

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

PRINTED: 09/21/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155344</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/15/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MICHIGAN CITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>802 US HIGHWAY 20 EAST</b> <b>MICHIGAN CITY, IN 46360</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) Life Safety Code Recertification and State Licensure Survey conducted on 06/21/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 09/15/22</p> <p>Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700</p> <p>At this PSR survey, Life Care Center of Michigan City was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction in the 300, 400 and 500 wings and Type IV (2HH) construction in the 100 and 200 wings and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in the resident rooms. The building is partially protected by a 200 kW diesel powered generator. The facility has a capacity of 120 beds dually certified for Medicare and Medicaid and had a census of 68 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had one detached garage and two sheds used for facility</p>	{K 000}		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

PRINTED: 09/21/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155344</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/15/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MICHIGAN CITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>802 US HIGHWAY 20 EAST</b> <b>MICHIGAN CITY, IN 46360</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	Continued From page 1 storage which were not sprinklered.  Quality Review completed on 09/19/22	{K 000}		