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	04/28/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00402546. Complaint IN00402546 - No deficiencies related to the allegations are cited. Survey dates: April 24, 25, 26, 27, and 28, 2023 Facility number: 000236 Provider number: 155344 AIM number: 100287700 Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 36 Medicaid: 42 Other: 11 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/3/23.	F 0000	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 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 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	F 0554	This plan of correction is prepared and executed because the	05/19/2023

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

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	had an assessment to self-administer their own medications for 2 random residents reviewed for self-administration of medication. (Residents 50 and 74) Findings include: 1. On 4/24/23 at 10:52 a.m., Resident 50 was observed in her room with a nasal spray and an inhaler at her bedside. The record for Resident 50 was reviewed on 4/26/23 at 10:36 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was cognitively intact. A Care Plan, dated 5/23/22 and revised on 3/31/23, indicated the resident had a Physician's Order for self-administration of Vicks Vapo Rub, saline nasal spray, sore throat spray, Luden's throat drops, and an inhaler. Interventions included, but were not limited to, assess the resident's ability to safely self-administer medications specified on admission/readmission, quarterly, with a change in medication orders, and with significant changes in condition. A Physician's Order, dated 4/25/23, indicated the resident was to receive an Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) mcg (micrograms), 1 puff, inhale orally every 4 hours as needed for wheezing, may self-administer and keep at the bedside. Physician's Orders, dated 5/17/22 and listed as current on the April 2023 Physician's Order		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 554 – Resident Self-Admin Meds-Clinically Approp What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #50: Self-administration assessment was completed. No negative outcomes were noted. 2. Resident #74: No longer a resident at facility. 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. The DON completed a full house audit on 5/10/23 and no	

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	Summary (POS), indicated the resident was to receive Sore Throat Spray Liquid 1.4 % (Phenol). Give 1 spray by mouth as needed for sore throat, may keep at bedside and self-administer. Saline Nasal Spray Solution 1 spray alternating nostrils as needed for nasal congestion may keep at bedside and self-administer. Vicks Vapo Rub ointment 4.7-1.2-2.6%, apply to chest topically as needed for nasal congestion. May keep at bedside and self-administer. A Physician's Order, dated 3/22/22 and listed as current on the April 2023 POS, indicated the resident may keep her Albuterol MDI inhaler at the bedside and self-administer. There was no self-administration of medication assessment available for review. Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated she thought an assessment had been completed last fall. 2. On 4/25/23 at 9:40 a.m. and 3:15 p.m., Resident 74 was observed in his room. An Albuterol inhaler was observed on his bed. Interview with the resident at that time, indicated he was allowed to keep the inhaler in his room. On 4/26/23 at 9:29 a.m., the resident was in his room seated in his wheelchair. The resident's inhaler remained at the bedside. The record for Resident 74 was reviewed on 4/27/23 at 8:58 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, malignant neoplasm of right bronchus of lung, and emphysema. The Admission Minimum Data Set (MDS)		additional residents were identified that were self-administering medications without an assessment. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All licensed nursing staff were educated by the DON on 5/11/23 on the right to self-administer medications when clinically appropriate along with the need for the completion of a self-administration assessment. 2. New licensed nursing employees will receive this education prior to working. 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. The DON/designee will audit all intake assessments for all residents to verify a self-administration assessment has been completed and those that can self-administer, have the opportunity to self-administer their medications, weekly for 3 months, then monthly for 3 months. 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 once compliance is at 100%. Frequency and duration of reviews	

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	assessment, dated 3/27/23, indicated the resident was moderately impaired for daily decision making. The resident did not have a self-administration of medication assessment available for review. He also did not have a care plan related to self-administration of medications. A Care Plan, dated 3/31/23, indicated the resident had impaired cognitive ability/ impaired thought processes related to short term memory deficits. Interventions included, but were not limited to, administer medications as ordered and allow extra time for the resident to respond to questions and instructions. A Physician's Order, dated 4/7/23, indicated the resident was to receive ProAir HFA Inhalation Aerosol Solution 108 (90 Base) micrograms (mcg) Albuterol Sulfate, 2 puffs, inhale orally every 4 hours as needed for wheezing, dyspnea, or prior to physical activity. May keep at bedside. Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated a self-administration of medication assessment should have been completed. 3.1-11(a)		will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to	F 0641	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life	05/19/2023

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	oxygen use for 1 of 21 MDS assessments reviewed. (Resident 37) Finding includes: On 4/24/23 at 11:34 a.m., Resident 37 was observed sitting in his wheelchair. An oxygen concentrator was observed next to the resident's wheel chair. The resident's nasal cannula was sitting on the outside of the resident's nose. The resident indicated the cannula would often come off. The oxygen tubing was not connected to the oxygen concentrator and the oxygen concentrator was not turned on. On 4/25/23 at 9:28 a.m., Resident 37 was observed sitting in his wheel chair with the nasal cannula in his nose. The resident was receiving oxygen from his portable oxygen concentrator connected to the back of his wheel chair. The oxygen dial was observed at 1 liter. The record review for Resident 37 was completed on 4/25/23 at 1:42 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), respiratory failure, hypertension, and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 3/5/23, indicated the resident was moderately cognitively impaired for daily decision making. Oxygen was marked as not being in use while a resident. A Physician's Order, dated 3/2/23, indicated supplemental oxygen via nasal cannula at 5 LPM (liters/minute) continuously per nasal cannula. A Care Plan, dated 3/28/23, indicated the resident was receiving oxygen therapy due to respiratory		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 641 – Accuracy of Assessments What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. On 4/25/23 the MDS coordinator updated resident 37 MDS to reflect his oxygen 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. On 5/1/23 the MDS coordinator audited all MDS of those people with oxygen to verify that it was on the MDS assessment. No further issues were What measures and what systemic changes will be made to ensure that the deficient practice	

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	illness. Interventions included, but were not limited to, observe for signs and symptoms of respiratory distress and report to MD as needed. During an interview on 4/28/23 at 11:39 am., the MDS Coordinator indicated oxygen should have been marked as being used on the assessment and she would correct it. 3.1-31(i)		doesn't recur: 1. On 5/11/23 MDS staff was educated by the DON r/t assessments must accurately reflect the resident's 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. The MDS coordinator/designee will audit all MDS of people receiving oxygen therapy weekly for six 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	
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 activities of daily living (ADLs) related to nail care. (Resident 69)	F 0677	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	05/23/2023

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	Finding includes: Interview with Resident 69 on 4/24/23 at 10:35 a.m., indicated her toenails were very long and they needed to be cut. The resident had told staff that she needed assistance cutting them, but they had not helped her. The resident's toenails were observed during the interview and were noted to be very long. Resident 69's record was reviewed on 4/26/23 at 1:22 p.m. Diagnoses included, but were not limited to, heart disease, chronic obstructive pulmonary disease, end stage renal disease, and type 2 diabetes mellitus. A Significant Change in Status Minimum Data Set (MDS) assessment, dated 3/28/23, indicated the resident was cognitively intact for daily decision making. She required extensive assistance with one person physical assist for personal hygiene. Interview with the Assistant Director of Nursing on 4/27/23 at 2:38 p.m., indicated the resident was on the list to be seen by podiatry upon their next visit to the facility. Interview with the Director of Nursing on 4/28/23 at 9:58 a.m., indicated she assessed the resident's toenails and cut her toenails as they were very long and needed cut. They should have been addressed sooner. 3.1-38(a)(3)(E)		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 677– ADL Care Provided for Dependent Residents What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #69: Nail care provided on 4/28/23 by DON. No negative outcomes were noted. 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. The DON completed a full house audit on 5/11/23 and no additional residents were identified that failed to receive activities of daily living assistance relating to nail care. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All nursing staff	

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			were educated by the DON on 5/11/23 on residents that are unable to carry out activities of daily living receiving the necessary services to maintain good nutrition, grooming, personal and oral hygiene. 2. New nursing employees will receive this education prior to working. 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. The DON/designee will review shower sheets to verify nail care was provided if indicated 3 times weekly months, then 2X weekly for 2 months, then weekly for 2 months. 2. Nursing management will complete observational rounds to ensure audited ADL documentation accurately reflects completed care 3X weekly for 2 months, then 2X weekly for 2 months, then weekly for 2 months. 3. 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: 5/23/23. The Administrator at Life Care	

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			Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure the resident received 1 to 1 activities at least 3 times a week for 1 of 1 residents reviewed for activities. (Resident 6) Finding includes: On 4/24/23 at 1:33 p.m. Resident 6 was observed in bed. At that time, the television was on, however, there was no sound and it was trying to connect to the internet. On 4/25/23 at 9:00 a.m., the resident was observed in bed with his eyes closed. There was no television or radio playing. The record for Resident 6 was reviewed on 4/26/23 at 1:45 p.m. Diagnoses included, but were not limited to, pericardial effusion, cerebral	F 0679	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	05/19/2023

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	hemorrhage, intellectual disabilities, altered mental status, acute kidney failure, and expressive language disorder. The resident was admitted to the hospital on 4/13/23 and returned on 4/17/23 with hospice services. A Significant Change Minimum Data Set (MDS) Assessment, dated 4/21/23, was in progress. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/23, indicated the resident was severely impaired for decision making. The resident needed extensive assist with a 2 person physical assist for bed mobility and transfers. A Care Plan, dated 4/19/23, indicated the resident had little or no activity involvement related to his preference of being in an environment without a lot of noise. The resident would benefit from having a 1 to 1 activity three times a week. The 1 to 1 activities documented for the resident were music, watched TV, and read short stories. The resident's response was documented as well. The resident received 1 to 1 activities on the following dates: January/February 2023: 1/30, 2/2, 2/7, 2/11, 2/16, 2/20, and 2/25/23 March 2023: 3/1, 3/6, 3/10, 3/13, 3/17, 3/21, 3/25, and 3/29/23 April 2023: 4/2, 4/6, 4/10, 4/12, (hospital 4/13-4/17), 4/19, 4/22, and 4/24/23 The 1 to 1 activities were not completed at least three times a week. Interview with the Activity Director on 4/27/23 at		or will take the actions set forth in this plan of correction. We respectfully request a desk review. F 679– Activities Meet Interest/Needs Each Resident What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #6: On 4/24/23 the television was connected to TV services and the sound was turned on. No negative outcomes were noted. 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. The activity director completed a full house audit on residents that receive one on one activities on 5/11/23 to verify residents receive one on one activities as scheduled. Three additional residents were identified that did not receive one on one activities as scheduled. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. The activity director was educated by the ED on activities meeting resident interest and needs on 5/11/23. 2. A monthly schedule was developed for all residents that one on one activities to ensure 3 times a week. 3. The activity director educated the activity staff on	

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	11:18 a.m., indicated the resident was to have 1:1 activities 3 times a week and she would be addressing the issue with her staff. 3.1-33(b)(8)		5/13/23 on activities meeting resident interest and need along with implementation of monthly schedule. 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. The activity director will audit one on one activities for completion 5x/week for one month, 1x/week for 2 months, and monthly for 3 months to verify completion as required. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 0684 SS=E 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			

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure skin tears and areas of bruising were assessed, monitored, and treatments were completed as ordered for 4 of 5 residents reviewed for skin conditions non-pressure related and 1 of 2 residents reviewed for anticoagulant (a blood thinner) medication side effects. The facility also failed to ensure an edema glove was in use as ordered for 1 of 1 residents reviewed for edema and treatment was completed timely for 1 of 1 residents reviewed for a change in condition. (Residents 1, 74, 181, 59, and 384) Findings include: 1. On 4/24/23 at 1:46 p.m., Resident 1 was observed in her room in bed. She did not have an edema glove to her right hand. On 4/26/23 at 9:30 a.m., 11:30 a.m., and 1:40 p.m., the resident's edema glove to the right hand was not in use. On 4/27/23 at 9:10 a.m., the resident's edema glove to the right hand was not in use. The record for Resident 1 was reviewed on 4/26/23 at 1:28 p.m. Diagnoses included, but were not limited to, cerebral palsy, profound intellectual disabilities, and disorder of the nose and nasal sinuses. The 3/27/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making. A Care Plan, dated 3/27/23, indicated the resident	F 0684	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 684 Quality of Care What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #1: On 4/27/23 was seen by the NP and an order to discontinue edema glove was given. No negative outcomes were noted. 2. Resident #74: On 4/27/23 a treatment to right elbow was completed by midnight nurse and verified by ADON. On 4/27/23 the treatment was discontinued by NP. No negative outcomes were	05/19/2023

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	155344	A. BUILDING 00 B. WING	04/28/2023

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	had an ADL (activities of daily living) self-care performance deficit in bed mobility, dressing/grooming, bathing, transfers, eating, locomotion, and toileting related to her disease process. She required total assist with bed mobility, eating, transfers, and toileting. She also required assist with upper body dressing. Interventions included, but were not limited to, edema glove to her right hand. A Physician's Order, dated 3/27/23, indicated the resident was to have an edema glove to the right hand. The order for the edema glove was not listed on the March and April 2023 Treatment Administration Records (TARs). Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated the resident's edema glove should have been in use. She also indicated the order should have been listed on the TAR. 2. On 4/24/23 at 2:10 p.m., a foam dressing was observed to Resident 74's right elbow. The dressing was dated 4/20/23 and areas of dried blood were observed on the dressing. Multiple areas of reddish/purple discoloration were observed on the resident's right arm and hand. The resident did not have a dressing to his right hand. On 4/25/23 at 9:40 a.m. and 3:15 p.m., the discoloration remained to the resident's right arm and hand. There was no dressing to the resident's right elbow or hand. On 4/26/23 at 9:29 a.m., the discoloration remained to the resident's right arm and hand. There was no dressing to the resident's right elbow or hand.		noted. 3. Resident #181: No negative outcomes were noted. 4. Resident #59: No negative outcomes were noted. 5. Resident #384: No longer at facility. 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. On 5/1/23 audited the 24 hour and reports for any concerns and no additional concerns were noted. 2. On 5/2/23 audited all anti-coagulant orders to ensure monitoring for bruising, no additional concerns were noted. 3.The ADON completed a full house skin audit on 5/11/23 to identify any new skin concerns that were not addressed. One additional concern was and a new order was added to the TAR to monitor the identified areas daily until healed. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1 nursing staff were educated by the SDC on 5/9/23 for skin tears and areas of bruising assessed, monitored and treatments received as ordered. All nursing staff were educated by the SDC on 5/9/23 related to anti-coagulant medication side effects and monitoring. All nursing staff was educated on change of condition notification by the DON on 5-11-23.2 nursing staff will receive this education prior to	

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	The record for Resident 74 was reviewed on 4/27/23 at 8:58 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, malignant neoplasm of right bronchus of lung, emphysema, and COVID-19. The Admission Minimum Data Set (MDS) assessment, dated 3/27/23, indicated the resident was moderately impaired for daily decision making and she required extensive assistance for bed mobility and transfers. The resident was also identified as having skin tears. A Care Plan, dated 3/29/23, indicated the resident was receiving anticoagulant therapy, Apixaban (a blood thinner). Interventions included, but were not limited to, observe for and report as needed (prn) adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. A Physician's Order, dated 3/23/23, indicated the resident was to receive Apixaban 5 milligrams (mg) twice a day for atrial fibrillation (an irregular heart beat). Monitor for signs and symptoms of bleeding, including black tarry stools, bleeding gums, bruising, and nose bleed related to anticoagulant use every shift. Document (+) if signs and symptoms were present and (-) if signs and symptoms were not present. The April 2023 Medication Administration Record (MAR), indicated the resident did not have any		working. 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 will review report 5x weekly to verify notification for change of condition, treatments are given as ordered, and monitoring for anticoagulant side effects for 6 months. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	

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	signs or symptoms of side effects each shift for the month of April. There were no Physician's Orders to monitor the bruising to the resident's right arm and hand. A Care Plan, dated 4/7/23, indicated the resident had a skin tear to the right hand. Interventions included, but were not limited to, assess location, size and treatment of the skin tear. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the Physician. There was no Care Plan related to the area to the right elbow. A Physician's Order, dated 4/6/23, indicated to cleanse the area to the right hand with normal saline, pat dry, and cover with a foam dressing every day shift every 3 day(s) for a skin tear. Start on 4/9/23. The April 2024 Treatment Administration Record (TAR), indicated the resident's treatment was signed out as being completed on 4/24/23. A Physician's Order, dated 4/20/23, indicated Bacitracin Plus External Ointment 500 units/gram was to be applied to the right elbow topically every night shift every 3 days. Cleanse the area with normal saline, apply bacitracin, and cover with a foam dressing. The April 2023 TAR, indicated the treatment to the right elbow was signed out as being completed on 4/23 and 4/26/23. The Weekly Skin Integrity Data Collection forms, dated 4/20 and 4/27/23, identified the skin tear to the right elbow. There was no documentation			

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	related to the bruising on the right arm and hand. Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated the dressing to the elbow and hand should have been changed as ordered and documentation related to the bruising should have been completed. 3. During an observation on 4/24/23 at 10:21 a.m., Resident 181 was observed sitting in a wheelchair. At that time, she had large bruises observed to the right outer and upper arm. The bruises were dark purple and blue in color. The record for Resident 181 was reviewed on 4/25/23 at 2:30 p.m. The resident was admitted to the facility on 4/18/23. Diagnoses included but were not limited to, cirrhosis of the liver, atrial fibrillation, high blood pressure, heart disease, heart failure, and dementia. The Admission Minimum Data Set (MDS) assessment was still in progress. A Care Plan, dated 4/24/23, indicated the resident was on anticoagulant therapy. The approaches were to observe for and report adverse reactions such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, and bruising. A Nursing Admission Assessment, dated 4/18/23, indicated the resident was admitted with "right arm-multiple purple/red bruises and left arm-1.3 [cm] centimeters by 1 cm purple/red bruise." There was no other documentation of any other bruising at the time of admission or measurements taken of the other bruises on the right arm. Physician's Orders, dated 4/18/23, indicated Rivaroxaban (an anticoagulant medication) tablet 20 milligrams (mg). Give 1 tablet by mouth in the			

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	evening and monitor for signs and symptoms of bleeding, including black tarry stools, bleeding gums, bruising, and nose bleed every shift. Document a (+) if signs and symptoms were present and (-) if signs and symptoms were not present. A Weekly Skin Integrity Data Collection Assessment, dated 4/25/23, indicated the resident's skin was intact and there were no new areas. There was no documentation in Nursing Notes from 4/18/23 to 4/27/23 regarding any bruising to her left or right arms. The 4/2023 Treatment Administration Record (TAR) indicated there was a "-" sign documented from 4/19-4/27/23, indicating there were no adverse signs or symptoms of anticoagulant use. Interview with the Director of Nursing on 4/27/23 at 10:45 a.m., indicated she had been having trouble with the nursing staff documenting and following up on the bruises after they were identified. The facility's policy was that bruises were to be assessed, measured, and documented on a wound report and then measured and assessed weekly until healed. There were no other measurements or assessments of the bruising after the resident was admitted. 4. During an observation on 4/24/23 at 10:30 a.m., Resident 59 was observed in bed. At that time, there was a large discoloration to the right arm that was dark red in color. The record for Resident 59 was reviewed on 4/26/23 at 9:55 a.m. The resident was admitted to the facility on 3/22/23. Diagnoses included, but			

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	were not limited to, atrial fibrillation, heart failure, chronic kidney disease, dementia, COPD, sleep apnea, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 3/28/23, indicated the resident was not cognitively intact. She was an extensive assist with a 2 person physical assist for bed mobility and transfers. She used oxygen while a resident and in the last 7 days, received an anticoagulant medication 6 times. A Care Plan, dated 3/29/23, indicated the resident was on anticoagulant therapy. The approaches were to observe for and report adverse reactions such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, and bruising. Physician's Orders, dated 3/22/23, indicated Apixaban (an anticoagulant medication) 5 milligrams (mg). Give 1 tablet by mouth 2 times a day and monitor for signs and symptoms of bleeding, including black tarry stools, bleeding gums, bruising, and nose bleed every shift. Document a (+) if signs and symptoms were present and (-) if signs and symptoms were not present. The Nursing Admission Assessment, dated 3/22/23, indicated the resident had bruises in the following areas: right antecubital that measured 2 centimeters (cm) by 2 cm, the right upper forearm that measured 1 cm by 1 cm, the right forearm that measured 2 cm by 4 cm, the left antecubital that measured 1 cm by 0.5 cm, and the back of the left wrist that measured 3 cm by 2.5 cm. The Weekly Skin Integrity Data Collection Assessment, completed on 3/29, 4/5, 4/12, 4/19,			

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	and 4/26/23 indicated the resident had no bruising on her body. A Nurses' Note, dated 4/3/23 at 2:42 p.m., indicated a lump was found on the resident's sternum that measured 3 cm by 3 cm. The Nurse Practitioner (NP) was notified and no new orders were obtained. A Nurses' Notes, on 4/4/23 at 3:11 p.m., indicated the resident had no complaints of pain to the lump on her sternum. A Nurses' Note, dated 4/6/23 at 12:30 a.m., indicated upon assessment a large hard mass was observed to the left rib cage just below the left breast that measured 6 cm by 9 cm. A message was left for the NP. The resident denied any pain or discomfort to the area. A Nurses' Note, dated 4/6/23 at 2:05 p.m., indicated masses remained to the sternum and left rib cage area. There was a hard mass to the right rib cage area that measured 5 cm by 7 cm. The NP and the resident's daughter were notified. A NP Progress Note, recorded as a late entry on 4/26/23 at 9:10 p.m., for 4/7/23 at 9:09 p.m., indicated the patient requested a NP visit for complaints of soreness along the chest. She reported the CNA told her she had a bony lump in the center of her chest. The patient reported she begun to feel tenderness at the lump and along the lower anterior rib cage with palpation. A physical exam indicated there were no abnormal bony prominences or masses palpated at the tender areas of ribs and the sternum. It could have possibly been a case of mild "barrel chest" deformity from COPD.			

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	Physician's Orders, dated 4/7/23 at 3:38 p.m., indicated X-ray sternum and bilateral lower anterior rib cage. The X-rays were completed on 4/10/23 and indicated there was no evidence of a fracture. Interview with the Director of Nursing on 4/27/23 at 10:45 a.m., indicated she had been having trouble with the nursing staff documenting and following up on the bruises after they were identified. Bruises were to be assessed, measured, and documented on a wound report and then measured and assessed weekly until healed. There were no other measurements or assessments of the bruising after the resident was admitted. The NP was made aware of the masses, however, she wanted to assess the areas before ordering anything, and she believed she was out of town that week. The NP made a progress note on 4/7/23 and ordered the X-rays. The Physician could have been notified on 4/3/23 instead of the NP and the X-ray could have been completed earlier and before 4/10/23.5. On 4/24/23 at 10:45 a.m., a reddish/purple discoloration was observed on Resident 384's right and left lower hands. On 4/26/23 at 10:34 a.m., the reddish/purple discoloration remained to the resident's right and left lower hands. The record for Resident 384 was reviewed on 4/26/23 at 9:30 a.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation (irregular heart rhythm), heart failure, and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 4/18/23, indicated the resident had cognitive impairment. The resident needed limited assistance with 1-person physical assist			

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	for bed mobility and transfers. A Physician's Order, dated 4/14/23, indicated the resident received Aspirin 81 milligrams (mg) daily for heart health and clopidogrel bisulfate (Plavix, anti platelet medication) 75 mg daily for heart. A Physician's Order, dated 4/18/23, indicated to monitor for signs and symptoms (s/s) of bleeding: including black tarry stools, bleeding gums, bruising/nosebleed related to anticoagulant use; document every shift. Document a (+) if signs and symptoms were present and (-) if signs and symptoms were not present. The Weekly Skin Observation sheet, dated 4/21/23, indicated the resident's skin was intact and there was no documentation of bruising. There was no documentation on the April 2023 Treatment Administration Record (TAR) related to monitoring for medication side effects. . Interview on 4/26/23 at 10:36 a.m. with Agency LPN 1 regarding the areas on the resident's hands indicated she did not see any orders and she would assess the resident and let the Nurse Practitioner know. Interview on 4/27/23 at 2:37 p.m., with the Assistant Director of Nursing, regarding the resident's bruising indicated she was unaware and had no further information to provide. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the treatment and services necessary to promote healing related to treatments not being completed as ordered and pressure reduction devices not being used for 2 of 3 residents reviewed for pressure ulcers. (Residents 1 and 50) Findings include: 1. On 4/28/23 at 10:59 a.m., Resident 1 was observed in her room in bed. Agency LPN 2 used hand sanitizer and donned gloves and proceeded to remove the resident's blanket exposing her feet. Three foam dressings, dated 4/24/23, were observed on the resident's right foot. Three foam dressings on the resident's overbed table, were dated 4/28/23. The LPN indicated she would take care of the resident's dressings and proceeded to remove each dressing one at a time and replace them with the pink foam dressings, dated 4/28. The LPN did not cleanse the wounds with normal saline and Medihoney (a debriding ointment) was not applied.	F 0686	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 686 – Treatment/ to Prevent/Heal Pressure	05/19/2023

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	The record for Resident 1 was reviewed on 4/26/23 at 1:28 p.m. Diagnoses included, but were not limited to, cerebral palsy, profound intellectual disabilities, and disorder of the nose and nasal sinuses. The 3/27/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making. She was also dependent on staff for bed mobility. The resident was identified as having one Stage 1 and four Stage 2 pressure areas that were present on readmission. A Care Plan, dated 3/27/23, indicated the resident had a break in skin integrity. She had a blister to the right heel, two Stage 2 areas to the right foot, a blister to the left heel, and a Stage 1 to her left hip. Interventions included, but were not limited to, weekly skin checks and treatments as ordered. A Physician's Order, dated 3/31/23, indicated Medihoney Wound/Burn Dressing External Gel was to be applied to the top of the right foot and side of the foot topically on the evening shift every 3 days. Cleanse areas to the top of the right foot and side of the right foot with NS, apply Medihoney and cover with foam dressings. This order also applied to the right heel and left hip. The April 2023 Medication Administration Record (MAR), indicated the treatments were signed out as being completed on the evening shift on 4/27/23. Interview with the Assistant Director of Nursing on 4/28/23 at 11:10 a.m., indicated the treatment should have been completed as ordered on 4/27/23. She also indicated the wounds should have been cleansed with normal saline and		Ulcer What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #1: Treatment/dressings changes were completed immediately. No negative outcome noted. 2. Resident #50: Order for right heel boot clarified with physician and care plan updated. No negative outcome noted. 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. The ADON completed a full house audit on 5/11/23 to ensure that treatments were in place to prevent/heal pressure ulcers. No additional concerns were found. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. On 5/12/23, the evening shift LPN was educated on following treatment orders. Agency LPN2 no longer works at . 2. On 5/11/23 the DON educated all nursing staff on providing treatments as ordered and having pressure relieving devices in place.. 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. The DON/designee will audit treatments to prevent/heal pressure ulcers 3 times weekly for	

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	155344	A. BUILDING 00 B. WING	04/28/2023

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	Medihoney should have been applied as ordered. 2. On 4/25/23 at 2:05 p.m. and 3:10 p.m., Resident 50 was seated in her wheelchair in her room. She was wearing non-skid socks and slippers. She did not have a heel boot in use. On 4/26/23 at 9:30 a.m., the resident was again in her room watching television. She was wearing non-skid socks and slippers. She did not have a heel boot in use. At 11:30 a.m., she was seated in her wheelchair in the hall. She was propelling her wheelchair with her feet. She was wearing slippers and non-skid socks. At 1:39 p.m., the resident continued to wear her slippers and non-skid socks with no heel boot in use. On 4/27/23 at 9:10 a.m., the resident was seated in her wheelchair in her room. She was wearing her slippers and non-skid socks. Interview with the resident at that time, indicated she did not like wearing the boot and at night she elevated her foot on a pillow. The record for Resident 50 was reviewed on 4/26/23 at 10:36 a.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, hypertension, and edema. The Quarterly Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was cognitively intact and she had a Stage 2 pressure ulcer. A Care Plan, dated 3/2/23, indicated the resident required ADL (activities of daily living) assistance and therapy services needed to maintain or attain highest level of function. The resident required limited assistance with toileting, transfers, bed mobility and set up assistance for meals.		2 months, then 2 times weekly for 2 months, then weekly for 2 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	

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	Interventions included, but were not limited to, pressure reducing boot to the right lower extremity, may remove for care. A Physician's Order, dated 3/15/23, indicated the resident was to wear a pressure reducing boot to the right lower extremity. The boot could be removed for care. A Physician's Order, dated 4/14/23, indicated the resident was to receive Santyl Ointment to her right heel daily. The area was to be cleansed with normal saline, apply Santyl, and cover with a dry dressing. The April 2023 Treatment Administration Record (TAR), indicated the pressure reducing boot had been signed out as being applied every shift for the month. Interview with the Assistant Director of Nursing on 4/27/23 at 1:30 p.m., indicated the resident preferred to wear the boot at night and her orders and care plan should have been updated. The Director of Nursing also indicated at that time, the boot shouldn't have been signed out as being applied if it wasn't worn. 3.1-40(a)(2)			
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 §483.25(d)(2)Each resident receives			

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	adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was free from accidents and received supervision with medications related to proper interventions not in place to prevent the resident from falling and not staying with the resident until all of her medications were consumed for 1 of 3 residents reviewed for accidents. (Resident 27) Finding includes: On 4/25/23 at 9:00 a.m., Resident 27 was observed lying sideways in bed. At that time, she had on a pair of fuzzy socks, there was nothing on the bottom of them to prevent the resident from falling. Her wheelchair was parked by the bed and there was no dycem on top of the cushion to prevent the resident from sliding out of the wheelchair. There was no floor mat beside her bed. On 4/25/23 at 10:00 a.m., the resident was observed sitting up in her wheelchair, wearing the same fuzzy socks and self-propelling her wheelchair On 4/25/23 at 2:00 p.m., the resident was observed lying sideways in bed, wearing the same pair of fuzzy socks. There was no floor mat on the ground beside the bed, nor was there a dycem in the wheelchair on top or under the cushion. On 4/26/23 9:20 a.m., the resident was observed lying on her side in bed with her head slightly elevated. At that time, she was holding a medication cup full of pills in her right hand. There was no nurse in the room at that time. She was wearing a pair of fuzzy socks with no skids on the	F 0689	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 What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #27: On 4/25/23 slip resistant socks, , and a floor mat were placed in the appropriate areas. No negative outcomes were noted related to safety interventions or self-administering of medications. How other residents having the potential to be affected by the same deficient practice will	05/19/2023

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	bottom of them. There was no floor mat beside the bed, nor was there a dycem on top of or under the cushion in the wheelchair. Shortly, thereafter, LPN 1 entered the room and asked if the resident had taken her medications. Interview with LPN 1 at that time, indicated the resident took a long time to take her medications. She was asked if this was the facility's policy to leave the medications with the resident and not observe them being swallowed. The LPN indicated she was just outside the door in the hallway, but was not in full view of the resident. The LPN took the medication cup from the resident's hand and assisted her to a sitting position so the pills could be administered. The nurse indicated she was aware she was supposed to stay with each resident until the medications were swallowed. On 4/26/23 at 10:40 a.m., and 1:35 p.m., the resident was observed self-propelling her wheelchair, wearing the same pair of fuzzy socks with no skids on the bottom of them. The record for Resident 27 was reviewed on 4/25/23 at 2:50 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, edema, major depressive disorder, osteoporosis, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/21/23, indicated the resident was not cognitively intact. The resident needed extensive assist with a 1 person physical assist with bed mobility and transfers and has had no falls since the last assessment. A Care Plan, updated 3/14/23, indicated the resident was at risk for falls. The approaches were to provide a dycem to the wheelchair, a floor mat		be identified and what corrective action will be taken: 1. The DON completed a full house audit on 5/12/23 to verify all safety interventions were in place. No additional concerns were identified. 2. Audit completed on 5/10 by DON to ensure all residents that administer their own medications have an assessment completed that reflects ability to self-administer medications. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All nursing staff were educated by the SDC on 5/11/23 on residents having the appropriate safety devices in place and not leaving medications with a resident or at bedside. On 5/12/23 LPN 1 was educated by the DON on not leaving meds at bedside or with resident. 2. New licensed nursing employees will receive this education prior to working. 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. The DON/designee will audit safety devices and supervision during medication administration 3X weekly for 2 months, then 2x weekly for 2 months, then weekly for 2 months 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a	

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	bedside the bed, and appropriate footwear. The Quarterly Fall Risk Evaluation, dated 3/7/23, indicated the resident has had no falls in the last 90 days. Interview with the Director of Nursing on 4/27/23 at 10:45 a.m., indicated the resident would put herself to bed and get out of bed without assistance. She was able to self-propel her wheelchair with her feet. She should have been wearing non-skid socks and the dycem should be in her wheelchair. The nurse should not have left the medications with the resident for her to take by herself. It was the facility's policy for nursing staff to stay with the resident until all of the medications were consumed. Interview with the Assistant Director of Nursing at that time, indicated she had just discontinued the floor mat yesterday. 3.1-45(a)(1) 3.1-45(a)(2)		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: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.¿¿	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates			

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	that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for a resident with a history of weight loss for 1 of 1 residents reviewed for nutrition. (Resident 74) Finding includes: The record for Resident 74 was reviewed on 4/27/23 at 8:58 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, malignant neoplasm of right bronchus of lung, and emphysema. The Admission Minimum Data Set (MDS) assessment, dated 3/27/23, indicated the resident was moderately impaired for daily decision making. He required supervision with eating and received a therapeutic diet. A Care Plan, dated 3/29/23, indicated the resident was at risk for weight fluctuations related to his current health status. He had the diagnosis of cancer and his body mass index (BMI) was 22. Interventions included, but were not limited to, assistance with meals as needed and diet per order. A Physician's Order, dated 3/23/23, indicated the resident was to receive a regular diet with diet	F 0692	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 692 – Nutrition/Hydration Status Maintenance What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #74: No negative outcomes were	05/19/2023

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	condiments. A Physician's Order, dated 3/29/23, indicated the resident was to receive Ensure (a nutritional supplement) three times a day. The resident's admission weight on 3/23/23 was 153 pounds. On 4/13/23, the resident weighed 115 pounds. A Dietary Note, dated 4/12/23 at 3:41 p.m., indicated the resident tolerated his diet and texture well and he fed himself with some set up in his room. His food intake was 76-100% and he received Ensure three times a day for extra nutritional support. His current weight was 153 pounds. Continue to monitor weights and intakes. A Registered Dietitian (RD) Progress Note, dated 4/25/23 at 11:07 a.m., indicated the resident weighed 153 pounds on 3/23/23, 115 pounds on 4/13/23, and 117 pounds per staff verbalization. The resident had a 23.5% weight loss since admission. The Food Consumption sheets for March and April 2023 indicated the following: - No food intake was documented on 4/11, 4/16, 4/18, 4/19, 4/21, 4/23, and 4/26/23. - No breakfast or lunch intake was documented on 3/29 and 4/24/23. - No dinner intake was documented on 3/31, 4/1, 4/5, 4/6, 4/7, 4/10, 4/12, and 4/20/23. Interview with the Assistant Director of Nursing on 4/27/23 at 2:30 p.m., indicated that she questioned the accuracy of the resident's admission weight. She also indicated the food consumption logs should have been completed.		noted 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. The MDS coordinator did a full house audit on 5/12/23 and additional documentation errors were identified. All errors identified were immediately addressed. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All nursing staff were educated by the SDC on 5-11-23 on documenting daily food intake after meals. 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. The DON/designee will review meal consumption logs 3 times weekly for 2 months, then 2X weekly for 2 months, then weekly for 2 months. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of	

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	3.1-46(a)(1)		Correction.	
F 0695 SS=E 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 set at the correct flow rate and positioned correctly for 5 of 5 residents reviewed for oxygen. (Residents 1, 132, 59, 69, and 37) Findings include: 1. On 4/24/23 at 11:36 a.m. and 1:46 p.m., Resident 1 was observed in her room in bed. Her nasal cannula was not in her nares and her oxygen concentrator was set at 2 liters. On 4/25/23 at 2:09 p.m., the resident's oxygen concentrator was set at below 2 liters. At 3:13 p.m., the resident's oxygen prongs were not in both nares. The oxygen concentrator remained below 2 liters. The record for Resident 1 was reviewed on 4/26/23 at 1:28 p.m. Diagnoses included, but were not limited to, cerebral palsy, profound intellectual disabilities, and disorder of the nose and nasal sinuses.	F 0695	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.	05/19/2023

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	The 3/27/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making and she was receiving oxygen while a resident of the facility. A Care Plan, dated 3/28/23, indicated the resident had oxygen therapy related to respiratory illness. Interventions included, but were not limited to, oxygen per Physician's Order. A Physician's Order, dated 3/27/23, indicated the resident was to receive oxygen at 2 liters per minute continuously per nasal cannula. Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated the resident's oxygen should have been in both nares and the concentrator should have been set at 2 liters. 2. On 4/25/23 at 9:08 a.m., Resident 132 was observed in his room in bed. He was wearing oxygen via nasal cannula and his oxygen concentrator was set at 3 liters. At 1:59 p.m., the resident was seated in his wheelchair and oxygen per nasal cannula was in use. His portable oxygen tank was set at 3 liters. At 3:10 p.m., the resident was in his room sleeping. Oxygen per nasal cannula was in use and his oxygen concentrator was set at 3 liters. The record for Resident 132 was reviewed on 4/25/23 at 2:11 p.m. Diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation (an irregular heart beat), pulmonary edema, and dyspnea (difficulty breathing). The resident was admitted to the facility on 4/17/23. The Admission Minimum Data Set (MDS)		F 695 – Respiratory/Tracheostomy Care and Suctioning What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #1: Nasal cannula immediately placed on resident correctly and set to correct oxygen setting per order. No negative outcomes were noted. 2. Resident #132: Oxygen immediately set to correct setting per order. No negative outcomes were noted. 3. Resident #59: Oxygen immediately set to correct setting per order. No negative outcomes were noted. 4. Resident #69: Oxygen immediately set to correct setting per order. No negative outcomes were noted. 5. Resident #37: Nasal cannula immediately placed on resident correctly, tubing was connected to concentrator, concentrator turned on and set to correct oxygen setting per order. No negative outcomes were noted. 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. The DON completed a full house audit on 5/11/23 to verify that any resident with oxygen had their tanks the correct setting and appropriately placed. No additional concerns were identified. What measures and what systemic changes will be made to ensure that the deficient practice doesn't	

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	assessment, dated 4/21/23, was in progress. A Physician's Order, dated 4/17/23, indicated the resident was to receive oxygen at 2 liters continuously per nasal cannula. Interview with the Director of Nursing on 4/27/23 at 1:30 p.m., indicated the oxygen flow rate should have been set at 2 liters. 3. On 4/24/23 at 10:30 a.m., and 2:48 p.m., on 4/25/23 at 9:00 a.m., 2:00 p.m., and 3:10 p.m., and on 4/26/23 at 9:10 a.m., Resident 59 was observed in bed. At those times, she was wearing oxygen at 4 liters per minute. The record for Resident 59 was reviewed on 4/26/23 at 9:55 a.m. The resident was admitted to the facility on 3/22/23. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, chronic kidney disease, dementia, COPD, sleep apnea, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 3/28/23, indicated the resident was not cognitively intact. She was an extensive assist with a 2 person physical assist for bed mobility and transfers. She used oxygen while a resident and in the last 7 days. A Care Plan, dated 3/29/23, indicated the resident had oxygen therapy related to COPD. The approaches were to administer oxygen as ordered. Physician's Orders, dated 3/27/23, indicated oxygen at 3 liters per minute continuously per nasal cannula. Interview with the Assistant Director of Nursing on 4/27/23 at 10:30 a.m., indicated the resident's oxygen should be set at 3 liters per minute.4. On 4/24/23 at 10:41 a.m., Resident 69's oxygen		recur: 1. All nursing staff were educated by the DON on 5/11/23 on oxygen being administered as ordered and appropriately placed. 2. On 5/12/23 placed setting tags on all oxygen concentrators for those residents that receive oxygen therapy. 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. The DON/designee will observe 5 residents daily Monday through Friday for 2 months, then 3 residents daily for 2 months, then 2 residents daily for 2 months for correct flow and placement. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this plan.	

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	155344	A. BUILDING 00 B. WING	04/28/2023

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	concentrator was set to 3 liters per minute and the tubing was dated 4/24/23. On 4/26/23 at 9:22 a.m., Resident 69's oxygen concentrator was set to 3 liters per minute and the tubing was dated 4/24/23. Resident 69's record was reviewed on 4/26/23 at 1:22 p.m. Diagnoses included, but were not limited to, heart disease, chronic obstructive pulmonary disease, end stage renal disease, and type 2 diabetes mellitus. A Significant Change in Status Minimum Data Set (MDS) assessment, dated 3/28/23, indicated the resident was cognitively intact for daily decision making. She used oxygen therapy. A Physician's Order, dated 4/11/23, indicated oxygen at 2 liters per minute continuously via nasal cannula. It could be off for up to 10 minutes for up to 6 times daily for refills. A Care Plan, dated 3/1/23, indicated the resident had oxygen therapy related to a respiratory illness. Interventions included, but were not limited to, oxygen per Physician's Orders. Interview with the Director of Nursing on 4/27/23 at 1:15 p.m., indicated the resident's oxygen concentrator should have been set to 2 liters per minute as per the Physician's Orders. 5. On 4/24/23 at 11:34 a.m., Resident 37 was observed sitting in his wheelchair. An oxygen concentrator was observed next to the resident's wheel chair. The resident's nasal cannula was sitting on the outside of the resident's nose. The resident indicated the cannula would often come off. The oxygen tubing was not connected to the oxygen concentrator and the oxygen concentrator			

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	was not turned on. On 4/25/23 at 09:28 a.m., Resident 37 was observed sitting in his wheel chair with the nasal cannula in his nose. The resident was receiving oxygen from his portable oxygen concentrator connected to the back of his wheel chair. The oxygen dial was observed at 1 liter. The record review for Resident 37 was completed on 4/25/23 at 1:42 p.m. Diagnoses included, but were not limited to COPD, respiratory failure, hypertension and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 3/5/23, indicated the resident was moderately cognitively impaired for daily decision making. A Physician's Order, dated 3/2/23, indicated supplemental oxygen via nasal cannula at 5 LPM (liters/minute) continuously per nasal cannula. A Care Plan, dated 3/28/23, indicated the resident was receiving oxygen therapy due to respiratory illness. Interventions included, but were not limited to, observe for signs and symptoms of respiratory distress and report to MD as needed. Nurses' Notes, dated 4/21, 4/22, 4/24 and 4/25/23 indicated the resident's oxygen flow rate was 2 LPM. During an interview on 4/26/23 at 9:17 a.m., Agency LPN 1 indicated she had corrected the oxygen flow rate to 5 LPM. During an interview on 4/27/23 at 2:37 p.m., the ADON indicated she was not aware of the incorrect flow rate.			

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	3. 1-47(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure psychotropic medications were monitored for side effects and effectiveness as well as ensuring Abnormal Involuntary Movement Scale (AIMS) assessments were completed for 1 of 5 residents reviewed for unnecessary medications. (Resident 47) Finding includes: Resident 47's record was reviewed on 4/25/23 at 1:31 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 3/24/23, indicated the resident was cognitively intact for daily decision making. She received antidepressant, anti-anxiety, and antipsychotic medications. A Physician's Order, dated 2/17/22, indicated the resident was to receive brexpiprazole (an antipsychotic medication) 0.5 milligrams (mg) one time a day. The order was discontinued on 6/12/22.	F 0758	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 758 – Free from Unnecessary Psychotropic Meds/PRN Use What Corrective Action will be	05/19/2023

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	A Physician's Order, dated 6/15/22, indicated the resident was to receive brexpiprazole 0.5 mg one time a day. The order was discontinued on 8/15/22. A Physician's Order, dated 8/16/22, indicated the resident was to receive brexpiprazole 0.25 mg one time a day. The order was discontinued on 2/21/23. A Physician's Order, dated 3/19/22, indicated the resident was to receive brexpiprazole 1 mg one time a day. The order was discontinued on 4/10/23. A Physician's Order, dated 4/11/23, indicated the resident was to receive brexpiprazole 0.5 mg one time a day. The order was discontinued on 4/24/23. A Physician's Order, dated 4/25/23, indicated the resident was to receive brexpiprazole 0.25 mg one time a day. A Care Plan, dated 4/8/23, indicated the resident used a psychotropic medication related to behavior management. Interventions, included but were not limited to, observe and report any adverse reactions of psychotropic medications such as unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, or shaking. An Abnormal Involuntary Movement Scale (AIMS) initial assessment was completed on 3/17/22. A Quarterly AIMS assessment was completed on 2/13/23.		accomplished for those residents found to have been affected by this deficient practice: 1. Resident #47: AIMS assessment completed on 4/27/23. No negative outcomes were noted. 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 The DON. completed a full house AIMS audit on 5/10/23 to verify completion on all residents receiving antipsychotic medications. No additional concerns were identified. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. All licensed nursing staff were educated by the DON on 5/11/23 regarding completing an AIMS assessment on all residents receiving a new order for an antipsychotic medication. 2. New licensed nursing employees will receive this education prior to working. 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. The DON/designee will audit UDA schedule for completion of AIMS assessments daily Monday through Friday for 2 months, then 3x weekly for 2 months, then 2X weekly for 2 months. 2. The results of these reviews will be discussed at the monthly facility	

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	Interview with the Assistant Director of Nursing on 4/28/23 at 9:58 a.m., indicated the AIMS should have been completed quarterly. A Policy titled, "Area of Focus: Psychotropic Medication Management," indicated " ...How ...Evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of medications; (Abnormal Involuntary Movement Scale, AIMS) Assessment tool should be used for all antipsychotic medications ..." 3.1-48(a)(3)		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: 5/19/23 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
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, interview, and record review, the facility failed to ensure a resident was free from significant medication errors related to the incorrect administration of insulin for 1 of 5 residents observed during medication pass. (Resident 331) Finding includes: During a medication administration observation on 4/28/23 at 10:50 a.m., RN 1 prepared Resident 331's insulin and checked the resident's orders. She dialed the resident's Lispro insulin pen to 2 units. She washed her hands and applied her gloves. She cleaned the resident's right arm and injected the insulin pen into the resident's arm. She had not primed the insulin pen or performed an air shot prior to administering the insulin.	F 0760	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	05/19/2023

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	Interview with RN 1 on 4/28/23 at 11:04 a.m., indicated she did not know she was supposed to prime the insulin pen prior to administering insulin to the resident. Interview with the DON on 4/28/23 at 11:12 a.m. indicated RN 1 should have primed the insulin pen prior to injecting the resident and she would inservice RN 1. A facility policy titled, "Medication Storage and Administration Quick Reference Guide, Insulin Vials and Pens" and provided by the DON as current, indicated, "... Prime ["Air Shot"] insulin pens prior to each administration with 2 units or manufacturer's recommendations. Hold the pen with the needle up, tap to move any air bubbles to the top ..." 3.1-48(c)(2)		regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. F 760 – Free of Significant Med Errors What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident #331: Physician and no new orders received. No negative outcomes were noted. 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. completed a full house audit on 5/10/23 to verify there were no medication errors. No areas of concern were found. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. On 5/12/23 RN1 was educated by DON on the proper procedure of administering insulin with an insulin pen. Education included administering insulin correctly by "priming" the pen prior to administration. 2. All licensed nursing staff were educated by the DON on 5/11/23 regarding proper procedure for insulin administration with insulin pen. 3. New licensed nursing employees will receive this education prior to working. How the corrective action will be monitored to ensure	

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			the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. The DON/designee will observe three weekly who receive insulin via insulin pen 3x weekly for 3 months, then two residents weekly for 3 months. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were properly stored for safety, labeled, and dated for 1 of 1 medication storage rooms observed. (West Wing Medication Storage Room). Finding includes: During a medication storage observation on 4/28/23 at 10:12 a.m., the West Wing Medication Storage Room was observed with LPN 2. Ativan (2 vials) were found in the refrigerator inside a plastic container. The plastic container did not have a lock on it. The Medication room was locked, however the refrigerator was not locked. Interview Agency LPN 2 and she indicated she thought the plastic zip tie on the container was a lock. 4/28/23 10:18 a.m., the DON indicated the Ativan should have been in a locked box, or the refrigerator should have a lock on it. The pharmacist had told her to put a lock on the refrigerator "a while ago."	F 0761	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 761 – Label/Store Drugs and Biologics What Corrective Action will be accomplished for those	05/19/2023

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	A facility policy titled, "Medication Storage and Administration Quick Reference Guide, Medication Cart Security and HIPPA", provided by the DON as current, indicated, " ... Med storage keys are retained by designated staff. Controlled medications must be stored separately, double locked, permanently affixed compartments..." 3.1-25(j) 3.1-25(o)		residents found to have been affected by this deficient practice: 1. No residents were . No negative outcomes were noted. 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. On 4/28/23 the DON audited the medication rooms for narcotics that require refrigeration being double locked. No further concerns were identified. 2. On 4/28/23 the pharmacy removed the refrigerated Ativan. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. On 5/11/23 all licensed nursing staff educated by DON on any controlled refrigerated medications must be placed under a double lock. 2. New licensed nursing employees will receive this education prior to working. 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. The DON/designee will audit medication rooms daily to ensure any refrigerated narcotics are double locked 3x weekly for 2 months, then 2X weekly for 3 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	

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			thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/11/23 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to two dishes of food sitting open and not covered on the top of the stove and an accumulation of	F 0812	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life	05/19/2023

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	grease and dried food spillage in and around the stove in 1 of 1 kitchen observed. (Main Kitchen). This had the potential to affect 87 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 4/24/23 at 8:58 a.m. with the Food Service Manager the following was observed: a. Two dishes filled with green beans, carrots and corn were opened and not covered on top of the stove. b. There was accumulation of grease on the stove and on the back splash. c. Inside the oven was a large amount of burnt substances with aluminum foil scattered on the bottom of the oven. d. There was a large accumulation of grease and dry food spillage inside the convection oven. e. There was an accumulation of grease and dust in the slats of the oven hood. f. The pipes in the kitchen had a buildup of grease and dust next to the stove right by the stove top. Interview with the Food Service Manager at that time, indicated all the above areas needed to be cleaned. 3.1-21(i)(3)		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 812 Food Procurement, Store/Prepare/Serve-Sanitary Wha t Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. No negative outcomes were noted. 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. On 4/23/23 the dishes of corn and carrots, and green beans were covered. 2. On 4/24/23 the accumulation of grease and burnt substances was cleaned the stove and back splash area, the grease and dried food was cleaned off the convection oven, the oven hood was cleaned, and the pipes in the	

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	155344	A. BUILDING 00 B. WING	04/28/2023

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			kitchen that had a build-up were cleaned. 3. The food service director completed a full kitchen audit on 5/10/23 and did not identify any additional areas of concern regarding food being stored, prepared, and distributed in accordance with professional standards for food service safety. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1 kitchen staff were educated by the food service director and ED on food being stored, prepared, and distributed in accordance with professional standards for food service safety on 5/12/23. 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. The dietary director will audit the kitchen on food being stored correctly with a lid on, stove and back splash being clean, convection oven clean and free from grease and dried food, hood being free of dust and grease, and pipes being clean with no build-up of grease or dirt 5x/week for one month, then 1x/week for 2 months, then monthly for 3 months 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 once	

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			compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
F 0921 SS=E 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 kitchen area was clean and in good repair related to dirty floors, cabinets, pipes and walls in 1 of 1 kitchens observed. (Main Kitchen) Findings include: During the initial kitchen tour on 4/24/23 at 8:58 a.m. with the Food Service Manager, the following was observed: a. The floor had a buildup of dirt and debris. b. Dirt was observed on the pipes in kitchen and underneath the dishwasher. c. Dirt was observed underneath the cabinets in the dish room. d. There was an accumulation of dirt and dust on the wall behind the stove.	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 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	05/19/2023

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	Interview with the Food Service Manager at that time, indicated all the above areas needed to be cleaned. 3.1-19(f)		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. No negative outcomes noted. 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. On 4/24/23 the kitchen had the following completed: the floor was cleaned, the accumulation of grease and burnt substances were cleaned the stove and back splash area, the pipes in the kitchen and under the dishwasher were cleaned, under the cabinet in the dish room was cleaned, and the wall behind the stove was cleaned. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. The food service director completed a full kitchen audit on 5/10/23 and did not identify any additional areas of concern regarding a safe functional sanitary comfortable environment. 2. All kitchen staff were educated by the food service director and ED on providing a safe functional, sanitary environment on 5/12/23. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality	

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			assurance program will be put in place: 1. The dietary director will audit the kitchen to ensure the floor is free of build-up of dirt and debris, pipes and under the dishwasher and cabinets free from dirt and wall behind the stove 5x/week for one month, then 1x/week for 2 months, then monthly for 3 months. 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 once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/19/23 The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	