed the hold button and the machine stopped beeping. At 10:25 a.m., the pump started to beep again, CNA 1 placed the tube feeding on hold by pushing the button. The CNA had finished most of the care and rolled the resident's head of the bed up and repositioned him. She then started to clean and cut his fingernails. The pump begun beeping again at 10:35 a.m., the CNA was in the middle of care and let the pump beep. At 10:39 a.m., CNA 1 indicated since his head was up, she was going to turn the enteral feeding back on. The pump indicated the enteral feeding was now infusing. Interview with CNA 1 at 10:45 a.m., indicated she normally put the tube feeding on hold for care. When she finished with care, she pressed the start button and feeding was resumed. She was unaware she was not supposed to manage feeding pumps and it was out of her scope of practice. The record for Resident B was reviewed on 05/17/22 at 1:46 p.m. Diagnoses included but were not limited to, stroke, right side hemiplegia, major depressive disorder, paranoid		5-18-22, 5-19-22, 5-20-22, 5-21-22, 5-23-22 and 5-24-22. No other staff were observed providing services outside of their scope of practice. Zero residents were harmed by this alleged deficient practice. CNA 1 and CNA 2 were trained by the SDC on 5/18 in areas that are in their scope of practice. CNAs were re-educated regarding scope of practice on 5-24-22. The DON or designee will audit all CNAs that provide service to residents on all three shifts to verify they are only completing what is in their scope of practice weekly for two months, 2X monthly for 2 months, monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	

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	schizophrenia, dysphagia following a stroke, dementia without behaviors, high blood pressure, psychosis, and mental disorders. The Significant Change Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately cognitively impaired, and had no impairment to the upper or lower extremities. Physician's Orders, dated 1/27/22, indicated Enteral Feed Jevity 1.5 at 75 milliliters per hour times 20 hours. Interview with the Director of Nursing on 5/18/22 at 11:30 a.m., indicated CNAs were not to turn enteral feedings on, off or place enteral feedings on hold. 3.1-35(g)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure insulin was administered as ordered by the Physician for 2 of 2 residents reviewed for insulin dependent diabetes mellitus. (Residents 9 and 18) Findings include: 1. The record for Resident 9 was reviewed on 5/18/22 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes, acute kidney failure, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/22, indicated the resident was cognitively intact and received insulin in the last 7 days. Physician's Orders, dated 7/7/21, indicated Novolog insulin flex pen. Inject 15 units subcutaneously before meals. Physician's Orders, dated 7/19/21, indicated the resident received dialysis every Monday, Wednesday and Fridays with a 10:30 a.m. chair time. Physician's Orders, dated 3/10/22, indicated Basaglar KwikPen Solution Pen-injector (Glargine) 100 units per milliliter. Inject 36 unit subcutaneously one time a day. The Medication Administration Record (MAR)	F 0757	The DON completed a whole house audit on all residents that have dialysis to verify that orders address medication clarification during dialysis on 5-19-22. No other residents were identified who had unclarified orders during dialysis. Zero residents were found to have had a negative outcome related to the alleged deficient practice. The DON obtained clarification orders for the insulin that was ordered during dialysis for resident 9 and 18 on 5-19-22. The SDC in serviced nursing staff on obtaining clarification orders when medications are scheduled to be given during dialysis days on 5-24-22. To ensure future compliance all nursing staff will be trained at least annually on clarifying orders. The DON or designee will audit all residents on dialysis to verify clarification orders are obtained during dialysis weekly for two months, 2X monthly for 2 months, monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	06/05/2022

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	for 4/2022 indicated the insulin scheduled for 11 a.m. was not signed out on dialysis days of 4/1, 4/4, 4/5 4/6, 4/8. 4/11, 4/13, 4/16, 4/18, 4/20, 4/22, 4/25, 4/27 and 4/29/22. All of the above days were coded with a "5" meaning the resident was absent from the facility. The MAR for 5/2022 indicated the insulin scheduled for 11 a.m. was not signed out on dialysis days of 5/2, 5/4, 5/6, 5/9, 5/11, 5/13, 5/16 and 5/18/22. All of the above days were coded with a "5" meaning the resident was absent from the facility. Interview with the Director of Nursing on 5/19/22 at 1:30 p.m., indicated the resident was out of the building at dialysis on Mondays, Wednesdays, and Fridays during the time when the 11:00 a.m. insulin was scheduled. 2. The record for Resident 18 was reviewed on 5/17/22 at 3:15 p.m. Diagnoses included, but were not limited to, heart disease, end stage renal disease, atrial fibrillation, high blood pressure, heart failure, anemia, right and left leg below the knee amputation, type 1 diabetes, and osteoarthritis. The Significant Change Minimum Data Set (MDS) assessment, dated 3/12/22, indicated the resident was cognitively intact and received Insulin in the last 6 days. Physician's Orders on the current 5/2022 order statement indicated the resident received dialysis on Mondays, Wednesdays and Fridays. Physician's Orders, dated 3/5/22, indicated Insulin Lispro Solution: Inject as per sliding			

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	scale: if 150 - 179 = 1U (unit); 180 - 209 = 2U; 210 - 239 = 3U; 240 - 269 = 4U; 270 - 299 = 5U; 300 - 329 = 6U; 330 - 359 = 7U; 360 - 400 = 8U, subcutaneously before meals for diabetes. If blood sugar over 400 give 9U and notify doctor. The Medication Administration Record (MAR) for 4/2022, indicated a "5" was coded in the box for 4/16 and 4/23/22 at 11:00 a.m. The number 5 indicated the resident was absent from the building. The MAR for 5/2022, indicated a "5" was coded for the 11:00 a.m. insulin on 5/4, 5/16 and 5/18/22 Interview with the Director of Nursing on 5/19/22 at 1:15 p.m., indicated the resident went to dialysis on Mondays, Wednesdays, and Fridays and he did have an insulin order for sliding scale insulin before meals. 3.1-48(a)(6)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a resident was free from significant medication errors related to the incorrect administration of insulin for 1 of 6 residents observed during medication pass. (Resident 18) Finding includes: On 5/18/22 at 4:00 p.m., LPN 2 was observed	F 0760	The DON observed all nurses on 5-19-22, 5-20-22 and 5-21-22 on giving insulin correctly by first priming the pen prior to administration. No other incidents were discovered. Zero residents were found to have had a negative outcome related to the alleged deficient practice. The SDC in serviced all nurses on priming	06/05/2022

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	preparing Insulin for Resident 18. She removed an insulin pen from the medication cart. She placed a disposable needle on the pen and dialed it to 1 unit. She entered the resident's room and he indicated he would like it in his arm. She wiped his arm with an alcohol wipe and administered the insulin. The LPN did not prime the needle prior to administration. Interview with LPN 2 on 05/18/22 at 4:19 p.m. indicated she was aware the insulin pen should have been primed prior to use with either 1.5 or 2 units of insulin. Interview with the Director of Nursing (DON) on 5/19/22 at 1:20 p.m., indicated most of the floor nurses were unaware the insulin pen needed to be primed prior to use. The current 2021 "Guidance for Using Insulin Products" policy, provided by the DON, indicated "To minimize air bubbles in pen-like devices prime the pen prior to use each and every injection by pushing 2 units into the air until a drop of insulin is seen at the top of the needle." 3.1-48(c)(2)		insulin pens prior to injection on 5-18-22 and again on 5-24-22. LPN 2 was in serviced by the SDC on 5-18-22 on priming the insulin pen prior to administration. To insure future compliance all nurses will be trained at least annually on priming insulin pens. The DON or designee will observe all nurses on all shifts that give insulin using a pen for correct administration weekly for two months, 2X monthly for 2 months, monthly for 2 months. Audits will be reviewed by the QUAPI committee to identify trends and missed opportunities.	
F 0921 SS=B Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty floors, marred walls, and peeling wallpaper for 2 of 5 units. (Units 300 and 400)	F 0921	The maintenance director and housekeeping director did a full house audit on 6/1/22 to verify that the environment was clean and in good repair for every	06/10/2022

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	Finding includes: During the Environmental Tour with the Housekeeping Supervisor on 5/20/22 at 11:00 a.m., the following was observed: The 300 Unit a. The tile floor in Room 302 was discolored near the entryway and by the closet. The bathroom floor was also discolored. The wall next to bed 2 was discolored with a tan substance. There were also areas of peeling paint. Two residents resided in this room. b. The caulk around the base of the toilet in Room 303 was discolored and cracked in sections. The floor tile in the bathroom was discolored along the base board. Two residents resided in this room. c. The wallpaper next to bed 2 in Room 305 was loose in sections. The wall next to the assist side rail was also marred. Two residents resided in this room. d. The wallpaper next to bed 1 in Room 309 was peeling in sections. Two residents resided in this room. The 400 Unit a. The wallpaper next to bed 1 in Room 404 was buckled in sections. Two residents resided in this room. b. The floor tile in the bathroom of Room 407 was discolored. Two residents resided in this room.		resident room. Additional areas were noted and repaired/cleaned immediately. Zero residents were found to be harmed from this alleged deficient practice. The housekeeping director cleaned the tile in room 302 and 303 on 5/20/22. The wall in room 302 and the peeling paint was cleaned and repainted by the maintenance director on 5/20/22. The maintenance director will pull the toilet and recaulk by 6/10/22 in room 303. The maintenance director reglued the wallpaper in room 305, 309, 404 and painted the walls in on 5/20/22. The maintenance director will replace the floor in room 407 by 6/8/22. The ED inserviced the maintenance director and housekeeping director on 5/20/22 on providing a safe functional sanitary and comfortable environment. To ensure future compliance the housekeeping and maintenance department staff will be trained at least annually on providing a safe functional sanitary and comfortable environment. The Maintenance director and housekeeping director will inspect 25% of the rooms weekly for peeling wallpaper, marred walls, dirty, stained tiles, discolored tiles weekly for two months, then twice monthly for 2 months, then monthly for 2 months. Audits will be reviewed by the QUAPI	

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	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

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	Interview with the Housekeeping Supervisor at that time, indicated the floors were in need of cleaning and the wallpaper needed to be repaired. 3.1-19(f)		committee to identify trends and missed opportunities.	