	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344		JILDING	NSTRUCTION	(X3) DATE COMPL 05/22/	ETED
	ROVIDER OR SUPPLIER			802 US	NDDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST SAN 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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 05/22 Facility Number: 0 Provider Number: 1002 At this Emergency I Center of Michigan compliance with En Requirements for M Participating Provided 483.73	200236 155344 287700 Preparedness survey, Life Care City was found not in mergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR	E 0	000			
E 0004 SS=F Bldg	484.102(a), 485.6: 485.727(a), 485.9: 491.12(a), 494.62: Develop EP Plan, Annually §403.748(a), §416: §441.184(a), §460: §483.73(a), §485.9: §485.68(a), §485.9: §485.920(a), §486: §494.62(a).	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),					

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.

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	OF CORRECTION	IDENTIFICATION NUMBER 155344	A. BUILDING B. WING		COMPLETED 05/22/2023
	PROVIDER OR SUPPLIEF		802 U	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST IGAN 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)	(X5) COMPLETION DATE
	preparedness req must develop esta comprehensive er program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness platand updated at leamust do all of the * [For hospitals at §485.625(a):] Emergency Planust develop and main preparedness req CAH] must develop and main preparedness platand updated at leamust develop and main preparedne	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.			
		view and interview, the facility I update the Emergency	E 0004	E 004- Develop EP Plan What Corrective Action will	06/01/2023

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Event ID:

L0GD21 Facility ID: 000236

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) E		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155344	B. W	ING		05/22/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360		
(III) ID	CID O () DV	CTATE AT A PROPERTY OF DEPARTMENT	1		· T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	NCY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION (EPP) at least annually in	+	TAG			DATE
		•			accomplished for those residents found to have bee	n	
	accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.				affected by this deficient	11	
	practice could arrect	et an occupants.			practice:		
	Findings include:				1. The EMP had been reviewe	ed on	
	i mamga meraac.				5/25/22 but was not available		
	Based on records re	eview with the Maintenance			time of survey. See Attached	u.	
		23 between 09:02 a.m. and 12:03			How other residents having	the	
		a date of March 2022 on the			potential to be affected by the		
	_	er date could be found to show			same deficient practice will		
		ved and updated within the last			identified and what corrective		
	year. Based on an i	nterview during records			action will be taken:		
	review, the Mainter	nance Director stated that they			1. The management team		
	were in the process	of updating the EPP at the			reviewed the EMP on 05/25/2	3	
	time of survey.				during the QAPI meeting. The	plan	
					was approved. See		
	This finding was re	eviewed with the Administrator			attached		
		Director during the exit			What measures and what		
	conference.				systemic changes will be ma	ade	
					to ensure that the deficient		
					practice doesn't recur:		
					1. On 6/1/23 The ED inservice	ed .	
					the Maintenace Director on th	е	
					EMP must be reviewed and		
					updated at least		
					annually. See		
					attached	:	
					How the corrective action w	III	
					be monitored to ensure the	0115	
					deficient practice will not re i.e., what quality assurance	.ui,	
					program will be put in place		
					1. The Maintenace Director w		
					audit the EMP monthly for any		
					updates or changes. See atta		
					2. The results of these review		
					be discussed at the monthly	- *****	
					facility Quality Assurance		
					Committee meeting monthly for	or a	
			1		total of 3 months and then		

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	OF CORRECTION	IDENTIFICATION NUMBER 155344	A. BUILDING B. WING		COME	PLETED 2/2023
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP C S HIGHWAY 20 EAST GAN CITY, IN 46360	COD	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
				quarterly thereafter on compliance is at 100%. Frequency and duratio will be increased as no compliance is below 1. Compliance date: 6/1/2. Administrator at Life C of Michigan City is resensuring compliance in of Correction.	on of reviews eeded, if 00%. 23. The care Center ponsible in	
E 0013 SS=F Bldg	484.102(b), 485.62 485.727(b), 485.92 491.12(b), 494.62(Development of El §403.748(b), §416 §441.184(b), §460 §483.73(b), §483.4 §485.68(b), §485.6	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),				
	develop and imple preparedness policon the emergency (a) of this section, paragraph (a)(1) o communication plasection. The polici	ocedures. [Facilities] must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this ies and procedures must apdated at least every 2				
	and procedures. T develop and imple preparedness poli	at §483.73(b):] Policies The LTC facility must Thement emergency The cies and procedures, based The plan set forth in paragraph				

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Event ID:

L0GD21

Facility ID: 000236

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	UILDING	NSTRUCTION	(X3) DATE COMPL 05/22 /	ETED
	OF PROVIDER OR SUPPLIED		802 US	NDDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST SAN CITY, IN 46360		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	(a) of this section paragraph (a)(1) communication placetion. The policities: *[For PACE at §4 procedures. The develop and imples preparedness pole on the emergency (a) of this section paragraph (a)(1) communication placetion. The policities and procedures and reviewed and upon the emergency (a) of this section paragraph (a)(1) communication placetion. The policities and procedures and reviewed and upon the emergency (a) of this section paragraph (a)(1) communication placetion. The policities and procedures develop and implessed preparedness pole on the emergency (a) of this section paragraph (a)(1) communication placetion. The policities and procedures. These ements in the policities and procedures are developed and implessed and years. These ements in the policities are the policities and procedures. These ements in the policities are the policities and procedures are the policities are the	risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least annually. rements for PACE and 60.84(b):] Policies and PACE organization must ement emergency licies and procedures, based y plan set forth in paragraph, risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be dated at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must ement emergency licies and procedures, based y plan set forth in paragraph, risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are, equipment or power ted emergencies, water	TAG			DATE

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Event ID:

L0GD21 Facility ID: 000236

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPLETED	
		155344	B. W	ING	_	05/22	/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		PROVIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TT.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
PREFIX	supply interruptior likely to occur in the area. Based on record reversible failed to review and Preparedness Plan's at least annually in a 483.73(a). This definition occupants. Findings include: Based on records represent the EPP had a cover page, no other the EPP's Policies a and updated within interview during records represent the EPP's representation of the survey. This finding was reversible for the survey.	cy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION In, and natural disasters the facility's geographic View and interview, the facility I update the Emergency I (EPP) Policies and Procedures accordance with 42 CFR Icient practice could affect all Eview with the Maintenance I between 09:02 a.m. and 12:03 I date of March 2022 on the I date could be found to show Ind Procedures were reviewed I the last year. Based on an Bords review, the Maintenance I between 09:02 and Procedures I could be found to show I co	EO	PREFIX	E 013– Develop EP Policies a Procedures What Corrective Action will accomplished for those residents found to have been affected by this deficient practice: 1. The EMP had been reviewed 5/25/22 but was not available time of survey. See Attached How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken: 1. The management team reviewed the EMP on 05/25/2 during the QAPI meeting. The was approved. See attached What measures and what systemic changes will be matted to ensure that the deficient practice doesn't recur: 1. On 6/1/23 The ED inservice the Maintenace Director on the EMP policies and procedures must be reviewed and update least annually. See attached How the corrective action will be monitored to ensure the	and be n ed on at the he be /e 3 e plan ade	COMPLETION
					deficient practice will not re	cur,	
					i.e., what quality assurance		
					program will be put in place.		
					The Maintenace Director w audit the EMP monthly for any		

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	OF CORRECTION	IDENTIFICATION NUMBER 155344	A. BUILDING B. WING	JNSTRUCTION 	COMPLETED 05/22/2023
	ROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD 5 HIGHWAY 20 EAST GAN 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)	DATE
E 0018 SS=F Bldg	and (v), 441.184(b 483.475(b)(2), 483.475(b)(2), 483.485.920(b)(1), 486. Procedures for Tra §403.748(b)(2), §46 (ii) and (v), §441.1 §482.15(b)(2), §46 (1), §494.62(b)(1). [(b) Policies and proparedness policion the emergency (a) of this section, paragraph (a)(1) ocommunication pla section. The policion reviewed and updates.	3.73(b)(2), 485.625(b)(2), 5.360(b)(1), 494.62(b)(1) acking of Staff and Patients 16.54(b)(1), §418.113(b)(6) 84(b)(2), §460.84(b)(2), 33.73(b)(2), §483.475(b)(2), 85.920(b)(1), §486.360(b)		policies and procedures updator changes. See attached 2. The results of these review be discussed at the monthly facility Quality Assurance Committee meeting monthly fotal of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of revisible beincreased as needed, it compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Cer of Michigan City is responsible ensuring compliance in this Plof Correction.	s will or a views f

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 2/2023
	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	O BE	(X5) COMPLETION DATE
	the policies and p the following:]	rocedures must address				
	on-duty staff and a [facility's] care dur on-duty staff and a relocated during the must document the	em to track the location of sheltered patients in the ring an emergency. If sheltered patients are ne emergency, the [facility] e specific name and eiving facility or other				
	§483.73(b), ICF/II §460.84(b):] Polic system to track th and sheltered resi ICF/IID or PACE] emergency. If on- residents are relo- emergency, the [F PACE] must docu	Ds at §483.475(b), PACE at ies and procedures. (2) A e location of on-duty staff dents in the [PRTF's, LTC, care during and after an eduty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other				
	Policies and proce (ii) Safe evacuation includes consideranceds of evacueed transportation; ideal location(s) and proceed from the process of communication assistance. (v) A system to transported from the hospice's care the on-duty employer relocated duri	spice at §418.113(b)(6):] edures. on from the hospice, which ation of care and treatment s; staff responsibilities; entification of evacuation mary and alternate means with external sources of ack the location of hospice ty and sheltered patients in e during an emergency. If eyees or sheltered patients ing the emergency, the ument the specific name				

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Facility ID: 000236

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DEPARTMENT OF HEALTH AND HUMAN SER	RVICES
CENTERS FOR MEDICARE & MEDICAID SER	VICES

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGA (X4) ID SUMMARY STATEM PREFIX (EACH DEFICIENCY MUS TAG REGULATORY OR LSC ID: and location of the receive location. *[For CMHCs at §485.92 procedures. (2) Safe evan CMHC, which includes company and treatment needs of each content of the received location.	AN CITY MENT OF DEFICIENCIE IST BE PRECEDED BY FULL DENTIFYING INFORMATION iving facility or other 20(b):] Policies and	802	REET ADDRESS, CITY, STATE, ZIP COD 2 US HIGHWAY 20 EAST CHIGAN CITY, IN 46360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETED 05/22/2023 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGA (X4) ID SUMMARY STATEM PREFIX (EACH DEFICIENCY MUS TAG REGULATORY OR LSC ID) and location of the receive location. *[For CMHCs at §485.92 procedures. (2) Safe evan CMHC, which includes company and treatment needs of each content of the received supplies the content of the content of the received supplies th	AN CITY MENT OF DEFICIENCIE IST BE PRECEDED BY FULL DENTIFYING INFORMATION iving facility or other 20(b):] Policies and	STR 802 MIC ID PREFI	2 US HIGHWAY 20 EAST CHIGAN CITY, IN 46360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
LIFE CARE CENTER OF MICHIGA (X4) ID SUMMARY STATEM PREFIX (EACH DEFICIENCY MUS REGULATORY OR LSC ID and location of the receiv location. *[For CMHCs at §485.92 procedures. (2) Safe eva CMHC, which includes c and treatment needs of 6	MENT OF DEFICIENCIE IST BE PRECEDED BY FULL DENTIFYING INFORMATION iving facility or other 20(b):] Policies and	802 MIC ID PREFI	2 US HIGHWAY 20 EAST CHIGAN CITY, IN 46360 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
PREFIX TAG REGULATORY OR LSC ID: and location of the receive location. *[For CMHCs at §485.92 procedures. (2) Safe evan CMHC, which includes can and treatment needs of examples.	DENTIFYING INFORMATION iving facility or other 20(b):] Policies and	PREFI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
of evacuation location(s) alternate means of commexternal sources of assis *[For OPOs at § 486.360 procedures. (2) A system documentation that present actual donor information, confidentiality of potential information, and secures availability of records. *[For ESRD at § 494.62(procedures. (2) Safe evadialysis facility, which incresponsibilities, and need Based on record review and failed to ensure emergency and procedures include a sylocation of on-duty staff and in the LTC facility's care demergency. If on-duty staff residents are relocated during LTC facility must document location of the receiving fain accordance with 42 CFR deficient practice could affirm	evacuees; staff ortation; identification s); and primary and munication with istance. (0(b):] Policies and m of medical serves potential and n, protects ial and actual donor is and maintains the (b):] Policies and recuation from the icludes staff eds of the patients. Ind interview, the facility y preparedness policies system to track the und sheltered residents during and after an iff and sheltered ring the emergency, the ent the specific name and accility or other location R 483.73(b) (2). This	E 0018	E 018– Procedures for trackistaff and residents What Corrective Action will accomplished for those residents found to have bee affected by this deficient practice: 1. The EMP had been reviewe 5/25/22 but was not available time of survey. See Attached How other residents having	be n ed on at the
Findings include: Based on record review wi Director on 05/22/23 between			potential to be affected by the same deficient practice will identified and what corrective action will be taken:	be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLETED	
		155344	B. W	'ING		05/22/2023	
NAME OF F	PROVIDER OR SUPPLIER	· }	-		ADDRESS, CITY, STATE, ZIP COD	-	
					HIGHWAY 20 EAST		
LIFE CAF	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	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		procedure that includes a			reviewed the EMP on 05/25/2		
	_ ·	location of sheltered residents			during the QAPI meeting. The	plan	
	-	s care during and after an			was approved and the staff		
		vided, but the policy did not track the location for on-duty			tracking form was added. See attached		
	-	rview at the time of record			What measures and what		
		nance Director stated that the			systemic changes will be ma	ado	
		ble only pertain to residents in			to ensure that the deficient	aue	
	the facility, not staf				practice doesn't recur:		
	•	contacted and unable to			1. On 6/1/23 The ED inservice	-d	
		tion for tracking residents at			the Maintenace Director on th		
	the time of the surv	e			EMP must include policies and		
		,			procedures to track the location		
	Findings were discu	assed with the Administrator			on duty staff and sheltered		
	and Maintenance D	irector at exit conference.			residents during and after an		
					emergency including their nan	nes	
					and location of receiving facili	ty or	
					other location See		
					attached		
					How the corrective action w	ill	
					be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance		
					program will be put in place.	:	
					1. The Maintenace Director		
					developed a staff tracking forr		
					5/25/23 The maintenance dire		
					will review the form quarterly the QAPI meeting for any cha		
					or updates. See attached	nges	
					2. The results of these reviews	s will	
					be discussed at the monthly	· ·····	
					facility Quality Assurance		
					Committee meeting monthly for	or a	
					total of 3 months and then		
					quarterly thereafter once		
					compliance is at 100%.		
					Frequency and duration of rev	views	
					will be increased as needed, i		
					compliance is below 100%.		

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L0GD21 Facility ID: 000236

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		CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING		COMPLETED	
		155344	B. WING		05/22/2023
	PROVIDER OR SUPPLIER		802 (ET ADDRESS, CITY, STATE, ZIP COD JS HIGHWAY 20 EAST HIGAN CITY, IN 46360	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	BROWINED'S BLANCE 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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				Compliance date: 6/1/23. The Administrator at Life Care Cer of Michigan City is responsible ensuring compliance in this Prof Correction.	nter e in
E 0029 SS=F Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62(c) Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §485.6 §485.68(c), §485.6 §485.920(c), §486 §494.62(c). (c) The [facility] must emergency preplan that complies local laws and must least every 2 yes facilities].	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),	E 0029	E 029– Development of	06/01/2023
	to review and updat Preparedness Plan's least annually in acc		2 002	Communication Plan What Corrective Action will accomplished for those residents found to have bee affected by this deficient practice:	be
	Findings include:	ning with the No.		The EMP had been reviewe 5/25/22 but was not available	
		view with the Maintenance 3 between 09:02 a.m. and 12:03		time of survey. See Attached	tho
		date of March 2022 on the		How other residents having potential to be affected by the	
	-	r date could be found to show		same deficient practice will	
		cation Plan was reviewed and		identified and what corrective	
		ast year. Based on an		action will be taken:	

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L0GD21

Facility ID: 000236

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PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED B. WING 05/22/2023		
		155344	B. WING		03/22/2023
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	
		CLUCAN CITY		S HIGHWAY 20 EAST	
LIFE CAI	RE CENTER OF MI	CHIGAN CITY	MICH	IGAN CITY, IN 46360	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	cords review, the Maintenance		1. The management team	
		EPP's Communication Plan was		reviewed the EMP on 05/25/2	
	_	ing revised at the time of the		during the QAPI meeting. The	
	survey.			communication plan was revie	ewed.
	This finding was no	viewed with the Administrator		See attached	
	_	viewed with the Administrator		What measures and what	ado
	and Maintenance Director during the exit conference.			systemic changes will be me to ensure that the deficient	aue
				practice doesn't recur:	
				1. On 6/1/23 The ED inservice	-d
				the Maintenace Director on th	
				EMP must be reviewed and	
				updated annually including the	e
				communication plan.	
				See attached	
				How the corrective action w	ill
				be monitored to ensure the	
				deficient practice will not re	cur,
				i.e., what quality assurance	
				program will be put in place	:
				The Maintenance Director	will
				audit and update the	
				communication plan quarterly	
				any changes that might be ne	eded
				and discuss at QAPI. See	
				attached	
				2. The results of these review	S WIII
				be discussed at the monthly	
				facility Quality Assurance	or o
				Committee meeting monthly f total of 3 months and then	ui a
				quarterly thereafter once	
				compliance is at 100%.	
				Frequency and duration of rev	views
				will be increased as needed, i	
				compliance is below 100%.	
				Compliance date: 6/1/23. The	
				Administrator at Life Care Cer	
				of Michigan City is responsible	
				ensuring compliance in this P	

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EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICA	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	COMPLETED				
	155344	B. WING	05/22/2023				

	155344	B. W	ING		05/22/2023
	PROVIDER OR SUPPLIER RE CENTER OF MICHIGAN CITY	•	802 US	ADDRESS, CITY, STATE, ZIP COD S HIGHWAY 20 EAST SAN CITY, IN 46360	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
IAG	REGULATORY OR ESC IDENTIFY TING INFORMATION		TAG	of Correction.	DAIL
E 0036 SS=F Bldg	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.				
	*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155344	B. WI	NG		05/22/2023	
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			HIGHWAY 20 EAST		
LIFF CAF	RE CENTER OF MI	ICHIGAN CITY			GAN CITY, IN 46360		
LII L OAI	OLIVILIK OI IVII			IVIIOTIIC			<u> </u>
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	. , , ,	on, policies and procedures					
		of this section, and the					
		an at paragraph (c) of this					
		ning and testing program					
	must be reviewed and updated at least annually.						
		§483.475(d):] Training and					
	_	ID must develop and					
		gency preparedness training					
		am that is based on the					
	emergency plan set forth in paragraph (a) of						
		assessment at paragraph					
	. , , ,	on, policies and procedures					
		of this section, and the					
	-	an at paragraph (c) of this					
		ning and testing program					
		and updated at least every					
	2 years. The ICF/						
	1	evacuation drills and training					
	at §483.470(i).						
	*IE EODD E:!!	::					
	•	ities at §494.62(d):]					
		and orientation. The					
	1 -	ust develop and maintain an					
		redness training, testing					
	· ·	ation program that is based					
	1	/ plan set forth in paragraph					
	1 ' '	, risk assessment at					
	. •	of this section, policies and					
		ragraph (b) of this section,					
		cation plan at paragraph (c)					
		he training, testing and					
		m must be evaluated and					
	updated at every		E 00	26	F 000 FD Tuelelen and T		06/01/2022
		view and interview, the facility	E 00	136	E 036- EP Training and Testi		06/01/2023
		l updated the Emergency			What Corrective Action will I	be	
	_	s (EPP) Training and Testing			accomplished for those	_	
		lly in accordance with 42 CFR			residents found to have been	n	
	483./3(a). This def	icient practice could affect all			affected by this deficient		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/22/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) DYACTICE:	TION (X5) LD BE COMPLETION OPRIATE DATE			
	occupants. Findings include: Based on records redirector on 05/22/2 p.m., the EPP had a cover page, no other the EPP's Training and updated within interview during redirector stated the Plan was in the protime of the survey. This finding was redirectors.	eview with the Maintenance 23 between 09:02 a.m. and 12:03 a date of March 2022 on the er date could be found to show and Testing Plan was reviewed the last year. Based on an cords review, the Maintenance EPP's Training and Testing cess of being reviewed at the viewed with the Administrator birector during the exit		practice: 1. The EMP had been revisiting of survey. See Attack How other residents have potential to be affected it same deficient practice identified and what correaction will be taken: 1. The management team reviewed the EMP on 05/2 during the QAPI meeting. training and testing plan were viewed. See attached What measures and what systemic changes will be to ensure that the deficient practice doesn't recur: 1. On 6/1/23 The ED inset the Maintenace Director of EMP must be reviewed an updated annually including training and testing plan. attached How the corrective action be monitored to ensure a deficient practice will not i.e., what quality assurant program will be put in plantation. The Maintenace Director review and update the traitesting plan quarterly and at QAPI. See attached 2. The results of these reviewed at the month facility Quality Assurance Committee meeting month total of 3 months and there quarterly thereafter once	riewed on able at med ring the by the will be ective at a sective at a section will at a section will a section with a section will be section will a section will be section will a section will be sect			

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344 A. BUILDING B. WING		INSTRUCTION	COMPL 05/22/	ETED			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST				
LIFE CAF	RE CENTER OF MI	CHIGAN CITY	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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					compliance is at 100%. Frequency and duration of rev will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Cen of Michigan City is responsible ensuring compliance in this Pla of Correction.	ter in	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/22/ Facility Number: 00 Provider Number: 1002 At this Life Safety C of Michigan City w with Requirements i Medicare/Medicaid, Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one story facili Type V (111) constr wings and Type IV and 200 wings and v facility has a fire ala detection in the corr	200236 155344 287700 Code survey, Life Care Center as found not in compliance	K 00	000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155344		A. BUILDING 01 COMPLETED B. WING 05/22/2023			
		155344	B. W	ING		05/22/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			SAN 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	TE	COMPLETION
K 0291 SS=F Bldg. 01	the resident rooms. protected by a 200 k The facility has a ca certified for Medica census of 84 at the t All areas where the access were sprinkle detached garage and storage which were Quality Review com NFPA 101 Emergency Lightin Emergency Lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observatio failed to ensure 1 of lights were maintain LSC 7.9.2.6 states b lights shall use only batteries provided w maintaining them in Batteries used in sur approved for their in with NFPA 70 Natio states the emergency either continuously capable of repeated manual intervention affect all residents a Findings include: Based on observation	residents have customary ered. The facility had one of two sheds used for facility not sprinklered. Impleted on 05/25/23 Ing and graph of at least 1-1/2-hour ed automatically in 1.9. In and interview, the facility of 2 battery powered emergency and in accordance with LSC 7.9. In accordance with LSC 7.9. In accordance with LSC 7.9. In accordance with suitable facilities for a properly charged condition. In the lights or units shall be antended use and shall comply onal Electric Code. LSC 7.9.2.7 by lighting system shall be automatic operation without an This deficient practice could	K 0	291	K 291 Emergency Lighting What Corrective Action will a accomplished for those residents found to have been affected by this deficient practice: 1. The Maintenance Director completed a full house audit of emergency lighting on 5/31/23 additional lights were found the did not work. How other residents having potential to be affected by the same deficient practice will in identified and what corrective action will be taken: The maintenance director repl the entire lighting unit on 5/23, see attached No residents we found to have been harmed by	be n 3. No at the be re laced /23. re	DATE 06/01/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/22/2023
	PROVIDER OR SUPPLIER		802 US	S 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0324	p.m., the battery-op generator transfer s' tested. Based on int observations, the M the battery-operated function when its re- pushed.	erated emergency light in the witch room did not work when erview at the time of the aintenance Director agreed demergency light failed to espective test button was eviewed with the Maintenance liministrator during the exit		alleged deficient practice. What measures and what systemic changes will be m to ensure that the deficient practice doesn't recur: 1. On 6/1/23 The ED inservice the Maintenance Director on ensuring that battery powered lighting is functional at all time. See attached How the corrective action where the deficient practice will not refice, what quality assurance program will be put in place. 1. The Maintenance Director audit the battery powered light weekly for 2 months, weekly months, monthly for 2 months ensure that they are functional See attached. 2. The results of these review be discussed at the monthly facility Quality Assurance. Committee meeting monthly total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance date: 6/1/23. The Administrator at Life Care Ce of Michigan City is responsible ensuring compliance in this For Correction.	ed des vill ecur, will nts 2X for 2 s to al. vs will for a views if enter le in
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED			
		155344	B. W	ING		05/22/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST 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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer p conditions under 1 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazal be open to the core	NFPA 96, Standard for II and Fire Protection of ing Operations, unless: ng equipment (i.e., small is microwaves, hot plates, If for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer if the conditions under .5.3, or in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not					
	failed to ensure 1 of systems were UL 30 19.3.2.5.1 states coor protected in accordary otherwise permitted 19.3.2.5.4. NFPA 1 cooktop or range is suppression system 300 Standard for Fi Systems for Protect Equipment, or is tes Extinguishing Syste Top Cooking Surfact applicable testing dideficiency could affi	on and interview, the facility of 1 kitchen suppression on approved. NFPA 101 oking facilities shall be ance with 9.2.3, unless I by 19.3.2.5.2, 19.3.2.5.3, or on 19.3.2.5.3.5(a) states the protected with a fire listed in accordance with UL re Testing of Fire Extinguishing ion of Commercial Cooking sted and meets UL 300A, em Units for Residential Range ces, in accordance with the ocument's scope. This fect approximately 30 staff and itchen and main dining area.	KO	324	K 324 Cooking facilities What Corrective Action will is accomplished for those residents found to have been affected by this deficient practice: 1. The Maintenance Director completed a full house audit of cooking equipment requiring ventilation control used at the facility on 5/23/23 and found nother cooking suppression systems without a UL300 tag see attached How other residents having potential to be affected by the same deficient practice will be identified and what corrective is seen attached.	n on the ne be	06/01/2023

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

	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER 155344	A. BU	A. BUILDING <u>01</u> B. WING		COMPLETED 05/22/2023	
NAME OF PF	ROVIDER OR SUPPLIER	<u>-</u>	STREET ADDRESS, CITY, STATE, ZIP COD				
LIFE CAR	RE CENTER OF MI	CHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		on during a tour with the			action will be taken:		
	Maintenance Direct	or on 05/22/23 between 12:03			The maintenance director obta	ained	
		the kitchen suppression			documentation on 5/23/23 that	t	
		ge stove labeled that the			indicates our current system is		
		bliance with UL 1656. No other			300 certified. see attached. N		
		ould be found. It could not be			residents were found to have I		
		the kitchen suppression			harmed by this alleged deficie	nt	
	-	00 approved system or tested			practice.		
		a UL 300 system. Based on			What measures and what	-1-	
	interview at the time of observation, the Maintenance Director stated that the system had				systemic changes will be ma to ensure that the deficient	iae	
been previously been redone, but was not sure					practice doesn't recur:		
whether the system was a UL 300 listed system					1. On 6/1/23 The ED inservice	hd	
	and would follow up with the inspection				the Maintenance Director on		
	company.	1			ensuring that all cooking facilit	ies	
	1 ,				are protected with UL 300 cert		
	Findings were revie	ewed with the Maintenance			equipment See		
	Director and Admin	nistrator at exit conference.			attached		
					How the corrective action wi	II	
	3.1-19(b)				be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance		
					program will be put in place:		
					1. The Maintenance Director v		
					audit the UL 300 information for	or	
					the suppression system is available at all times 2X weekl	v for	
					2 months, weekly for 2 months	•	
					monthly for 2 months to ensur		
					that they are functional. See		
					attached		
					2. The results of these reviews	s will	
					be discussed at the monthly		
					facility Quality Assurance		
					Committee meeting monthly for	or a	
					total of 6 months and then		
					quarterly thereafter once		
					compliance is at 100%.		
					Frequency and duration of rev		
					will be increased as needed, it		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155344	B. W	ING	_	05/22/2	2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI 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		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
K 0345	NFPA 101				compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Cer of Michigan City is responsible ensuring compliance in this Pl of Correction.	nter e in		
SS=C	Fire Alarm System	ı - Testing and						
Bldg. 01	Maintenance	1 - Teating and						
3	Fire Alarm System	n - Testing and						
	Maintenance	S						
	A fire alarm syster	n is tested and maintained						
	in accordance with	n an approved program						
		e requirements of NFPA 70,						
		Code, and NFPA 72,						
		m and Signaling Code.						
	and testing are rea	n acceptance, maintenance						
	9.6.1.3, 9.6.1.5, N	_						
		on and interview, the facility	K 0	345	K 345 Fire Alarm		06/01/2023	
		e fire alarm system to assure	110	5 15	system-Testing and		00/01/2023	
	that it had accurate	time and date information in			maintenance			
		requirements of NFPA 101-			What Corrective Action will I	be		
		ons 19.3.4 and 9.6 and NFPA 72			accomplished for those			
		ions 14.1, 14.1.1. This deficient			residents found to have been	n		
	^	t all residents, staff and			affected by this deficient			
	visitors.				practice:			
	Eindings in sluder				1. The Maintenance Director			
	Findings include:				completed a full house audit of the fire system and did not find			
	Based on observation	on of the fire alarm control			any other components that ha			
		etween 12:03 p.m. and 1:59 p.m.			the incorrect time and date on			
	•	facility with the Maintenance			5/23/23 . see attached			
	-	nd date on the fire alarm			How other residents having	the		
	· ·	ncorrect. The display on the			potential to be affected by th			
	main fire alarm con	trol panel indicated the date			same deficient practice will l			
	and time to be 05/05	5/23 at 02:56 a.m. Based on			identified and what corrective			
	interview at the time	e of observation, the			action will be taken:			
	Maintenance Direct	or indicated he was unaware			The maintenance director			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155344	B. W	NG		05/22/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN 46360		
	Г		1		. ,		A15
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	, The state of the	NCY MUST BE PRECEDED BY FULL BLSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION and would contact the alarm	+	TAG		imo	DATE
		the displayed date and time			reprogrammed the date and to into the system on 5/24/23 se		
		alarm control panel.			attached. No residents were	C	
	apaaca on me me	alaim control panel.			found to have been harmed b	v this	
	This finding was re	eviewed with the Maintenance			alleged deficient practice.	y uno	
	_	nistrator at exit conference.			What measures and what		
					systemic changes will be ma	ade	
	3.1-19(b)				to ensure that the deficient		
					practice doesn't recur:		
					1. On 6/1/23 The ED inservice	ed	
					the Maintenance Director on		
					ensuring that is tested and		
					maintained in accordance with	n the	
					NFPA 70 requirements.	See	
					attached		
					How the corrective action w	ill	
					be monitored to ensure the		
					deficient practice will not re	cur,	
					i.e., what quality assurance		
					program will be put in place		
					The Maintenance Director	will	
					audit the fire system for the		
					correct date and time 2X wee	•	
					for 2 months, weekly for 2 mo		
					monthly for 2 months to ensur	re	
					that they are functional. See		
					attached		
					2. The results of these review	S WIII	
					be discussed at the monthly		
					facility Quality Assurance Committee meeting monthly f	or a	
					total of 6 months and then	ога	
					quarterly thereafter once		
					compliance is at 100%.		
					Frequency and duration of rev	/iews	
					will be increased as needed, i		
					compliance is below 100%.	•	
					Compliance date: 6/1/23. The	:	
					Administrator at Life Care Cer		
					of Michigan City is responsible		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 05/22/2023	
	PROVIDER OR SUPPLIE			802 US	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST GAN 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)	ATE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of syster inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAI coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on observe failed to ensure the heads were not obs closets in accordance edition, Section 8.5 located so as to min discharge as define additional sprinkler adequate coverage and 8.5.5.3 do not p noncontinuous obst	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. It system last checked I system test	K 0:			lan be n on here	DATE 06/14/2023
	sprinkler deflector from fully developi	that prevent the spray pattern ing. This deficient practice imately 30 staff and residents.			and to verify the spray pattern the sprinkler heads were not obstructed in storage closets 5/31/23. No additional issues	on	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	ETED
		155344	B. W	ING		05/22/2	2023
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			HIGHWAY 20 EAST		
LIEECAE	DE CENTED OF MI	CHICAN CITY					
LIFE CAP	RE CENTER OF MI	CHIGAN CITY		MICHIC	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					found. The maintenance direc	tor	
	Findings include:				did a full house audit on sprink	der	
					pipes to verify that there were		
		on with the Maintenance			additional cable lines wrapped		
		3 from 12:03 p.m. to 1:59 p.m.,			around the sprinkler pipes on		
		ets in both the 300 and 400-hall			6/1/23. No additional issues w	ere	
		nen within 10 inches of the			identified. see attached		
	*	ed on interview at the time of			How other residents having		
	observation, the Ma				potential to be affected by th		
		forementioned sprinkler heads			same deficient practice will l		
	were obstructed and	d did move some of the items.			identified and what correctiv	re	
					action will be taken:		
	_	ussed with the Maintenance			The sprinkler head that has th		
	Director and Admir	nistrator at exit conference.			gap is scheduled to be repaire		
					6/14/23. The maintenance dire		
	3.1-19(b)				removed the obstructions from	I	
	0 D 1 1				storage closets on 5/23/23. Or		
		ation and interview, the facility			5/23/23 the maintenance direct		
		ne ceiling construction in 1 of 5			removed the cable that was or	n the	
	-	ts. The ceiling traps hot air and			sprinkler pipes. see attached.		
	-	rinkler and cause the sprinkler			No residents were found to ha	ave	
		fied temperature. NFPA 13, 1.1 states the distance between			been harmed by this alleged		
	· ·	tor and the ceiling above shall			deficient practice.		
	-	n the type of sprinkler and the			What measures and what		
		n the type of sprinkler and the This deficient practice			systemic changes will be ma to ensure that the deficient	iue	
		imately 20 residents and staff					
	in one smoke comp	-			practice doesn't recur: 1. On 6/1/23 The ED inservice	, _d	
	in one smoke comp	artificite.			the Maintenance Director on	iu	
	Findings include:				maintaining and testing the		
	1 manigo merade.				sprinkler system including no		
	Based on observation	on with the Maintenance			gaps from ceiling, no obstructi	ons	
		3 between 12:03 p.m. and 1:59			of the spray pattern of sprinkle		
		l housekeeping closet			heads, and pipes free from ca		
		p in between the escutcheon			On 6/5/23 the maintenance		
		g. This condition could delay			director inserviced all staff on	_{the}	
		e sprinklers installed in ceiling.			18 inch rule in closets to keep		
		at the time of observation, the			spray pattern clear. see attach		
		for acknowledged the gaps in			How the corrective action wi		
		ed they had installed fire caulk			be monitored to ensure the		
1	ı	•	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155344	B. W	ING		05/22/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			HIGHWAY 20 EAST		
LIFF CAF	RE CENTER OF MI	CHIGAN CITY			SAN CITY, IN 46360		
					· · · · · · · · · · · · · · · · · · ·	1	
(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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		eon plate, but gaps were			deficient practice will not red	cur,	
	noticed during the t	our.			i.e., what quality assurance		
	F: 1: 1:	1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			program will be put in place:		
	Findings were discussed with the Administrator and Maintenance Director at exit conference.				1. The Maintenance Director v		
	and Maintenance D	irector at exit conference.			audit the sprinkler system for		
	2.1.10/1->				gaps in ceiling and sprinkler h		
	3.1-19(b)				no obstructions in closets, and		
	2 D1 1	Allow and intermiting of 100 MM			pipes free from cables 2X wee	-	
		ation and interview, the facility			for 2 months, weekly for 2 months		
		of 2 sprinkler systems in			monthly for 2 months to ensur	е	
		C 9.7.5. LSC 9.7.5 requires all			that they are functional. See		
	-	systems shall be inspected			attached		
		ccordance with NFPA 25,			2. The results of these reviews	S WIII	
		pection, Testing, and ter-Based Fire Protection			be discussed at the monthly		
					facility Quality Assurance		
	-	, 2011 edition, 5.2.2.2 requires			Committee meeting monthly fo	or a	
		all not be subjected to external either resting on the pipe or			total of 6 months and then		
	-	This deficient practice could			quarterly thereafter once		
		y 20 residents and staff in one			compliance is at 100%.		
	smoke compartmen	-			Frequency and duration of rev		
	smoke compartmen	ι.			will be increased as needed, it	ļ	
	Eindines includes				compliance is below 100%.	_	
	Findings include:				Compliance date: 6/14/23. The		
	Raced on observation	on during a tour of the facility			Administrator at Life Care Cer		
		ce Director on 05/22/23			of Michigan City is responsible ensuring compliance in this Pl		
		and 1:59 p.m., sprinkler pipes			of Correction.	arı	
		room 106 had cable line			or correction.		
		d the sprinkler line. Based on					
		e of observation, the					
		for agreed a wire was wrapped					
		ine in the resident room and					
	would remove the c						
	Findings were discu	ussed with the Administrator					
		irector at exit conference.					
		· ··· 					
	3.1-19(b)						
	>(=)						
	4. Based on observa	ation and interview, the facility					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155344		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 05/22	ETED
	PROVIDER OR SUPPLIER RE CENTER OF MICHIGAN CITY	STREET A 802 US MICHIG			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP	N BE RIATE	(X5) COMPLETION DATE
K 0355	failed to ensure 1 of 2 sprinklers in the laundry room were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 30 residents and staff in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., the sprinkler head above the washers in the washer room was green and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director agreed sprinkler head in the washer room showed signs of corrosion. The findings were reviewed with Maintenance Director and Administrator during the exit conference. 3.1-19(b) NFPA 101				
SS=E Bldg. 01	Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.				

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Event ID:

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Facility ID: 000236

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 05/22/2023	
	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 APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
	18.3.5.12, 19.3.5. 1. Based on observation failed to ensure 1 of were not obstructed Standard for Portab Edition. Section 6.1 extinguishers shall a from view. This defapproximately 25 recompartments. Findings include: Based on observation with the Maintenant between 12:03 p.m. portable fire extinged dining area next to a blocked due to the opropped open. Base observation, the Maacknowledged the best Findings were discubirector and Admir 3.1-19(b) 2. Based on observation failed to ensure 1 of the kitchen were ins NFPA 10, Standard 2010 Edition. Section extinguishers other shall be installed us means. (1) Securely extinguishers. (2) Ir extinguisher manufactured in the standard extinguisher manufactured in the section of the standard extinguishers. (2) Ir extinguisher manufactured in the section of the section of the standard extinguishers. (2) Ir extinguisher manufactured in the section of t	ation and interview, the facility of 33 portable fire extinguishers in accordance with NFPA 10, le Fire Extinguishers, 2010 and the obstructed or obscured of the control of the facility exidents in two smoke ons during a tour of the facility one Director on 05/22/23 and 1:59 p.m., one ABC disher located near the main a set of corridor doors was doors being magnetically don interview at the time of	K 0		K 355 Portable fire extinguishers What Corrective Action will accomplished for those residents found to have bee affected by this deficient practice: 1. The Maintenance Director completed a full house audit of 5/31/23 on fire extinguishers a did not find any other extinguishers that were obstructed. On 5/31/23 the maintenance director did a full house audit of extinguishers to verify they were installed in accordance with NFPA 10 standards including securely of hangar intended for extinguish bracket supplied by manufactor in a cabinet or wall recess. additional issues were found. attached How other residents having potential to be affected by the same deficient practice will identified and what correctivaction will be taken: The maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher that was block in the hallway on 5/23/23. On 5/23/23 the maintenance director rem the extinguisher an approved hangar, see attan No residents were found to have the provided deficient practice. What measures and what	on and loo on a hers, loo see the he h	06/01/2023
	approved for such p	ourpose. (3) in a cabinet or wall	- 1		What measures and what	l.	I

recess. This deficient practice was not in a

systemic changes will be made

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155344	B. W	ING		05/22/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	8			HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ut could affect staff in the			to ensure that the deficient		
	kitchen.				practice doesn't recur:		
	Eindiner in de la				1. On 6/1/23 The ED inservice	ed	
	Findings include:				the Maintenance Director on		
	Dagad on abasement	and during a taum of the facility			portable fire extinguishers are		
		ons during a tour of the facility			selected, installed, inspected,		
	with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., a K-class fire				maintained in accordance with NFPA 10 standards and are n		
	between 12:03 p.m. and 1:59 p.m., a K-class fire extinguisher in the kitchen was located in a fire				blocked, see attached.	OL	
	-	t, however a metal plate was			How the corrective action wi		
	_	bottom of the fire extinguisher			be monitored to ensure the	"	
	* *	_			deficient practice will not rec	-ur	
	and no cabinet door was installed due to the fire extinguisher being too big to fit properly.				i.e., what quality assurance	,ui,	
	extinguisher semig	tee eig te in properly.			program will be put in place:	.	
	Findings were disci	ussed with the Maintenance			The Maintenance Director v		
	_	nistrator at exit conference.			audit the fire extinguishers to		
					that they are free from	,	
	3.1-19(b)				obstructions and on proper		
					hangars or cabinets 2X weekl	v for	
					2 months, weekly for 2 months		
					monthly for 2 months . See	-,	
					attached		
					2. The results of these reviews	s will	
					be discussed at the monthly		
					facility Quality Assurance		
					Committee meeting monthly for	or a	
					total of 6 months and then		
					quarterly thereafter once		
					compliance is at 100%.		
					Frequency and duration of rev	riews	
					will be increased as needed, it		
					compliance is below 100%.		
					Compliance date: 6/1/23. The		
					Administrator at Life Care Cer	nter	
					of Michigan City is responsible	e in	
					ensuring compliance in this Pl		
					of Correction.		
K 0363	NFPA 101						
SS=E	Corridor - Doors						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155344		A. BUILDING 01 B. WING			COMPLETED 05/22/2023	
	PROVIDER OR SUPPLIER			802 US	DDRESS, CITY, STATE, ZIP COD HIGHWAY 20 EAST AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or come Clearance between covering is not except to a complying with the door closed with a containing of the door release when the permitted. Nonrate unlimited height at the materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of the permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155344	B. WI	ING		05/22/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	R			S HIGHWAY 20 EAST	
LIFE CA	RE CENTER OF MI	ICHIGAN CITY			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 APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	devices, etc.					
	Based on observation and interview, the facility failed to ensure 3 of 40 corridor doors in the		K 0	363	K 363 Corridor-Doors	06/21/2023
					What Corrective Action will	be
		led with a means suitable for			accomplished for those	
		osed, had no impediment to			residents found to have been	en
		d would resist the passage of			affected by this deficient	
		ent practice could affect			practice:	
	**	esidents and staff in two smoke			1. The Maintenance Director	
	compartments.				completed a full house audit	
					6/1/23 to verify doors latching	
	Findings include:				correctly, doors were self clos	=
					and doors latched into the fra	
	Based on observation with the Maintenance				No further issues were identif	fied.
	Director on 05/22/23 between 12:03 p.m. and 1:59				see attached	
		deficiencies were noted:			How other residents having	
	, , , , , , , , , , , , , , , , , , ,	403 did close, but unable to			potential to be affected by t	
	latch when tested th				same deficient practice will	
	1 '	an linen closet was self-closing,			identified and what correcti	ive
	-	tely close or latch into the			action will be taken:	
	frame when tested t				The maintenance director rep	
	1	n door next to the nurses			the knob on room 403 reside	
	when tested three ti	lid not latch into the frame			door, the 300 hall clean linen	
		at the time of observations,			shower door in 300 are sched	
		irector acknowledged each of			for repair/replacement on 6/2 see attached.	11/23.
		d would start the necessary			No residents were found to h	nave
	repairs.	card start the necessary			been harmed by this alleged	IUVC
	1 spans.				deficient practice.	
	The findings were i	reviewed with the			What measures and what	
	_	the Maintenance Director			systemic changes will be m	nade
	during the exit conf				to ensure that the deficient	
	<i>g</i> == ==== <i>y</i> ===				practice doesn't recur:	
	3.1-19(b)				1. On 6/1/23 The ED inservice	ced
					the Maintenance Director on	
					protecting corridor openings	
					are self closing and latch into	
					frame see attached.	
					How the corrective action w	vill
					be monitored to ensure the	
					deficient practice will not re	ecur,

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/22/2023		
	PROVIDER OR SUPPLIE		802 US	STREET ADDRESS, CITY, STATE, ZIP COD 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	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		
				i.e., what quality assurance program will be put in place: 1. The Maintenance Director waudit all doors in the facility to verify that they latch correctly, close, and latch into the frame weekly for 2 months, weekly for months, monthly for 2 months. See attached 2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly facility Quality Assurance Committee meeting monthly for total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviewll be increased as needed, if compliance is below 100%. Compliance date: 6/21/23. The Administrator at Life Care Center of Michigan City is responsible ensuring compliance in this Plate of Correction.	self . 2X or 2 s will or a iews iews ie		
K 0511 SS=E Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1 Based on observatifailed to ensure 1 of service hall was see personnel. NFPA 7	I Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0511	K 511 utilities gas and electri What Corrective Action will k accomplished for those residents found to have beer affected by this deficient	pe		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155344	B. W	ING		05/22	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			HIGHWAY 20 EAST		
LIEE CAI	RE CENTER OF M	ICHICAN CITY					
LIFE CA	RE CENTER OF IVI	ICHIGAN CITT		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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	enclosed as specific	ed in 230.62(A) or guarded as			practice:		
	specified in 230.62	(B).			1. The Maintenance Director		
	(A) Enclosed. Energized parts shall be enclosed				completed a full house audit o	n	
		t be exposed to accidental			5/23/23 to verify that all electr	ical	
	1	guarded as in 230.62(B).			panels were secure from non		
	_ ' '	gized parts that are not enclosed			authorized personnel. No furt	her	
		n a switchboard, panelboard, or			issues were identified. see		
	_	guarded in accordance with			attached		
		Where energized parts are			How other residents having	the	
		d in 110.27(A)(1) and (A)(2), a			potential to be affected by the	1 e	
	_	or sealing doors providing			same deficient practice will	be	
	1	parts shall be provided. This			identified and what corrective	⁄e	
	^	ould affect 20 residents and			action will be taken:		
	staff in 400 hall.				The panel was secured on 6/5	5/23	
					see attached		
	Findings include:				No residents were found to h	ave	
					been harmed by this alleged		
		on with Maintenance Director			deficient practice.		
		en 12:03 p.m. and 1:59 p.m., the			What measures and what		
	_	he 400-hall next to room 401			systemic changes will be ma	ade	
		tested. The panel included			to ensure that the deficient		
		ting system for that portion of			practice doesn't recur:		
		on interview at the time of			1. On 6/1/23 The ED inservice	ed	
		aintenance Director stated the			the Maintenance Director on		
	•	ould be locked, but the			securing electrical panels fron		
	mechanism to lock	the panel had broken.			unauthorized personnel see		
					attached.		
		ussed with the Maintenance			How the corrective action w	ill	
	Director and Admir	nistrator at exit conference.			be monitored to ensure the		
					deficient practice will not re	cur,	
	3.1-19(b)				i.e., what quality assurance		
					program will be put in place		
					1. The Maintenance Director v		
					audit all electrical panels to ve		
					that they are secure. 2X week	-	
					2 months, weekly for 2 months	s,	
					monthly for 2 months. See		
					attached	•11	
					2. The results of these review	s will	
	1		1		be discussed at the monthly		I

· · · · · · · · · · · · · · · · · · ·		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/22/2023	
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	.TE ((X5) COMPLETION DATE
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Gas Equipment - Transfilling of oxyganother is in acco Transfilling of Higl Oxygen Used for any gas from one prohibited in patie to liquid oxygen containers over 50 under 11.5.2.3.1 (liquid oxygen cont containers under 3 conditions under 3 11.5.2.2 (NFPA 9 Based on records re failed to ensure staft trans-filling proceder room where oxyger NFPA 99 2012 edit requires the individ container(s) to be p trans-filling proceder	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable o psi comply with conditions NFPA 99). Transfilling to rainers or to portable for psi comply with 11.5.2.3.2 (NFPA 99). o) view and interview, the facility of was properly trained on the property	K 0927	facility Quality Assurance Committee meeting monthly for total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rev will be increased as needed, it compliance is below 100%. Compliance date: 6/21/23. The Administrator at Life Care Cer of Michigan City is responsible ensuring compliance in this Pl of Correction. K 927 transfilling cylinders What Corrective Action will is accomplished for those residents found to have been affected by this deficient practice: On 5/24/23 The Maintenance director completed an audit oxygen tanks and no issues	views f e nter e in an	06/01/2023

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application and maintenance of medical gases and

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were identified. All were in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/22/2023 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 others who handle medical gases and the proper working order. see cylinders that contain the medical gases shall be attached trained on the risks associated with their handling How other residents having the and use. Health care facilities shall provide potential to be affected by the programs of continuing education for their same deficient practice will be personnel. Continuing education programs shall identified and what corrective include periodic action will be taken: review of safety guidelines and usage No residents were found to have requirements for medical gases and their been harmed by this alleged cylinders. deficient practice. This deficient practice could affect up to all staff What measures and what and residents in the facility. systemic changes will be made to ensure that the deficient Findings include: practice doesn't recur: 1. The ADON trained all nurse Based on records review with the Maintenance staff on 5/25/23on the risks Director on 05/22/23 between 09:02 a.m. and 12:03 associated with application and p.m., no documentation was available for review maintance of medical gases to indicate that staff who trans-fill liquid oxygen their handling and use. was properly trained or had a policy in place for 2.. On 6/1/23 The ED inserviced transfilling. Based on interview at the time of the Maintenance Director on observation, the Maintenance Director stated the verifying that all staff that are issue was discussed with the Director of Nursing authorized to transfill oxygen who stated the facility has no annual training containers are trained on the risks program or a policy that could be found. associated with handling and their use as part of a conducing Findings were discussed with the Maintenance education program. Director and Administrator at exit conference. How the corrective action will be monitored to ensure the 3.1-19(b) deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. The Maintenance Director and/or designee will audit training records of all staff authorized to transfill oxygen containers are properly trained upon hire and at least annually. 2X weekly for 2 months, weekly for 2 months, monthly for 2 months. See

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155344	` '		(X3) DATE SURVEY COMPLETED 05/22/2023		
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 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)	ATE	(X5) COMPLETION DATE	
				attached 2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, it compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Cer of Michigan City is responsible ensuring compliance in this Plof Correction.	or a views f nter e in		

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