STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155344	A. BUILDING -- B. WING	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/22/23 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 At this Emergency Preparedness survey, Life Care Center of Michigan City was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 120 certified beds. At the time of the survey, the census was 84. Quality Review completed on 05/25/23	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

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	155344	A. BUILDING -- B. WING	05/22/2023

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	**E 004– Develop EP Plan** ***What Corrective Action will be***	06/01/2023

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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03 p.m. , the EPP had a date of March 2022 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated that they were in the process of updating the EPP at the time of survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		***accomplished for those residents found to have been affected by this deficient practice:*** 1. The EMP had been reviewed on 5/25/22 but was not available at time of survey. See Attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. The management team reviewed the EMP on 05/25/23 during the QAPI meeting. The plan was approved. See attached ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenace Director on the EMP must be reviewed and updated at least annually. See attached ***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 Maintenace Director will audit the EMP monthly for any updates or changes. See attached 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	

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			quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	155344	A. BUILDING -- B. WING	05/22/2023

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water			

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	supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03 p.m.,, the EPP had a date of March 2022 on the cover page, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EPP's Policies and Procedures were currently in the process of being revised at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	**E 013– Develop EP Policies and Procedures** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The EMP had been reviewed on 5/25/22 but was not available at time of survey. See Attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. The management team reviewed the EMP on 05/25/23 during the QAPI meeting. The plan was approved. See attached ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenace Director on the EMP policies and procedures must be reviewed and updated at least annually. See attached ***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 Maintenace Director will audit the EMP monthly for any	06/01/2023

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			policies and procedures updates or changes. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum,			

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	the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name			

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	and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include: Based on record review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03	E 0018	**E 018– Procedures for tracking staff and residents** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The EMP had been reviewed on 5/25/22 but was not available at time of survey. See Attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. The management team	06/01/2023

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	p.m., a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency was provided, but the policy did not provide a system to track the location for on-duty staff. Based on interview at the time of record review, the Maintenance Director stated that the actions plans available only pertain to residents in the facility, not staff. Furthermore, the Administrator was contacted and unable to provide documentation for tracking residents at the time of the survey. Findings were discussed with the Administrator and Maintenance Director at exit conference.		reviewed the EMP on 05/25/23 during the QAPI meeting. The plan was approved and the staff tracking form was added. See attached ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenace Director on the EMP must include policies and procedures to track the location of on duty staff and sheltered residents during and after an emergency including their names and location of receiving facility or other location.. See attached ***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 Maintenace Director developed a staff tracking form on 5/25/23 The maintenance director will review the form quarterly at the QAPI meeting for any changes or updates. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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			Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03 p.m., the EPP had a date of March 2022 on the cover page, no other date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an	E 0029	**E 029– Development of Communication Plan** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The EMP had been reviewed on 5/25/22 but was not available at time of survey. See Attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***	06/01/2023

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	interview during records review, the Maintenance Director stated the EPP's Communication Plan was in the process of being revised at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		1. The management team reviewed the EMP on 05/25/23 during the QAPI meeting. The communication plan was reviewed. See attached ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenace Director on the EMP must be reviewed and updated annually including the communication plan. See attached ***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 Maintenance Director will audit and update the communication plan quarterly for any changes that might be needed and discuss at QAPI. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan	

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			of Correction.	
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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	155344	A. BUILDING -- B. WING	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN 46360

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	(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 annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID 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. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation 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, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all	E 0036	**E 036– EP Training and Testing** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient***	06/01/2023

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	occupants. Findings include: Based on records review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03 p.m., the EPP had a date of March 2022 on the cover page, no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the EPP's Training and Testing Plan was in the process of being reviewed at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		***practice:*** 1. The EMP had been reviewed on 5/25/22 but was not available at time of survey. See Attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. The management team reviewed the EMP on 05/25/23 during the QAPI meeting. The training and testing plan was reviewed. See attached ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenace Director on the EMP must be reviewed and updated annually including the training and testing plan. See attached ***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 Maintenace Director will review and update the training and testing plan quarterly and discuss at QAPI. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once	

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			compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/22/23 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 At this Life Safety Code survey, Life Care Center of Michigan City was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction in the 300, 400 and 500 wings and Type IV (2HH) construction in the 100 and 200 wings and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in	K 0000		

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	the resident rooms. The building is partially protected by a 200 kW diesel powered generator. The facility has a capacity of 120 beds dually certified for Medicare and Medicaid and had a census of 84 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had one detached garage and two sheds used for facility storage which were not sprinklered. Quality Review completed on 05/25/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents and staff. Findings include: Based on observation with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59	K 0291	**K 291 Emergency Lighting** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on emergency lighting on 5/31/23. No additional lights were found that did not work. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The maintenance director replaced the entire lighting unit on 5/23/23. see attached No residents were found to have been harmed by this	06/01/2023

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	p.m., the battery-operated emergency light in the generator transfer switch room did not work when tested. Based on interview at the time of the observations, the Maintenance Director agreed the battery-operated emergency light failed to function when its respective test button was pushed. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on ensuring that battery powered lighting is functional at all times.. See attached ***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 Maintenance Director will audit the battery powered lights 2X weekly for 2 months, weekly for 2 months, monthly for 2 months to ensure that they are functional. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities			

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	Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen suppression systems were UL 300 approved. NFPA 101 19.3.2.5.1 states cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. NFPA 101 19.3.2.5.3.5(a) states the cooktop or range is protected with a fire suppression system listed in accordance with UL 300 Standard for Fire Testing of Fire Extinguishing Systems for Protection of Commercial Cooking Equipment, or is tested and meets UL 300A, Extinguishing System Units for Residential Range Top Cooking Surfaces, in accordance with the applicable testing document's scope. This deficiency could affect approximately 30 staff and residents near the kitchen and main dining area.	K 0324	**K 324 Cooking facilities** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on cooking equipment requiring ventilation control used at the facility on 5/23/23 and found no other cooking suppression systems without a UL300 tag.. see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	06/01/2023

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	Based on observation during a tour with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., the kitchen suppression cylinder next to range stove labeled that the system was in compliance with UL 1656. No other UL identification could be found. It could not be determined whether the kitchen suppression system was a UL 300 approved system or tested in accordance with a UL 300 system. Based on interview at the time of observation, the Maintenance Director stated that the system had been previously been redone, but was not sure whether the system was a UL 300 listed system and would follow up with the inspection company. Findings were reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***action will be taken:*** The maintenance director obtained documentation on 5/23/23 that indicates our current system is UL 300 certified. see attached. No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on ensuring that all cooking facilities are protected with UL 300 certified equipment.. See attached ***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 Maintenance Director will audit the UL 300 information for the suppression system is available at all times 2X weekly for 2 months, weekly for 2 months, monthly for 2 months to ensure that they are functional. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if	

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			compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 05/22/23 between 12:03 p.m. and 1:59 p.m. during a tour of the facility with the Maintenance Director, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 05/05/23 at 02:56 a.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware	K 0345	**K 345 Fire Alarm system-Testing and maintenance** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on the fire system and did not find any other components that had the incorrect time and date on 5/23/23 . see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The maintenance director	06/01/2023

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	of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel. This finding was reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		reprogrammed the date and time into the system on 5/24/23 see attached. No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on ensuring that is tested and maintained in accordance with the NFPA 70 requirements. See attached ***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 Maintenance Director will audit the fire system for the correct date and time 2X weekly for 2 months, weekly for 2 months, monthly for 2 months to ensure that they are functional. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in	

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			ensuring compliance in this Plan of Correction.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 2 of 4 storage closets in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect approximately 30 staff and residents.	K 0353	**K 353 Sprinkler -Testing and maintenance** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on sprinkler heads to verify that there were no gaps between the escutcheon plate and the ceiling and to verify the spray pattern for the sprinkler heads were not obstructed in storage closets on 5/31/23. No additional issues were	06/14/2023

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	Findings include: Based on observation with the Maintenance Director on 05/22/23 from 12:03 p.m. to 1:59 p.m., the clean linen closets in both the 300 and 400-hall had blankets and linen within 10 inches of the sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler heads were obstructed and did move some of the items. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 20 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., in the 300-hall housekeeping closet contained a 1/2" gap in between the escutcheon plate and the ceiling. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the gaps in the ceiling and stated they had installed fire caulk		found. The maintenance director did a full house audit on sprinkler pipes to verify that there were no additional cable lines wrapped around the sprinkler pipes on 6/1/23. No additional issues were identified. see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The sprinkler head that has the gap is scheduled to be repaired on 6/14/23. The maintenance director removed the obstructions from the storage closets on 5/23/23. On 5/23/23 the maintenance director removed the cable that was on the sprinkler pipes. see attached. No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on maintaining and testing the sprinkler system including no gaps from ceiling, no obstructions of the spray pattern of sprinkler heads, and pipes free from cables. On 6/5/23 the maintenance director inserviced all staff on the 18 inch rule in closets to keep the spray pattern clear. see attached. ***How the corrective action will be monitored to ensure the***	

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	around the escutcheon plate, but gaps were noticed during the tour. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 2 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect approximately 20 residents and staff in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., sprinkler pipes located in resident room 106 had cable line wrapped around and the sprinkler line. Based on interview at the time of observation, the Maintenance Director agreed a wire was wrapped around a sprinkler line in the resident room and would remove the cable. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 4. Based on observation and interview, the facility		***deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. The Maintenance Director will audit the sprinkler system for no gaps in ceiling and sprinkler head, no obstructions in closets, and pipes free from cables 2X weekly for 2 months, weekly for 2 months, monthly for 2 months to ensure that they are functional. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/14/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	

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	155344	A. BUILDING 01 B. WING	05/22/2023

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	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)			
K 0355 SS=E Bldg. 01	NFPA 101 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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	18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 33 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect approximately 25 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., one ABC portable fire extinguisher located near the main dining area next to a set of corridor doors was blocked due to the doors being magnetically propped open. Based on interview at the time of observation, the Maintenance Director acknowledged the blocked fire extinguisher. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the kitchen were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a	K 0355	**K 355 Portable fire extinguishers** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on 5/31/23 on fire extinguishers and 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 on a hangar intended for extinguishers, bracket supplied by manufacturer, or in a cabinet or wall recess. No additional issues were found. see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The maintenance director removed the extinguisher that was blocked in the hallway on 5/23/23. On 5/23/23 the maintenance director hung the kitchen extinguisher on an approved hangar. see attached. No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made***	06/01/2023

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	resident care area but could affect staff in the kitchen. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., a K-class fire extinguisher in the kitchen was located in a fire extinguisher cabinet, however a metal plate was used to support the bottom of the fire extinguisher and no cabinet door was installed due to the fire extinguisher being too big to fit properly. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10 standards and are not blocked. see attached. ***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 Maintenance Director will audit the fire extinguishers to verify that they are free from obstructions and on proper hangars or cabinets 2X weekly for 2 months, weekly for 2 months, monthly for 2 months . See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 3 of 40 corridor doors in the facility were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 30 residents and staff in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., the following deficiencies were noted: a) Resident Room 403 did close, but unable to latch when tested three times. b) The 300 hall clean linen closet was self-closing, but did not completely close or latch into the frame when tested three times c) The shower room door next to the nurses station in 100 hall did not latch into the frame when tested three times. Based on interview at the time of observations, the Maintenance Director acknowledged each of the deficiencies and would start the necessary repairs. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K 363 Corridor-Doors** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. The Maintenance Director completed a full house audit on 6/1/23 to verify doors latching correctly, doors were self closing, and doors latched into the frame. No further issues were identified. see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The maintenance director replaced the knob on room 403 resident door, the 300 hall clean linen and shower door in 300 are scheduled for repair/replacement on 6/21/23. see attached. No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on doors protecting corridor openings latch, are self closing and latch into the frame. . see attached. ***How the corrective action will be monitored to ensure the deficient practice will not recur,***	06/21/2023

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			i.e., what quality assurance program will be put in place: 1. The Maintenance Director will audit all doors in the facility to verify that they latch correctly, self close, and latch into the frame. 2X weekly for 2 months, weekly for 2 months, monthly for 2 months. See attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/21/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 2 electrical panel in the service hall was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be	K 0511	**K 511 utilities gas and electric** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient***	06/21/2023

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	enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 20 residents and staff in 400 hall. Findings include: Based on observation with Maintenance Director on 05/22/23 between 12:03 p.m. and 1:59 p.m., the electrical panel in the 400-hall next to room 401 was unlocked when tested. The panel included breakers to the heating system for that portion of the building. Based on interview at the time of observation, the Maintenance Director stated the electrical panel should be locked, but the mechanism to lock the panel had broken. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***practice:*** 1. The Maintenance Director completed a full house audit on 5/23/23 to verify that all electrical panels were secure from non authorized personnel. No further issues were identified. see attached ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** The panel was secured on 6/5/23 see attached No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. On 6/1/23 The ED inserviced the Maintenance Director on securing electrical panels from unauthorized personnel. . see attached. ***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 Maintenance Director will audit all electrical panels to verify that they are secure. 2X weekly for 2 months, weekly for 2 months, monthly for 2 months. See attached 2. The results of these reviews will be discussed at the monthly	

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			facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/21/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, Section 11.5.2.3.1 (4) requires the individual trans-filling the container(s) to be properly trained in the trans-filling procedures. Sections 11.5.2.1.1 thru 11.5.2.1.3 require personnel concerned with the application and maintenance of medical gases and	K 0927	**K 927 transfilling cylinders** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** ***On 5/24/23 The Maintenance director completed an audit on oxygen tanks and no issues were identified. All were in***	06/01/2023

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	others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. Health care facilities shall provide programs of continuing education for their personnel. Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders. This deficient practice could affect up to all staff and residents in the facility. Findings include: Based on records review with the Maintenance Director on 05/22/23 between 09:02 a.m. and 12:03 p.m., no documentation was available for review to indicate that staff who trans-fill liquid oxygen was properly trained or had a policy in place for transfilling. Based on interview at the time of observation, the Maintenance Director stated the issue was discussed with the Director of Nursing who stated the facility has no annual training program or a policy that could be found. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***proper working order. see attached*** ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** No residents were found to have been harmed by this alleged deficient practice. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** ***1. The ADON trained all nurse staff on 5/25/23on the risks associated with application and maintance of medical gases their handling and use.*** 2.. On 6/1/23 The ED inserviced the Maintenance Director on verifying that all staff that are authorized to transfill oxygen containers are trained on the risks associated with handling and their use as part of a conducing education program. ***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 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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			attached 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 6/1/23. The Administrator at Life Care Center of Michigan City is responsible in ensuring compliance in this Plan of Correction.	