CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155344	B. WI	NG		04/28/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for a	Recertification and State	F 00	000	This plan of correction is prepa	ared	
	Licensure Survey. This visit included the				and executed because the		
	Investigation of Cor	mplaint IN00402546.			provisions of state and federal	law	
	-				require it and not because Life		
	Complaint IN00402	2546 - No deficiencies related to			Care Center of Michigan City		
	the allegations are c	ited.			agrees with the allegations and	d	
					citations listed. Life Care Cent	er of	
	Survey dates: April	1 24, 25, 26, 27, and 28, 2023			Michigan City maintains that th	ne	
					alleged deficiencies do not		
	Facility number: 00				jeopardize the health and safe	ty of	
	Provider number: 1				the residents nor is it of such		
	AIM number: 1002	287700			character to limit our capabilitie	es	
					to render adequate care. Pleas		
	Census bed type:				accept this plan of correction a	ıs	
	SNF/NF: 89				our credible allegation of		
	Total: 89				compliance that the alleged deficiencies have or will be con	rrect	
	Census payor type:				by the date indicated to remain	n in	
	Medicare: 36				compliance with state and fede	eral	
	Medicaid: 42				regulations, the facility has tak	en	
	Other: 11				or will take the actions set forth	n in	
	Total: 89				this plan of correction. We		
					respectfully request a desk rev	view.	
		reflect State Findings cited in					
	accordance with 410	0 IAC 16.2-3.1.					
	Quality review com	pleted on 5/3/23.					
F 0554	483.10(c)(7)						
SS=D		nin Meds-Clinically Approp					
Bldg. 00	- , , , ,	right to self-administer					
		interdisciplinary team, as					
		1(b)(2)(ii), has determined					
	•	s clinically appropriate.					
		on, record review, and	F 05	554	This plan of correction is prepa	ared	05/19/2023
	interview, the facilit	ty failed to ensure residents			and executed because the		
			1				

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: L0GD11 Facility ID: 000236 If continuation sheet Page 1 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155344 B. WING 04/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE had an assessment to self-administer their own provisions of state and federal law medications for 2 random residents reviewed for require it and not because Life self-administration of medication. (Residents 50 Care Center of Michigan City and 74) agrees with the allegations and citations listed. Life Care Center of Findings include: Michigan City maintains that the alleged deficiencies do not 1. On 4/24/23 at 10:52 a.m., Resident 50 was jeopardize the health and safety of observed in her room with a nasal spray and an the residents nor is it of such inhaler at her bedside. character to limit our capabilities to render adequate care. Please The record for Resident 50 was reviewed on accept this plan of correction as 4/26/23 at 10:36 a.m. Diagnoses included, but our credible allegation of were not limited to, chronic obstructive pulmonary compliance that the alleged disease (COPD) and respiratory failure. deficiencies have or will be correct by the date indicated to remain in The Quarterly Minimum Data Set (MDS) compliance with state and federal assessment, dated 3/30/23, indicated the resident regulations, the facility has taken was cognitively intact. or will take the actions set forth in this plan of correction. We A Care Plan, dated 5/23/22 and revised on 3/31/23, respectfully request a desk review. indicated the resident had a Physician's Order for F 554 – Resident Self-Admin self-administration of Vicks Vapo Rub, saline Meds-Clinically Approp nasal spray, sore throat spray, Luden's throat What Corrective Action will be drops, and an inhaler. Interventions included, accomplished for those residents but were not limited to, assess the resident's found to have been affected by this ability to safely self-administer medications deficient practice: specified on admission/readmission, quarterly, 1. Resident #50: with a change in medication orders, and with Self-administration assessment significant changes in condition. was completed. No negative outcomes were noted. A Physician's Order, dated 4/25/23, indicated the 2. Resident #74: No longer a resident was to receive an Albuterol Sulfate HFA resident at facility. Aerosol Solution 108 (90 Base) mcg (micrograms), How other residents having the 1 puff, inhale orally every 4 hours as needed for potential to be affected by the wheezing, may self-administer and keep at the same deficient practice will be bedside. identified and what corrective action will be taken: Physician's Orders, dated 5/17/22 and listed as 1. The DON completed a full current on the April 2023 Physician's Order house audit on 5/10/23 and no

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 2 of 49

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	NG		04/28/	/2023
				·			
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	ICHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Summary (POS), ir	ndicated the resident was to			additional residents were iden	tified	
	receive Sore Throat	t Spray Liquid 1.4 % (Phenol).			that were self-administering		
	Give 1 spray by mo	outh as needed for sore throat,			medications without an		
		e and self-administer. Saline			assessment.		
		on 1 spray alternating nostrils			What measures and what		
		congestion may keep at			systemic changes will be mad	e to	
		minister. Vicks Vapo Rub			ensure that the deficient practi		
		6%, apply to chest topically as			doesn't recur:		
		ngestion. May keep at			All licensed nursing staff we	ere	
	bedside and self-ad				educated by the DON on 5/11		
					on the right to self-administer		
	A Physician's Orde	r, dated 3/22/22 and listed as			medications when clinically		
		1 2023 POS, indicated the			appropriate along with the nee	ed for	
	_	her Albuterol MDI inhaler at			the completion of a		
	the bedside and self				self-administration assessmer	nt	
					New licensed nursing		
	There was no self-a	administration of medication			employees will receive this		
	assessment available				education prior to working.		
					How the corrective action will	be	
	Interview with the	Director of Nursing on 4/27/23			monitored to ensure the deficient		
		ted she thought an assessment			practice will not recur, i.e., what		
	had been completed	-			quality assurance program wil		
	1				put in place:		
	2. On 4/25/23 at 9:	40 a.m. and 3:15 p.m., Resident			1. The DON/designee will aud	it all	
		his room. An Albuterol			intake assessments for all	it uii	
		ed on his bed. Interview with			residents to verify a		
		time, indicated he was allowed			self-administration assessmen	nt	
	to keep the inhaler				has been completed and those		
					that can self-administer, have		
	On 4/26/23 at 9:29	a.m., the resident was in his			opportunity to self-administer t		
		wheelchair. The resident's			medications, weekly for 3 mor		
	inhaler remained at				then monthly for 3 months.	,	
					2. The results of these reviews	s will	
	The record for Resi	dent 74 was reviewed on			be discussed at the monthly		
		. Diagnoses included, but were			facility Quality Assurance		
		nic obstructive pulmonary			Committee meeting monthly for	or a	
	disease (COPD), pneumonia, malignant neoplasm				total of 3 months and then	u	
	of right bronchus of lung, and emphysema.				quarterly thereafter once		
	l light stonends of				compliance is at 100%.		
	The Admission Mi	nimum Data Set (MDS)			Frequency and duration of rev	iews	
	1 110 / 101111331011 19111	minimin Dam Set (MIDS)	1		Li reduction and adjusted of 160	CVVO	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155344	B. W	ING _		04/28	/2023
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	3			HIGHWAY 20 EAST		
LIFE CAR	RE CENTER OF MI	ICHIGAN CITY			SAN CITY, IN 46360		
LII L OAI	TE OLIVILITY OF IVII			IVIIOTIIC			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	3/27/23, indicated the resident			will be increased as needed, i	f	
		paired for daily decision			compliance is below 100%.		
	making.				Compliance date: 5/19/23. The		
					Administrator at Life Care Cer		
		t have a self-administration of			of Michigan City is responsible		
		nent available for review. He			ensuring compliance in this Pl	an	
	also did not have a	•			of Correction		
	self-administration	of medications.					
	A Coro Diam datal	3/31/23, indicated the resident					
	· ·	tive ability/ impaired thought					
		short term memory deficits.					
	•	ded, but were not limited to,					
		ions as ordered and allow extra					
		at to respond to questions and					
	instructions.	it to respond to questions and					
	msu actions.						
	A Physician's Orde	r, dated 4/7/23, indicated the					
		eive ProAir HFA Inhalation					
	Aerosol Solution 10	08 (90 Base) micrograms (mcg)					
		2 puffs, inhale orally every 4					
	hours as needed for	wheezing, dyspnea, or prior					
	to physical activity.	. May keep at bedside.					
		Director of Nursing on 4/27/23					
	at 1:30 p.m., indica	ted a self-administration of					
	medication assessm	nent should have been					
	completed.						
	3.1-11(a)						
E 0044	400.00/ >						
F 0641	483.20(g)						
SS=A	Accuracy of Asses						
Bldg. 00	ισ,	acy of Assessments.					
		must accurately reflect the					
	resident's status.	on mooded novious d	F.	C 4.1	This was of as westing in		05/10/2022
		on, record review, and	F 0	541	and executed because the		05/19/2023
		ity failed to ensure the (MDS) comprehensive					
		curately completed related to			provisions of state and federal		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 4 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	NG		04/28/	/2023
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HIGHWAY 20 EAST		
LIEE CAE	RE CENTER OF MI	CHICAN CITY			SAN CITY, IN 46360		
LIFE CAI	RE CENTER OF IVII	CHIGAN CITY		MICHIC	SAN CITT, IN 40300		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	oxygen use for 1 of	21 MDS assessments			Care Center of Michigan City		
	reviewed. (Resident 37)				agrees with the allegations an	d	
					citations listed. Life Care Cent	er of	
	Finding includes:				Michigan City maintains that the	ne	
					alleged deficiencies do not		
	On 4/24/23 at 11:34 a.m., Resident 37 was				jeopardize the health and safe	ty of	
	observed sitting in	his wheelchair. An oxygen			the residents nor is it of such		
	concentrator was of	oserved next to the resident's			character to limit our capabiliti	es	
	wheel chair. The re	sident's nasal cannula was			to render adequate care. Plea	se	
	sitting on the outsid	le of the resident's nose. The			accept this plan of correction a	as	
		he cannula would often come			our credible allegation of		
	off. The oxygen tu	bing was not connected to the			compliance that the alleged		
	oxygen concentrato	or and the oxygen concentrator			deficiencies have or will be co	rrect	
	was not turned on.				by the date indicated to remain	n in	
					compliance with state and fed	eral	
	On 4/25/23 at 9:28	a.m., Resident 37 was observed			regulations, the facility has tak	en	
	sitting in his wheel	chair with the nasal cannula in			or will take the actions set fort	h in	
	his nose. The reside	ent was receiving oxygen from			this plan of correction. We		
	his portable oxygen	concentrator connected to			respectfully request a desk		
	the back of his whe	el chair. The oxygen dial was			review.		
	observed at 1 liter.				F 641 – Accuracy of		
					Assessments What Corrective	;	
	The record review f	for Resident 37 was completed			Action will be accomplished fo	r	
	_	p.m. Diagnoses included, but			those residents found to have		
		chronic obstructive pulmonary			been affected by this deficient		
	disease (COPD), re	spiratory failure, hypertension,			practice: 1. On 4/25/23 the MI	os	
	and hyperlipidemia				coordinator updated resident 3	37	
					MDS to reflect his oxygen Ho	w	
		nimum Data Set (MDS)			other residents having the		
		3/5/23, indicated the resident			potential to be affected by the		
		gnitively impaired for daily			same deficient practice will be		
		xygen was marked as not being			identified and what corrective		
	in use while a resid	ent.			action will be taken: 1. On 5/1/	/23	
					the MDS coordinator audited a		
		r, dated 3/2/23, indicated			MDS of those people with oxy	_	
		en via nasal cannula at 5 LPM			to verify that it was on the MD	S	
	(liters/minute) cont	inuously per nasal cannula.			assessment. No further issues	3	
					were What measures and wh	at	
	A Care Plan, dated	3/28/23, indicated the resident			systemic changes will be mad	e to	
	was receiving ovvo	en therapy due to respiratory	1		encure that the deficient pract	ico	I

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

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S COMPLI 04/28/2	ETED
	PROVIDER OR SUPPLIEF		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	limited to, observe respiratory distress During an interview MDS Coordinator i	is included, but were not for signs and symptoms of and report to MD as needed. or on 4/28/23 at 11:39 am., the indicated oxygen should have ingused on the assessment eet it.		doesn't recur: 1. On 5/11/23 Nataff was educated by the DC assessments must accurately reflect the resident's. How the corrective action will be monit to ensure the deficient praction not recur, i.e., what quality assurance program will be purplace: 1. The MDS coordinator/designee will aud MDS of people receiving oxyon therapy weekly for six. 2. The results of these reviews will be discussed at the monthly facil Quality Assurance Committee meeting monthly for a total of months and then quarterly thereafter once compliance is 100%. Frequency and durative reviews will be increased as needed, if compliance date: 5/19. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	on r/t cored ce will t in cit all gen ce city con of con of con of con of	
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene;	ed for Dependent Residents esident who is unable to of daily living receives the es to maintain good g, and personal and oral				
	interview, the facili residents received a	on, record review, and ty failed to ensure dependent ssistance with activities of related to nail care. (Resident	F 0677	This plan of correction is prep and executed because the provisions of state and federa require it and not because Lift Care Center of Michigan City	ıl law	05/23/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 6 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155344 B. WING 04/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE agrees with the allegations and Finding includes: citations listed. Life Care Center of Michigan City maintains that the Interview with Resident 69 on 4/24/23 at 10:35 alleged deficiencies do not a.m., indicated her toenails were very long and jeopardize the health and safety of they needed to be cut. The resident had told staff the residents nor is it of such that she needed assistance cutting them, but they character to limit our capabilities had not helped her. The resident's toenails were to render adequate care. Please observed during the interview and were noted to accept this plan of correction as be very long. our credible allegation of compliance that the alleged Resident 69's record was reviewed on 4/26/23 at deficiencies have or will be correct 1:22 p.m. Diagnoses included, but were not limited by the date indicated to remain in to, heart disease, chronic obstructive pulmonary compliance with state and federal disease, end stage renal disease, and type 2 regulations, the facility has taken diabetes mellitus. or will take the actions set forth in this plan of correction. We A Significant Change in Status Minimum Data Set respectfully request a desk review. (MDS) assessment, dated 3/28/23, indicated the F 677- ADL Care Provided for resident was cognitively intact for daily decision Dependent Residents making. She required extensive assistance with What Corrective Action will be one person physical assist for personal hygiene. accomplished for those residents found to have been affected by this Interview with the Assistant Director of Nursing deficient practice: 1. Resident on 4/27/23 at 2:38 p.m., indicated the resident was #69: Nail care provided on 4/28/23 on the list to be seen by podiatry upon their next by DON. No negative outcomes visit to the facility. were noted. How other residents having the potential to be affected Interview with the Director of Nursing on 4/28/23 by the same deficient practice will at 9:58 a.m., indicated she assessed the resident's be identified and what corrective toenails and cut her toenails as they were very action will be taken: 1. The DON long and needed cut. They should have been completed a full house audit on addressed sooner. 5/11/23 and no additional residents were identified that failed 3.1-38(a)(3)(E)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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 7 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/22/2023 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			ON	AB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>00</u>	COMP	LETED
		155344	B. WING		04/28	3/2023
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD		
01 1	No (IDDN on Soll Did.		80)2 US HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY	MI	ICHIGAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
				PROVIDER'S PLAN OF CORRECT	TION LD BE	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREI	CROSS-REFERENCED TO THE APPR	ROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA			DATE
				were educated by the DC		
				5/11/23 on residents that		
				unable to carry out activit		
				daily living receiving the r	necessary	
				services to maintain good		
				nutrition, grooming, perso		
				oral hygiene. 2. New nurs	sing	
				employees will receive the	is	
				education prior to		
				working. How the corr	ective	
				action will be monitored to	o ensure	
				the deficient practice will	not	
				recur, i.e., what quality as		
				program will be put in pla		
				The DON/designee will re		
				shower sheets to verify na		
				was provided if indicated		
				weekly months, then 2X v		
				_	-	
				2 months, then weekly for	2	
				months.		
					•••	
				2. Nursing management v		
				complete observational ro	ounds to	
				ensure audited ADL		
				documentation accurately		
				completed care 3X weekl	-	
				months, then 2X weekly f		
				months, then weekly for 2		
				3. The results of these re-	views will	
				be discussed at the mont	hly	
				facility Quality Assurance		
				Committee meeting mont	hly for a	
				total of 3 months and the	า	
				quarterly thereafter once		
				compliance is at 100%.		
				Frequency and duration of	of reviews	
				will be increased as need		
				compliance is below	,	
				100%. Compliance date:	5/23/23	
			I	100 /0. Compliance date.	J12J12J.	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

The Administrator at Life Care

If continuation sheet

Page 8 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155344	B. W			04/28/		
		1		_		_ : ::=0/		
NAME OF P	ROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
					HIGHWAY 20 EAST			
LIFE CAF	RE CENTER OF M	ICHIGAN CITY		MICHIO	GAN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE).TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE	
					Center of Michigan City is			
					responsible in ensuring			
					compliance this Plan of			
					Correction.			
					Correction.			
F 0679	483.24(c)(1)							
SS=D	` '\ '	erest/Needs Each Resident						
Bldg. 00	§483.24(c) Activit							
Blug. 00	` '	e facility must provide, based						
	- ',','	nsive assessment and care						
	-	erences of each resident, an						
		to support residents in their						
		* *						
		s, both facility-sponsored						
	group and individu							
	-	ities, designed to meet the						
		upport the physical, mental,						
		well-being of each resident,						
		independence and						
	interaction in the	•						
		on, record review, and	F 0	679	This plan of correction is prep	ared	05/19/2023	
		ty failed to ensure the resident			and executed because the			
		vities at least 3 times a week for			provisions of state and federa			
	1 of 1 residents rev	iewed for activities. (Resident			require it and not because Life	3		
	6)				Care Center of Michigan City			
					agrees with the allegations an			
	Finding includes:				citations listed. Life Care Cent			
					Michigan City maintains that t	he		
		p.m. Resident 6 was observed in			alleged deficiencies do not			
		ne television was on, however,			jeopardize the health and safe	ety of		
	there was no sound	and it was trying to connect			the residents nor is it of such			
	to the internet.				character to limit our capabiliti	ies		
					to render adequate care. Plea	ise		
	On 4/25/23 at 9:00	a.m., the resident was observed			accept this plan of correction	as		
	in bed with his eyes	s closed. There was no			our credible allegation of			
	television or radio	playing.			compliance that the alleged			
					deficiencies have or will be co	rrect		
	The record for Resi	ident 6 was reviewed on 4/26/23			by the date indicated to remai			
	at 1:45 p.m. Diagno	oses included, but were not			compliance with state and fed			

FORM CMS-2567(02-99) Previous Versions Obsolete

limited to, pericardial effusion, cerebral

Event ID:

L0GD11

Facility ID: 000236

regulations, the facility has taken

If continuation sheet

Page 9 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	NG		04/28/	2023
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	ICHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDED'S DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	hemorrhage, intelle	ectual disabilities, altered mental			or will take the actions set fort	h in	
	status, acute kidney	failure, and expressive			this plan of correction. We		
		The resident was admitted to			respectfully request a desk		
		3/23 and returned on 4/17/23			review.		
	with hospice service				F 679– Activities Meet		
	1				Interest/Needs Each		
	A Significant Chan	ge Minimum Data Set (MDS)			Resident What Corrective Acti	ion	
	-	4/21/23, was in progress.			will be accomplished for those		
		-, <u> </u> F B 200.			residents found to have been		
	The Quarterly Mini	imum Data Set (MDS)			affected by this deficient		
		/30/23, indicated the resident			practice: 1. Resident #6: On		
		red for decision making. The			4/24/23 the television was		
		ensive assist with a 2 person			connected to TV services and	the	
		ped mobility and transfers.				No	
	physical assist for t	sed moonity and transfers.			negative outcomes were	10	
	A Care Plan dated	4/19/23, indicated the resident			noted. How other residents ha	avina	
		vity involvement related to his			the potential to be affected by	•	
		in an environment without a			same deficient practice will be		
		sident would benefit from			identified and what corrective		
		vity three times a week.			action will be taken: 1. The ac	tivity	
	naving a 1 to 1 acti	vity times times a week.			director completed a full house	-	
	The 1 to 1 activities	s documented for the resident			audit on residents that receive		
		ed TV, and read short stories.			on one activities on 5/11/23 to		
		onse was documented as well.			verify residents receive one or		
		ed 1 to 1 activities on the			activities as scheduled. Three		
	following dates:	ed 1 to 1 activities on the			additional residents were iden		
	Tollowing dates.				that did not receive one on one		
	Ianuary/February 2	023: 1/30, 2/2, 2/7, 2/11, 2/16,			activities as scheduled. What		
	2/20, and 2/25/23	023. 1/30, 2/2, 2/7, 2/11, 2/10,					
	2/20, and 2/23/23				measures and what systemic	ro	
	March 2022, 2/1 2	/6, 3/10, 3/13, 3/17, 3/21, 3/25,			changes will be made to ensu		
	and 3/29/23	70, 3/10, 3/13, 3/17, 3/21, 3/23,			that the deficient practice does		
	aliu 3/29/23				recur: 1. The activity director v		
	April 2022, 4/2, 4/4	6, 4/10, 4/12, (hospital 4/13-4/17),			educated by the ED on activiti	es	
					meeting resident interest and		
	4/19, 4/22, and 4/24	1 /23			needs on 5/11/23. 2. A monthl		
	The 1 4- 1 - 2' '2'				schedule was developed for a	II	
		s were not completed at least			residents that one on one		
	three times a week.				activities to ensure 3 times a		
	T	A			week. 3. The activity director		
	Interview with the	Activity Director on 4/27/23 at	1		educated the activity staff on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 10 of 49

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

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155344	B. W	ING		04/28/	2023
	PROVIDER OR SUPPLIER		•	802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	11:18 a.m., indicate	ed the resident was to have 1:1			5/13/23 on activities meeting		
		week and she would be			resident interest and need alo	٠ .	
	addressing the issue	with her staff.			with implementation of monthl	у	
	2.4.22(1)(0)				schedule. How the corrective		
	3.1-33(b)(8)				action will be monitored to ens	sure	
					the deficient practice will not		
					recur, i.e., what quality assura program will be put in place: 1		
					The activity director will audit of		
					on one activities for completion		
					5x/week for one month, 1x/we		
					for 2 months, and monthly for		
					months to verify completion as		
					required. 2. The results of the	se	
					reviews will be discussed at th	e	
					monthly facility Quality Assura		
					Committee meeting monthly for	or a	
					total of 3 months and then		
					quarterly thereafter once		
					compliance is at 100%.	iowo	
					Frequency and duration of rev will be increased as needed, it		
					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	402.05						
SS=E	483.25 Quality of Care						
Bldg. 00	§ 483.25 Quality of	of care					
2.4g. 00	-	a fundamental principle that					
		ment and care provided to					
	facility residents.						
	,	ssessment of a resident, the					
		e that residents receive					
		e in accordance with					
	professional stand	lards of practice, the					

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/28/2023 155344 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE comprehensive person-centered care plan, and the residents' choices. F 0684 Based on observation, record review, and This plan of correction is prepared 05/19/2023 interview, the facility failed to ensure skin tears and executed because the and areas of bruising were assessed, monitored, provisions of state and federal law and treatments were completed as ordered for 4 of require it and not because Life 5 residents reviewed for skin conditions Care Center of Michigan City non-pressure related and 1 of 2 residents reviewed agrees with the allegations and for anticoagulant (a blood thinner) medication citations listed. Life Care Center of side effects. The facility also failed to ensure an Michigan City maintains that the edema glove was in use as ordered for 1 of 1 alleged deficiencies do not residents reviewed for edema and treatment was jeopardize the health and safety of completed timely for 1 of 1 residents reviewed for the residents nor is it of such a change in condition. (Residents 1, 74, 181, 59, character to limit our capabilities and 384) to render adequate care. Please accept this plan of correction as Findings include: our credible allegation of compliance that the alleged 1. On 4/24/23 at 1:46 p.m., Resident 1 was deficiencies have or will be correct observed in her room in bed. She did not have an by the date indicated to remain in edema glove to her right hand. compliance with state and federal regulations, the facility has taken On 4/26/23 at 9:30 a.m., 11:30 a.m., and 1:40 p.m., or will take the actions set forth in the resident's edema glove to the right hand was this plan of correction. We not in use. respectfully request a desk review. F 684 Quality of Care On 4/27/23 at 9:10 a.m., the resident's edema glove What Corrective Action will be to the right hand was not in use. accomplished for those residents found to have been affected by this The record for Resident 1 was reviewed on 4/26/23 deficient practice: 1. Resident #1: at 1:28 p.m. Diagnoses included, but were not On 4/27/23 was seen by the NP limited to, cerebral palsy, profound intellectual and an order to discontinue edema disabilities, and disorder of the nose and nasal glove was given. No negative sinuses. outcomes were noted. 2. Resident #74: On 4/27/23 a The 3/27/23 Significant Change Minimum Data Set treatment to right elbow was

FORM CMS-2567(02-99) Previous Versions Obsolete

(MDS) assessment indicated the resident was

severely impaired for daily decision making.

A Care Plan, dated 3/27/23, indicated the resident

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

completed by midnight nurse and

verified by ADON. On 4/27/23 the treatment was discontinued by

NP. No negative outcomes were

Page 12 of 49

PRINTED: 06/22/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMPI	
		155344	B. WI	NG		04/28	
				·			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
		IOLUO ANI OLTY			S HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	ICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	had an ADL (activ	ities of daily living) self-care			noted. 3. Resident #181: No		
	performance defici	t in bed mobility,			negative outcomes were noted	d. 4.	
	dressing/grooming	, bathing, transfers, eating,			Resident #59: No negative		
	locomotion, and to	ileting related to her disease			outcomes were noted. 5. Resi	dent	
	process. She requi	red total assist with bed			#384: No longer at facility. Ho	W	
	mobility, eating, tra	ansfers, and toileting. She also			other residents having the		
	required assist with	n upper body dressing.			potential to be affected by the		
	Interventions inclu	ded, but were not limited to,			same deficient practice will be	!	
	edema glove to her	right hand.			identified and what corrective		
					action will be taken: 1. On 5/1	/23	
	A Physician's Orde	er, dated 3/27/23, indicated the			audited the 24 hour and repor	ts for	
	resident was to hav	e an edema glove to the right			any concerns and no additiona	al	
	hand.				concerns were noted. 2. On 5	/2/23	
					audited all anti-coagulant orde	ers to	
	The order for the e	dema glove was not listed on			ensure monitoring for bruising	, no	
	the March and Apr	ril 2023 Treatment			additional concerns were		
	Administration Red	cords (TARs).			noted. 3.The ADON complete	ed a	
					full house skin audit on 5/11/2	3 to	
	Interview with the	Director of Nursing on 4/27/23			identify any new skin concerns	S	
	-	ated the resident's edema glove			that were not addressed. One		
	should have been in	n use. She also indicated the			additional concern was and a	new	
	order should have	been listed on the TAR.			order was added to the TAR to	0	
					monitor the identified areas da	aily	
		:10 p.m., a foam dressing was			until healed. What measures a		
		ent 74's right elbow. The			what systemic changes will be	;	
	_	4/20/23 and areas of dried			made to ensure that the defici		
		ed on the dressing. Multiple			practice doesn't recur: 1 nursi	•	
		rple discoloration were			staff were educated by the SD		
		sident's right arm and hand.			on 5/9/23 for skin tears and ar		
		ot have a dressing to his right			of bruising assessed, monitore	ed	
	hand.				and treatments received as		
					ordered. All nursing staff were		
		a.m. and 3:15 p.m., the			educated by the SDC on 5/9/2	23	
		ined to the resident's right arm			related to anti-coagulant		
		vas no dressing to the resident's			medication side effects and		
	right elbow or hand	d.			monitoring. All nursing staff wa		
					educated on change of condit	ion	
	On 4/26/23 at 9:29	a.m., the discoloration remained			notification by the DON on		

FORM CMS-2567(02-99) Previous Versions Obsolete

to the resident's right arm and hand. There was

no dressing to the resident's right elbow or hand.

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

5-11-23.2 nursing staff will receive

this education prior to

Page 13 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/28/2023 155344 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE working. How the corrective action The record for Resident 74 was reviewed on will be monitored to ensure the 4/27/23 at 8:58 a.m. Diagnoses included, but were deficient practice will not recur, not limited to, chronic obstructive pulmonary i.e., what quality assurance disease (COPD), pneumonia, malignant neoplasm program will be put in place: 1 of right bronchus of lung, emphysema, and DON/designee will review report 5x COVID-19. weekly to verify notification for change of condition, treatments The Admission Minimum Data Set (MDS) are given as ordered, and assessment, dated 3/27/23, indicated the resident monitoring for anticoagulant side was moderately impaired for daily decision making effects for 6 and she required extensive assistance for bed 2. The months. mobility and transfers. The resident was also results of these reviews will be identified as having skin tears. discussed at the monthly facility **Quality Assurance Committee** A Care Plan, dated 3/29/23, indicated the resident meeting monthly for a total of 3 was receiving anticoagulant therapy, Apixaban (a months and then quarterly blood thinner). Interventions included, but were thereafter once compliance is at not limited to, observe for and report as needed 100%. Frequency and duration of (prn) adverse reactions of anticoagulant therapy: reviews will be increased as blood tinged or red blood in urine, black tarry needed, if compliance is below stools, dark or bright red blood in stools, sudden 100%. Compliance date: 5/19/23. severe headaches, nausea, vomiting, diarrhea, The Administrator at Life Care muscle joint pain, lethargy, bruising, blurred Center of Michigan City is vision, shortness of breath, loss of appetite, responsible in ensuring sudden changes in mental status, significant or compliance this Plan of sudden changes in vital signs. Correction. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

(MAR), indicated the resident did not have any

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 14 of 49

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/28/2023	
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST GAN CITY, IN 46360	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ALCO DEPUTIENT OF DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE COMPLETION
TAG		of side effects each shift for	TAG	DEI KLENCTI	DATE
		sician's Orders to monitor the lent's right arm and hand.			
	had a skin tear to th included, but were to size and treatment of abnormalities, failu	4/7/23, indicated the resident e right hand. Interventions not limited to, assess location, of the skin tear. Report re to heal, signs and symptoms ation, etc. to the Physician.			
	There was no Care right elbow.	Plan related to the area to the			
	cleanse the area to t saline, pat dry, and	r, dated 4/6/23, indicated to the right hand with normal cover with a foam dressing ry 3 day(s) for a skin tear. Start			
	(TAR), indicated th	atment Administration Record e resident's treatment was completed on 4/24/23.			
	Bacitracin Plus Extension Plus Extens	r, dated 4/20/23, indicated ernal Ointment 500 units/gram of the right elbow topically ery 3 days. Cleanse the area apply bacitracin, and cover g.			
	-	R, indicated the treatment to signed out as being and 4/26/23.			
	dated 4/20 and 4/27	ntegrity Data Collection forms, 7/23, identified the skin tear to there was no documentation			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 15 of 49

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155344	B. WI	NG		04/28	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	related to the bruis	ing on the right arm and hand.					
		D:					
		Director of Nursing on 4/27/23					
	-	ated the dressing to the elbow					
		ave been changed as ordered					
		related to the bruising should					
	_	ed. 3. During an observation on					
		m., Resident 181 was observed					
	-	hair. At that time, she had large					
		o the right outer and upper arm. ark purple and blue in color.					
	The ordises were d	ark purple and blue in color.					
	The record for Doo	ident 181 was reviewed on					
		n. The resident was admitted to					
	-	2/23. Diagnoses included but					
		o, cirrhosis of the liver, atrial					
		lood pressure, heart disease,					
	heart failure, and d	-					
	neart failure, ailu u	Omonda.					
	The Admission Mi	nimum Data Set (MDS)					
	assessment was sti						
	,						
	A Care Plan, dated	4/24/23, indicated the resident					
		ant therapy. The approaches					
	_	r and report adverse reactions					
		ed or red blood in urine, black					
	_	r bright red blood in stools, and					
	bruising.						
	_	ion Assessment, dated 4/18/23,					
		ent was admitted with "right					
		e/red bruises and left arm-1.3					
		y 1 cm purple/red bruise." There					
		mentation of any other bruising					
		ssion or measurements taken of					
	the other bruises or	n the right arm.					
	Discriping 1 O 1	4-4-4 4/10/22 :1' 4 1					
	Physician's Orders, dated 4/18/23, indicated						
	· ·	nticoagulant medication) tablet					
	20 milligrams (mg). Give 1 tablet by mouth in the	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155344		(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION	(X3) DATE SURVEY COMPLETED 04/28/2023	
	PROVIDER OR SUPPLIER		802 U	SADDRESS, CITY, STATE, ZIP CO S HIGHWAY 20 EAST GAN CITY, IN 46360	DD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	bleeding, including gums, bruising, and Document a (+) if s present and (-) if sign present. A Weekly Skin Into Assessment, dated	or for signs and symptoms of black tarry stools, bleeding I nose bleed every shift. signs and symptoms were gns and symptoms were not egrity Data Collection 4/25/23, indicated the intact and there were no new			
		mentation in Nursing Notes 7/23 regarding any bruising to as.			
	(TAR) indicated the from 4/19-4/27/23,	ent Administration Record ere was a "-" sign documented indicating there were no mptoms of anticoagulant use.			
	at 10:45 a.m., indic trouble with the nur following up on the identified. The faci were to be assessed on a wound report a assessed weekly un	Director of Nursing on 4/27/23 ated she had been having rsing staff documenting and bruises after they were lity's policy was that bruises and documented and then measured and til healed. There were no other seessments of the bruising as admitted.			
	Resident 59 was ob	vation on 4/24/23 at 10:30 a.m., served in bed. At that time, scoloration to the right arm a color.			
	4/26/23 at 9:55 a.m	dent 59 was reviewed on . The resident was admitted to /23. Diagnoses included, but			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 17 of 49

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155344	B. W			04/28	/2023
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
	RE CENTER OF MI	ICHIGAN CITY			HIGHWAY 20 EAST SAN CITY, IN 46360		
				<u> </u>	MIN OIT I, IIN 40300		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		, atrial fibrillation, heart failure,		IAU			DATE
		ease, dementia, COPD, sleep					
	apnea, and anemia.						
	The Admission Minimum Data Set (MDS)						
		3/28/23, indicated the resident					
		vintact. She was an extensive					
	-	on physical assist for bed ers. She used oxygen while a					
		last 7 days, received an					
	anticoagulant medi	• .					
	S						
	A Care Plan, dated 3/29/23, indicated the resident						
	_	nt therapy. The approaches					
		and report adverse reactions					
	_	d or red blood in urine, black bright red blood in stools, and					
	bruising.	bright red blood in stools, and					
	oraising.						
	Physician's Orders,	dated 3/22/23, indicated					
		oagulant medication) 5					
	,	ive 1 tablet by mouth 2 times a					
	-	r signs and symptoms of					
		black tarry stools, bleeding					
		I nose bleed every shift.					
	` ′	gns and symptoms were not					
	present.	6 7 F					
	_	ssion Assessment, dated					
	· ·	he resident had bruises in the					
		tht antecubital that measured 2					
	` ′ •	y 2 cm, the right upper forearm by 1 cm, the right forearm that					
		4 cm, the left antecubital that					
	-	0.5 cm, and the back of the left					
	wrist that measured						
		•					
	-	ntegrity Data Collection					
	Assessment, compl	eted on 3/29, 4/5, 4/12, 4/19,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 18 of 49

SUMMARY STATEMENT OF DEFICIENCIE

PRINTED: 06/22/2023

(X5)

DEPARTMENT OF HEALTH AND HUN	PARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>00</u>	COMPLETED					
	155344	B. W	NG	04/28/2023					
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD						
NAME OF FROVIDER OR SUFFLIER	X.		802 US HIGHWAY 20 EAST						
LIEE CADE CENTED OF MI	CHICAN CITY		MICHICANICITY IN 46360						

PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	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.			
	determiny from COLD.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 19 of 49

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155344	B. W.	ING		04/28	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF	PROVIDER OR SUPPLIER	C .		802 US	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	dated 4/7/23 at 3:38 p.m.,					
	1	rnum and bilateral lower					
	anterior rib cage.						
	The X-rays were co	empleted on 4/10/23 and					
	indicated there was	no evidence of a fracture.					
	Interview with the I	Director of Nursing on 4/27/23					
		ated she had been having					
		rsing staff documenting and					
		bruises after they were					
		were to be assessed, measured,					
		a wound report and then					
		sed weekly until healed. There					
		urements or assessments of					
		e resident was admitted. The					
	NP was made aware	e of the masses, however, she					
	wanted to assess the	e areas before ordering					
	anything, and she b	elieved she was out of town					
	that week. The NP 1	made a progress note on 4/7/23					
	and ordered the X-r	rays. The Physician could have					
	been notified on 4/3	3/23 instead of the NP and the					
	X-ray could have be	een completed earlier and					
	before 4/10/23.5. O	n 4/24/23 at 10:45 a.m., a					
	reddish/purple disco	oloration was observed on					
	Resident 384's right	t and left lower hands.					
	On 4/26/23 at 10:34	a.m., the reddish/purple					
		ned to the resident's right and					
	left lower hands.	Č					
	The mane of few P	dont 204 11100 mari 1					
		dent 384 was reviewed on					
		. Diagnoses included, but were					
	· ·	nia, atrial fibrillation (irregular					
	neart rnythm), neart	t failure, and hypertension.					
	The Admission Mir	nimum Data Set (MDS)					
		/18/23, indicated the resident					
		irment. The resident needed					

FORM CMS-2567(02-99) Previous Versions Obsolete

limited assistance with 1-person physical assist

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 20 of 49

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	1 1	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155344	B. W		00	04/28/	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF				HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	for bed mobility and			mg			DATE
	-	r, 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:						
		ry stools, bleeding gums,					
	_	related to anticoagulant use;					
	-	ft. Document a (+) if signs and					
	symptoms were present and (-) if signs and symptoms were not present.						
	The Weekly Skin C	Observation sheet, dated					
		he resident's skin was intact					
	and there was no do	ocumentation of bruising.					
	There was no docu	mentation on the April 2023					
		tration Record (TAR) related to					
	monitoring for med	ication side effects.					
	Interview on 4/26/2	3 at 10:36 a.m. with Agency					
		e areas on the resident's hands					
		ot see any orders and she					
	would assess the re-	sident and let the Nurse					
	Practitioner know.						
	Interview on 4/27/2	3 at 2:37 p.m., with the					
		of Nursing, regarding the					
		ndicated she was unaware and					
	had no further infor	rmation to provide.					
	3.1-37(a)						
F 0686	483.25(b)(1)(i)(ii)						
SS=D		Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin Ir	ntegrity					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 21 of 49

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155344	B. W.	ING	_	04/28	/2023
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					S HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	ICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	§483.25(b)(1) Pre						
		nprehensive assessment of					
	a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent						
		nd does not develop					
	l -	nless the individual's clinical					
	l '	trates that they were					
	unavoidable; and	arates that they were					
	· ·	pressure ulcers receives					
	' '	ent 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						
			F 0	686	This plan of correction is prep	ared	05/19/2023
	interview, the facili	ty failed to ensure a resident			and executed because the		
	with pressure ulcers	s received the treatment and			provisions of state and federal law require it and not because Life		
	services necessary	to promote healing related to					
		g completed as ordered and			Care Center of Michigan City		
	_	devices not being used for 2 of			agrees with the allegations an	d	
		d for pressure ulcers.			citations listed. Life Care Cent		
	(Residents 1 and 50	0)			Michigan City maintains that t	he	
					alleged deficiencies do not		
	Findings include:				jeopardize the health and safe	ety of	
					the residents nor is it of such		
		0:59 a.m., Resident 1 was			character to limit our capabiliti		
		m in bed. Agency LPN 2 used			to render adequate care. Plea		
		donned gloves and proceeded			accept this plan of correction	as	
		ent's blanket exposing her feet.			our credible allegation of		
		gs, dated 4/24/23, were			compliance that the alleged deficiencies have or will be co	rraat	
		ident's right foot. Three foam sident's overbed table, were					
	_	ELPN indicated she would take			by the date indicated to remai		
		's dressings and proceeded to			compliance with state and fed regulations, the facility has tal		
		ng one at a time and replace			or will take the actions set fort		
		foam dressings, dated 4/28.			this plan of correction. We	.11 111	
		eanse the wounds with normal			respectfully request a desk		
		ney (a debriding ointment) was			review.		
	not applied.	(accitant ontone) was			F 686 – Treatment/ to		
					Prevent/Heal Pressure		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 22 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/28/2023 155344 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The record for Resident 1 was reviewed on 4/26/23 Ulcer What Corrective Action will at 1:28 p.m. Diagnoses included, but were not be accomplished for those limited to, cerebral palsy, profound intellectual residents found to have been disabilities, and disorder of the nose and nasal affected by this deficient sinuses. practice: 1. Resident #1: Treatment/dressings changes The 3/27/23 Significant Change Minimum Data Set were completed immediately. No (MDS) assessment indicated the resident was negative outcome noted. 2. severely impaired for daily decision making. She Resident #50: Order for right heel was also dependent on staff for bed mobility. The boot clarified with physician and resident was identified as having one Stage 1 and care plan updated. No negative four Stage 2 pressure areas that were present on outcome noted. How other readmission. residents having the potential to be affected by the same deficient A Care Plan, dated 3/27/23, indicated the resident practice will be identified and what had a break in skin integrity. She had a blister to corrective action will be taken: 1. the right heel, two Stage 2 areas to the right foot, a The ADON completed a full house blister to the left heel, and a Stage 1 to her left hip. audit on 5/11/23 to ensure that Interventions included, but were not limited to, treatments were in place to weekly skin checks and treatments as ordered. prevent/heal pressure ulcers. No additional concerns were A Physician's Order, dated 3/31/23, indicated found. What measures and what Medihoney Wound/Burn Dressing External Gel systemic changes will be made to was to be applied to the top of the right foot and ensure that the deficient practice side of the foot topically on the evening shift doesn't recur: 1. On 5/12/23, the every 3 days. Cleanse areas to the top of the right evening shift LPN was educated foot and side of the right foot with NS, apply on following treatment orders. Medihoney and cover with foam dressings. This Agency LPN2 no longer works at order also applied to the right heel and left hip. . 2. On 5/11/23 the DON educated all nursing staff on providing The April 2023 Medication Administration Record treatments as ordered and having (MAR), indicated the treatments were signed out pressure relieving devices in as being completed on the evening shift on place.. How the corrective action 4/27/23. will be monitored to ensure the deficient practice will not recur, Interview with the Assistant Director of Nursing i.e., what quality assurance on 4/28/23 at 11:10 a.m., indicated the treatment program will be put in place: 1. should have been completed as ordered on The DON/designee will audit 4/27/23. She also indicated the wounds should treatments to prevent/heal have been cleansed with normal saline and pressure ulcers 3 times weekly for

L0GD11

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W			04/28/	
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	Medihoney should	have been applied as ordered.			2 months, then 2 times weekly	y for	
					2 months, then weekly for 2 2	2.	
	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				The results of these reviews v	vill be	
					discussed at the monthly facil	ity	
	was wearing non-sk	kid socks and slippers. She did			Quality Assurance Committee	;	
	not have a heel boot in use.				meeting monthly for a total of	3	
					months and then quarterly		
	On 4/26/23 at 9:30 a.m., the resident was again in				thereafter once compliance is	at	
	_	television. She was wearing			100%. Frequency and duration	on of	
		slippers. She did not have a			reviews will be increased as		
	heel boot in use. At 11:30 a.m., she was seated in				needed, if compliance is below	N	
	her wheelchair in the hall. She was propelling her				100%. Compliance date: 5/19	/23.	
	wheelchair with her feet. She was wearing				The Administrator at Life Care)	
		id socks. At 1:39 p.m., the			Center of Michigan City is		
		to wear her slippers and			responsible in ensuring		
	non-skid socks with	n no heel boot in use.			compliance this Plan of		
					Correction.		
		a.m., the resident was seated in					
		er room. She was wearing her					
		id socks. Interview with the					
		e, indicated she did not like					
		nd at night she elevated her					
	foot on a pillow.						
		dent 50 was reviewed on					
		m. Diagnoses included, but					
		atherosclerotic heart disease,					
	hypertension, and e	dema.					
	TEL O . 1 M.	D + G + (14DG)					
		imum Data Set (MDS)					
		3/30/23, indicated the resident					
	1 - 1	act and she had a Stage 2					
	pressure ulcer.						
	A Care Plan dated	3/2/23, indicated the resident					
		vities of daily living) assistance					
		s needed to maintain or attain					
		ction. The resident required					
	~	vith toileting, transfers, bed					
		assistance for meals.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 24 of 49

STATEMEN		X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155344	B. W	ING		04/28/	2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID			(X5)	
PREFIX	(EACH DEFICIEN	EFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY) D.		
		led, but were not limited to, oot to the right lower ove for care.						
	A Physician's Order, dated 3/15/23, indicated the							
		r a pressure reducing boot to						
	_	emity. 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.							
	on 4/27/23 at 1:30 p preferred to wear th and care plan should Director of Nursing	Assistant Director of Nursing o.m., indicated the resident e boot at night and her orders d have been updated. The also indicated at that time, the been signed out as being worn.						
	3.1-40(a)(2)							
F 0689 SS=D Bldg. 00	remains as free of possible; and	ents.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 25 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155344	B. W	ING		04/28	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		sion and assistance devices					
	to prevent accider						
		on, record review, and	F 0	689	This plan of correction is prepared	ared	05/19/2023
		ty failed to ensure a resident			and executed because the		05,15,2025
	was free from accidents and received supervision				provisions of state and federal	law	
		elated to proper interventions			require it and not because Life		
		ent the resident from falling			Care Center of Michigan City		
		n the resident until all of her			agrees with the allegations an	d	
		onsumed for 1 of 3 residents			citations listed. Life Care Cent		
	reviewed for accide				Michigan City maintains that the		
					alleged deficiencies do not		
	Finding includes:				jeopardize the health and safe	ty of	
					the residents nor is it of such	-	
	On 4/25/23 at 9:00 a.m., Resident 27 was observed				character to limit our capabiliti	es	
	lying sideways in b	ed. At that time, she had on a			to render adequate care. Plea		
	pair of fuzzy socks,	there was nothing on the			accept this plan of correction a		
	bottom of them to p	revent the resident from			our credible allegation of		
	falling. Her wheelcl	hair was parked by the bed and			compliance that the alleged		
	I	on top of the cushion to			deficiencies have or will be co	rrect	
	1 ~	from sliding out of the			by the date indicated to remain	n in	
		vas no floor mat beside her			compliance with state and fed		
	bed.				regulations, the facility has tak		
					or will take the actions set fort	h in	
		a.m., the resident was			this plan of correction. We		
		in her wheelchair, wearing the			respectfully request a desk		
	1	nd self-propelling her			review.		
	wheelchair				F 689 – Free of Accident Wh	at	
	0 4/05/00 0000				Corrective Action will be		
		p.m., the resident was observed			accomplished for those reside		
	1	ed, wearing the same pair of			found to have been affected b	-	
	1 -	was no floor mat on the			deficient practice: 1. Resident		
		ed, nor was there a dycem in			#27: On 4/25/23 slip resistant		
	ine wheelchair on to	op or under the cushion.			socks, , and a floor mat were	_	
	On 4/26/22 0:20	the mediant was showed			placed in the appropriate area		
		n., the resident was observed			No negative outcomes were n		
	lying on her side in bed with her head slightly elevated. At that time, she was holding a				related to safety interventions	or	
					self-administering of	onto	
	_	of pills in her right hand. There			medications. How other resid		
		room at that time. She was			having the potential to be affect		
	wearing a pair of fu	zzy socks with no skids on the	1		by the same deficient practice	WIII	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 26 of 49

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155344	B. W	NG		04/28/	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	bottom of them. Th	ere was no floor mat beside the			be identified and what correcti	ve	
	bed, nor was there a	a dycem on top of or under the			action will be taken: 1. The DC	N	
	cushion in the whee	elchair. Shortly, thereafter, LPN			completed a full house audit o	n	
	1 entered the room and asked if the resident had				5/12/23 to verify all safety		
	taken her medication	ons.			interventions were in place. No)	
					additional concerns were		
	Interview with LPN	I 1 at that time, indicated the			identified. 2. Audit completed	on	
		time to take her medications.			5/10 by DON to ensure all		
	She was asked if this was the facility's policy to				residents that administer their	own	
	leave the medications with the resident and not				medications have an assessm	ent	
	observe them being swallowed. The LPN				completed that reflects ability	to	
	indicated she was just outside the door in the				self-administer medications. W		
	hallway, but was not in full view of the resident.				measures and what systemic		
	The LPN took the medication cup from the				changes will be made to ensu	re	
	resident's hand and	assisted her to a sitting			that the deficient practice does		
	position so the pills	could be administered. The			recur: 1. All nursing staff were		
	nurse indicated she	was aware she was supposed			educated by the SDC on 5/11/	23	
	to stay with each re	sident until the medications			on residents having the		
	were swallowed.				appropriate safety devices in p	olace	
					and not leaving medications w	rith a	
	On 4/26/23 at 10:40	a.m., and 1:35 p.m., the resident			resident or at bedside. On 5/1	2/23	
	was observed self-p	propelling her wheelchair,			LPN 1 was educated by the D	ON	
	wearing the same p	air of fuzzy socks with no skids			on not leaving meds at bedsid	e or	
	on the bottom of the	em.			with resident. 2. New licensed		
					nursing employees will receive	this	
	The record for Resi	dent 27 was reviewed on			education prior to working. Ho	DW .	
	_	. Diagnoses included, but were			the corrective action will be		
	not limited to, strok	te, hemiplegia, edema, major			monitored to ensure the defici-	ent	
	depressive disorder	, osteoporosis, and dementia.			practice will not recur, i.e., wha	at	
					quality assurance program wil	l be	
	The Quarterly Mini	mum Data Set (MDS)			put in place: 1. The DON/desi	gnee	
	assessment, dated 3	3/21/23, indicated the resident			will audit safety devices and		
		intact. The resident needed			supervision during medication		
		h a 1 person physical assist			administration 3X weekly for 2		
		nd transfers and has had no			months, then 2x weekly for 2		
	falls since the last a	ssessment.			months, then weekly for 2 mor	nths	
					2. The results of these review	s	
	_	ed 3/14/23, indicated the			will be discussed at the month	ly	
	resident was at risk	for falls. The approaches were			facility Quality Assurance		
	to provide a dycem	to the wheelchair, a floor mat			Committee meeting monthly for	or a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 27 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155344 B. WING 04/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE bedside the bed, and appropriate footwear. total of 3 months and then quarterly thereafter once The Quarterly Fall Risk Evaluation, dated 3/7/23, compliance is at 100%. indicated the resident has had no falls in the last Frequency and duration of reviews 90 days. will be increased as needed, if compliance is below Interview with the Director of Nursing on 4/27/23 100%. Compliance date: 5/19/23. at 10:45 a.m., indicated the resident would put The Administrator at Life Care herself to bed and get out of bed without Center of Michigan City is assistance. She was able to self-propel her responsible in ensuring wheelchair with her feet. She should have been compliance this Plan of wearing non-skid socks and the dycem should be Correction.¿¿ 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) F 0692 483.25(g)(1)-(3) SS=D Nutrition/Hydration Status Maintenance Bldg. 00 §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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 28 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155344	B. Wl	NG		04/28	/2023
	PROVIDER OR SUPPLIEF			802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that this is not pos preferences indica						
	§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 rev failed to ensure resi parameters of nutrit consumption record with a history of we reviewed for nutriti Finding includes:	view and interview, the facility dents maintained acceptable tional status related to meal dis not completed for a resident eight loss for 1 of 1 residents on. (Resident 74)	F 06	592	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Life Care Center of Michigan City agrees with the allegations an citations listed. Life Care Cent Michigan City maintains that the alleged deficiencies do not incorrection to the provision of the correction of the co	l law e d er of ne	05/19/2023
	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.				jeopardize the health and safe the residents nor is it of such character to limit our capabiliti to render adequate care. Plea accept this plan of correction a our credible allegation of	es se	
	assessment, dated 3 was moderately imp	nimum Data Set (MDS) /27/23, indicated the resident paired for daily decision ed supervision with eating and tic diet.			compliance that the alleged deficiencies have or will be co by the date indicated to remain compliance with state and fed regulations, the facility has tak or will take the actions set fort	n in eral en	
	was at risk for weig current health status cancer and his body Interventions include assistance with mea- order.	3/29/23, indicated the resident that fluctuations related to his s. He had the diagnosis of mass index (BMI) was 22. ded, but were not limited to, als as needed and diet per r, dated 3/23/23, indicated the			this plan of correction. We respectfully request a desk review. F 692 – Nutrition/Hydration Status Maintenance What Corrective Action will be accomplished for those reside found to have been affected b deficient practice: 1. Resident	nts y this	
		rive a regular diet with diet			#74. No negative outcomes w		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236 If continuation sheet Page 29 of 49

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED		
		155344	B. W	ING		04/28/	2023		
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIEF	R			HIGHWAY 20 EAST				
LIFF CA	LIFE CARE CENTER OF MICHIGAN CITY			MICHIGAN CITY, IN 46360					
	ı		1						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE		
	condiments.				noted How other residents ha	•			
	, pi	1 . 12/20/22 . 1 1.1			the potential to be affected by				
		r, dated 3/29/23, indicated the			same deficient practice will be	!			
		eive Ensure (a nutritional			identified and what corrective				
	supplement) three t	ames a day.			action will be taken: 1. The MI				
	T 1 4 1 1				coordinator did a full house au	Idit			
		ission weight on 3/23/23 was			on 5/12/23 and additional				
	-	13/23, the resident weighed 115			documentation errors were				
	pounds.				identified. All errors identified				
	A Distant Note : 1-4	4-14/12/22 -42.41			immediately addressed. What	ι			
	-	ted 4/12/23 at 3:41 p.m., ent tolerated his diet and			measures and what systemic				
					changes will be made to ensu				
		fed himself with some set up in intake was 76-100% and he			that the deficient practice does				
		ree times a day for extra		recur: 1. All nursing staff were					
		His current weight was 153			educated by the SDC on 5-11-23				
		to monitor weights and			on documenting daily food intake after meals. How the corrective				
	intakes.	to monitor weights and		action will be monitored to ensure					
	ilitakes.					sure			
	A Pagistared Dietit	tian (RD) Progress Note, dated			the deficient practice will not recur, i.e., what quality assura	noo			
	_	m., indicated the resident			program will be put in place: 1				
		ds on 3/23/23, 115 pounds on			The DON/designee will review				
		ounds per staff verbalization.			meal consumption logs 3 time				
	_	23.5% weight loss since			weekly for 2 months, then 2X	3			
	admission.	23.370 weight loss since			weekly for 2 months, then wee	akly			
	administrati.				for 2 months, 2. The results of	-			
	The Food Consumr	otion sheets for March and			these reviews will be discusse				
	April 2023 indicate				the monthly facility Quality				
	_	as documented on 4/11, 4/16,			Assurance Committee meeting	a			
	4/18, 4/19, 4/21, 4/2				monthly for a total of 3 months	-			
	- No breakfast or lunch intake was documented on			and then quarterly thereafter once					
	3/29 and 4/24/23.				compliance is at 100%.				
	- No dinner intake was documented on 3/31, 4/1,				Frequency and duration of rev	riews			
	4/5, 4/6, 4/7, 4/10, 4/12, and 4/20/23.				will be increased as needed, it				
	,,,,,				compliance is below				
	Interview with the	Assistant Director of Nursing			100%. Compliance date: 5/19/	/23.			
		p.m., indicated that she			The Administrator at Life Care				
		iracy of the resident's			Center of Michigan City is				
	_	She also indicated the food			responsible in ensuring				
	consumption logs should have been completed.				compliance this Plan of				

PRINTED: 06/22/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		155344	B. WING 04/28/2023					
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF	PROVIDER OR SUPPLIE	R		l	S HIGHWAY 20 EAST			
LIFE CA	RE CENTER OF M	ICHIGAN CITY		l	GAN CITY, IN 46360			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΔTF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	3.1-46(a)(1)				Correction.			
F 0695	483.25(i)							
SS=E	Respiratory/Trach	neostomy Care and						
Bldg. 00	Suctioning							
	§ 483.25(i) Respir	§ 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							
				50.5	This plan of correction is propored		05/10/2022	
		ity failed to ensure oxygen was	F 06	193	This plan of correction is prepared		05/19/2023	
		ow rate and positioned			and executed because the provisions of state and federa			
		-			require it and not because Life			
	correctly for 5 of 5 residents reviewed for oxygen. (Residents 1, 132, 59, 69, and 37) Findings include:				Care Center of Michigan City	7		
					agrees with the allegations an	ıd		
					citations listed. Life Care Cent			
					Michigan City maintains that the			
	1. On 4/24/23 at 1	1:36 a.m. and 1:46 p.m., Resident			alleged deficiencies do not			
		ner room in bed. Her nasal			jeopardize the health and safety of the residents nor is it of such			
	cannula was not in	her nares and her oxygen						
	concentrator was se	et at 2 liters.			character to limit our capabiliti	ies		
					to render adequate care. Plea	ıse		
	On 4/25/23 at 2:09	p.m., the resident's oxygen			accept this plan of correction			
		et at below 2 liters. At 3:13			our credible allegation of			
	_	oxygen prongs were not in			compliance that the alleged			
		ygen concentrator remained			deficiencies have or will be co			
	below 2 liters.				by the date indicated to remai			
					compliance with state and fed			
	The record for Resident 1 was reviewed on 4/26/23				regulations, the facility has tak			
		oses included, but were not			or will take the actions set fort	.h in		
	limited to, cerebral palsy, profound intellectual				this plan of correction. We			

FORM CMS-2567(02-99) Previous Versions Obsolete

sinuses.

disabilities, and disorder of the nose and nasal

Event ID:

L0GD11

Facility ID: 000236

review.

respectfully request a desk

If continuation sheet

Page 31 of 49

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED			
		155344	B. W	B. WING 04/28/2			2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF F	PROVIDER OR SUPPLIEF				HIGHWAY 20 EAST				
LIFE CARE CENTER OF MICHICAN CITY									
LIFE CARE CENTER OF MICHIGAN CITY				MICHIGAN CITY, IN 46360					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
					F 695 – Respiratory/Tracheos	tomy			
	The 3/27/23 Signifi	cant Change Minimum Data Set			Care and Suctioning What				
	(MDS) assessment	indicated the resident was			Corrective Action will be				
	severely impaired for	or daily decision making and			accomplished for those reside	nts			
	she was receiving o	xygen while a resident of the			found to have been affected b	y this			
	facility.				deficient practice: 1. Resident	#1:			
					Nasal cannula immediately pla				
	A Care Plan, dated	3/28/23, indicated the resident			on resident correctly and set to				
	had oxygen therapy	related to respiratory illness.			correct oxygen setting per ord				
	1	led, but were not limited to,			No negative outcomes were				
	oxygen per Physicia				noted. 2. Resident #132: Oxyg	gen			
					immediately set to correct sett	-			
	A Physician's Order	r, dated 3/27/23, indicated the			per order. No negative outcom	•			
	1	vive oxygen at 2 liters per		were noted. 3. Resident #59:					
	minute continuously			Oxygen immediately set to correct					
					setting per order. No negative				
	Interview with the I	Director of Nursing on 4/27/23		outcomes were noted. 4. Resident					
		ted the resident's oxygen		#69: Oxygen immediately set to					
	should have been in				correct setting per order. No				
		have been set at 2 liters.			negative outcomes were noted	d. 5.			
					Resident #37: Nasal cannula				
	2. On 4/25/23 at 9:	08 a.m., Resident 132 was			immediately placed on resider	nt			
		m in bed. He was wearing			correctly, tubing was connected				
		nnula and his oxygen			concentrator, concentrator tur				
		et at 3 liters. At 1:59 p.m., the			on and set to correct oxygen				
		in his wheelchair and oxygen			setting per order. No negative				
		ras in use. His portable oxygen			outcomes were noted. How of				
		ers. At 3:10 p.m., the resident			residents having the potential				
		eping. Oxygen per nasal			be affected by the same defici				
					practice will be identified and				
	cannula was in use and his oxygen concentrator was set at 3 liters.				corrective action will be taken:				
					The DON completed a full ho				
	The record for Resi	dent 132 was reviewed on			audit on 5/11/23 to verify that				
		. Diagnoses included, but were			resident with oxygen had their	-			
	_	estive heart failure, atrial			tanks the correct setting and				
		rular heart beat), pulmonary			appropriately placed. No addit	ional			
	, ,	a (difficulty breathing). The			concerns were identified. What				
		ed to the facility on 4/17/23.				ıı			
	resident was admitte	ed to the facility off 4/1//23.			measures and what systemic	ro			
	The Admission Mi	nimum Data Sat (MDS)			changes will be made to ensu				
	i ne Admission Mir	nimum Data Set (MDS)	1		that the deficient practice does	SnT			

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	a. Building <u>00</u>		COMPLETED	
		155344	B. WING 04/28/2023				2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	t			HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY					GAN CITY, IN 46360		
					T	Т	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		+	DATE
	assessment, dated 4	/21/23, was in progress.			recur: 1. All nursing staff were	I .	
	A Dhygiaian's Orda	r, dated 4/17/23, indicated the			educated by the DON on 5/11	I .	
	•	eive oxygen at 2 liters			on oxygen being administered	ias	
	continuously per na				ordered and appropriately placed. 2. On 5/12/23 placed		
	continuously per na	sai camura.			setting tags on all oxygen		
	Interview with the I	Director of Nursing on 4/27/23			concentrators for those reside	nte	
		ted the oxygen flow rate should			that receive oxygen therapy. F		
	-	iters. 3. On 4/24/23 at 10:30			the corrective action will be	1044	
		on 4/25/23 at 9:00 a.m., 2:00			monitored to ensure the defici	_{ent}	
	_	, and on 4/26/23 at 9:10 a.m.,			practice will not recur, i.e., who		
		served in bed. At those times,			quality assurance program wil	I .	
		ygen at 4 liters per minute.			put in place: 1. The DON/desi		
		1			will observe 5 residents daily	·	
	The record for Resi	dent 59 was reviewed on			Monday through Friday for 2		
	4/26/23 at 9:55 a.m	. The resident was admitted to			months, then 3 residents daily	for	
	the facility on 3/22/	23. Diagnoses included, but			2 months, then 2 residents da		
	were not limited to,	atrial fibrillation, heart failure,			for 2 months for correct flow a	nd	
	chronic kidney dise	ase, dementia, COPD, sleep			placement. 2. The results of the	nese	
	apnea, and anemia.				reviews will be discussed at th	ne	
					monthly facility Quality Assura	ince	
		nimum Data Set (MDS)			Committee meeting monthly for	or a	
		/28/23, indicated the resident			total of 3 months and then		
		intact. She was an extensive			quarterly thereafter once		
	_	on physical assist for bed			compliance is at 100%.		
	-	ers. She used oxygen while a			Frequency and duration of rev		
	resident and in the l	ast / days.			will be increased as needed, i	†	
	A Claus D1 1 1 1	2/20/22 :1:4-1.1			compliance is below	, ₍₀₀	
		3/29/23, indicated the resident			100%. Compliance date: 5/19	I .	
		related to COPD. The administer oxygen as ordered.			The Administrator at Life Care	•	
	approaches were to	aummister oxygen as ordered.			Center of Michigan City is		
	Physician's Orders	dated 3/27/23 indicated			responsible in ensuring compliance in this plan.		
	Physician's Orders, dated 3/27/23, indicated oxygen at 3 liters per minute continuously per				Compliance in this plan.		
	nasal cannula.						
	manus caminana.						
	Interview with the A	Assistant Director of Nursing					
		a.m., indicated the resident's					
		et at 3 liters per minute.4. On					
		n., Resident 69's oxygen					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/G		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPLETED	
		155344	B. WING	G		04/28/	/2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LIEE CAI	DE CENTER OF MI	CHICAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360				
LIFE CARE CENTER OF MICHIGAN CITY				MICITIG	JAN CITT, IN 40300		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	concentrator was set to 3 liters per minute and the						
	tubing was dated 4/	24/23.					
		a.m., Resident 69's oxygen					
		et to 3 liters per minute and the					
	tubing was dated 4/	24/23.					
		d was reviewed on 4/26/23 at					
		es included, but were not limited					
		ronic obstructive pulmonary					
		enal disease, and type 2					
	diabetes mellitus.						
	A C:::::	in Chatan Minimum Data Cat					
	_	ge in Status Minimum Data Set					
		dated 3/28/23, indicated the					
	making. She used o	ively intact for daily decision					
	making. She used o	xygen merapy.					
	A Physician's Order	r, dated 4/11/23, indicated					
	-	er minute continuously via					
		uld be off for up to 10 minutes					
	for up to 6 times da	-					
	lor up to o times du	ing for fermion					
	A Care Plan, dated	3/1/23, indicated the resident					
		related to a respiratory					
		ns included, but were not					
		per Physician's Orders.					
		•					
	Interview with the l	Director of Nursing on 4/27/23					
		ted the resident's oxygen					
	concentrator should	have been set to 2 liters per					
	minute as per the P	hysician'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 re	sident's nasal cannula was					
	sitting on the outsid	le of the resident's nose. The					
		he cannula would often come					
	off. The oxygen tu	bing was not connected to the					
	oxygen concentrato	or and the oxygen concentrator					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 34 of 49

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00		COMPLETED	
		155344	B. WING 04/28/2023					
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	No. of the control of	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE	
	was not turned on.							
	On 4/25/23 at 09:2 observed sitting in I cannula in his nose. oxygen from his po connected to the bar oxygen dial was observed sitting in I cannula in his nose. oxygen from his po connected to the bar oxygen dial was observed in the record review of on 4/25/23 at 1:42 properties were not limited to hypertension and hypertension and hypertension and hypertension and hypertension and hypertension making. A Physician's Order supplemental oxygen (liters/minute) control in the diagram of the respiratory distress. Intervention limited to, observed respiratory distress. Nurses' Notes, dated indicated the reside LPM. During an interview Agency LPN 1 indicated to oxygen flow rate to During an interview oxygen flow rate to D	For Resident 37 was completed o.m. Diagnoses included, but COPD, respiratory failure, sperlipidemia. Inimum Data Set (MDS) 1/5/23, indicated the resident gnitively impaired for daily 1/23, indicated the resident gnitively impaired for daily 1/24, dated 3/2/23, indicated the resident en via nasal cannula at 5 LPM inuously per nasal cannula. 1/28/23, indicated the resident en therapy due to respiratory as included, but were not for signs and symptoms of and report to MD as needed. 1/25/23 at 9:17 a.m., cated she had corrected the 5 LPM. 1/26/23 at 2:37 p.m., the						
	incorrect flow rate.	ne was not aware of the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 35 of 49

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

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344			JILDING	00	COMPL 04/28/	ETED			
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	3. 1-47(a)(6)								
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychomics §483.45(c)(3) A periodic street by the street by with mental process.	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any orain activities associated sses and behavior. These are not limited to, drugs in gories:							
	· ·	rehensive assessment of a ty must ensure that							
	psychotropic drug	_							
	reductions, and be	s receive gradual dose ehavioral interventions, ontraindicated, in an effort							
	psychotropic drug unless that medica a diagnosed speci	sidents do not receive s pursuant to a PRN order ation is necessary to treat ific condition that is e clinical record; and							
	- , , , ,	N orders for psychotropic to 14 days. Except as							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet

Page 36 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155344 B. WING 04/28/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. F 0758 05/19/2023 Based on record review and interview, the facility This plan of correction is prepared failed to ensure psychotropic medications were and executed because the monitored for side effects and effectiveness as provisions of state and federal law well as ensuring Abnormal Involuntary require it and not because Life Movement Scale (AIMS) assessments were Care Center of Michigan City completed for 1 of 5 residents reviewed for agrees with the allegations and unnecessary medications. (Resident 47) citations listed. Life Care Center of Michigan City maintains that the Finding includes: alleged deficiencies do not jeopardize the health and safety of Resident 47's record was reviewed on 4/25/23 at the residents nor is it of such 1:31 p.m. Diagnoses included, but were not limited character to limit our capabilities to, hemiplegia and hemiparesis following cerebral to render adequate care. Please infarction affecting right dominant side, anxiety, accept this plan of correction as and depression. our credible allegation of compliance that the alleged The Quarterly Minimum Data Set (MDS) deficiencies have or will be correct assessment, dated 3/24/23, indicated the resident by the date indicated to remain in was cognitively intact for daily decision making. compliance with state and federal She received antidepressant, anti-anxiety, and regulations, the facility has taken antipsychotic medications. or will take the actions set forth in this plan of correction. We A Physician's Order, dated 2/17/22, indicated the respectfully request a desk resident was to receive brexpiprazole (an review. antipsychotic medication) 0.5 milligrams (mg) one F 758 – Free from Unnecessary time a day. The order was discontinued on Psychotropic Meds/PRN 6/12/22. Use What Corrective Action will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 37 of 49

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
11112 12111	or conditions	155344	B. WING	<u> </u>	04/28/2023	
				_	0 1/20/2020	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
		IOLUGANI OLTV		S HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	ICHIGAN CITY	MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				accomplished for those resider	nts	
	A Physician's Orde	r, dated 6/15/22, indicated the		found to have been affected by	y this	
	resident was to rece	eive brexpiprazole 0.5 mg one		deficient practice: 1. Resident		
	time a day. The ord	ler was discontinued on		#47: AIMS assessment comple	eted	
	8/15/22.			on 4/27/23. No negative outco	mes	
				were noted. How other resider	nts	
	A Physician's Orde	r, dated 8/16/22, indicated the		having the potential to be affect	oted	
	resident was to rece	eive brexpiprazole 0.25 mg one		by the same deficient practice	will	
	time a day. The ord	ler was discontinued on		be identified and what corrective	ve	
	2/21/23.			action will be taken: 1 The DO	N.	
				completed a full house AIMS a	audit	
	A Physician's Orde	r, dated 3/19/22, indicated the		on 5/10/23 to verify completion	ı on	
resident was to receive brexpiprazole 1 mg one			all residents receiving			
time a day. The order was discontinued on			antipsychotic medications. No			
4/10/23.			additional concerns were			
				identified. What measures and	I	
	A Physician's Orde	r, dated 4/11/23, indicated the		what systemic changes will be		
	resident was to rece	eive brexpiprazole 0.5 mg one		made to ensure that the deficie	ent	
	time a day. The ord	ler was discontinued on		practice doesn't recur: 1. All		
	4/24/23.			licensed nursing staff were		
				educated by the DON on 5/11/	/23	
	A Physician's Orde	r, dated 4/25/23, indicated the		regarding completing an AIMS	i	
	resident was to rece	eive brexpiprazole 0.25 mg one		assessment on all residents		
	time a day.			receiving a new order for an		
				antipsychotic medication. 2. N	lew	
	A Care Plan, dated	4/8/23, indicated the resident		licensed nursing employees w	ill	
		e medication related to		receive this education prior to		
	_	ent. Interventions, included but		working. How the correctiv	е	
		, observe and report any		action will be monitored to ens	ure	
		f psychotropic medications		the deficient practice will not		
		nit, tardive dyskinesia,		recur, i.e., what quality assura		
	shuffling gait, rigid	muscles, or shaking.		program will be put in place: 1.		
				The DON/designee will audit U		
		luntary Movement Scale		schedule for completion of AIM	1S	
		ssment was completed on		assessments daily Monday		
	3/17/22.			through Friday for 2 months, th		
				3x weekly for 2 months, then 2	2X	
		assessment was completed on		weekly for 2 months. 2. The		
	2/13/23.			results of these reviews will be		
				discussed at the monthly facilit	ty	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING <u>00</u> COMPLETED		(X3) DATE SURVEY COMPLETED 04/28/2023	
NAME OF F	PROVIDER OR SUPPLIER			FADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST	
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		IGAN CITY, IN 46360	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE COMPLETION DATE
F 0760 SS=D	Interview with the A on 4/28/23 at 9:58 a have been complete A Policy titled, "Are Medication Manage Evaluation of a re mental, and psychos order to identify the including adverse of (Abnormal Involunt Assessment tool she antipsychotic medical 3.1-48(a)(3) 483.45(f)(2)	Assistant Director of Nursing a.m., indicated the AIMS should d quarterly. ea of Focus: Psychotropic ament," indicated "How sident's physical, behavioral, social signs and symptoms, in a underlying cause(s), consequences of medications; tary Movement Scale, AIMS) build be used for all cations"		Quality Assurance Committee meeting monthly for a total of months and then quarterly thereafter once compliance is 100%. Frequency and duratireviews will be increased as needed, if compliance is belo 100%. Compliance date: 5/19. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	e 3 3 s at on of w 0/23
Bldg. 00	The facility must e §483.45(f)(2) Resi significant medica Based on observation review, the facility	dents are free of any	F 0760	This plan of correction is prepand executed because the provisions of state and federa require it and not because Life	al law
	the incorrect administration of insulin for 1 of 5 residents observed during medication pass. (Resident 331) Finding includes:			Care Center of Michigan City agrees with the allegations ar citations listed. Life Care Cen Michigan City maintains that alleged deficiencies do not jeopardize the health and safe	nd ter of the
	on 4/28/23 at 10:50 331's insulin and ch She dialed the resid units. She washed h gloves. She cleaned injected the insulin She had not primed	a administration observation a.m., RN 1 prepared Resident ecked the resident's orders. ent's Lispro insulin pen to 2 er hands and applied her the resident's right arm and pen into the resident's arm. the insulin pen or performed		the residents nor is it of such character to limit our capabilit to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be compliance with state and feed	cies ase as orrect in in

EPARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED			
	455044	D WING	04/00/0000			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING B. WING	00	COMPLETED 04/28/2023	
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
IAU	Interview with RN indicated she did no prime the insulin pe to the resident. Interview with the I indicated RN 1 show prior to injecting the inservice RN 1. A facility policy titl Administration Quivers and Pens" and current, indicated, "pens prior to each a manufacturer's reco	1 on 4/28/23 at 11:04 a.m., at know she was supposed to a prior to administering insulin DON on 4/28/23 at 11:12 a.m. ald have primed the insulin pense resident and she would ed, "Medication Storage and ack Reference Guide, Insulin a provided by the DON as Prime ["Air Shot"] insulin dministration with 2 units or mmendations. Hold the pense tap to move any air bubbles to	IAU	regulations, the facility has tak or will take the actions set forth this plan of correction. We respectfully request a desk review. F 760 – Free of Significant Me Errors What Corrective Action 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 outcome were noted. How other resider having the potential to be affect by the same deficient practice be identified and what corrective action will be taken: 1. complete a full house audit on 5/10/23 to verify there were no medication errors. No areas of concern we found. What measures an what systemic changes will be made to ensure that the deficite practice doesn't recur: 1. On 5/12/23 RN1 was educated by DON on the proper procedure administering insulin with an insulin pen. Education included administering insulin correctly "priming" the pen prior to administering insulin correctly "priming" the pen prior to administration. 2. All licensed nursing staff were educated by DON on 5/11/23 regarding proprocedure for insulin administration with insulin pen New licensed nursing employed will receive this education prior working. How the corrective action will be monitored to ensure	en in in ed will es ats eted will eve ted on neere d ent ent of d by of the per es ats

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 40 of 49

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/28/2023
	ROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD B HIGHWAY 20 EAST GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs			the deficient practice will r recur, i.e., what quality as program will be put in place. The DON/designee will obtuine weekly who receive via insulin pen 3x weekly months, then two resident weekly for 3 months. 2. The results of these reviews weekly for 3 months. 2. The results of these reviews we discussed at the monthly for Quality Assurance Commeeting monthly for a total months and then quarterly thereafter once compliance 100%. Frequency and dureviews will be increased needed, if compliance is be 100%. Compliance date: The Administrator at Life Center of Michigan City is responsible in ensuring compliance this Plan of Correction.	surance se: 1. serve insulin for 3 s ne ill be facility ittee il of 3 e is at ration of as selow 5/19/23. Care
85=D Bldg. 00	§483.45(g) Labelii Drugs and biologic must be labeled in accepted professi the appropriate ac- instructions, and tapplicable.	ng of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary the expiration date when			
	§483.45(h)(1) In a Federal laws, the and biologicals in	ccordance with State and facility must store all drugs locked compartments perature controls, and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 41 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (f '		DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
155344		B. WING 04/28/2023			/2023			
	PROVIDER OR SUPPLIER		•	802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST GAN CITY, IN 46360	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE	
	permit only author access to the keys	rized personnel to have s.						
	separately locked compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the f package drug dist the quantity stored dose can be readile. Based on observation	on and interview, the facility	F 0°	761	This plan of correction is prep and executed because the		05/19/2023	
	for safety, labeled, storage rooms obse Storage Room). Finding includes: During a medication	dications were properly stored and dated for 1 of 1 medication rved. (West Wing Medication n storage observation on			provisions of state and federa require it and not because Life Care Center of Michigan City agrees with the allegations an citations listed. Life Care Cent Michigan City maintains that the alleged deficiencies do not jeopardize the health and safe	e d ter of he		
	Storage Room was (2 vials) were found plastic container. The have a lock on it. The locked, however the Interview Agency	n., the West Wing Medication observed with LPN 2. Ativan d in the refrigerator inside a he plastic container did not he Medication room was e refrigerator was not locked. LPN 2 and she indicated she			the residents nor is it of such character to limit our capabiliti to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be coby the date indicated to remai	ise as orrect n in		
	lock. 4/28/23 10:18 a.m., should have been ir refrigerator should	the DON indicated the Ativan a locked box, or the have a lock on it. The I her to put a lock on the e ago."			compliance with state and fed regulations, the facility has tak or will take the actions set fort this plan of correction. We respectfully request a desk review. F 761 – Label/Store Drugs ar Biologics What Corrective Act will be accomplished for those	ken h in nd ion		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet Page 42 of 49

	EMENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/28/2023
	COF PROVIDER OR SUPPLIE		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST GAN CITY, IN 46360	
(X4) I PREFI TAC	X (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAC	A facility policy ti Administration Qu Medication Cart So by the DON as cur storage keys are re	tled, "Medication Storage and ick Reference Guide, ecurity and HIPPA", provided rent, indicated, " Med tained by designated staff. tions must be stored separately,	TAG	residents found to have been affected by this deficient practice: 1. No residents were No negative outcomes were noted. How other residents he the potential to be affected by same deficient practice will be identified and what corrective action will be taken: 1. On 4/2 the DON audited the medicat rooms for narcotics that requirefrigeration being double lock No further concerns were identified. 2. On 4/28/23 the pharmacy removed the refrigentation action will be made ensure that the deficient practice doesn't recur: 1. On 5/11/23 alicensed nursing staff educated DON on any controlled refrigent medications must be placed and aduble lock. 2. New licensed nursing employees will receive education prior to working. How the correctinaction will be monitored to enthe deficient practice will not recur, i.e., what quality assumprogram will be put in place: The DON/designee will audit medication rooms daily to enany refrigerated narcotics are double locked 3x weekly for 3 the results of these reviews discussed at the monthly facion Quality Assurance Committee meeting monthly for a total of months and then quarterly and the guarterly and then quarterly and the guarterly and the guarterly and the guarterly and then quarterly and then quarter	e . aving y the e e e e e e e e e e e e e e e e e e

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED	
155344			B. WING		04/28/2023
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY		802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0812	483.60(i)(1)(2)			thereafter once compliance is 100%. Frequency and duration reviews will be increased as needed, if compliance is below 100%. Compliance date: 5/11. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	on of v /23
SS=E Bldg. 00	Food Procurement, Stor §483.60(i) Food some facility must an approved or considered from local applicable State are gulations. (ii) This provision facilities from using gardens, subject applicable safe gulations. (iii) This provision facilities from using gardens, subject applicable safe gulations. (iii) This provision facilities from using facilities from using gardens, subject applicable safe gulations. (iii) This provision from consuming facility. §483.60(i)(2) - St serve food in acc standards for food Based on observations.	ocure food from sources idered satisfactory by ocal authorities. de food items obtained producers, subject to and local laws or does not prohibit or preventing produce grown in facility to compliance with rowing and food-handling does not preclude residents foods not procured by the ore, prepare, distribute and ordance with professional deservice safety.	F 0812	This plan of correction is prep and executed because the	ared 05/19/2023
	failed to ensure a s dishes of food sitti	anitary kitchen related to two ng open and not covered on and an accumulation of	1 0012		l law

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11

Facility ID: 000236

If continuation sheet

Page 44 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED 04/28/2023		
NAME OF P	ROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP COD	•	
	RE CENTER OF MI			S HIGHWAY 20 EAST GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	od spillage in and around the		Care Center of Michigan City		
		nen observed. (Main Kitchen).		agrees with the allegations ar	l l	
	received food from	ial to affect 87 residents who		citations listed. Life Care Cen		
	received food from	the kitchen.		Michigan City maintains that	ine	
	Findings include:			alleged deficiencies do not	atu of	
	rindings include.			jeopardize the health and saf the residents nor is it of such	ety of	
	During the initial ki	itchen tour on 4/24/23 at 8:58		character to limit our capabilit	ios	
		Service Manager the following		to render adequate care. Plea		
	was observed:	Service Manager the following		accept this plan of correction	l l	
	was observed.			our credible allegation of	as	
	a Two dishes filled	with green beans, carrots and		compliance that the alleged		
	a. Two dishes filled with green beans, carrots and corn were opened and not covered on top of the			deficiencies have or will be co	orrect	
	stove.			by the date indicated to remain in		
		nulation of grease on the stove		compliance with state and fed		
	and on the back spl	_		regulations, the facility has taken		
	-	vas a large amount of burnt		or will take the actions set forth in		
		minum foil scattered on the		this plan of correction. We		
	bottom of the oven.			respectfully request a desk		
		e accumulation of grease and		review.		
		side the convection oven.		F 812 Food Procurement,		
		umulation of grease and dust		Store/Prepare/Serve-Sanitary Wha		
	in the slats of the ov			t Corrective Action will be		
	f. The pipes in the k	titchen had a buildup of grease		accomplished for those reside	ents	
	and dust next to the	stove right by the stove top.		found to have been affected I		
				deficient practice: 1. No nega	-	
	Interview with the I	Food Service Manager at that		outcomes were noted. How	other	
	time, indicated all ti	he above areas needed to be		residents having the potential	to	
	cleaned.			be affected by the same defic	eient	
				practice will be identified and	what	
	3.1-21(i)(3)			corrective action will be taker	: 1.	
				On 4/23/23 the dishes of corr		
				carrots, and green beans wer	e	
				covered. 2. On 4/24/23 the		
				accumulation of grease and b		
				substances was cleaned the		
				and back splash area, the gre		
				and dried food was cleaned of		
				convection oven, the oven ho		
				was cleaned, and the pipes in	the I	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344 NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION A. BUILDING DO ON A BUILDING DO ON A BUILDING DEFICIENCY MICHIGAN CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE 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
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (Each correction of Completion of Compl
LIFE CARE CENTER OF MICHIGAN CITY SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
LIFE CARE CENTER OF MICHIGAN CITY (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (AS) (COMPLETION DATE (EACH DEFICIENCY) (AS) (COMPLETION DATE
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION 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
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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
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
cleaned. 3. The food service director completed a full kitchen audit on 5/10/23 and did not identify any additional areas of
director completed a full kitchen audit on 5/10/23 and did not identify any additional areas of
audit on 5/10/23 and did not identify any additional areas of
identify any additional areas of
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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L0GD11 Facility ID: 000236

If continuation sheet

Page 46 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155344	B. WING 04/28/20				
100011							2020
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F 0921					compliance is at 100%. Frequency and duration of rev will be increased as needed, if compliance is below 100%. Compliance date: 5/19/ The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	f /23	
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.		F 09	921	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Life Care Center of Michigan City agrees with the allegations and citations listed. Life Care Center Michigan City maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capability to render adequate care. Pleat accept this plan of correction a cour credible allegation of compliance that the alleged deficiencies have or will be cour compliance with state and feder regulations, the facility has tak or will take the actions set fortithis plan of correction. We	d der of ne esse as rrect n in eral cen	05/19/2023
	the wall behind the	umulation of dirt and dust on stove.			respectfully request a desk		

	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155344	A. BUILDING B. WING	00	COMPLETED 04/28/2023		
	F PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		Food Service Manager at that the above areas needed to be		review. F 921 —Safe/Functional/Sanitary/Co able Environment What Corre Action will be accomplished for those residents found to have been affected by this deficient practice: 1. No negative outco noted. How other residents ha the potential to be affected by same deficient practice will be identified and what corrective action will be taken: 1. On 4/2 the kitchen had the following completed: the floor was clean the accumulation of grease at burnt substances were cleaned the stove and back splash are the pipes in the kitchen and u the dishwasher were cleaned under the cabinet in the dish in was cleaned, and the wall bel the stove was cleaned. What measures and what systemic changes will be made to ensu that the deficient practice doe recur: 1. The food service dire completed a full kitchen audit 5/10/23 and did not identify at additional areas of concern regarding a safe functional sanitary comfortable environment. 2. All kitchen sta were educated by the food se director and ED on providing a safe functional, sanitary environment on 5/12/23. How corrective action will be monit to ensure the deficient practic not recur, i.e., what quality	ective or		
	1		1	I HOLICOUL, I.C., WHAL QUAILLY	I		

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/28/2023	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PF	D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
					assurance program will be purplace: 1. The dietary director audit the kitchen to ensure the floor is free of build-up of dirt debris, pipes and under the dishwasher and cabinets free 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 faci Quality Assurance Committee meeting monthly for a total of months and then quarterly thereafter once compliance is 100%. Frequency and duratireviews will be increased as needed, if compliance is belo 100%. Compliance date: 5/19. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	will e and from e lity e 3 at on of	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LOGD11 Facility ID: 000236 If continuation sheet Page 49 of 49