STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155343	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lagrange	0770 North 075 East Lagrange, IN 46761

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 45794 Based on observation, interview and record review the facility failed to ensure nurse staffing hours were posted for 3 of 4 days reviewed. Findings include: On 3/24/24 at 9:35 AM the facility nurse staffing hours were observed posted near the facility entrance. The nurse staffing hours form was a single sheet of paper dated 3/21/24. On 3/24/24 at 11:45 AM the posted facility nurse staffing hours were observed to be dated 3/21/24. On 3/24/24 at 1:10 PM the posted facility nurse staffing hours were observed to be dated 3/21/24. In an interview on 3/26/24 at 2:20 PM the Director of Nursing (DON) indicated they had been unaware of the nurse staffing hours posted on 3/24/24 was dated 3/21/24. The DON indicated nurse staffing hours should be posted daily. In an interview on 3/28/24 at 10:14 AM the Administrator indicated they were unaware nurse staffing hours had not been posted for 3 days on 3/24/24. The Administrator indicated nurse staffing hours should be posted daily. A current facility policy dated 4/24/19 provided by the Administrator on 3/27/24 at 9:15 AM indicated the facility must post the nurse staffing data every day at the beginning of each shift. No State Rule.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46756 Based on interview and record review the facility failed to ensure quality improvement plans were developed for identified recurrent environmental concerns. 41 residents resided in the facility. Findings include: The facility annual survey completed on 6/7/23 identified concern regarding repair and maintenance of facility floors, walls, and handrails. The facility indicated the noncompliance would be corrected by 6/30/23. The repair and maintenance of facility floors, walls, and handrails was also found to be a concern on the annual survey completed 3/28/24. See F921 for additional information about current environmental findings. A QAPI (Quality Assurance Performance Improvement) committee list was provided by the ED on 3/25/24 at 12:39 PM. The member list included the Executive Director, Director of Nursing Services, Assistant Director of Nursing/Infection Preventionist, Rehab Director, Social Services, Business Office Manager, Admissions/Marketing, Dietary Manager, Activity Director, Medical Records, Maintenance Director, and Compliance Coordinator. In an interview on 3/28/24 at 10:25 AM, the Executive Director (ED) indicated segments of care including clinical services, dietary, maintenance, housekeeping and administration were reviewed in each monthly QAPI meeting. He indicated the meeting reviewed topics identified by staff observations discussed in daily morning meetings, resident and family reports of concerns, survey results, electronic medical record software generated reports and corporate quality measure reports. The environment was an ongoing topic in QAPI meetings. He indicated there was not a current performance improvement plan pertaining to the environment in place. A current policy dated 2024 provided by the ED on 3/25/24 at 12:39 PM indicated Maintenance should provide comprehensive building safety and repairs to ensure all aspects of safety and well-being for each resident, visitor, and associates. The policy indicated the QAPI committee was ultimately responsible for assuring compliance with federal and state regulations. 3.1-52

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure a sanitary environment free of hazards on 4 of 4 halls where residents resided or received services. Findings include: During an observation on 3/24/24 at 10:15 AM. handrails on the 200, 300, 400, and 500 halls were observed to have bare portions missing finish. Baseboards were missing throughout the 100, 200, 300, 400, and 500 halls. Drywall on portions of the walls on each hall below the handrails had grey linear marks scattered throughout in too many locations to count. The bottom of the drywall had chipped, jagged edges observed on all halls. In an observation and interview on 3/27/24 at 9:45 AM the Maintenance Director indicated repairs had been delayed due to problems with the company contracted to install flooring throughout the building. A raised buckle in the vinyl plank flooring was observed on the 100 hall near the door to the maintenance office. The Maintenance Director indicated the flooring installers did not install the flooring correctly resulting in the raised area in the floor. He indicated he had contacted the flooring company requesting repair of this area and others throughout the building. He indicated he was not aware of any current plans for contractors to fix the flooring problems. He indicated the lower portions of the walls were to be painted, then baseboards applied, and handrails refinished after the flooring was laid. He indicated the flooring was completed about three months ago. During an observation and interview on 3/27/24 at 10:35 AM, a buckle in the flooring was observed in front of the door to room [ROOM NUMBER]. Buckled areas were also identified outside rooms 210, 308, 310, 311, 312, 314, 401, and 410. Qualified Medicine Aide (QMA) 2 indicated he noticed raised areas in the flooring throughout the halls and the flooring had not been installed properly. During an interview on 3/27/24 at 10:58 AM, the Executive Director (ED) indicated he began work for the facility in December 2023 and the flooring was complete at that time. He indicated he was not aware of any plans for repairs of the floor. He indicated the painting was in progress and he had not been aware of handrail concerns. A current policy titled Plant Operations last reviewed 7/12/23 provided by the ED on 3/27/24 at 11:12 AM indicated the facility should maintain a safe, clean, and structurally sound environment. 3.1-19(4)(f)