

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE 802 US Highway 20 East Michigan City, IN 46360	

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)
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>32664</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received the assistive devices needed to maintain hearing related to hearing aids not administered to a resident as per the physician's order for 1 of 2 residents reviewed for vision/hearing. (Resident 4)</p> <p>Finding includes:</p> <p>On 6/11/24 at 11:48 a.m., Resident 4 was observed sitting in the dining area with other residents. The resident kept saying huh when other people were talking. The resident did not have hearing aids observed to either ear.</p> <p>On 6/11/24 at 3:08 p.m., Resident 4 was sitting in a wheelchair in his room. The resident indicated he could not hear the questions being asked. The resident did not have hearing aids observed to either ear and was unaware where his hearing aids were.</p> <p>Record review for Resident 4 was completed on 6/11/24 at 3:11 p.m. Diagnoses included, but were not limited to coronary artery disease, heart failure, and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/26/24, indicated the resident was cognitively impaired. The resident had difficulty hearing and used a hearing aid. The resident required a partial moderate assistance for dressing the upper body.</p> <p>A Care Plan, dated 9/19/23, indicated the resident required extensive assistance from staff to complete his ADL (assistance of daily living) tasks of bed mobility, transfers, and limited assistance for meals. An intervention, dated 1/25/24, included for his hearing aids to be put in his ears in the morning and taken out at night time.</p> <p>A Care Plan, dated 4/2/24, indicated the resident had a communication problem related to hearing deficit. The resident had hearing aids which he removed at times and misplaced them under the bed, under dressers, and his covers. Interventions included to assist with hearing aids (left and right), remove hearing aids and place in container as needed, and search the resident's room if the resident, staff, or visitors report the hearing aids are missing.</p> <p>The June 2024 Physician's Order Summary indicated the following order:</p> <p>- Hearing aids in the morning and out at night time. Document when put in and removal at bedtime.</p> <p>(continued on next page)</p>

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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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The June 2024 Medication Administration Record and Treatment Administration Record did not have any documentation related to the hearing aid order.</p> <p>During an interview on 6/11/24 at 3:09 p.m., CNA 1 indicated she was unaware if the resident wore hearing aids.</p> <p>During and interview on 6/11/24 at 3:16 p.m., LPN 1 looked into her medication cart and could not find the resident's hearing aids. She indicated she believed the resident's hearing aids were lost and she would go to his room and look for them. The resident would take them out himself sometimes, set them down and lose them. The staff were supposed to put them in and take them out every day and put them in the medication cart. She was unaware if that was supposed to be documented anywhere.</p> <p>During an interview on 6/11/24 at 3::25 p.m., the Director of Nursing (DON) indicated she was not sure why the hearing aid order did not populate for the nursing staff to document the resident's hearing aids were put in and taken out each day. The facility had replaced the resident's hearing aids once because he had lost them. The staff were supposed to be making sure they had documented when they are put in and then taken out, and that they are placed into the medication cart after they are removed.</p> <p>3.1-39(a)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>32664</p> <p>Based on record review and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 3 of 5 residents reviewed for nutrition. (Residents 59, 14, and 42)</p> <p>Findings include:</p> <p>1. Record review for Resident 59 was completed on 6/12/24 at 3:11 p.m. Diagnoses included, but were not limited to, hypertension, dementia, and failure to thrive.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance with eating.</p> <p>A Care Plan, dated 1/11/24, indicated the resident had unplanned/unexpected weight loss related to poor food intake. Interventions included to alert the dietician when consumption was poor for more than 48 hours and to record food intake at each meal.</p> <p>The resident weighed 109 pounds on 11/30/23. A weight obtained on 6/7/24 indicated the resident weighed 97 pounds, which was a 11.01 % (percent) weight loss.</p> <p>The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals:</p> <ul style="list-style-type: none"> - Breakfast on 5/16/24, 5/22/24, 5/25/24, 5/26/24, 5/29/24, 6/1/24, 6/3/24, 6/9/24, 6/10/24, and 6/12/24. - Lunch on 5/18/24, 5/22/24, 6/10/24, and 6/12/24. - Dinner on 5/16/24, 6/9/24, 6/10/24, and 6/11/24. <p>During an interview on 6/13/24 at 1:20 p.m., the Director of Nursing (DON) indicated the CNAs were expected to document meal consumption percentage eaten in the computer under the Task section for Meal Consumption.</p> <p>48055</p> <p>2. On 6/13/24 at 12:15 p.m., Resident 14 was observed eating lunch. Resident 14 received a house shake with her lunch. Resident 14 consumed about 75% of her shake and ate about 50% of the food on her plate.</p> <p>The resident's record was reviewed on 6/13/24 at 11:26 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux disease without esophagitis, constipation, and type 2 diabetic mellitus with diabetic neuropathy.</p> <p>The Quarterly MDS assessment, dated 3/12/24, indicated the resident was cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Care Plan, dated 5/14/24, indicated to record Resident 14's food intake at each meal.</p> <p>Weight Assessments indicated the resident weighed 177 pounds on 1/12/24 and 162 pounds on 6/7/24, which was an 8.47% weight loss.</p> <p>The meal consumption logs indicated the following:</p> <p>5/17/24 - dinner meal was not documented</p> <p>5/18/24 - no meals were documented</p> <p>5/19/24 - breakfast and lunch meals were not documented</p> <p>5/20/24 - breakfast and dinner were not documented</p> <p>5/27/24 - dinner meal were not documented</p> <p>5/31/24 - breakfast and lunch meals were not documented</p> <p>6/6/24 - breakfast and lunch were not documented</p> <p>6/7/24 - no meals were documented</p> <p>6/8/24 - breakfast and lunch were not documented</p> <p>6/10/24 - no meals were documented</p> <p>During an interview on 6/13/24 at 2:35 p.m., the Assistant Director of Nursing (ADON) indicated the food consumption logs should have been completed for the resident.</p> <p>48383</p> <p>3. The record for Resident 42 was reviewed on 6/10/24 at 12:19 p.m. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), dementia, depression, muscle weakness, adult failure to thrive, anxiety, and left shoulder fracture.</p> <p>The Significant Change MDS assessment, dated 5/29/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating and oral hygiene required supervision or touching assistance. Lower body dressing, toileting and bathing required dependent assistance.</p> <p>A Care Plan, dated 4/12/24, indicated the resident had unplanned/unexpected weight loss related to poor intake. Interventions were to record food intake for each meal, and alert the dietician when supplements were not being consumed for more than 48 hours.</p> <p>The resident weighed 106 pounds on 2/27/24. A weight obtained on 5/24/24 indicated the resident weighed 87 pounds, which was a 28.57% weight loss in 3 months.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The meal consumption intake logs indicated the following:</p> <ul style="list-style-type: none"> - The breakfast meal was not documented on 5/15, 5/21,5/22, 5/25, 5/26, 5/30, 6/1, 6/8, 6/10, 6/11, and 6/12/24. - The lunch meal not documented on 5/22, 5/25, and 6/1/24. - The dinner meal was not documented on 5/18, 5/19, 6/3,6/4, 6/5, 6/9, and 6/10/24. <p>During an interview on 6/13/24 at 1:20 p.m., the DON indicated the CNAs were expected to document meal consumption percentage eaten in the computer under the Task section for Meal Consumption.</p> <p>A current facility policy titled, Nutritional Intake, provided by the Director of Nursing on 6/14/24 at 3:03 p.m., indicated the facility will document the nutritional intake on each individual resident.</p> <p>3.1-46(a)(1)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48383</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 2 of 3 residents reviewed for oxygen use. (Residents 42 and 48)</p> <p>Findings include:</p> <p>1. On 6/10/24 at 11:25 a.m., Resident 42 was observed lying in bed wearing oxygen via nasal cannula. The oxygen flow rate was set under 2 liters.</p> <p>On 6/10/24 at 12:04 p.m., the resident's oxygen was in place and the flow rate was set under 2 liters.</p> <p>On 6/11/24 at 11:59 a.m., the resident was observed lying in bed and oxygen was in place via nasal cannula. The flow rate was set just under 2 liters.</p> <p>On 6/11/24 at 3:36 p.m., the resident was observed asleep in bed. Oxygen was in place and the flow rate was set below 2 liters.</p> <p>The record for Resident 42 was reviewed on 6/10/24 at 12:19 p.m. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), dementia, depression, muscle weakness, adult failure to thrive, anxiety, and left shoulder fracture.</p> <p>The Significant Change Minimum Data Set (MDS) Assessment, dated 5/29/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating and oral hygiene required supervision or touching assistance. Lower body dressing, toileting and bathing required dependent assistance.</p> <p>A Care Plan, dated 4/25/24, indicated the resident received oxygen therapy. Interventions were to administer oxygen settings per physician orders and administer medications as ordered.</p> <p>A Physician's order, dated 4/25/24, indicated to administer oxygen via nasal cannula continuously at 2 liters/minute for hypoxia.</p> <p>The June 2024 Medication Administration Record (MAR) indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 6/10/24 and 6/11/24.</p> <p>During an interview on 6/12/24 at 11:34 a.m., the Director of Nursing (DON) indicated she would correct the resident's oxygen flow rate. No additional information was provided.</p> <p>2. On 6/10/24 at 9:18 a.m., Resident 48 was observed sitting in her wheelchair watching her phone. The resident wore oxygen via nasal cannula and the flow rate was set at 3.5 liters. The oxygen canister had an oxygen sticker label that was marked 2 liters in red.</p> <p>On 6/10/24 at 11:55 a.m., the resident was observed asleep in bed, her nasal cannula was in place and the oxygen flow rate was set at 2.5 liters.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/24 at 11:58 a.m., the resident's oxygen was in place via nasal cannula and the flow rate was set at 2.5 liters.</p> <p>The record for Resident 48 was reviewed on 6/11/24 at 3:19 p.m. The diagnoses included, but were not limited to, hemiplegia, heart failure, stroke, diabetes, hypertension (high blood pressure), and chronic obstructive pulmonary disease.</p> <p>The Quarterly MDS Assessment, dated 6/6/24, indicated the resident was cognitively intact for daily decision making. The resident had an impairment on one side of her upper and lower extremity. The resident used oxygen and a wheelchair.</p> <p>A Care Plan, dated 6/11/24, indicated the resident received oxygen therapy. Interventions were to administer oxygen settings per physician orders and to administer medications as ordered.</p> <p>A Physician's order, dated 6/3/24, indicated to administer oxygen via nasal cannula continuously at 2 liters/minute for shortness of breath.</p> <p>The June 2024 MAR indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 6/10/24 and 6/11/24.</p> <p>During an interview on 6/12/24 at 11:34 a.m., the DON indicated she would correct the resident's oxygen flow rate. No additional information was provided.</p> <p>3.1-47(a)(6)</p>		