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	10/07/2022

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

(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 the Investigation of Complaints IN00381873, IN00390355, and IN00391568. Complaint IN00381873 - Unsubstantiated due to lack of evidence. Complaint IN00390355 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00391568 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600. Survey dates: October 6 and 7, 2022. Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 19 Medicaid: 40 Other: 12 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/11/22.	F 0000		
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect			

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

terri phillips | executive director | 11/01/2022

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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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure each resident was free from abuse related to facility staff forcibly moving a resident back into the facility against her will for 1 of 3 residents reviewed for abuse. (Resident C) Finding includes: Interview with Resident C on 10/6/22 at 1:34 p.m., indicated that last month she was sitting out in front of the facility smoking a cigarette 9/14/22 at 3:00 p.m. The Administrator had came out and told her she could not smoke due to the facility being a nonsmoking facility. The resident indicated she had told her she was unaware the facility was nonsmoking because she could see the staff outside smoking all of the time . The Administrator told her when she came back into the facility, the staff would take her cigarettes and lighter away from her. The Administrator then went back into the facility. The resident indicated after the conversation with the Administrator, she was upset and wanted to just sit outside in the sun for a while so she could calm herself down.	F 0600	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 Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City 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. 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.	10/23/2022

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	She then proceeded to propel herself in her wheelchair down the facility driveway onto a sidewalk by the 300 unit. The sidewalk area had full sun coming through and she wanted to sit there for a while. She indicated a couple staff members came out to the sidewalk where she was sitting. They told her she wasn't allowed to sit outside on the sidewalk by herself and that she had to come back into the facility. The resident asked them why. They told her it wasn't safe due to being close to the highway. The resident indicated that she was alert and oriented and the sidewalk was far enough away from the highway and that she could sit there safely. She told them there was the sidewalk, grass, a ditch, and then the highway. The staff members continued to tell her she had to go inside. The resident indicated the Environmental Services Director (ESD) came out and told her she had to go into the facility right now. She then proceeded to go behind her wheelchair and push it. The resident then put her feet down on the ground. She told the staff members again that she did not want to go back into the facility. At this time, the 300 unit door was propped open and a couple more staff members were standing there. Everyone kept telling her she had to come in. She told them all again that she did not want to go inside right then. The ESD then tried to push her wheelchair from the back again and the resident put her feet down again. The ESD then came around to the front of her wheelchair, grabbed her legs, and then pulled her into the facility by her legs while she was sitting in her wheelchair. She pulled her at least "10 feet" by her legs into the facility. The resident indicated she was in shock and couldn't believe she had been treated the way she was treated by the staff. They made her feel like she had done something wrong when all she wanted to do was calm herself down by sitting outside in		F 600- Free from Abuse and Neglect What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Physician, RP, and ISDH was notified of abuse allegation regarding allegation in which staff brought resident C back inside facility due to resident safety concerns. Resident reported not wanting to come inside. Facility is located directly off of a busy highway. 2. ED/Designee reviewed resident rights with resident C on 9-19-22. Resident signed acknowledgement and understands that she may go outside upon request. 3. Environmental Service Director was educated regarding abuse and resident rights. How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken: 1. Cognitively intact residents who	

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	the sun for awhile. They had made her more upset then she had been prior. No one had asked her if she would like to sit outside in a different area at the facility. They all just told her that she couldn't be outside and had to go back into the facility. Record review for Resident C was completed on 10/6/22 at 11:09 a.m. Diagnoses included, but were not limited to, hypertension, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 8/8/22, indicated the resident was cognitively intact. The resident had no behaviors of wandering. A reportable facility incident indicated that on 9/14/22, Resident C had reported alleged elder abuse when the ESD touched her and wheeled her back into the building. The follow up to the incident on 9/19/22 indicated: Resident C was observed the by Administrator sitting in front of the facility smoking. The resident was informed the facility was a nonsmoking facility. The resident became upset and stated she was leaving. Staff observed resident propelling herself towards the highway and onto the 300 hall sidewalk area. Staff encouraged resident to return to the front of the building or come back inside. The resident refused to come back into the building. A staff member was attempting to re-direct the resident back into the building and the resident became upset with this staff member. Another staff member came and assisted getting the resident back in the facility safely. No abuse identified. Associate will receive re-training on abuse, neglect, and de-escalation. A Witness Interview/Statement Form, dated 9/14/22 at 4:00 p.m., by CNA 2 who no longer		wish to go outside of the facility without supervision have the potential to be affected. p paraid="473011571" paraeid="{0befe623-960a-4c0e-ad5b-d7c099adfab4}{5}" >2. Random interviews of cognitively intact residents will be conducted by DON/designee to ensure residents feel they can go outside without supervision. Any findings will be addressed as stated below. 3. Full house abuse audit was completed on 10/20/2022 to ensure no other alleged abuse was identified. No concerns were identified via this audit. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: Random interviews of cognitively intact residents will be conducted by DON/designee to ensure residents feel they can go outside without supervision. Any findings will be addressed as stated below. ol class="NumberListStyle1	

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	worked at the facility, indicated, while passing ice water, they were asked to let a staff member in. Upon opening the door, a resident was out on the sidewalk. They asked the resident to come inside or allow them to take her back to the front. The resident said no and that she wanted to stay there. Another staff member got behind her and the resident said, "don't push me". The staff member started to push her and the resident planted her feet on the ground. Staff tried again and resident planted her feet on the ground. Staff got behind resident while another was in front, staff lifted residents feet while another pushed the wheelchair from behind. Interview with the ESD on 10/6/22 at 2:18 p.m., indicated she saw the resident outside smoking a cigarette and talking with the Administrator. A little bit later she was taking out the garbage and she saw the resident on the sidewalk with a couple other staff members. The staff members were from therapy she believed. They were telling the resident she had to go back into the facility and couldn't sit outside on the sidewalk because she was too close to the highway. The resident said no and that she didn't want to go back into the facility. At that point there was other staff at the doorway holding it open. She indicated that she lifted the resident's feet off the ground while another staff member pushed her wheelchair into the facility. No one had asked the resident if she wanted to sit anywhere else outside the facility that they felt was more safe. No one went and told the Administrator that the resident was refusing to come inside the facility. Interview with the Administrator on 10/6/22 at 2:30 p.m., indicated she had seen the resident smoking outside. She went outside and told the resident she couldn't smoke due to it being a nonsmoking		SCXW83078277 BCX0" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Staff were educated on 10/12/2022 and 10/13/2022 regarding resident abuse and providing resident with alternatives if they are refusing a task. 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. DON/Designee to conduct random cognitively intact resident interviews to ensure they are freely allowed to go outside facility without supervision. Interviews to be conducted: 10 residents 2x weekly x 2 months, then 10 residents weekly x2 months, then 10 residents monthly x2 months for a total of 6 months of monitoring. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if	

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	facility. She told her to finish her cigarette and that when the resident came back into the facility the nurse would get her cigarettes and lighter from her and hold them until her family could pick them up. The Administrator then went back into the facility and informed the Social Services Director (SSD) about the incident. She indicated she was unsure how long after the conversation with the resident that she saw multiple staff outside on the sidewalk with the resident. She yelled over at them and asked if everything was ok. The staff replied to her "we got this" so the Administrator went back into the building. She was only informed of the incident after the fact of staff making the resident come back into the facility. The staff at no point came to inform her that the resident was refusing to come inside. The Administrator indicated staff should have tried other things before they forcibly moved the resident into the facility. Interview with the Insurance Coordinator (IC) on 10/6/22 at 2:47 p.m., indicated she and ST (Speech Therapist) 1 saw the resident on the sidewalk going towards the 300 Unit door. She indicated ST 1 went out first and then she went out after. The resident was sitting in her wheelchair on the sidewalk and said she just wanted to sit outside in the sun and didn't want to come back into the facility right then. They had told the resident it wasn't safe. She had told them she was alert and oriented and she was fine to sit there. The resident kept saying "no" to going inside. The ESD came out and told the resident she needed to go into the facility because it wasn't safe. The IC tried to push her wheelchair from behind down the sidewalk into the facility but the resident had put her feet down. The ESD then lifted her feet and she herself had pushed the wheelchair into the facility. No one had asked the resident if she		compliance is below 100%. Date of compliance: 10-23-22 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction	

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	wanted to sit anywhere else outside the facility that they felt was more safe. No one went and told the Administrator that the resident was refusing to come inside the facility. Interview with ST 1 on 10/7/22 at 9:29 a.m., indicated she saw the resident from the therapy window wheeling herself down the driveway by herself. She went outside and at that time, the resident was on the sidewalk in front of the building by the 300 unit. She asked the resident what she was doing. The resident indicated she just wanted to get some fresh air and sit outside in the sun for a little bit. She indicated she talked calmly with the resident and asked her to come back inside but the resident refused. She indicated at that point, she was just going to stay outside with the resident for a little bit. Then the IC came out and told the resident she needed to come back in due to being unsafe outside on the sidewalk. The resident was refusing. Then a few more staff members came out and told her she had to go in and at that point the resident started to get combative and refused to come in. Someone had started to push her wheelchair in. The resident put her feet down and said "no I am not going in." She indicated the staff member had tried to push the resident's wheelchair a few more times and if she had done it anymore the resident's soles of her slippers would have been wore off from putting her feet down so much. She indicated the ESD then picked the resident's legs up and the door was open with staff in doorway, someone took the resident's hand and placed them on her lap so they were not touching her wheelchair and then they wheeled her into the facility. She was approximately 10 feet from the door. She indicated she had been talking with the resident calmly at first, but when multiple staff came out the situation escalated and the resident			

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	was adamant about not wanting to go in. No one had offered her to go sit around the back of the facility on the patio or another area outside that wasn't considered dangerous. No one went and told the Administrator that the resident was refusing to come inside the facility. Interview with the SSD on 10/7/22 at 9:41 a.m., indicated the Administrator had told her the resident was out front of the facility smoking a cigarette. She then called the daughter and she agreed to come in and take the resident's cigarettes. She was unaware of the incident that was occurring outside of the facility between the resident and the staff. She was unaware until after the fact that staff forcibly made the resident come inside. She went and spoke to the resident approximately 20 minutes after the incident occurred and the daughter was with her in the facility at that time. The resident's main concern was that she couldn't smoke. Staff should have tried other interventions and come to get her to talk with the resident before they forcibly made her come into the facility. Throughout interviews with the staff involved, they indicated that they did not ask the resident if she would like to sit somewhere else outside they felt was more safe or attempted to let the Administrator, SSD, Director of Nursing or the resident's nurse know the resident was refusing to come back inside. A facility policy titled, "Abuse - Identification of Types", and received as current from the Administrator on 10/7/22, indicated, "...Definition..." "...Abuse - is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.			

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	Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are residents from abuse. necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish..." "Neglect - is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress..." "...Willful - is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..."...The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction by staff, residents, or others, such as:..." "...Resistive to care and services..." "...Deprivation of Goods and Services by Staff..." "...Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and service, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s)..." This Federal tag relates to Complaint IN00391568. 3.1-27(a)(3)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 3 residents reviewed for accidents. (Resident J) Finding includes: On 10/7/22 at 1:24 p.m., Resident J was lying in bed. There was no floor mat on the floor next to the bed. There was a wheelchair across from the bed by the wall. The wheelchair did not have anti-roll backs attached to it. On 10/7/22 at 1:54 p.m., Resident J was lying in bed. There was still no mat on the floor next to the resident's bed and the same wheelchair was in the room. Record review for Resident J was completed on 10/7/22 at 12:56 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 9/23/22, indicated the resident was cognitively impaired. The resident required an extensive 1 person assistance for bed mobility, and transfers. The resident required a limited 1 person assistance for locomotion. The resident used a wheelchair. A Care Plan, dated 3/21/22 and revised on 4/8/22, indicated the resident was at risk for falls due to a history of falls. An intervention, dated 7/19/22, was for anti-roll backs to the wheelchair. Another	F 0689	p="" paraid="1301162264" paraeid="{4af46357-754c-4b8d-96c4-bf81202402c0}{43}">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 Michigan City agrees with the allegations and citations listed. Life Care Center of Michigan City 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 689- Free of Accident Hazards/Supervision/Devices Wh at Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: Resident J has had no incidents. p="" paraid="24685454" paraeid="{4af46357-754c-4b8d-96c4-bf81202402c0}{102}">How other residents having the potential to	10/23/2022

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	intervention, dated 4/8/22, was for a floor mat. A Progress Note, dated 7/8/22 at 1:14 p.m., indicated the resident was seen in the dining room starting to stand up out of her wheelchair. When the resident went to sit back down, the wheelchair slid backwards and the resident laid down on the floor in front of the wheelchair. Interview with CNA 1 on 7/8/22 at 1:55 p.m., indicated she wasn't taking care of the resident that day. The resident normally had a floor mat on the floor next to her bed and was unsure why there wasn't one in the room, but she would go and get her one. She further indicated the resident tended to walk around the facility using her wheelchair as a walker and would leave her wheelchair in different places. At times they wouldn't be able to locate her wheelchair so they would have to get a different one out of storage. The wheelchair in her room was probably not her wheelchair. A facility policy titled, "Fall Management", as received as current from the Administrator on 10/7/22, indicated, "...Avoidable Accident..." "3. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk on an accident..." This Federal tag relates to Complaint IN00390355. 3.1-45(a)(2)		be affected by the same deficient practice will be identified and what corrective action will be taken: Audit was completed by ADON on all residents with a history of falls to ensure all fall precautions are in place. No issues were identified via this audit. All safety/fall interventions were updated and on the care profile. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: Education will be completed by ADON to nursing staff to ensure proper fall precautions are in place. New nursing associates will receive this education prior to working. Education will be completed by ADON to licensed and certified nursing staff to ensure all fall precautions are updated in care profile, along with notifying nursing management of any discrepancies. New licensed or certified nursing employees will receive this education prior to working. p="" paraid="747787064" paraeid="{4af46357-754c-4b8d-96c4-bf81202402c0}{183}">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: DON/Designee will review incident reports 5 times weekly, and complete direct observations in rooms to insure safety devices	

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	10/07/2022

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

(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
			are in place 3X weekly for 2 months, 2X weekly for 2 months, weekly 2 months to ensure all fall precautions are in place x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. Competencies and education will be completed by date of compliance by Nursing Management. 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: 10-23-22. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction	